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Sheepdog or watchdog? The role of statutory public involvement institutions in political management of the NHS, 1974-2010

by

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A thesis submitted in fulfilment of the requirements for the degree of
Doctor of Philosophy awarded by the University of London

July 2012

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Eleanor Ruth Carlyle

Abstract

Since 1974, governments have created a series of statutory public involvement institutions in the English NHS: Community Health Councils; Patient and Public Involvement Forums; Local Involvement Networks; and, from 2013, local Healthwatch. This study presents the role of these institutions as a puzzle, given the growth of alternative forms of public involvement. Public involvement in the NHS tends to be studied for its contribution to democratising the NHS or for its role in a choice-led consumer market, but these analyses generally focus on involvement led by NHS personnel or by independent patient organisations. This dissertation uses a different body of political science theory to assess roles that statutory public involvement institutions may play in Ministers' political management of the NHS.

One approach is to see these institutions as 'sheepdogs', rounding up and organising diverse groups, thus providing a form of corporatist interest intermediation. Alternatively, they could be 'watchdogs', raising the alarm when standards slip critically and thereby helping to safeguard the NHS against disasters. The explanatory value of these two interpretations is reviewed over the period 1974-2010, using policy documents and archive material, including the records of these organisations and the archives of public inquiries into problems in hospitals.

The findings suggest that at various times national political actors have used statutory public involvement institutions to manage the representation and mobilisation of interests and to alert them to problems in local health services. There is more recent evidence for the watchdog than for the sheepdog role. The watchdog role has been reappraised following the failure of statistical monitoring and regulatory police patrols to prevent disasters in the NHS. The discussion also shows how the sheepdog powers of these institutions mean that they can round up opposition, rather than moderating it, resulting in Ministerial reforms to statutory public involvement institutions.

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Flyer in figure 5.1 reproduced with the permission of Sharon Grant, former Chair of the Commission for Patient and Public Involvement in Health

Abbreviations

ACHCEW	Association of Community Health Councils for England and Wales
AHA	Area Health Authority
CHC	Community Health Council
CPPIH	Commission for Patient and Public Involvement in Health
CQC	Care Quality Commission
DHA	District Health Authority
DHSS	Department of Health and Social Security
FT	Foundation Trust
GP	General Practitioner (also known as a family doctor)
HA	Health Authority
HCC	Healthcare Commission
HC Deb	House of Commons Debate (Hansard reference)
LINK	Local Involvement Network
MP	Member of Parliament
NHS	National Health Service
NICE	National Institute for Clinical Excellence (later renamed the National Institute for Health and Clinical Excellence, but the original acronym was retained)
PALS	Patient Advice and Liaison Service
PCT	Primary Care Trust
PFI	Private Finance Initiative
PPI Forum	Patient and Public Involvement Forum
RHA	Regional Health Authority
RHB	Regional Hospital Board

Chapter One: Introduction to statutory public involvement

A Secretary of State for Health is faced with the complex task of overseeing the management of the National Health Service (NHS). The political aspects of management involve both oversight of expert health service providers and accountability to the public for NHS services. On the accountability dimension, many members of the public wish to influence the range of services that is available through the NHS. In particular, people who have an issue-specific concern, such as experience of living with a particular health condition, form groups that aim both to provide mutual support and to ensure that the NHS meets the needs of their members (Baggott, Allsop and Jones, 2005; Wood, 2000). NHS personnel also seek to engage the public, gathering their input into proposed changes to health services (Chambers, Drinkwater and Boath, 2003). In addition to these self-generating and NHS-led forms of public involvement, the state invests in statutory public involvement institutions. When first established in 1974, the statutory public involvement institutions cost £4 million annually; whilst this had fallen in real terms by 2010, the institutions still represented a significant investment at £24.4 million per year (Department of Health and Social Security and Welsh Office, 1979; Commissioning, Analysis and Intelligence Team, 2010). The state has created and funded a series of statutory public involvement institutions in England, abolishing and replacing each in turn: Community Health Councils; Patient and Public Involvement Forums; and Local Involvement Networks. Research into these institutions is timely, as the Government is planning a further reform, replacing Local Involvement Networks with local Healthwatch in 2013. Given the existence of alternative public involvement mechanisms, this study starts from the perspective that the state's ongoing investment in funding and reforming statutory public involvement institutions is something of a puzzle.

In this study, I identify theoretical approaches from the political science literature and use these to explore the role played by statutory public involvement institutions in the NHS. One approach is to see these institutions as 'sheepdogs', rounding up and organising the diverse patient and community groups that have an interest in NHS management and reform. Alternatively, they could be 'watchdogs', raising the alarm when standards slip critically and thereby helping to safeguard the NHS against scandals. These approaches cast light on national politicians' interest in the institutions and on the roles the institutions have played over time in political management of the NHS. They add to the existing literature, which tends to portray public involvement as a means either to support consumerism in the NHS or to reduce a democratic deficit (Lupton, Peckham and Taylor, 1998: 45). This chapter introduces the study. The opening section sets the

context for the study in terms of political management of the NHS. The second section introduces the research territory and presents the history of statutory public involvement institutions within the context of wider changes affecting the NHS. This leads into a discussion of self-generating interest groups and NHS-led engagement as alternatives to statutory public involvement institutions. The chapter closes by introducing the specific aims of this study, including an introduction to the forthcoming chapters.

1.1 Political management of the NHS

Under the Westminster model of government, the Secretary of State for Health is accountable nationally to the public for the locally-delivered National Health Service (Weale, 2003: 44). As a national politician, the Secretary of State needs to create the means to provide a form of accountability for the NHS at a local level, both for NHS decision-making processes and for the services that it delivers. Whilst involvement in local decisions can be seen as a means to address a democratic deficit, localising activity also provides tools for political management of the NHS. There are two major incentives in keeping these political management activities at a local level: on a practical basis, local experience of health services is needed to inform decisions and to identify problems; and on a more political basis, resolution of issues at a local level keeps problems at a distance from the Secretary of State. There is a fine line, however, between supporting local resolution of issues and ensuring that there is a means to gather intelligence nationally when it is needed, most notably when there are serious problems in local NHS services that could become disasters. Disasters in the NHS are likely to gain media attention and the centralised accountability mechanisms mean that Ministers may be blamed by the public for failure either to prevent the problem or to act swiftly enough to reduce its impact (Alaszewski and Brown, 2012: 138). A Secretary of State therefore needs both mechanisms that enable the public to participate locally and the means to ensure an alarm before a problem becomes a disaster.

This research starts from the premise that statutory public involvement institutions, as state-funded mechanisms granted powers by the state, may have roles to play in political management of the NHS. In this context, 'public involvement' refers to 'the involvement of members of the public in strategic decisions about health services and policy', rather than the involvement of individuals in decisions about their personal treatment and care (Florin and Dixon, 2004: 159). The 'public' therefore includes citizens with an interest in health services, not just patients who are active consumers of health

services at a given point in time (Klein, 1984: 20). The statutory public involvement institutions consist of local groups of volunteers supported by a paid secretariat. Working with committed volunteers could provide local intelligence to a Secretary of State, whilst keeping resolution of issues at a local level. Political management of the NHS extends beyond health policy to local service delivery (Moran, 1999: 4). Health services are experienced locally, but have never been fully devolved, leaving complex tensions over the balance of local and national responsibility (Dawson and Dargie, 2002: 50). The National Health Service enjoys unparalleled popularity amongst citizens as a public service (Salter, 1998: 1). This popularity makes it difficult for politicians to undertake reforms. Health services are experienced locally and, particularly in the case of hospitals, are visible locally. It is these visible hospital services for which a Secretary of State is accountable, rather than primary care services such as dentistry, pharmacy or the activity of General Practitioners (also known as family doctors) (Harrison and McDonald, 2008: 89). As part of strategies for national management of the NHS, a Secretary of State therefore needs to be able to manage the impact of local opposition to changes to local services, particularly changes to hospitals. This local experience of NHS services has implications for different dimensions to the political management of the NHS, whether limiting expenditure, overseeing professional activity in the NHS, demonstrating public accountability or managing interest groups.

Finite resources for the NHS mean that there will always be individuals whose health needs cannot be met. In a mature welfare state, the ageing population and the creation of expensive new medical interventions, often for conditions that were previously untreatable, mean that there is a climate of perpetual austerity (Pierson, 2001: 103). The welfare state retrenchment literature suggests that there has been a shift from an expanding welfare state to one that faces cost-constraints and has to be managed. Rather than politicians taking credit for the expansion of services, welfare state retrenchment highlights a new kind of politics in which politicians seek to avoid the spread of opposition (Pierson, 1994: 8). The National Health Service was established on 'the rhetorical promise' of citizen entitlements to health services, despite the reality that access to health services would always need to be rationed (Moran, 1999: 63). The rationing of health services is an emotive issue, which can generate adverse publicity for those who are seen to be putting the lives of citizens at risk. The reality of rationing is also unpopular with health professionals. When the NHS was first established, many health professionals hoped that the new service would enable them to practise their craft without financial inhibitions, only to find that they became agents for the state's rationing of resources

(Klein, 2006: 27). Many of the costs in the NHS, such as building costs, are fixed; the costs that vary are those for treatments that have been prescribed by health professionals. Managing the cost of NHS services therefore involves overseeing the activities of health professionals.

National politicians are dependent on health professionals to deliver health services. Within their specific areas of work, health professionals generally have greater expertise than the Ministers overseeing their activity; during the period between 1968 and 2012 none of the Secretaries of State for Health were medically qualified (Alaszewski and Brown, 2012: 39). Considered in terms of the roles played by Ministers and those played by health professionals, a Secretary of State may be seen as a principal who is dependent upon the activity of expert agents to deliver services. Where there are expert agents, they may seek to maximise the budget available to them in order to deliver what they perceive to be the best public service (Niskanen, 1971: 39). This presents national politicians with financial challenges, particularly in a context of limited resources. When politicians seek to introduce top-down reforms, Harrison and Pollitt suggest that governments tend to see health professionals as obstacles to change (1994: 5).

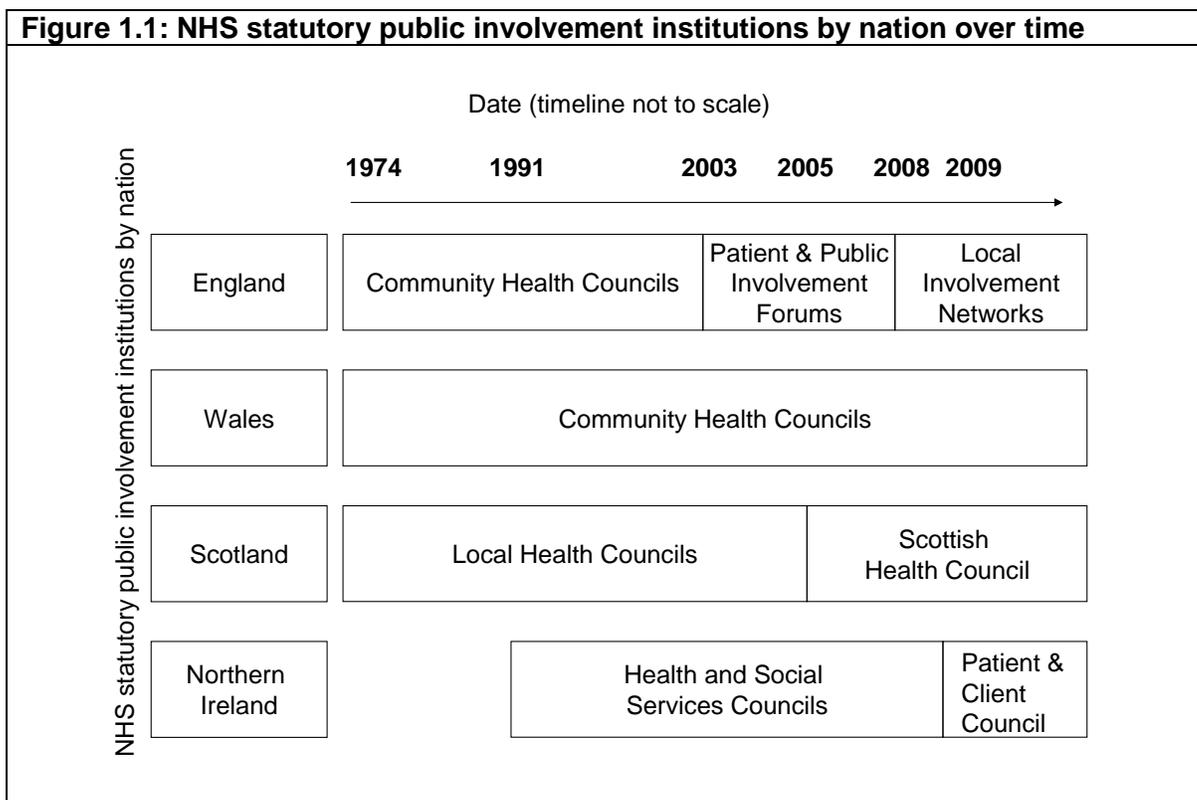
In addition to the politics of limiting budgets and introducing reforms, Ministers have to be confident of the quality of the services provided. This leads to the introduction of regulatory strategies to assure Ministers of the quality of services (Moran, 1999: 99). If a Secretary of State is accountable to the public for the NHS, then Ministers want to know that health professionals are providing a high-quality service and that there are regulatory mechanisms in place to reduce the risk of any high-profile disasters in NHS services. Disasters are not new phenomena, but there has been an increase in disasters that have been created through human intervention (as opposed to disease), for which members of the public blame Ministers (Alaszewski and Brown, 2012: 115-116). The pressures around being seen to respond to a disaster limit opportunities for rational decision-making processes (Alaszewski and Brown, 2012: 138). Creating regulatory mechanisms enables Ministers to oversee the quality of health services and helps them to retain accountability through oversight of the National Health Service.

There are several different forms of accountability within the NHS. Baggott distinguishes between managerial accountability of the NHS to Government, the political accountability of Government to Parliament and the clinical accountability of health professionals to patients (2004: 187). These forms are not entirely discrete, as clinical accountability of individual health professionals to individual patients, particularly since the introduction of a national quality framework in 1999, forms part of a managed mechanism

for clinical governance (Gray, 2004: 2). The clinical accountability of health professionals to individual patients then becomes integrated into management structures developed by governments and, since major structural changes require legislation, authorised by Parliament. Whilst there are connections between the different forms of accountability, they are different types of accountability: a patient is dependent on a health professional to deliver a medical service in a clinical relationship that is unconnected to the role played by that same patient as a citizen electing a Member of Parliament, unless the local Member of Parliament happens also to be the Secretary of State for Health. Where providing services to a particular patient impinges on the services available to the wider population, accountability of the NHS to that patient may be in conflict with accountability to a wider group of citizens (Cooper *et al.*, 1995: 4). The lack of a direct electoral relationship, whether local or national, between citizens and health service management, has been interpreted as a democratic deficit in health (Cooper *et al.*, 1995: 75). Weale discusses the implications of centralised political accountability for the National Health Service. He suggests that the national accountability has resulted in local health service issues being brought to the national agenda (Weale, 2003: 45). In this context, public involvement can be seen as a means both to devolve routine decisions and to act as a local collective voice that counterweights local professional dominance (Weale, 2003: 46-47).

One of the ways, I suggest, that governments have shaped public involvement into mechanisms for devolved decision-making and countering local professional expertise is through the creation of statutory public involvement institutions. In this study, I use the phrase 'statutory public involvement institution' to describe state-funded local volunteer-led groups established by governments and granted both public involvement roles and statutory powers. The precise structure and powers of the successive statutory public involvement institutions has varied over time. The NHS is increasingly devolved across the UK nations, which is also reflected in the statutory public involvement institutions (Greer, 2004a, 2004b). The variations over time and by nation are presented in Figure 1.1. There are five main characteristics to the institutions: they are local bodies; they are established and funded by the state; they are volunteer-led groups with voluntary members, supported by a paid secretariat; they have statutory powers, such as the authority to enter and inspect NHS premises; and they have statutory rights, generally the right to be consulted on proposed changes to local health services. The first institutions, Community Health Councils and Local Health Councils, were established in England, Wales and Scotland in 1974-75. Health and Social Services Councils in Northern Ireland started to operate in 1991. With the exception of Wales, where Community Health

Councils have been retained, there have been changes to the institutions in each UK nation since 2000. Where statutory public involvement institutions have been abolished, the institutions have been replaced. Given that these are state-funded bodies, they could have been abolished without replacement and there would have been opportunities for the voluntary members of statutory public involvement institutions to join interest groups or to get involved in NHS-led activities.



Changes to statutory public involvement institutions have been most marked in England. Community Health Councils (CHCs) were replaced by Patient and Public Involvement Forums (PPI Forums) in 2003, to be followed by Local Involvement Networks (LINKs) in 2008. The LINKs will in turn be replaced with local Healthwatch¹ in 2013. It is this succession of statutory public involvement institutions in England that is the focus of this study.

Funding and reforming institutions is a difficult and costly process, particularly as the voluntary members of statutory public involvement institutions are likely to have a high degree of commitment and not to want their organisations to be abolished. The ongoing funding suggests that the institutions fulfil a role for national politicians, which is not met by

¹ Initial consultation documents referred to local HealthWatch <sic>, but this was revised to local Healthwatch (without the capitalised W). The latter form is used in this document.

other forms of public involvement. As discussed in Section 1.3, both self-generating interest groups and NHS-led activity provide alternative forms of public involvement. Successive changes may reflect a deliberate re-shaping if the institutions evolve in ways that no longer meet political needs. An explicitly political approach to examining the role of these state-sponsored institutions complements existing studies of public involvement in the NHS and may increase understanding of the ways in which politicians seek to involve members of the public in the management of public services.

To provide a context for possible understandings of the roles these institutions may play in political management of the NHS, the next section discusses changes to the statutory public involvement institutions in England within the context of wider developments affecting the National Health Service.

1.2 The context for statutory public involvement, 1974-2010

Political management of the NHS varied considerably during the period of this study. The trends in the style of political management provide context both for apparent stability and for changes to statutory public involvement institutions. This section discusses changes to political management of the NHS, including changes to statutory public involvement institutions in England. The history of statutory public involvement institutions is covered in greater detail in Chapter Four and Chapter Five. This section closes with a timeline in Figure 1.2 charting the history of statutory public involvement institutions against major events affecting the NHS in England. The timeline includes references for relevant Acts of Parliament and Statutory Instruments. The focus of this study is from the creation of Community Health Councils in 1974 to the announcement in 2010 that Local Involvement Networks would be replaced by local Healthwatch. This discussion, however, starts from the point when Community Health Councils were proposed in 1971 and continues to the formal legislation in the *Health and Social Care Act 2012* that confirmed the replacement of Local Involvement Networks.

The phrase 'community health council' first appeared as part of proposals by the Conservative Keith Joseph within a consultation document on the future structure of the NHS (Secretary of State for Social Services, 1971a: §17; Hogg, 2009: 18). Edward Heath's Conservative government introduced the *NHS Reorganisation Act 1973* and associated statutory instrument *National Health Service (Community Health Councils) Regulations 1973*, but the two General Elections in 1974 resulted in Labour governments under Harold Wilson and so the Community Health Councils formed part of the

implementation of the NHS reorganisation under Labour. A Community Health Council was established in each District Management Team area, the most local level of NHS administration. The CHC members were appointees: half of the members appointed by local authorities; a third by local voluntary organisations; and a sixth by the Regional Health Authority overseeing that district. The guidance ensured that interest groups, particularly those representing more vulnerable communities, were represented within the CHCs' membership (Department of Health and Social Security, 1974a). The preceding NHS hierarchy had included a degree of local representation, with local authority appointees in the Hospital Management Committees. Community Health Councils provided a new form of local representation within the NHS (Klein and Lewis, 1976: 11).

The *NHS Reorganisation Act 1973* introduced a more structured hierarchy for the NHS, in which the prestigious teaching hospitals lost their independence (Klein, 2006: 71). The line of authority for the nationalised hospitals went directly to Ministers (Harrison and McDonald, 2008: 89). Incorporating hospitals was significant, as it gave politicians influence over the distribution of hospital services (Webster, 2002: 59). Barbara Castle and David Owen, as Secretary of State and Minister for Health, extended the powers of CHCs on the specific consultation issue of hospital closures. Whereas hospital closures had needed to be approved by the Secretary of State, Barbara Castle and David Owen gave CHCs the authority to agree a local hospital closure without the proposal needing to be considered by the Secretary of State (Department of Health and Social Security, 1974b). Plans for hospital development were controversial during the 1970s: there was a predominance of Victorian hospital buildings that were no longer fit for purpose; and the additional funding to develop new District General Hospitals under the 1962 hospital plan came to an end in 1972 (Alaszewski and Brown, 2012: 20, 23). In 1976, the Resource Allocation Working Party reviewed the distribution of NHS services on the basis of the need of local populations and found that there were more hospitals than necessary for the population in London and Oxfordshire and that there was a deficit in hospital services in the north of England (Webster, 2002: 85-87). This meant that there were unpopular decisions to be made in relation to the closure of hospitals in the south of England.

In the austerity of the 1970s, the Labour government was criticised for underfunding the NHS. This led to the establishment of the Royal Commission on the NHS, also known as the Merrison commission, to look into the management of human resources and finances (Crinson, 2009: 63; Ham, 2009: 26). Despite the financial crisis that called a halt to the expansion of public services, funding continued for CHCs themselves and for their support mechanisms. The Royal Commission on the NHS

proposed additional resources for Community Health Councils (Gerrard, 2006: 114). Its report, however, came out following the 1979 General Election and a change of Government. It was therefore the Conservative government of Margaret Thatcher that responded to the Royal Commission on the NHS.

The Conservative government's response to the Royal Commission was the *Patients first* consultation paper (Department of Health and Social Security and Welsh Office, 1979). The main thrust of *Patients first* was the need to reduce bureaucracy, replacing the tiers of District Management Teams and Area Health Authorities with the single tier of District Health Authorities (Ham, 2009: 27). As part of the reduction in NHS bureaucracy, respondents to *Patients first* were asked to consider whether there was a need for Community Health Councils as the smaller District Health Authorities would be 'more closely in touch with the needs of the community' (Department of Health and Social Security and Welsh Office, 1979: §26). Responses to *Patients first* affirmed public and professional support for Community Health Councils (Hogg, 2009: 42). A further consultation, *Community Health Councils in England*, stated that 'Ministers see CHCs as local bodies, representing the interests of their local population in the health service, and not having a role in the formation of policies at national level' (Department of Health and Social Security, 1981a: 1). Community Health Councils were asked to 'take the opportunity to consider' whether the national Association of Community Health Councils for England and Wales (ACHCEW) should continue (Department of Health and Social Security, 1981a: 6). ACHCEW was retained alongside the local Community Health Councils, but the Conservative government had demonstrated its willingness to consider changes to statutory public involvement institutions within structural changes to reduce bureaucracy in the NHS.

Ministers in the Conservative government had hoped that granting greater discretion to District Health Authorities would mean that less national input was needed in steering the NHS, but economic austerity meant that a more direct role was needed to control NHS expenditure (Harrison and McDonald, 2008: 90). Rather than making further structural changes to the NHS, Ministers introduced a new management approach (Harrison and McDonald, 2008: 90-91). This new management approach drew upon expertise from the retail sector. Initially, Ministers focused on curtailing costs by commissioning Derek Rayner, from the retail chain Marks and Spencers, to review the efficiency of the NHS (Webster, 2002: 166). This was followed by a wider inquiry into management within the NHS by Roy Griffiths, Chairman of the Sainsbury's retail group (Klein, 2006: 117). In a now-famous statement, Griffiths suggested that 'if Florence

Nightingale were carrying her lamp through the corridors of the NHS today, she would almost certainly be searching for the people in charge' (Department of Health and Social Security, 1983: General Observation 5). Griffiths proposed the introduction of general managers overseeing the activity of clinical personnel. Within a general management framework, Griffiths refers to Community Health Councils briefly as a means to gather feedback from consumers (Department of Health and Social Security, 1983: §30).

Through the emphasis on general management and efficiency, Ministers aimed to restrain NHS expenditure in order to make the choice of private healthcare more attractive (Pierson, 1994: 133). A market with the choice of private healthcare fitted a Conservative ideology, but market advocates in the 1980s were restricted by the lack of substantive alternatives to the NHS for much of the population (Pierson, 1994: 132; Hogg, 1999: 32). In the early-to-mid 1980s, policies were put into place to make private health insurance more affordable and regulations on the medical profession were relaxed, so that it became easier for NHS doctors to see patients privately (Pierson, 1994: 133). Rumours of reviews of NHS funding, including the possibility of moving away from a centrally-funded health service, created a difficult atmosphere for the Conservatives – resulting in statements such as Margaret Thatcher declaring in 1982 that the NHS is 'safe in our hands' (Webster, 2002: 154-155). The popularity of the NHS, alongside the lack of a viable alternative in the private sector, meant that Ministers were reluctant to introduce market-based reforms in the 1980s (Crinson, 2009: 64). It was clear by 1988 that a privatised alternative to the NHS was not possible and that radical approaches to funding, such as compulsory health insurance, needed to be considered (Pierson, 1994: 134).

The radical alternative developed by the Thatcher government was an 'internal market', splitting purchasers from providers. Plans for the internal market were announced in the 1989 White Paper *Working for patients*. Within the internal market, hospitals were encouraged to opt out of District Health Authority management and to compete for patients (Crinson, 2009: 65). General Practitioners had the opportunity to become fund-holding GPs; the fund-holding GPs were granted budgets and so became the purchasers of services from hospitals and other health service providers. The internal market provided a form of choice, but the selection was made by a fund-holding GP rather than the patient, so the selection of services did not provide direct consumer feedback. *Working for patients* referred to Community Health Councils in England, as being 'a channel for consumer views' (Secretaries of State for Health, Wales, Northern Ireland and Scotland, 1989: 66). Community Health Councils were therefore framed as a means to provide feedback to NHS management in order to improve services. John Major, Margaret

Thatcher's successor as Prime Minister, continued to develop the internal market, producing the first guidance on market management in 1994 (Ham, 2009: 43). Despite being encouraged to take on a fund-holding role, over half of General Practitioners in 1997 had not taken on fund-holding status (Crinson, 2009: 65). It was therefore a partial internal market. Whilst Community Health Councils were cited in the policy documentation as a means to gather consumer feedback, NHS-led alternative mechanisms were also encouraged, as discussed in Section 1.3.

The 1997 General Election brought Labour into power. The new Government proposed to reform the internal market into an integrated care system, based on partnership and driven by performance (Secretary of State for Health, 1997). Instead of GP fund-holding, GPs were encouraged to collaborate through primary care organisations, which from 2000 became Primary Care Trusts, holding the majority of the NHS budget and commissioning services from hospitals and other health service providers (Harrison and McDonald, 2008: 94-97). In essence, Labour's modernisation of the NHS balanced the market with command-and-control style regulation (Klein, 2006: 216). From 1999, standards were set by the National Institute for Clinical Excellence (NICE), establishing guidelines for clinical management of health conditions and judging whether it was cost-effective to make drugs and other treatments available to NHS patients. Implementation of NICE guidance was fostered by the Commission for Health Improvement, which conducted clinical audit reviews of NHS services (Webster, 2002: 248). The combination of guidance from NICE and review by the Commission for Health Improvement provided a clear quality framework within the NHS for the first time.

Initially, New Labour seemed to show greater interest in Community Health Councils than the preceding Conservative government had done. A new All-Party Parliamentary Group on CHCs attracted 240 MPs as participants, many of whom had been CHC members (Hogg, 2009: 110). Community Health Councils did not fit the modernisation agenda for the NHS, however, and Alan Milburn announced the abolition of Community Health Councils and ACHCEW within the White Paper *The NHS plan: a plan for investment, a plan for reform*. The public involvement functions, including the statutory rights to enter and view services, were to be transferred to 'patients' forums' (later renamed Patient and Public Involvement Forums) and support for complainants was transferred to Patient Advocacy and Liaison Services (later renamed Patient Advice and Liaison Services, or PALS) (Secretary of State for Health, 2000: 93). Patient Advice and Liaison Services were NHS functions run by NHS staff, whereas PPI Forums were statutory groups of volunteers supported by a paid secretariat. It was therefore PPI

Forums that succeeded Community Health Councils as statutory public involvement institutions. Initially, legislation to abolish Community Health Councils in England was included in the *Health and Social Care Bill 2001*, alongside a new duty placed on NHS organisations to consult the public on proposed changes to NHS services. There was considerable opposition to the abolition of CHCs and the changes were deferred until after the 2001 General Election, passing into legislation in the *National Health Service Reform and Health Care Professions Act 2002*. Concerns about the changes led to a small-scale inquiry by the House of Commons Health Committee into public involvement in the NHS (House of Commons Health Committee, 2003). Community Health Councils in England and the Association of Community Health Councils for England and Wales were abolished in November 2003.

Patient and Public Involvement Forums (PPI Forums) replaced CHCs in December 2003. The Commission for Patient and Public Involvement in Health (CPPIH) recruited members for the PPI Forums. Under the *Commission for Patient and Public Involvement in Health (Functions) Regulations 2002*, CPPIH was responsible for providing the secretariats to support PPI Forums and for coordinating the PPI Forums' activity. This centralised activity reflects a greater emphasis on consistency and regulation in the NHS. CPPIH set up a PPI Forum for each of the NHS trusts; in most cases these were hospitals, but also included specialist trusts, such as ambulance services, and Primary Care Trusts. A public inquiry into the deaths of babies following heart surgery at the Bristol Royal Infirmary stated that 'the involvement of patients and the public in the NHS must be embedded in its structures' (Secretary of State for Health, 2001: 19). The Department of Health responded that 'we agree that the voices of citizens, patients and their carers should be on the inside' and the alignment of PPI Forums with NHS trust structures reflects this (Secretary of State for Health, 2002: 12). Initially, there were 572 PPI Forums, although the precise number shifted over time as trusts merged or changed boundaries (Hogg, 2009: 134).

Whilst PPI Forums were being established and developed, there were significant changes within the NHS that had implications for public involvement. Firstly, plans were made for the creation from 2004 of Foundation Trusts. NHS trusts that demonstrated good governance could apply to become Foundation Trusts and were then granted greater autonomy. Foundation Trusts provided new ways for local communities, patients and NHS personnel to become involved in decisions, including rights to be elected to governing boards (Baggott, 2005: 543). The Government confirmed that each Foundation Trust should still have a PPI Forum, but the existence of two forms of trust-level public

involvement created some confusion (Baggott, 2005: 543). Secondly, greater co-ordination across health and social care was planned as part of the 2006 reorganisation of the NHS (Ham, 2009: 67). Encouraging activity across health and care enabled regulators to consider the complete experience of a patient or carer and made the institution-specific role of the PPI Forums less relevant. Thirdly, consumer choice emerged as a stronger expectation, with patients gaining the right from 2006 to choose from at least four providers proposed by their General Practitioner (Klein, 2006: 234). If choices were made by patients as direct consumers of health services, rather than by fund-holding GPs on their behalf, the choices made by consumers rather than a collective voice on behalf of the community could be used to inform NHS service developments.

The Commission for Patient and Public Involvement in Health was given a very short life in which to prove itself as a model of national co-ordination for statutory public involvement institutions. In July 2004, a review of the Department of Health arm's-length bodies resulted in the decision to abolish CPPIH (Hogg, 2009: 140). An expert panel on patient and public involvement in health was set up following this decision (Department of Health, 2006a). On the basis of the expert panel's findings, Rosie Winterton, as Minister of State for Health Services, announced in July 2006 that PPI Forums would be abolished as well as the Commission (Department of Health, 2006b). The phrase suggested by the expert panel to describe looser mechanisms through which people could get involved was 'local involvement networks'. This phrase was used as the name of the new organisational structure, introduced in the *Local Government and Public Involvement in Health Act 2007*. Under the terms of the Act, PPI Forums were abolished and replaced by Local Involvement Networks (LINKs) with effect from April 2008. The House of Commons Health Committee took a keen interest in this further change to statutory public involvement institutions in the NHS and conducted a second, more extensive, inquiry into public involvement in the NHS (House of Commons Health Committee, 2007a, 2007b, 2007c). The committee members expressed disquiet at a further change to statutory public involvement institutions and concern that 'the Government has taken insufficient account of the cost of change' (2007a: 88).

Unlike their predecessors, Local Involvement Networks were granted a remit covering both health and social care. Reflecting this remit, arrangements for supporting Local Involvement Networks were established by local authorities, the bodies overseeing social care. As part of the 2006 reorganisation of the NHS, the number of Primary Care Trusts had been reduced from 303 to 152, aligned with the boundaries of local authorities (Ham, 2009: 67). The boundaries for LINKs were set up to follow these combined local

authority and Primary Care Trust areas. Local Involvement Networks did not have a centralised recruitment process or a definitive membership model. Each LINK could establish its own membership structure and, unlike PPI Forums, LINKs could include local voluntary organisations as members. Under the *Local Involvement Network Regulations 2008*, the LINKs were required to produce a list of authorised representatives who could enter and inspect NHS premises on the behalf of the LINK. The regulations required NHS and social care organisations to admit authorised LINK representatives to enable them to inspect premises. Service providers were also required to respond within 20 days to any requests for information or comments made by LINKs. The combined health and social care remit granted to LINKs when they were established in April 2008 was reflected in the combination of regulators for health and social care from April 2009 in the form of the Care Quality Commission (Ham, 2009: 71).

A new Conservative / Liberal Democratic Coalition government took office in May 2010. The Secretary of State, Andrew Lansley, had held the lead for health in the Shadow Cabinet during six years of Labour government and had plans to reshape the NHS. On 22 June 2010, Andrew Lansley launched the Coalition government's consultation on 'increasing democratic legitimacy in health', including the proposal to transfer Local Involvement Networks into a new set of organisations, local Healthwatch (Department of Health and Communities and Local Government, 2010). Rather than a further abolition and replacement, the proposal was to encourage existing LINKs to become the new local Healthwatch groups. The announcement came thirteen days after Andrew Lansley announced that there would be a full public inquiry into the events at the Mid Staffordshire NHS Foundation Trust, following earlier investigations that had included criticisms of the Stafford Hospital PPI Forum and the Staffordshire LINK in turn for failing in turn to alert authorities to the extent of problems at the hospital (Healthcare Commission, 2009; Francis, 2010a; Wood and Cunnett, 2009a, 2009b). Arrangements for local Healthwatch and a national body, Healthwatch England, were included in the *Health and Social Care Act 2012*. The transition was incorporated into a major reorganisation of the NHS, including the abolition of Strategic Health Authorities and the replacement of Primary Care Trusts with smaller, clinically-led commissioning groups. Arrangements for establishing the statutory public involvement institutions remained with the local authorities, a point of stability in the midst of major changes in the NHS.

The changes to statutory public involvement institutions and concurrent developments affecting the NHS are summarised in the timeline in Figure 1.2. Each replacement, including the proposed replacement as part of *Patients first*, of the statutory

public involvement institutions took place as part of wider structural changes in the NHS. In part, this is a reflection of the statutory nature of the institutions and the need for legislation to abolish them or to change their powers. Changes to statutory public involvement institutions were therefore likely to be incorporated into wider Acts of Parliament. The timeline also shows that alternative forms of public involvement have been encouraged at different points in time. Some of these are NHS-led forms of public involvement and some promote greater activity with self-generating interest groups, particularly patients' organisations, in the voluntary sector. As discussed in Section 1.3, these forms provided Ministers with alternatives to replacing statutory public involvement institutions and form part of the puzzle of ongoing investment.

Figure 1.2 Timeline for the history of statutory public involvement institutions against major events affecting the NHS in England		
Year	Major developments affecting NHS	Statutory public involvement institutions
1971		Keith Joseph proposes Community Health Councils (CHCs) as part of <i>NHS reorganisation: consultative document</i> ²
1973	<i>NHS Reorganisation Act 1973</i>	CHCs included in Act and subsequent statutory instrument ³
1974	Two General Elections: Labour minority government followed by Labour majority of 4 seats	Guidance on CHC appointments issued by Conservative government ⁴ ; 184 CHCs established; Barbara Castle includes right of CHCs to agree hospital closures in <i>Democracy in the NHS</i> ⁵
1975		David Owen announces steering committee to consider national council for CHCs; DHSS funding starts for <i>CHC News</i>
1976	Resource Allocation Working Party (RAWP) reports on redistribution of NHS services according to need; Royal Commission on the NHS established	Decision of the majority of CHCs to form the Association of CHCs for England and Wales
1977		Association of CHCs for England and Wales (ACHCEW) formed
1978	Normansfield Hospital Inquiry	Local CHC praised by Normansfield inquiry
1979	General Election: Conservative government majority of 43 seats; Report of the Royal Commission on the NHS ⁶	Royal Commission on the NHS proposes more resources for CHCs; <i>Patients first</i> ⁷ consultation questions the need for CHCs

² SECRETARY OF STATE FOR SOCIAL SERVICES, 1971. *NHS reorganisation: consultative document*. London: Cabinet Papers.

³ *National Health Service (Community Health Council) Regulations 1973*, S.I. 2217 of 1973, London: Her Majesty's Stationery Office.

⁴ DEPARTMENT OF HEALTH AND SOCIAL SECURITY, 1974. *NHS reorganisation circular: Community Health Councils*. HRC (74) 4. London: Department of Health and Social Security.

⁵ DEPARTMENT OF HEALTH AND SOCIAL SECURITY, 1974. *Democracy in the National Health Service*. London: Department of Health and Social Security.

⁶ ROYAL COMMISSION ON THE NATIONAL HEALTH SERVICE, 1979. *Report*. Cmnd. 7615. London: Her Majesty's Stationery Office.

Year	Major developments affecting NHS	Statutory public involvement institutions
1980	Reduction in layers of NHS bureaucracy, merging Area and District levels	Following <i>Patients first</i> responses, announcement that CHCs will remain, but functions will be reviewed
1981		<i>Community Health Councils in England</i> ⁸ consultation queries need for ACHCEW; DHSS announces withdrawal of central ACHCEW funding over two years
1982	First Rayner review	DHSS funding for <i>CHC News</i> withdrawn
1983	General Election: Conservative government majority of 144 seats Griffiths report ⁹ proposes general management in the NHS; Managers encouraged to gather consumer feedback	Griffiths supports CHCs as means to gather consumer feedback; ACHCEW in financial crisis
1985		DHSS restores central grant to ACHCEW; CHCs lose right to agree hospital closures
1987	General Election: Conservative government majority of 102 seats	
1988		Statutory rights of CHCs to access information reaffirmed ¹⁰
1989	<i>Working for patients</i> ¹¹ White Paper proposes NHS internal market	CHCs as means of gathering consumer feedback and representing the community in <i>Working for patients</i>
1990	<i>NHS and Community Care Act 1990</i> implements internal market	
1992	General Election: Conservative government majority of 21 seats; <i>Local voices</i> ¹² encourages involvement of local voluntary sector	
1996		Right to establish CHCs transferred to Secretary of State and delegated to regional offices of the NHS Executive ¹³
1997	General Election: Labour government majority of 179 seats	
1998	First Compact between Government and the voluntary sector ¹⁴	
1999	<i>Patient and public involvement in the new NHS</i> encourages NHS-led involvement ¹⁵	

⁷ DEPARTMENT OF HEALTH AND SOCIAL SECURITY AND WELSH OFFICE, 1979. *Patients first: consultative paper on the structure and management of the National Health Service in England and Wales*. London: Her Majesty's Stationery Office.

⁸ DEPARTMENT OF HEALTH AND SOCIAL SECURITY, 1981. *Community Health Councils in England: consultation paper on role and membership*. London: Department of Health and Social Security.

⁹ DEPARTMENT OF HEALTH AND SOCIAL SECURITY, 1983. Letter to Health Authority Chairmen, *DHSS Circular*. HC (84) 13. London: Department of Health and Social Security. [The Griffiths report]

¹⁰ *Community Health Councils (Access to Information) Act 1988*. London: Her Majesty's Stationery Office.

¹¹ SECRETARIES OF STATE FOR HEALTH, WALES, NORTHERN IRELAND AND SCOTLAND, 1989. *Working for patients*. London: Her Majesty's Stationery Office.

¹² NHS MANAGEMENT EXECUTIVE, 1992. *Local voices: the views of local people in purchasing for health*. London: NHS Management Executive.

¹³ *Community Health Councils Regulations 1996*, S.I. 640 of 1996, London: The Stationery Office.

¹⁴ SECRETARY OF STATE FOR THE HOME DEPARTMENT, 1998. *Compact on relations between Government and the voluntary and community sector in England*. London: Central Office of Information.

¹⁵ DEPARTMENT OF HEALTH, 1999. *Patient and public involvement in the new NHS*. London: Department of Health.

Year	Major developments affecting NHS	Statutory public involvement institutions
2000	<i>The NHS plan</i> White Paper ¹⁶ provides additional NHS funding in return for reforms	Abolition of CHCs announced in <i>The NHS plan</i> , to be replaced by 'patients' forums'
2001	General Election: Labour government majority of 167 seats; Bristol Royal Infirmary inquiry published; <i>Health and Social Care Act 2001</i> Section 11 introduces duty of NHS to consult the public	
2002		<i>National Health Service Reform and Health Care Professions Act 2002</i> abolishes CHCs and establishes Commission for Patient and Public Involvement in Health (CPPIH) and 'patients' forums' (PPI Forums)
2003	First House of Commons Health Committee inquiry into public involvement in the NHS	CPPIH starts formal role with PPI Forums; ACHCEW and CHCs abolished; 572 PPI Forums established
2004	First Foundation Trusts established	Review of Department of Health arm's-length bodies proposes abolition CPPIH
2005	General Election: Labour government majority of 66 seats	
2006	<i>Our health, our care, our say</i> ¹⁷ White Paper promises patients choice of GP and hospital; NHS reorganisation aligns boundaries of local authorities and Primary Care Trusts; <i>National Health Service Act 2006</i> Section 242 reaffirms duty of NHS to consult the public	NHS Centre for Involvement opens; <i>A stronger local voice</i> ¹⁸ proposes Local Involvement Networks (LINKs); PPI Forums' abolition announced
2007	Second House of Commons Health Committee inquiry into public involvement in health	<i>Local Government and Public Involvement in Health Act 2007</i> abolishes PPI Forums and CPPIH to be replaced by LINKs
2008		Closure of CPPIH and PPI Forums; 152 LINKs established
2009	Healthcare Commission publishes investigation into Stafford Hospital	NHS Centre for Involvement closes
2010	General Election: Conservative / Liberal Democrat coalition Renewed Compact ¹⁹ with voluntary sector; Independent inquiry by Robert Francis reports on Stafford Hospital	Consultation ²⁰ on transfer from LINKs to local Healthwatch is one of the first consultations by the new Coalition government

¹⁶ SECRETARY OF STATE FOR HEALTH, 2000. *The NHS plan: a plan for investment; a plan for reform*. London: The Stationery Office.

¹⁷ SECRETARY OF STATE FOR HEALTH, 2006. *Our health, our care, our say: a new direction for community services*. London: The Stationery Office.

¹⁸ DEPARTMENT OF HEALTH, 2006. *A stronger local voice: a framework for creating a stronger local voice in the development of health and social care services; a document for information and comment*. London: Department of Health.

¹⁹ CABINET OFFICE, 2010. *The Compact: the Coalition Government and civil society organisations working effectively in partnership for the benefit of communities and citizens in England*. London: Cabinet Office.

²⁰ DEPARTMENT OF HEALTH and COMMUNITIES AND LOCAL GOVERNMENT, 2010. *Liberating the NHS: local democratic legitimacy in health; a consultation on proposals*. London: Department of Health.

1.3 Alternative forms of public involvement in the NHS

Statutory public involvement institutions represent a particular form of public involvement in the NHS. As outlined in Section 1.2, Ministers have invested to varying degrees in reshaping and reforming statutory public involvement institutions since their inception. Alongside these statutory public forms of public involvement, Ministers have sometimes encouraged NHS-led forms of involvement and Ministers have also supported to differing degrees activity with self-generating interest groups in the voluntary sector. Given the existence of these alternative forms of public involvement, the ongoing investment in funding and reforming statutory public involvement institutions suggests that the statutory form of involvement provided a benefit for Ministers that was not met through self-generating interest groups or NHS-led participation. The following discussion considers the roles played by self-generating interest groups and by NHS-led public involvement in turn.

A high proportion of health care was provided under the auspices of voluntary organisations prior to the establishment of the NHS in 1948 (Hatch, 1984: 104). These voluntary organisations were often charitable institutions set up by local communities or by religious groups to provide care. During the 1950s and 1960s, groups based around specific medical conditions started to take on new roles in representing the interests of their constituents in the nationalised health service (Hatch, 1984: 105). The number of such patient organisations and other self-generating interest groups has increased significantly since the 1970s (Coulter, 2011: 165; Wood, 2000: 39). Interest groups started to promote the needs of their users, notably for users of mental health and maternity services, before the NHS started to take a managerial interest in consumer views in the 1980s (Barnes, 1999a: 73). Self-generating interest groups tend to focus on the needs of a specific community. In the health sector, interest groups usually consist of people with a particular health condition, although there are also 'Leagues of Friends' that support specific NHS institutions. Some groups have specific objectives and disband or change focus after these objectives have been met (Williamson, 2010: 11). Many groups, however, commenced as organisations for self-help amongst members and then, on discovering that members had problems which could only be resolved by changing the way that services were offered, started to campaign for change (Baggott, 2005: 535).

The Thatcher governments portrayed interest groups as selfish and their dominant response was to ignore particularly active groups, such as the Child Poverty Action Group (Pierson, 1994: 158). Pierson suggests that interest groups in the United Kingdom were

traditionally less influential than their counterparts in the United States, so the Thatcher government did not see reducing their power or managing their involvement as a priority (1994: 158). The major health issue that generated activity in the voluntary sector during the 1980s was the discovery of human immunodeficiency virus (HIV), the precursor to acquired immunodeficiency syndrome (AIDS). Early activists, such as representatives of the Terrence Higgins Trust, were mainly gay young men who did not observe the conventions of the core policy-making group in either dress or speech (Alaszewski and Brown, 2012: 93). Alaszewski and Brown suggest that their 'otherness' meant that they were treated with caution and not provided with information 'in case they made it available to the media' (2012: 93).

In 1992, the NHS Management Executive published *Local voices*, which encouraged NHS organisations to consult local interest groups (NHS Management Executive, 1992). As part of the developing market of alternatives to statutory health and social care services, some interest groups started to take on contracts to provide services (Harris, Rochester and Halfpenny, 2001: 5; Nevile, 2010). This changed the relationship between the state and interest groups, leading to the first compact between the Government and the voluntary sector shortly after the Labour government took office in 1997 (Secretary of State for the Home Department, 1998). The compact sets out codes of behaviour between the sectors, including consultation and contracting for services (Martin, 2011: 911).

At a national level, Baggott, Allsop and Jones discovered that since the 1990s issue-specific health groups in the voluntary sector have started to work together in broader alliances on policy-related matters, so that other healthcare stakeholders could not 'take advantage of differences between groups' (2005: 151). Baggott and his colleagues found that 'the desire for greater policy influence' was the main reason why voluntary groups in the health sector joined alliances (Baggott, Allsop and Jones, 2005: 183-184). The increasing influence of interest groups at the national level was reflected in the inclusion of voluntary sector representatives as co-signatories of *The NHS plan* (Secretary of State for Health, 2000: 6-7). The relationship between Government and the voluntary sector was renewed by the Coalition government of 2010 in an updated version of the compact (Cabinet Office, 2010). The increasing role of the voluntary sector in policy has provided national politicians with the opportunity to consult with the sector, rather than investing in funding and reforming statutory public involvement institutions.

The second main alternative to statutory public involvement institutions is the engagement activity that is led by NHS personnel. Since the Griffiths report on NHS

management in 1983, NHS personnel have been encouraged to seek feedback from consumers of health services in order to improve the services provided (Department of Health and Social Security, 1983). During the 1990s, innovative mechanisms were promoted to enable NHS personnel to engage with the public at a local level: this encouragement came both from Government and from think tanks such as the King's Fund. The King's Fund experimented with citizens' juries as a means to involve the public in complex choices about health services (McIver, 1998). Unlike juries in a court of law, citizens' juries in health services did not make decisions but provided evidence that could be considered by NHS managers alongside other sources (Mort, Harrison and Dowswell, 1999: 105). Harrison and Mort found in the late 1990s that NHS-facilitated public involvement exercises were often led by public relations or communications personnel and that public involvement was used as a 'legitimation strategy' to justify actions (1998: 64, 67).

The emphasis on NHS-led public involvement increased following the election of a Labour government in 1997. The 1999 guidance *Patient and public involvement in the new NHS* encouraged NHS personnel to involve members of the public in decisions at all levels of the NHS (Department of Health, 1999). This was followed by the creation of a new duty to consult the public on planned changes to services. The duty placed on the NHS to consult the public replaced the right of Community Health Councils to be consulted on proposed changes. The duty to consult was enshrined in Section 11 of the *Health and Social Care Act 2001* and later reaffirmed in the *National Health Service Act 2006* Section 242. The Department of Health published a two-part guide to the duty to involve patients and the public (2003a; 2003b). In the introduction to the guide, the Parliamentary Under Secretary for Health, David Lammy, described NHS-led public involvement in terms of 'strengthening accountability to local communities' and the guidance notes were entitled *Strengthening accountability* (Department of Health, 2003a: iii). By contrast, publications on NHS-led public involvement written by NHS personnel describe involvement as a means to improve services, essentially taking a consumerist approach to involvement as feedback to refine service provision (as examples, Bate and Robert, 2007; Chambers, Drinkwater and Boath, 2003; Tritter *et al.*, 2004). Local public involvement through NHS institutions was encouraged as part of the creation of NHS Foundation Trusts, incorporated into their membership arrangements (Department of Health, 2002: 15). This role in Foundation Trusts emphasises involvement of the public by the NHS as part of public accountability, although feedback from members also contributes towards service improvement. At the national level, members of the public were involved in developing

guidelines and monitoring standards through the National Institute for Clinical Excellence and the Commission for Health Improvement (Davies, Wetherell and Barnett, 2006: 21).

Interest groups and NHS-led engagement provide contrasting alternatives to statutory public involvement institutions as mechanisms for local participation. The potential to encourage either of these forms of public involvement provided Ministers with options for involving the public in the NHS. The repeated decision to invest in funding and reforming local statutory public involvement institutions suggests that the institutions fulfilled a role for Ministers that was not met either by self-generating interest groups or by NHS-led public involvement. In this study, I examine potential roles the institutions may play in political management of the NHS, providing a potential rationale for the ongoing investment in statutory public involvement institutions.

1.4 Focus of this study

In this study, I aim to add to the existing perspectives on public involvement by exploring the roles statutory public involvement institutions may have played over time in Ministers' political management of the NHS. This section summarises the elements in each of the chapters and the approaches taken to examining possible roles.

This chapter introduced the statutory public involvement institutions as potentially playing a role in political management of the NHS. The literature on public involvement in the NHS is discussed in Chapter Two. The literature review considers the existing approaches to examining public involvement specifically. It also reviews some of the broader issues in health service politics that are presented in the politics of health literature, but tend not to be drawn upon explicitly for studies of public involvement in the NHS. The chapter includes existing approaches to understanding the successive abolitions and replacements of statutory institutions.

Chapter Three presents the research framework. This integrates the research questions, the theoretical background to the research questions and the methods selected for this study. The principal research question for the study is: **what role(s) have statutory public involvement institutions played in political management of the English NHS, 1974-2010?** Two potential roles are examined. The first of these considers statutory public involvement institutions as a form of interest group intermediation, drawing upon a corporatist approach. In these terms, a statutory public involvement institution is presented as a 'sheepdog', rounding up participants. This gives rise to the first sub-question: **do the institutions act as 'sheepdogs' rounding up participants and**

managing potential opposition? Alternatively, statutory public involvement institutions may act as ‘watchdogs’, alerting national politicians to problems before they become disasters. This takes an approach from the legislative oversight literature, in which alarms raised by groups of volunteers may provide an alternative or complement to a professional police-patrol-style regulator. This is captured in the second sub-question: **do the institutions act as ‘watchdogs’ preventing disasters in the NHS?** As the research question examines these roles over a long time-frame, a documentary analysis approach was selected for this study. The first sub-question, or sheepdog role, is examined using policy documentation and materials from the archives of the statutory public involvement institutions themselves. The watchdog role is reviewed through the archives of public inquiries into disasters in the NHS, to assess whether any expectation is expressed that statutory public involvement institutions could or should have alerted Ministers to the problems before they became disasters. The selection of sources is discussed as part of the research framework in Chapter Three.

Chapters Four, Five and Six present the core empirical material in the study. The focus in Chapters Four and Five is on the potential of a sheepdog role. Chapter Four considers the period from 1974, when Community Health Councils were first established, to 1997, which introduced the Labour government that abolished Community Health Councils. The analysis of this period draws on policy documentation and archives from the statutory public involvement institutions to assess whether Community Health Councils acted as sheepdogs and rounded up interests in ways that could support political management of the NHS. Chapter Five takes a similar approach, but reviews materials over the period from 1997 to 2010. This period covers the successive changes between Community Health Councils, PPI Forums and Local Involvement Networks.

The second potential role examined in this study is that of a watchdog alerting politicians to problems before they become disasters. This is examined in Chapter Six using data from archives on public inquiries into disasters in the NHS. Four public inquiries were selected to provide insights at different points in time: Ely Hospital, Cardiff, 1969; Normansfield Hospital, Teddington, 1978; Bristol Royal Infirmary Inquiry, 2001; and Mid Staffordshire NHS Foundation Trust, inquiries from 2009 to 2012. This selection of inquiries provides both a spread over time and, with the exception of the Normansfield inquiry, considers inquiries which of themselves triggered changes to public involvement mechanisms. All of the public inquiries express expectations of the role to be played by statutory public involvement institutions. The chapter considers the implications of these

expectations for any political role played by statutory public involvement institutions and whether they acted as watchdogs.

The closing chapter, Chapter Seven, draws together the findings from the research. It opens with a summary of the findings in the preceding chapters and then discusses the four main conclusions from this study.

Chapter summary

This chapter introduced the study. It opened by considering the issue of political management of the NHS. The main section of the chapter discussed the specific research area of the statutory public involvement institutions, providing a history of the institutions between 1974 and 2010 within the context of wider changes affecting the NHS. The third section considered self-generating interest groups and NHS-led engagement as potential alternatives to statutory public involvement institutions. The chapter closed with a preview of the forthcoming chapters, including the aim of the study as exploring the role(s) played by statutory public involvement institutions in political management of the NHS between 1974 and 2010. This chapter leads into a review of approaches to public involvement in the existing literature.

Chapter Two: Literature on public involvement in the NHS

Changes to statutory public involvement institutions, and to public involvement more widely, have had an impact on research interests and what it has been possible for researchers to study over time. This chapter considers the existing literature on public involvement in the National Health Service. It opens with an introduction to key themes in the politics of health literature around the balance of state, professional and public interests in health services. This leads into a chronological discussion of the way in which public involvement in the NHS has been studied, identifying where it is statutory public involvement institutions that are the research interest and where the main focus is on NHS-led and interest group alternatives. The rationale for a chronological approach is to demonstrate how the research agenda has shifted over time. The chronology falls into three parts. It suggests that in the 1970s and 1980s there was a focus on the membership of statutory public involvement institutions and the way that they operated with NHS management. The second part of the chronology proposes greater interest during the 1990s in new forms of NHS-led public involvement and themes around consumerism, potential legitimisation of decisions through involvement and a perceived democratic deficit in the NHS. The third part of the chronology considers the literature from 2000 onwards, proposing that changes to the statutory public involvement institutions have been a focus of academic interest alongside the increased influence of interest groups and the impact of statutory requirements to consult on NHS-led forms of involvement. The chapter closes with a discussion of the threads from within the literature that contribute to examining the distinctive features of statutory public involvement institutions as statutory bodies. Two main themes emerge from this discussion: managing the input of issue-specific interest groups; and ensuring the quality of NHS services.

2.1 Balance of interests in health services

Public involvement activity takes place within the broader politics of structured interests within the health service. This balance of interests frames the potential roles that may be played by public involvement within the NHS. Alford identifies three structural interests: health professionals are the dominant interests; politicians and managers are 'corporate rationalisers' who challenge the dominant interest; and the community population consists of 'repressed interests' (1975: 192). In this framework, politicians have difficulties managing the activity of health professionals and members of the public are in a very weak position. This weak position means that public involvement activity is open to

being shaped by either politicians or health professionals. Alford suggests that the problems are exacerbated for members of the public as community groups may conflict with each other, effectively vetoing each other's input (1975: 221). Williamson draws upon Alford's framework and suggests that public involvement in the NHS needs to be understood in the context of the dynamics of dominant, challenging and repressed interests (1992: 2-3). Whilst language may differ to describe the balance of interests in health services, the triangle of professional, political and public interests is a common theme in the literature on health politics (Salter, 2004: 7; Baggott, 2004: 49-54; Alaszewski and Brown, 2012: 89-113). This section considers the health service politics literature from the perspective of political management of the NHS, starting with the dominant position of health professionals and then turning to lay involvement.

Professional dominance

Ministers are dependent upon health professionals to deliver services in the NHS. When professionals act together, they can be a very powerful force, as discussed in Eckstein's 1960 volume *Pressure group politics: a case of the British Medical Association*. Eckstein suggests that doctors work together through the British Medical Association as a pressure group actively pursuing 'collectively common political aims' (1960: 9). He proposes that pressure group politics are determined by a combination of the pattern of policy-making activity, the structure of decision making and political culture (1960: 38). In his case study, Eckstein found that the British Medical Association had achieved dominance over the Royal Colleges for different specialists due in part to the size of its membership, but also the behaviour of civil servants in treating the association as a preferred partner for negotiation:

'It is obviously a matter of great convenience for the Ministry to have available a single organisation which can deal with it in the name of the whole medical profession; everything is simplified thereby, from the problems of the size of formal negotiating committees to the all-important matter of day-to-day contact and consultations between public and voluntary officials.' (Eckstein, 1960: 52)

Eckstein acknowledges that professional associations acting as pressure groups may distort democratic processes (1960: 157). He suggests, however, that many discussions are confidential 'not so much because of any anti-democratic collusion among the negotiators, but, much more important, because very few people really care about them' (1960: 158). Where there are members of the public with an interest in influencing health services, Eckstein's classic account of the relationship in the 1950s between civil servants

and the British Medical Association gave no space for influence. In a book review of Eckstein's volume, Kornhauser comments that one of the most interesting implications of the study is that the British Medical Association and the Ministry for Health had developed a stable relationship between highly interdependent interests that constituted a joint form of regulation of the NHS (1961: 645). When Eckstein was gathering data for his case study in the late 1950s, his study suggests that there was a very close relationship at national level which helped civil servants and Ministers to implement policy as the British Medical Association could 'generally make decisions binding' for their members (Eckstein, 1960: 52).

The stable relationship described in Eckstein's study facilitated implementation of policy where the British Medical Association agreed with politicians on changes to NHS services, but also placed the British Medical Association in a very powerful position in which it could block change. More recent studies also demonstrate the power of health professionals to block reforms. In their study of health service dynamics in the early 1990s, Harrison and Pollitt identified that civil servants and managers had potential problems, to use the title of their volume, in 'controlling health professionals'. Harrison and Pollitt were writing after the introduction of general management in the NHS, following the Griffiths report in 1983. The authors suggest that health professionals' expectation that they will be managed through a clinical structure may pose difficulties for generalist managers of health services:

'...we can say that health professionals constitute a potential problem for management, either because (as in medicine) of their claim to non-managed status or because (as in most of the other professions) of their claim to be managed exclusively by members of their own profession.' (Harrison and Pollitt, 1994: 6)

Harrison and Pollitt make a distinction between the expectation of doctors that they would be self managing and the requirement by other health professional groups to be managed by professionals in their specific discipline. In the context of Ministerial assumptions in the early 1990s that management authority would expand and professional authority would diminish, these underlying expectations had implications for the achievement of a managerial vision for the NHS (Harrison and Pollitt, 1994: 10). Harrison and Pollitt identify a range of challenges to professional autonomy in the decade leading up to their research: the introduction of general management; the creation of a framework for performance information; challenges from the Conservative government to the power of trades unions and professional associations; and incorporating professionals into management activity (1994: 61-73). In the context of the power of professional groups and their sense of being threatened by management changes, the authors suggest that public involvement is only

influential in areas in which professionals have little interest, such as waiting room facilities, or where managers have discretion, such as appointments processes (1994: 125). Harrison and Pollitt do not, therefore, see the public as shaping developments in the NHS:

'It will be clear from our earlier analysis that we do not envisage the sudden transformation of the NHS into an organisation driven by expressed user needs or measured against standards or criteria the formulation of which has been largely shaped by the consumer's voice.' (Harrison and Pollitt, 1994: 146)

This lack of a space for the consumer voice suggests that NHS-led public involvement does not provide opportunities for members of the public to have a significant influence over health service provision.

These two seminal studies exemplify the issues for Ministers in managing health professionals as part of their political management of the NHS. As discussed in Chapter One, a dimension to political management is avoiding disasters; if Ministers cannot manage the activity of health professionals, they can at least be alerted to potential problems before they become disasters (Alaszewski and Brown, 2012: 115-116). In the context of Alford's classification of community groups as the 'repressed interests', patient groups and members of the public may find it difficult to challenge the power of professionals or politicians when they are involved in decisions about health services (1975: 192). Considered in the terms of professionalism as understood within the NHS, members of the public are "lay" people who do not share medical expertise. This lay status means that their understanding of health services may be built on personal experience, rather than professional knowledge, and forms part of the politics of public involvement in the NHS.

Lay involvement

Patient groups and members of the public are in a weaker position than health professionals in the balance of health service politics. At the level of individual interactions, people who are ill are rarely in a position to be able to challenge the authority of health professionals. Users of health services may also perceive problems differently, drawing upon lay knowledge rather than professional expertise. This section considers the issue of the lay challenge to scientific rationality.

Barnes explores the ways in which the input of service users challenges the scientific rationality of service providers. She suggests that there are three specific

challenges: affect, or the role of emotion within debate; anecdote and the nature of story telling; and diverse debates, which she presents as the 'potential for deliberative spaces to engage with cultural difference' (Barnes, 2004: 122). Barnes observes that much of the political science literature on participation considers processes to ensure representation or presence, which has 'led to considerable attention being given to who was taking part in forums and how they were recruited' (2004: 130). From her perspective, considering the challenge of lay experience within debates, Barnes posits that greater attention needs to be given to the ways in which processes for deliberation are shaped 'to ensure that a diverse group of participants could bring to the table issues *they* wanted to talk about and could discuss those issues in a way which was genuinely inclusive' (2004: 130; italics in original). Denying the value of personal experience and the role of affect, anecdote and diversity in debates provides a means to undermine the contribution of lay participants to deliberation. Barnes proposes that the nature of dialogue within deliberation needs to be enhanced so that participation is genuine and does not provide another site for disputes between lay and scientific perspectives on evidence:

'Our notions of dialogue need to be expanded if the challenge to scientific rationality from service users is to result in more creative ways of working, rather than to provide another site for conflict.' (Barnes, 2004: 131)

The challenge to scientific rationality posed by service users, who interpret illness and the value of health services through their personal experience, is a theme from the broader literature on the politics of health services that complicates the willingness of professionals to work with service users on decisions relating to service development.

Hogg suggests in her monograph *Patients, power and politics: from patients to citizens* that the assumptions underlying a model of scientific rationality need to be challenged. She argues that it is assumed that medicine is based on science and that any new development will be an improvement, whereas 'in reality most health care is about chronic conditions that people live with for years, and, in spite of greater scientific knowledge, diagnoses are uncertain and treatments unpredictable' (1999: 4). Anderson *et al.* within their account of public involvement in primary care organisations indicate that lay voices provide a critical check on professional service providers and should be viewed as having their own form of expertise:

'Lay voices should not be naïve voices, but voices of people who recognise the difference between professional interests and patient/public interests, people who can advocate for the user with an understanding of the priorities of the provider.' (Anderson *et al.*, 2002: 66)

The sense of the value of the lay voice introduced by Anderson *et al.* expands beyond the notion of lay knowledge having a value in itself to a view that lay people should be in a position to challenge professional priorities.

As discussed in Chapter One, the nature of statutory public involvement institutions changed significantly between 1974 and 2010. The number of issue-specific interest groups increased during the same period and the emphasis on NHS-led forms of involvement has varied. As the nature of involvement has changed, the research interests and options for study around public involvement in the NHS have also evolved. The next three sections therefore take a chronological approach to discussing the literature on public involvement in the NHS, starting with research interests in public involvement immediately prior to the establishment of Community Health Councils in 1974.

2.2 Public involvement and NHS management, 1970s-1980s

During the 1970s and early 1980s, Ministers used reorganisations of the NHS as mechanisms to control costs. From 1983 onwards, as outlined in Chapter One, new forms of general management were introduced into the NHS in order to increase the efficiency of NHS services. This shift from structural changes to management changes had implications for the roles that public involvement might play. This section considers research into both statutory and non-statutory public involvement during the 1970s and 1980s, leading up to the announcement of the NHS internal market in 1989.

Statutory public involvement institutions introduced a new form of public involvement when they were established in 1974. There had, however, been a great deal of academic interest in public involvement in public services immediately prior to the development of Community Health Councils. This account of the literature therefore opens with theoretical approaches to public involvement from the late 1960s and early 1970s.

Concepts of public involvement in late 1960s/early 1970s

During the late 1960s, there was a great deal of interest in the United States in developing mechanisms to ensure 'maximum feasible participation' in plans to involve communities in a 'war on poverty' (Kramer, 1969: 1). Arnstein worked on urban renewal aspects of the programme and published a model of the extent of public involvement in decisions about public services (Arnstein, 1969: 216). Her typology is arranged in the form

of a ladder and was 'designed to be provocative', with each rung on the ladder corresponding to the extent of citizens' power in determining the plan or programme (1969: 216). The two bottom rungs of the ladder, 'manipulation' and 'therapy', are categorised by Arnstein as non-participation; she sees the aim of these activities as being to educate or cure the participants. As the next level up, Arnstein has three rungs that she regards as degrees of tokenism: placation, consultation and informing. With this intermediate degree of involvement, participants will be seen and heard, but 'they lack the power to ensure that their views will be *heeded* by the powerful' (1969: 217; italics in original). At the top of the ladder, Arnstein presents three forms of participation that she regards as degrees of citizen power: partnership, delegated power and citizen control.

Arnstein's work has since been widely applied to analyses of NHS-led forms of public involvement, particularly where authors are interested in the extent to which a transfer of power is needed for members of the public to be fully involved (Florin and Dixon, 2004: 160; Lupton, Peckham and Taylor, 1998: 48). Writing at a similar time, Pateman explored power dynamics from a different perspective. She considered the way in which participation through local groups might increase 'a sense of political efficacy' and individuals' sense that it was worth engaging with politics as they could make change happen (Pateman, 1970: 46). Later interpretations of the frameworks proposed by Arnstein and by Pateman have contributed to a strong sense within the public involvement literature that involvement should be valued of itself (Anderson *et al.*, 2002: 1).

The early 1970s also saw academic interest in collective involvement, or 'voice', as a means to provide consumer feedback to improve the quality of services. Within competitive market models, economists tend to assume that quality is maintained in the overall system as firms that do not provide adequate services go out of business. Hirschman, himself an economist, found in the case of the Nigerian railways that the presence of road transport mechanisms meant that customers used alternative transport, rather than voicing concerns, and the state-supported service had no incentive to improve (1970: 44-45). In a competitive market model, Hirschman would have expected the loss of customers to have led 'the railroad administration to correct some of its more glaring inefficiencies' (1970: 44). This empirical puzzle inspired the development of the 'exit, voice and loyalty' approach (Hirschman, 1970: vii). It led Hirschman to think about what happens when there is a lapse in quality and the conditions under which either the exit of customers or consumers voicing concerns is likely to be effective as a feedback mechanism:

'In Nigeria, I had encountered a situation where the combination of exit and voice was particularly noxious for any recovery: exit did not have its usual attention-focussing effect because the loss of revenue was not a matter of the utmost gravity for the management, whilst voice did not work as long as the most aroused and therefore the potentially most vocal customers were the first ones to abandon the railroads for the trucks.' (Hirschman, 1970: 45)

The origination of Hirschman's work in this empirical puzzle means that his focus is on the very specific instance of how user responsiveness can assist management when services deteriorate (Klein, 1980: 419). Given this genesis, the model assumes that the customers are discontented and acting in their own self-interest to ensure that they have access to better services. Whilst Hirschman refers to voice as belonging to the political realm (1970: 15), it is the voice of a discontented consumer making a complaint about a product, rather than that of a citizen interested in the balance of services available to people in their community.

The lack of a realistic exit option for most users of the National Health Service means that Hirschman's model can be difficult to apply. Klein suggests that losing customers can be seen by NHS managers as a bonus, as it relieves the burden on the service, rather than as an incentive to improve services (1984: 22). Hogg argues that exit cannot be seen as a choice for users of the NHS, as most people do not have the option of accessing a service elsewhere (1999: 32). Similarly, she proposes that 'complaining patients do not fit into the medical model of the doctor-patient relationship', which deters patients from voicing their own complaints (1999: 32). Within Hirschman's model, he suggests that loyalty to a particular firm increases the likelihood that a customer will voice concerns about a product in preference to seeking an alternative (1970: 77). By contrast, Lupton Peckham and Taylor suggest that the extent of public loyalty to the NHS may 'inhibit those who wish to voice an opinion, but who do not wish to appear disloyal to the service overall' (1998: 115).

Arnstein's ladder of participation and Hirschman's model have been used explicitly within research into public involvement in the NHS to varying degrees. Whilst individual researchers may not have been aware of the models, the works by Arnstein and Hirschman have been a part of the literature throughout the period that statutory public involvement institutions have been in place. As discussed in Section 2.5, neither of these well-known frameworks has been applied directly in this study, although Hirschman's work contributes to modelling how concerns raised by statutory public involvement institutions may help to identify problems in health services.

Representation within CHCs, 1970s-1980s

Community Health Councils were created as a new form of involvement. As new bodies, they attracted research attention, particularly in terms of their membership and the representative role of CHC members. During their first year of operation, Klein and Lewis conducted what proved to be the most comprehensive survey of CHC members to be undertaken. Klein and Lewis issued a questionnaire to CHC members, which was completed by nearly two thirds of the members ($n = 3,796$) (1976: 28). They also examined the annual reports produced by CHCs at the end of their first year of operation. Klein and Lewis analysed the socio-economic profile of CHC members, on the basis that this provided a means of comparison with other representative organisations:

‘Here is a new institution designed to promote consumer representation in the National Health Service, with a uniquely eccentric system for choosing the membership. So the most obvious question would seem to be how different CHC members are from representatives chosen by more conventional methods and in other contexts.’ (Klein and Lewis, 1976: 27)

The most distinctive feature of the members was that 18 percent came from the professional classes, whereas the professional classes make up 4.9 percent of the population as a whole (1976: 30). Klein and Lewis suggest that part of the motivation behind the recruitment mechanisms for CHCs was to ensure membership by proxy of ‘the most vulnerable and perhaps least articulate members of the community’ (1976: 38). They found strong representation of groups for people with mental health problems, disabled people, older people, children and ethnic minority groups, with only 15 percent of members not associated with one or more voluntary organisations (1976: 38). This representation of interest groups, particularly groups representing vulnerable members of society, was a distinctive feature of Community Health Councils and is discussed in more detail in this study, principally in Chapter Four. Klein and Lewis also considered whether the recruitment processes for CHCs introduced members who had not previously been involved in public office roles, such as school governors or magistrates; they found that over a third of the members had not held any form of public office (1976: 52). The authors conclude that CHC members are articulate representatives of the consumer:

‘If the accents in which CHCs speak are heavily middle-class this may – it is possible to argue – even be an advantage, since (to paraphrase Nye Bevan) generalising the best in the NHS probably can be safely translated to mean generalise the standards which the most demanding middle-class consumers expect for themselves.’ (Klein and Lewis, 1976: 157)

In addition to analysing the profile of CHC members, Klein and Lewis reviewed the institutions’ activity as reflected in their first annual reports. They found that CHCs had set

up programmes to visit NHS services and that CHC members drew upon local knowledge to make better use of resources (1976: 137, 139). The authors suggest that visits by CHC members to local services enabled them to have 'the time and the opportunity to inquire into, and form a judgement about, the state of the local health services' (1976: 122). They suggested that where Community Health Councils did not receive access to or information about services, this could be indicative of problems in those health services; the specific instance they mention is the lack of information provided to Darlington CHC about Darlington Memorial Hospital, which was subsequently the subject of an inquiry by the Northern Regional Health Authority (1976: 130-131). Klein and Lewis's study provides a baseline account of the nature of the membership and activity of Community Health Councils, including their observations on the politics that had led to the development of CHCs. Their interest in the nature of representation and roles played by statutory public involvement institutions makes Klein and Lewis' study one of the closest precursors of this doctoral study and reanalysis of some of their data is included in Chapter Four. Klein returned in a 1984 article to the role of Community Health Councils in representing vulnerable groups, suggesting that the constitution of CHCs 'represents a deliberate attempt to rig the market in favour of those with the least resources for participation' (Klein, 1984: 30). This role in representing vulnerable groups and the interest expressed by Klein and Lewis in the significance of visiting rights for statutory public involvement institutions have informed the modelling of the theoretical framework in Chapter Three.

Phillips examined the processes for setting up Community Health Councils, attending meetings organised by Regional Health Authorities to establish CHCs. He frames his account as a comparison with the consumer councils in the nationalised industries, suggesting that CHCs would have needed their own national establishing body in order to be independent of the NHS (Phillips, 1980: 50). Like Klein and Lewis, Phillips was interested in the representation of local voluntary groups within CHCs, but his concern was with the variability between Regional Health Authorities in their establishing arrangements (1980: 56). The Regional Health Authorities, as discussed in Chapter Four, could determine the list of local voluntary organisations eligible to form part of discussions about which groups would be represented in the membership of a Community Health Council. Phillips found that whilst some Regional Health Authorities were happy to let voluntary organisations determine which organisations could be included in the list, other RHAs 'did some extensive pruning' of the organisations proposed (1980: 56). Phillips' account of establishment in practice suggests that the design of Community Health Council membership allowed for local voluntary group participation in the selection of

members, but that the establishing role of the Regional Health Authority impeded this where it was unpalatable locally.

NHS management and CHCs, 1980s

In the early 1980s, Ministers tried initially to restrain costs by reducing the layers of NHS bureaucracy and then by introducing general managers to oversee the activity of clinical professionals. During the period of this emphasis on health authority management of the NHS, Bates studied the relationship between CHCs and NHS administrators in order to establish the impact of Community Health Councils. She examined the influence of 24 CHCs in the four Thames regions, interviewing administrators at different levels in the NHS and the CHC Secretary in each case. When asked whether the CHCs had an impact on their activity, 63 percent of District Administrators, the level of administration with which the CHCs worked most closely, indicated that the CHC had an impact; by contrast, only 16 percent of the Family Practitioner Committee administrators concluded that the CHC had any impact (Bates, 1982: 93). Bates found in her interviews with administrators that CHCs were valued for four roles: informed discussion; providing feedback about the local community; acting as an independent body that patients would approach; and their articulation of the needs of vulnerable groups (1982: 94-97). Drawing explicitly on Hirschman, Bates concludes that CHCs 'are performing successfully the function of giving a voice to groups for whom no exit is possible from the NHS' (1982: 98). This voice for vulnerable groups continues a theme from the analysis of CHC members by Klein and Lewis.

Mullen, Murray-Sykes and Kearns were also interested in the relationship between CHCs and administration in the NHS. They published a pair of articles in 1982 and 1984, with a follow-up article by Mullen in 1987, in which they examined the role played by Community Health Councils in health care planning teams. The papers were based predominantly on a survey of planning teams conducted between October 1978 and September 1980 (Kearns, Murray-Sykes and Mullen, 1982: 86). The survey on which they were drawing therefore preceded the introduction of general management into the NHS. The authors indicate that the planning teams were established after the 1974 reorganisation of the NHS and were variously known as health care planning teams or as district planning teams. There was some controversy over whether CHC representatives should be included as members of planning teams, but about half the planning teams that responded to the authors' survey included a CHC representative (Kearns, Murray-Sykes

and Mullen, 1982: 91-92). Where CHCs were represented on planning teams, the majority (79 percent) of planning teams felt that the CHC presence was beneficial, whilst only 9 percent expressed the view that CHC representation was not beneficial (Mullen, Murray-Sykes and Kearn, 1984: 147). Where CHC presence was found to be beneficial, this tended to be associated with teams in which there was greater general satisfaction with team effectiveness (Mullen, Murray-Sykes and Kearn, 1984: 150).

In her follow-up article in 1987, Mullen established that planning teams were still in place, in greater numbers than they had been in 1979. There were still some misgivings expressed both by health authorities and by Community Health Councils about CHC representation on planning teams:

‘Some Districts consider it inappropriate for lay CHC members to participate in what they consider to be a managerial and professional activity. Many CHCs, whilst wishing to influence planning, fear being incorporated into management through their membership of planning teams. However, it can be argued that membership of planning teams can enable CHCs to play a pro-active role in planning, rather than the reactive role which often results when participation is conducted primarily via consultation.’ (Mullen, 1987: 224-225)

Mullen suggested in her findings that the apparent stability of ongoing planning teams with CHC members might be masking other changes that were taking place in the NHS. In particular, she was informed by interviewees that the implementation of the Griffiths report would be likely to have a significant impact on planning structures and roles (1987: 226). The focus on representation of CHC members within planning teams in the work by Mullen and her colleagues reflects the policy emphasis on planning structures in the early 1980s, an approach that was being superseded by a greater emphasis on consumer feedback as part of general management.

Also writing at the point of Griffiths report implementation, Winkler signs herself as Secretary of City and Hackney Community Health Council and uses her experience in the CHC to inform an opinion piece in *Policy and Politics* on consumerism and the NHS. The Griffiths report included the recommendation that views should be sought from consumers on their experience of services, including the suggestion that Community Health Councils could gather the views of service users on behalf of NHS personnel (Department of Health and Social Security, 1983). Winkler suggests that the emphasis on consumerism was very new to NHS managers and that NHS managers needed to expand their image of consumerism beyond a supermarket model:

‘The supermarket vision of customer relations extends to reducing waits at the check-out counter and exchanging faulty goods with the minimum of questions asked. It does not extend, even at Marks and Spencer, to inviting the customers

on to the board, nor to consulting them about investment or even what should be on the shelves, let alone in their products.' (Winkler, 1987: 1)

By implication, Winkler sees an increased emphasis on consumerism in the NHS as an opportunity to enable consumers to be involved in decisions rather than just acting as a source of information on consumer preference. Winkler proposes that Community Health Councils have a role to play in increased consumerism in the NHS. She notes that Community Health Councils had been producing consumer surveys in the 1970s and the early 1980s, but that the new policy direction provided CHCs with the opportunity to ask NHS managers to take note of their reports (1987: 2). In order for this to happen, she suggests that there is a need for medical professionals to relinquish some of their power and for users to overcome some of their dependence, so that consumers become partners in the development of high quality services (1987: 3). Winkler uses examples of activity by the City and Hackney CHC to demonstrate a different form of consumerism from a model in which local people receive a survey and are asked for their views, including the need for consumers to be involved in scrutiny of services.

Taking a more theoretical slant, Richardson wrote about Community Health Councils in her monograph on participation in 1983. She suggested that the welfare state had not been developed to include 'consumer participation' and that public expectation of involvement had arisen in the late 1960s (Richardson, 1983: 2-3). This later addition of public involvement meant that it was not embedded into welfare state decision-making structures. Richardson proposed that participation should not be assessed purely according to the extent of any influence, as being involved may of itself improve the well-being of participants (1983: 54). She made a distinction between direct and indirect involvement:

'Direct participation refers to all those means by which people take part in efforts to influence the course of public policy involving personal (face-to-face) interaction with official spokesmen. Indirect participation refers to those means by which people take part in such efforts but not involving personal interaction with these spokesmen.' (Richardson, 1983: 11)

Following the terms of this classification, Richardson views Community Health Councils as predominantly a mechanism for indirect participation. She indicates that CHCs are 'generally looked upon as the principal means of effecting consumer participation in the health service', but that they are not strictly composed of consumers and have little direct interaction with health service policy makers (1983: 32). Instead of a form of consumer participation, Richardson characterises CHCs as 'a kind of officially established pressure group, helping to mobilise consumer opinion and transmit it to those responsible for health

administration' (1983: 33). Seen in the context of general management developments, she was describing CHCs as gathering the views of consumers to inform managers about the preferences and concerns of health service users.

Interest groups and NHS-led involvement, 1970s-1980s

Alongside the creation of Community Health Councils, there was a considerable growth in the number of self-generating interest groups from the 1970s onwards (Wood, 2000: 39). Haywood and Hunter suggested in 1982 that earlier studies of interest group involvement in NHS policy tended to focus on professional groups, understating other forms of interest group (1982: 144). They expand the range of pressure groups in health to include consumer groups (Haywood and Hunter, 1982: 155). Using the example of the policy community around services for older people, Haywood and Hunter identify Age Concern and Help the Aged as contributors to national policy (1982: 156). They suggest that Community Health Councils are seen by Ministers as specifically local bodies and so they do not have a recognised role at national level (Haywood and Hunter, 1982: 160). At the national level, Haywood and Hunter hypothesised that there would be an increase in activity by voluntary organisations, particularly as interest groups for consumers sought to get involved in consultative processes (1982: 161).

At the local level, Green proposed in the 1980s that there were two forms of community participation in primary care: representation through Community Health Councils; and programmes of 'self care' that committed vulnerable communities to take responsibility for their health (1987:136). He suggested that where local input was sought from issue-specific interest groups, it was after the plans had been developed and at the instigation of health authority members:

'the mechanism within the NHS for the involvement of such organisations (e.g. Mind - a pressure group relating to mental health needs) often involves a negative process - with such bodies being consulted *after* service plans have been drawn up rather than *during* the planning stages. Clearly there are exceptions to this, with particular pressure groups being involved early on; however, this is rarely seen as their right but rather as the prerogative of the health authority, and often only as the result of the interests of a particular authority member.' (Green, 1987: 132; italics in original)

Unlike Community Health Councils, local voluntary interest groups did not have statutory rights to be consulted in the course of developing plans for service changes. Interest groups for users of mental health and maternity services were some of the first groups to attempt to influence local service delivery. Green's finding that Mind and other

organisations were dependent on individual health authority members to instigate opportunities for involvement suggests that interest groups in the 1980s had limited involvement in local decision-making processes.

The earliest NHS-led involvement in the NHS took the form of patient participation groups established by General Practitioners. Richardson and Bray published a study of the patient participation groups in 1987. They found that three GPs (one in Wales, one in Oxford and one in Bristol) had independently developed the concept of patient participation groups in the early 1970s, prior to the establishment of Community Health Councils (Richardson and Bray, 1987: 12). Richardson and Bray conducted a survey of the patient participation groups, to examine their membership and members' perception of their achievements. Survey responses were received from 63 functioning patient participation groups, of which 53 had been founded by doctors and the remainder by other health practitioners or at the request of patients (Richardson and Bray, 1987: 16-19). The researchers discovered that over half of the "patient" participants in the groups were current or former workers in either health or social care, giving them a general interest in how community health services operated (Richardson and Bray, 1987: 46). Richardson and Bray comment that interest groups for people with a particular health condition are likely to attract greater commitment than NHS-led groups:

'The commitment people feel to those with a common condition, especially where they have actively been given help, is not comparable to the commitment they feel for those whose job it is to serve their needs. Successful self-help groups harness this very striking resource. Successful patient participation groups, in contrast have to rely on a less strong form of commitment.' (Richardson and Bray, 1987: 68)

The looser engagement of members of the public, as opposed to people with a particular health condition, was indicative of a problem that would be ongoing for state-led and NHS-led forms of public involvement. In terms of achievements, Richardson and Bray noted that 33 of the 63 groups had taken action that led to new services, such as health education and transport, and that 21 had negotiated 'changes in the organisation of the practice' (1987: 48). They concluded that there were noteworthy achievements made by the patient participation groups, but that there were ongoing problems in assessing which decisions the groups had contributed to and whether consumer-led decisions had given the best outcomes (Richardson and Bray, 1987: 70).

During the 1970s and 1980s, statutory public involvement institutions received research attention as new bodies at a point when there was limited involvement of the public in NHS decision-making processes through either interest groups or NHS-led involvement mechanisms. The requirement for consumer feedback as part of the general

management role in the NHS started to introduce consumerism as a research interest, but it was not until the 1990s and 2000s that consumerism became a major theme in the literature on public involvement in health. As discussed in the next section, a new emphasis in the 1990s on NHS-led involvement mechanisms had an impact on academic approaches to studying public involvement.

2.3 Consumerism and democratic deficit, 1990s

The introduction of an internal market into the NHS, following the 1989 White Paper *Working for patients*, increased academic interest in how the views of consumers influenced services and whether, within the professionally-dominated NHS, gathering the views of consumers might be seen as a means to legitimate decisions. The 1990s also saw the rise of an interest in whether public involvement could be seen as a democratic element in the NHS. This section discusses the trends in the public involvement in health literature during the 1990s.

Consumerism, 1990s

As discussed in Chapter One, the internal market was introduced into the NHS following the 1989 White Paper *Working for patients*. The White Paper encouraged purchasers of services to gather customer feedback on the services needed and suggested that Community Health Councils might act as ‘a channel for consumer views’ (Secretaries of State for Health, Wales, Northern Ireland and Scotland, 1989: 66). This provided an opportunity for researchers to consider the extent to which Community Health Councils were channeling consumer views to health authorities. Lupton, Buckland and Moon hypothesised that Community Health Councils that worked closely with health authorities were more likely to be able to influence purchasing decisions (1995: 215). They suggest that there was opposition from Regional General Managers to the prospect of Community Health Councils taking a greater role in purchasing decisions, so they propose that CHCs that were seen to be difficult or confrontational would less likely to be influential (1995: 218). Lupton, Buckland and Moon identified differing relationships between health authorities and CHCs through survey findings, which they drew into a typology of five different types of CHC. Ranging from those working most closely with health authorities to those that were most independent, they describe the following categories: health authority partners; consumer advocates; patient’s friends (who

represented the concerns of individuals); independent arbiters; and independent challengers (1995: 220). The research team found that the health authority partner, consumer advocate and patient's friend CHCs appeared to be given more opportunities for participation than the independent arbiters or the independent challengers (1995:220). The authors also discovered that Community Health Councils tended to be involved in the detail of service development, rather than broad direction:

'Generally, across all the case studies, purchasers tended to view CHC influence as restricted largely to matters of detail rather than strategic direction. As one HA [health authority] officer in the *Partner* case study explained: "They're a useful mechanism for fine-tuning the service".' (Lupton, Buckland and Moon, 1995: 223; italics in original)

Health authorities valued Community Health Councils where they felt that they had credible knowledge about the changes taking place within the NHS and provided a good source of information about local opinion and local community networks (1995: 224). The authors conclude that 'the window of opportunity for involvement in the NHS appears to be barely open' and that public involvement in the early 1990s was being driven by a managerialist agenda (1995: 225).

Following her work with Buckland and Moon, Lupton collaborated with Peckham and Taylor on a more extensive consideration of the ways in which health authorities made sense of their responsibilities to involve the public in purchasing decisions. The authors propose two pairs of dichotomies which they use as the basis of their analysis: a distinction between consumerist and democratic understandings of involvement and a distinction between policy and operational imperatives. Lupton, Peckham and Taylor argue that Community Health Councils were created to address democratic problems of local accountability for health services, but they suggest that from the outset CHCs had problems representing the wider public as they were developed to support particular sectional interests (1998: 69). As part of their consideration of the balance of democratic and consumer involvement, the authors suggest that the development of the internal market shifted involvement towards consumerism and changed the roles open to Community Health Councils. With increased emphasis on gathering feedback, complaints management was improved within the NHS (1998: 103). This reduced the role played by Community Health Councils in handling complaints. The need to gather information from the public about their service preferences extended the role of CHCs initially (1998: 104). Nonetheless, the authors suggest that in the purchasing climate the role of CHCs was undermined in several ways: healthcare purchasers saw themselves as charged with responding directly to consumers; secondly, it was purchasers who acted as proxy

consumers on the behalf of patients, which reduced the opportunities for public involvement; and thirdly, concerns were expressed about the potentially political nature of CHCs, curtailing their remit (1998: 104).

The studies by Lupton and her colleagues demonstrate that Community Health Councils continued to be studied as forms of consumerism during the 1990s. The range of NHS-led forms of involvement, however, was also expanding at this time. In the latter study, Lupton Peckham and Taylor observe that managers within NHS services wanted to contact 'real' healthcare users and felt that they needed to create their own mechanisms to do this, rather than working either with interest groups or with statutory public involvement institutions (1998: 76). New mechanisms included citizens' juries, surveys and health panels (McIver, 1998; Davis and Daly, 1999: 60). As discussed below, in a professionally-dominated NHS, there was a risk that consumer feedback might be used by professionals to bolster their position or by managers to counter professional dominance.

NHS-led involvement and legitimisation, 1990s

Harrison and Mort examined the practices of 'public consultation' and 'user involvement' in the context of the expectation within the internal market that purchasers would become 'champions of the people' (1998: 60). In the terminology of their title, the authors question 'which champions, which people?' They found that constructions of the 'people' who would participate ranged from an informed public, whose members are able to deliberate on issues, to isolated individuals responding to briefings on a pre-determined topic (1998: 64). Within their study, Harrison and Mort found that the 'champions' were often public relations or communications personnel who were leading consultation activities. The authors studied health panels as examples of public consultation and found that 'in most cases it is the commissioning authority which sets the agenda for the panel because it is commonly agreed that there would be little point in panels and juries spending time deliberating questions which are not of immediate concern to the purchasers of health care' (1998: 64). Harrison and Mort investigated user involvement through a study of user groups, using six case studies over the period from 1994 to 1996. With user involvement, as opposed to public consultation, the authors suggested that the champions are 'plentiful', but 'unreliable' (1998: 66). Harrison and Mort found that health professionals and managers used the feedback from user involvement to legitimise their viewpoints:

'Many respondents also described how they *used* such groups in both short-term tactics and longer-term strategies. The former is neatly summed up in the phrase "[playing the] user card" spontaneously employed by several respondents; it refers to the use of user group opinion to buttress one or other manager's or professional's or their institution's preferred course of action as against that of a colleague's or other institution's.' (Harrison and Mort, 1998: 66; italics in original)

From their empirical work, the authors suggest that user involvement and public consultation can be seen as 'legitimation strategies' or 'technologies of legitimation' (1998: 67). Harrison and Mort argue that the development of the quasi-market increased the need for local decisions that took into account local needs, increasing the requirement to 'legitimise' decisions (1998: 68).

From the perspective of this study of statutory public involvement institutions, one of the interesting features of the paper by Harrison and Mort is the placement of Community Health Councils within their distinction between public consultation and user involvement. They include Community Health Councils as organisations that are likely to be seeking the view of the broader public as a form of public consultation (Harrison and Mort, 1998: 60). Classifying Community Health Councils as a mechanism for public consultation could suggest that they may act as means to manage local engagement in the NHS, potentially contributing to the legitimation process.

Harrison and Mort collaborated with Dowswell on a 1999 book chapter that expanded upon the health panel research from the 'which champions, which people?' article. Mort, Harrison and Dowswell identify that health panels take a range of forms and propose a matrix to help to classify consultation activities, presenting a two-by-two grid on which participation may be informed/uninformed and deliberative/undeliberative (1999: 98). The authors found that a problem in assessing the influence of health panels is that they represent just one aspect of a decision. They contrast a legal jury, which makes the conclusive decision, with a citizens' jury that just provides input (1999: 104). Mort, Harrison and Dowswell suggest that it is impossible to conclude that a panel has been influential where the results of a consultation do not challenge the authorities, yet authorities 'accrue legitimacy from having undertaken (increasingly sophisticated) ways of consulting the public' (1999: 106). The authors do not see legitimation as the sole function of consultation, as they conclude that consultations may be intended to gain knowledge, to establish consultees' values or to educate the public (1999: 106).

The aspects of legitimation considered in these studies are at a local level with locally-led involvement activities. Extending from Harrison and Mort's identification of Community Health Councils as a means to support public consultation, rather than user

involvement, part of the rationale for ongoing state funding of statutory public involvement institutions may be to legitimise decisions or actions that are difficult from a Ministerial perspective.

Addressing a democratic deficit, 1990s

Centralised accountability for the NHS through the Secretary of State for Health means that the only relationship that the electorate have with the health service is at the national level, whilst decisions about health services are made without direct electoral input at a local level. In the 1990s this was described, notably by Cooper, Coote, Davies and Jackson in *Voices off*, as a 'democratic deficit'. Cooper *et al.* consider the nature of accountability for NHS services, the role of public involvement in commissioning services, routes to public participation and the potential for greater involvement of local government in NHS services. Their research was conducted in 1994, when processes for commissioning health services through health authorities were becoming embedded. The researchers undertook interviews and attended meetings, including twelve visits to Community Health Councils (Cooper *et al.*, 1995: 120). Their research questioned the extent to which decisions about commissioning health services were taken democratically. The authors identified no democratic forum for involvement of citizens in decisions about rationing services. They considered a wide range of involvement mechanisms, but found that these were limited in scope and that there was a lack of opportunity for public debate about difficult decisions to be made in health service provision (1995: 74). The solution proposed by Cooper *et al.* is that accountability for NHS services is best achieved by making local government responsible for purchasing NHS services (1995: 119).

Davis and Daly share the concerns about democratic accountability raised by Cooper *et al.* and suggest it is a 'constitutional fiction to pretend that Ministers are either able or willing to take personal responsibility for every health service action in every locality' (1999: 59). The authors report that an increase in the use of participatory techniques, such as citizens' juries, may have informed decision makers, but they suggest that this trend does not negate the need for local decision makers to be democratically accountable (1999: 60). As one of the options for increasing democracy in the NHS, Davis and Daly consider increased democratisation of Community Health Councils, but they point out that this would democratise the 'watchdog' rather than the commissioner of services; the authors suggest, instead, democratically elected health mayors (1999: 61-61).

Academic accounts of public involvement in the NHS during the 1990s were framed by the extant arrangements for involvement in purchasing as part of the internal market. *The NHS plan* in 2000 introduced statutory duties for the NHS to consult and changed the nature of statutory public involvement institutions. This had a considerable impact on the area of study.

2.4 Public involvement and change, 2000s-2010s

Public involvement in health changed markedly following *The NHS plan* in 2000. The placement of a statutory duty on NHS organisations to consult about service changes renewed NHS-led activity and re-framed consumerist approaches to public involvement in the health literature. Voluntary organisations had been involved in the development of *The NHS plan*, a process from which Community Health Councils were excluded, and the growth of interest groups became a focus of research interest. The statutory public involvement institutions in England were subject to a series of changes. As discussed below, studies of the statutory public involvement institutions in this period tend to consider the changes, rather than the continuity of ongoing investment in funding and reforming statutory institutions for public involvement.

NHS-led involvement, 2000s

The reforms following *The NHS plan* encouraged both the gathering of consumer views and greater patient choice. Views gathered from consumers and monitoring of choices could both be used to inform service developments. Writing immediately following *The NHS plan*, Anderson and Gillam are critical of a consumerist involvement that is based on learning from the choices that people make. They suggest that the inclusion of private and NHS options takes health care back to a period before the creation of the NHS, when people received the care that they could afford to purchase (Anderson and Gillam, 2001: 14). The authors suggest that the text within *The NHS plan* demonstrates a tension between promotion of consumerism and state interest (2001: 16). Anderson and Gillam observe that *The NHS plan* 'represented top-down consumerism: patients would be given more choice whether they wanted it or not' (2001: 16).

The policy emphasis on choice-based consumerism alongside gathering consumer views renewed academic interest in Hirschman's 'exit, voice and loyalty' framework (Hirschman, 1970). As discussed below, some of the research interest in Hirschman's

framework took the form of comparisons between statutory public involvement institutions in England and Wales. Within studies of NHS-led involvement, Primary Care Trusts were a major focus of attention, as they held the budgets for purchasing services. Pickard found in a study of Primary Care Trusts that neither voice nor choice mechanisms acted effectively in a primary care-led health service. She identified that the voices of lay board members were seldom heard and their role was sometimes 'perceived to be to legitimate decisions in reality made by others' (Pickard, 2007: 79-80). In practice, the choices available to patients were also limited, in the case of her study to a private physiotherapy service as an option provided by one of the Primary Care Trusts, which did not provide sufficient information on preferences to inform service developments (2007: 81). Anderson *et al.* also studied NHS-led involvement through primary care organisations and suggested that more attention was given to lay voices if they had the support of external organisations, whether interest groups or statutory public involvement institutions (Anderson *et al.*, 2002: 28). This observation suggests a relationship between different forms of public involvement in the NHS.

Rowe and Shepherd considered NHS-led public involvement in the context of new public management. They noted a distinction between consumerist and democratic ideologies of participation in the literature (2002: 278). Understood in new public management terms, Rowe and Shepherd suggest that public involvement is to improve the efficiency and effectiveness of the health service by making it more responsive to consumer needs:

'...the NPM [new public management] perspective sees participation as a means to increase organisational learning, with decision-making power retained by health care professionals and health service managers.' (Rowe and Shepherd, 2002: 279)

The authors conducted a postal survey of 49 primary care organisations in April 2000, seeking views from members of their boards. Respondents to the survey indicated that public involvement was to improve the quality of services, legitimise decisions and improve public health through education (2002: 281). Rowe and Shepherd interpret this response from board members in the primary care organisations as indicating a bounded role for public involvement, as a means to gather information that informed decisions rather than being directly involved in the decision-making process (2002: 287). Acting as a source of information rather than being involved in the decisions tends to be a distinction between the consumerist and democratic approaches as applied to public involvement in the NHS.

Democratic interpretations of NHS-led public involvement were applied alongside consumerist approaches in the 2000s. Weale described NHS-led developments following

the abolition of Community Health Councils - such as the NICE Citizens Council²¹, citizens' juries and focus groups - as demonstrating that democratic values were breaking out 'like the darling buds of May' across the NHS (2003: 41). He considers the relationship between these mechanisms and accountability for health services in the Westminster parliamentary model and the purposes or values that can be achieved through these mechanisms. As plausible rationales for these forms of public involvement, he discusses identifying different moral judgements, addressing an imbalance in political influence, improving the quality of decisions, introducing a deliberative dimension, understanding public beliefs and increasing the legitimacy of decisions (Weale, 2003: 46-49). Weale indicates that there is less likelihood of the mechanisms establishing public preferences or reaching a social consensus on hard choices (2003: 49-50). In a later article, he suggests that there are benefits to a wider citizens' perspective alongside the voices of interest groups (Weale, 2006: 37). He illustrates a 'ripple of concern' from specific users as the central point, resonating out to general users, expert users, co-producers and wider interests (2006: 39). Weale's distinctions between different participants in the 'ripple of concern' demonstrate the complexity for NHS-led and other public involvement mechanisms in determining who is involved. He revisits the rationales for public involvement from his earlier article, presenting the first reason as 'planning services from the user point of view' (2006: 38). Weale considers the example of the NICE Citizens Council as a means by which public involvement tests the transparency of decision making. He indicates that the accountability of officials may be difficult to see in the 'maelstrom of voice and choice', but that democratic society is broader than specific institutions and that the value of public involvement in the NHS lies in its expression of a democratic civic culture (Weale, 2006: 43).

Duties to involve members of the public in decisions led to a growth in the literature for health professionals on how to involve members of the public. Texts written by or for health professionals tend to take a consumerist approach, based on gathering information about patients' experiences of services, rather than gathering the wider views of citizens. Chambers, Drinkwater and Boath open their volume with a statement that 'ordinary people' will not participate if they think that the exercise is 'just a public relations sham' (2003: 1). The inclusion of the statement at the opening suggests that this was seen by the authors to be a noteworthy risk for NHS-led forms of involvement. Tritter, Daykin, Evans and Sanidas produced a volume on improving cancer services through patient involvement.

²¹ The NICE Citizens Council is written without an apostrophe, following the style used by NICE, as it is a proper noun (Davies, Wetherell and Barnett, 2006: vii)

They discuss a user involvement cycle, with ongoing identification of service users, leading to (re)defining the aims of user involvement, documenting users' experience of services, involving service users in service and development, leading back to the start of the cycle with identification of service users to participate (Tritter *et al.*, 2004: 8). They emphasise the importance of clinical teams working together to involve users, rather than depending on a sole champion, and the need to give staff incentives to involve users, such as additional resources that are dependent upon having involved service users (2004: 116). Whereas the incentives for product managers in Hirschman's model were increased sales of an improved product, health professionals may not see a direct benefit from involving their consumers and so may need to be encouraged to promote user involvement.

Interest group influence, 2000s

Signatories to *The NHS plan* included representatives of patients' associations and other lay health interest groups (Secretary of State for Health, 2000: 9-10). This seems to be indicative of an increase in the profile of these interest groups – a topic that was receiving attention in the academic literature. In 2000, Wood published what he described as 'the first comparative study of patients' associations which relate to particular diseases or medical conditions that focuses on political power and influence' (2000: 4). He based his study on an analysis of survey data and interview material from Britain and America. Wood suggests that it is a puzzle, given the impact of health on people's lives, that the consumer health movement is relatively weak (2000: 5). He hypothesises that part of the reason why disease-specific voluntary organisations have been relatively weak is that until the 1990s they had a negative image amongst policy makers:

'They have traditionally been viewed with some suspicion, as being partial organisations interested only in those detailed aspects of health care which affect "their" members. This negative image, which in Britain has been changing as Governments of both parties in the 1990s have emphasised the importance of "patients' voice", is important because it may restrict associations' access to wherever it is that general health policy is effectively determined and hence limit the scope for them to exert political influence beyond the level of activities they undertake on behalf of individual patients.' (Wood, 2000: 13)

The increased scope for influence that Wood identified in the 1990s was matched by an increase in the number of disease-specific voluntary organisations. Wood establishes that although there are some well-known patients' associations with 'fairly long histories', there was a remarkable growth in the number of organisations in the last quarter of the twentieth century (2000: 39). Despite the increase in influence in the 1990s, Wood concludes that

neither in America nor in Britain do patients' associations offer a strong political challenge to established interests, describing their involvement as 'the politics of presence rather than of pressure' (2000: 113).

Baggott, Allsop and Jones undertook research between 1999 and 2003 to uncover different perspectives on the influence of health consumer groups in the policy process in the United Kingdom. They conducted surveys and interviews to examine condition-specific groups in two arenas that were a policy priority (cancer; and heart and circulatory conditions) and two that were not a policy priority (arthritis and related conditions; and maternity and childbirth). Baggott, Allsop and Jones found that individual organisations represented the needs of their members, but that they also collaborated within alliance organisations in order to increase their capacity to influence policy (2005: 136). In interviews, representatives of the health consumer groups were asked why they joined alliances. Interviewees from both large and small organisations indicated that they felt that they would have greater policy influence as part of an alliance, as it made it harder for other health care stakeholders to take advantage of differences between groups (2005: 149, 151). In addition to the increasing number of organisations identified by Wood, the researchers conclude that a health consumer movement had emerged in the decade leading up to their study, with a shared discourse, values and perceptions (Baggott, Allsop and Jones, 2005: 286).

These studies indicate that there was an increase in the influence of issue-specific interest groups at the national level and that they were also working in broader alliances to increase opportunities for influence. The focus of the research in each case is influence on national policy, rather than local service development. Academic and policy interest in local involvement has continued to focus predominantly on NHS-led and statutory forms of public involvement.

From CHCs to PPI Forums, 2000-2006

The NHS plan in 2000 announced that Community Health Councils would be abolished and replaced. This introduced the first in a series of changes to statutory public involvement institutions. This sub-section considers the literature on the transition from Community Health Councils to PPI Forums, followed by a sub-section on the changes that followed the PPI Forums. As outlined below, the changes have been a focus in their own right for academic interest. The studies represent a mixture of approaches to analysing the changes, without a single dominant approach.

The abolition of CHCs attracted literary attention from people who had personal experience of working with them. Gerrard's volume *A stifled voice* explores the history of the Community Health Councils and the abolition of Community Health Councils in England. Gerrard was the first Secretary, a post later titled Director, of the Association of Community Health Councils for England and Wales (ACHCEW). He therefore had access to the ACHCEW files and was able to use his contacts to interview or take statements from all the former health Ministers who were still living. Gerrard describes difficulties from the outset for institutions that were designed by a Conservative administration and then implemented following the election of a Labour government in 1974, resulting in 'the unloved offspring of two opposing political philosophies' (2006: vi-vii). Gerrard does not take an explicitly theoretical stance in his history, although he considers the abolition of the English CHCs in the context of what he sees as the two key elements in a New Labour approach: conviction politics and modernisation. He suggests that 'the essence of conviction politics is that it is utterly certain of what it proposes and does not tolerate any alternative' (2006: 28). Gerrard generously includes extensive direct quotations from his sources, which have been drawn upon as sources for this study. His volume provides a source for further studies of statutory public involvement institutions as much as it provides a personal account of the history of Community Health Councils.

Hughes, Mullen and Vincent-Jones examined the contrast between the retention of Community Health Councils in Wales and the abolition of Community Health Councils in England. Whilst they do not explicitly cite Hirschman, they draw upon a potential contrast between the introduction of 'choice' in England (or 'exit' in Hirschman's terms) and a stronger 'voice' model in Wales. The authors analysed policy documents for both nations and undertook interviews ($n = 16$) with NHS managers in Wales (Hughes, Mullen and Vincent-Jones, 2009: 241). They reviewed Welsh and English policies, considering the perspectives taken on voice, or democratic, and choice, or market, determinants for policy. They argue that Wales has taken 'voice' and integrated it into a clear hierarchical model, drawing on a 'small scale' that allows for better joining up with local government (2009: 246). Hughes, Mullen and Vincent-Jones suggest that the reforms to patient and public involvement in England have placed 'voice' in the shadow of 'choice'. They propose that the ensuing transition from PPI Forums to Local Involvement Networks was to ensure a better match with a 'choice' agenda: if the statutory public involvement institutions were no longer attached to a particular service provider, the feedback they provided on the quality of services was more likely to be seen by funders and providers of services as impartial.

Moving on from the abolition of the CHCs themselves, Klein produced an analysis of the changes in the wake of the abolition. He describes the developments as a 'layer-cake of initiatives, with no necessary logical link between the component parts' (2004: 207). The layers identified by Klein are the institutions mentioned in *The NHS plan* itself (PPI Forums, Patient Advocacy [later Advice] Liaison Services and the local authority Overview and Scrutiny Committees) and the parallel development of patient choice mechanisms and membership schemes for Foundation Trusts. Klein speculates that there are two assumptions underlying *The NHS plan*: that public involvement enables members of the public to influence decisions; and that NHS providers will seek the views of service users in order to tailor their services (2004: 208). Klein questions both of these assumptions and doubts there is an appetite amongst members of the public to become members of Foundation Trusts and to be elected to participate in Foundation Trust boards (2004: 208-209).

Milewa also considered the range of initiatives and institutions that emerged following the abolition of Community Health Councils. Unlike Klein, he does not present the new arrangements as disconnected, but sees them from a discourse perspective as a 'fusion of normative exhortation and structural reform' (2004: 240). Milewa's analysis suggests that there are two normative emphases in the reforms leading to PPI Forums: the first is an established discourse of a democratic deficit; and the second is an emergent 'quasi-communitarian rhetoric' that links health service entitlements to participatory responsibilities (2004: 249-250). He proposes that the new arenas created by Patient and Public Involvement Forums, Overview and Scrutiny Committees and membership arrangements for Foundation Trusts 'constitute, at least tentatively, a significant extension of the arenas within which citizens can explore and debate issues pertaining to the NHS' (2004: 250).

Whilst the abolition of Community Health Councils had proved difficult for Ministers, Baggott proposes that the introduction of PPI Forums represented an implementation problem. He suggests that Community Health Councils had been 'outflanked' by newer forms of participation, such as citizens' juries, and that CHCs had difficulty maintaining their legitimacy with the growth in the number and activity of patients' associations (2005: 538). Considered in terms of PPI Forum implementation, the Government failed to ensure that other initiatives, such as the development of Foundation Trusts, did not undermine the new PPI Forums (2005: 547). Baggott indicates that the PPI Forums were open to criticism for their lack of independence, which did not help them to establish themselves. He also maintains that the Government and authorities had failed to take into account the

low political leverage of patients that restricted their ability to influence decisions in the NHS (2005: 548). Fundamentally, even if implemented effectively, statutory public involvement institutions cannot operate in isolation to empower the public:

‘Institutional changes may be insufficient to promote genuine empowerment of citizens.’ (Baggott, 2005: 548)

When viewed in implementation terms, the transitions between the statutory public involvement institutions combine implementation problems with issues around what members of the public or patients can achieve in the face of professional dominance.

This summary of studies on the transition from Community Health Councils to PPI Forums demonstrates a focus in the literature on the impact of abolition and the issues around implementation of a new system. At the stage of this first change, it was the abolition of CHCs and the shape of the bodies that replaced them that attracted research attention, rather than why Ministers had continued to fund statutory public involvement institutions, given the opportunity not to do so. In terms of their statutory powers, PPI Forums were the successors to Community Health Councils, but the literature describes a confusion of concurrent changes to public involvement.

Local Involvement Networks and beyond, 2006-2012

A stronger local voice announced the replacement of PPI Forums with Local Involvement Networks (Department of Health, 2006b). This second abolition and replacement presented researchers with new opportunities to consider patterns in the transitions over time.

Hogg reviewed the transitions in a 2007 article and extended her work into a monograph in 2009. In the initial article, Hogg provides an overview of research into the effectiveness of Community Health Councils and PPI Forums, identifying learning to be applied in the establishment of Local Involvement Networks. She reviews the research in the context of debates about accountability, service improvement and the wider agenda of democratic renewal. Hogg suggests that debates from the 1970s about public involvement in health services remain current and that learning needs to be gathered on where Community Health Councils and PPI Forums are considered to have failed (2007: 130). She proposes that governments’ reasons for promoting patient and public involvement in health services have changed over time: in the 1970s, the institutions were seen as a means to overcome professionals’ opposition to change and through their membership structure bridged relationships with local authorities and the voluntary sector;

Hogg interprets the role of PPI Forums as representing a shift to Government interest in participation by patients in decisions within the NHS; and she suggests that the rhetoric around the transition to Local Involvement Networks could be interpreted either as contributing to local democracy across health and social care, or as assisting in setting priorities (2007: 131-132). On the matter of setting priorities, she indicates that governments may be unwilling to involve issue-specific voluntary organisations in decisions about budgets for treatments, as the input of issue-specific groups may be skewed by funding from pharmaceutical companies:

‘If LINKs are to advise on local priorities, they will need to operate in the public interest rather than the ‘patient’ or consumer interest. They may be reluctant to do this as it might lead to conflict as the major pressures for new drugs and new services come from patients and patient groups, often funded by the pharmaceutical industry.’ (Hogg, 2007: 132)

Hogg considers lessons from the previous state-sponsored organisations, indicating that there needs to be clarity about accountability to local communities, the form of representation, requirements of members, independence and standards (2007: 134-136). In her discussion of independence, she indicates that statutory public involvement institutions can be interpreted as meeting management needs:

‘State sponsored participation is always open to the accusation that it is manipulation – a cynical attempt to get support for management rather than enhance participatory democracy.’ (Hogg, 2007: 135)

Her principal message, however, is that there are lessons that need to be learned from past forms of statutory public involvement, to avoid the risk of systems that lack credibility and are seen as a waste of resources (2007: 137).

Hogg extended her research into the changes between statutory public involvement institutions as part of a broader review of public involvement in her 2009 volume *Citizens, consumers and the NHS: capturing voices*. She identifies differing views on patient and public involvement in the NHS, analysing debates within the framework of civil renewal and active citizenship, public participation and community engagement (2009: xiii). She suggests that part of the difficulty for public involvement has been ‘a persistent confusion about whether Government wants to involve people in order to provide better health services or to involve them as citizens as part of the democratic process’ (2009: 1). Hogg’s account is an analytical history of statutory public involvement institutions from the establishment of Community Health Councils to the implementation of Local Involvement Networks, based on documentary evidence and interviews. In her discussions of consumerist and democratic involvement, Hogg suggests that consumerist models of

choice of service are complex in the context of rationing, as a real choice depends on an oversupply in the market to ensure that the option requested is available (2009: 185). Given the finite resources in the NHS and the varying capacity of individuals to make choices, a consumerist approach may increase inequalities in access to health services (2009: 186). She identifies that with the confusions between democratic and consumerist models of participation and a succession of changes to statutory public involvement institutions, there is skepticism about public involvement in the NHS. To overcome this, Hogg recommends that statutory public involvement institutions need to be more closely aligned with citizen engagement rather than consumerism (2009: 187).

A theme in the literature on statutory public involvement from Klein and Lewis' 1976 report onwards is the membership of the institutions and who they are representing. Hogg suggests that having people with experience is important, as alluded to in her dedication of her 2009 book to 'the usual suspects'. Learmonth, Martin and Warwick use the analogy of the bureaucratic irrationality in Joseph Heller's novel *Catch-22* to present the conflicting requirement that 'you have to be ordinary to represent the community effectively, but, if you are ordinary, you cannot effectively represent your community' (2009: 106). The authors discuss the changes between Community Health Councils, PPI Forums and Local Involvement Networks. They suggest that CHCs 'were intended to consist of ordinary people who lived in the locality' (2009: 106). In the documentation to describe members of PPI Forums and Local Involvement Networks, the authors determine that 'ordinary people only' is a rhetorical device that is used to describe an ideal of membership, but which conflicts with expectations of what the members will be able to achieve (2009: 108, 110). Learmonth, Martin and Warwick consider four vignettes based on the practical experiences that Learmonth and Warwick had had of Community Health Councils and PPI Forums respectively. On the basis of the vignettes, the authors propose:

'...that to search for people who are ordinary *and* who have the ability to be committed to the level required for what Government hold to constitute "effectiveness" inevitably presents a *Catch-22*. Lay people are, by definition, not experts in health care; and as non-experts, especially in the professionalised and evidence-based culture of today's NHS, they lack the prestige and credibility enjoyed by many other voices in health care.' (Learmonth, Martin and Warwick, 2009: 113; italics in original)

In order to get away from this *Catch-22*, the authors recommend shifting away from a managerial sense of 'effectiveness' and giving statutory public involvement institutions the space and the time 'to pursue their agendas' (2009: 113-114). Whether such a move from managerial effectiveness is possible depends upon the expectations of Ministers as the funders of statutory public involvement institutions.

Vincent-Jones, Hughes and Mullen also explore the issue of who is involved in statutory public involvement institutions, examined through an analysis of public policy documents during the period from 2001 to 2008. They observe that the discourse has moved from an inclusive integration of ‘patient *and* public’ involvement to a more exclusive focus on the role of patients in consumer choice (Vincent-Jones, Hughes and Mullen, 2009; italics in original). Vincent-Jones *et al.* point out that the *Local Government and Public Involvement in Health Act 2007* refers to consultation of ‘users of services’, rather than the broader reference to consulting ‘persons to whom ... services are or might be provided’ in the earlier *Health and Social Care Act 2001* (2009: 259). The authors conclude that replacing PPI Forums with Local Involvement Networks made sense within the ‘changing organisational landscape of health and social care provision’ (2009: 270). The research team suggests that the role of the patient as consumer has taken over from the involvement of citizens in the discourse of policy documents in England:

‘We have suggested that the tension that exists between the different “patient” and “public” dimensions of PPI [Patient and Public Involvement] policy is being resolved by the strengthening of the former aspect at the expense of the latter. The traditional concern with patient *and* public involvement in healthcare governance is being displaced in contemporary political discourse by a focus on consumer choice and economic regulation.’ (Vincent-Jones, Hughes and Mullen, 2009: 271; italics in original)

As in the Hughes *et al.* (2009) paper on the contrast between retention of CHCs in Wales and their abolition in England, the research team use an implicitly Hirschmanian model of exit and voice, but do not cite Hirschman explicitly.

The same research team, this time in the sequence Mullen, Hughes and Vincent-Jones (2011), consider the democratic potential of public participation in healthcare governance in England. Their research formed part of a broader study of the necessary conditions for reflexive governance. The authors suggest that if democratic potential is judged by the extent to which people are able to have a say, the revisions between 2001 and 2007 weaken this democratic role (Mullen, Hughes and Vincent-Jones, 2011: 32). They speculate that the democratic potential of local Healthwatch as a successor to Local Involvement Networks may depend on the ability of local Healthwatch to attract people from a diverse range of backgrounds (2011: 35).

The research agenda for statutory public involvement institutions has shifted over time with the wider context: NHS reorganisations and management changes in the 1970s-1980s; internal market consumerism and potential legitimisation tactics in the 1990s; and as institutions subject to change alongside the growth of both NHS-led involvement and

interest groups in the 2000s-2010s. Mullen, Hughes and Vincent-Jones close their 2011 paper with speculation about the value of statutory public involvement institutions in today's environment (2011: 35). It is this speculation about the role(s) played by statutory forms of involvement that forms the springboard from the existing literature into this study.

2.5 Examining statutory public involvement

As illustrated in the history in Chapter One and the literature review in this chapter, there has been a growth in both interest group activity and NHS-led involvement in the NHS, providing alternatives to statutory public involvement institutions as means to involve members of the public in NHS decision-making processes. Given the growth of alternative mechanisms, ongoing Ministerial investment in funding and reforming statutory public involvement institutions suggests these bodies fulfil a role that is not met either by working with interest groups or by depending upon NHS-led involvement mechanisms.

Ongoing investment where there are alternatives available could be taken to suggest that Ministers have political incentives for retaining statutory public involvement institutions. Hogg mentioned that state-sponsored forms of involvement are open to the accusation that they are a form of manipulation and 'a cynical attempt to get support for management' (2007: 135). There is a strong theme of legitimation within the public involvement literature. Harrison and Mort suggested that information from service users might be used to legitimate decisions (1998: 66-67). Subsequent authors cited in this literature review also referred to lay representation or consultation as means to legitimate decisions (Rowe and Shepherd, 2002: 281; Pickard, 2007: 79-80). As state-funded bodies, there is the possibility that Ministers may be able to legitimate decisions or processes through statutory public involvement institutions. If the institutions provide a means to support political management of the NHS, including legitimising decisions or enabling Ministers to avoid blame, the clue to the areas of activity is likely to be found in the statutory powers of the institutions. These statutory powers receive little direct discussion within the public involvement literature; as discussed below, however, the powers are an implicit element in the literature as the powers determine the activities that are then the subject of research.

The statutory powers fall into two main areas: consultation rights; and inspection rights. For most of their history, statutory public involvement institutions have had privileged rights to be consulted on proposed changes to local services, a right that was replaced following *The NHS plan* with a duty of NHS institutions to consult on proposed

changes. Throughout their history, the institutions have had rights to enter and inspect NHS premises (a right broadened to include social care settings for Local Involvement Networks and local Healthwatch), to request information from service providers and to refer unresolved issues or problems to higher authorities. Viewed from the perspective of the institutions' statutory powers, two key threads emerge from within the literature discussed in this chapter: managing local representation in consultation exercises; and monitoring the quality of services.

Managing local representation

The balance of interests between the state, professionals and the public, as outlined in Section 2.1, is a central part of understanding the political management of the NHS. Within the wider politics of health literature, management of professional groups receives a great deal of attention (Salter, 2004: 7; Baggott, 2004: 49-54). Studies within the public involvement in health literature discussed in this chapter indicated that patients' associations and other lay interest groups are in a weaker position than professional groups and risk reducing their influence further through conflict between interest groups, so vetoing each other's input (Williamson, 1992: 2-3; Alford, 1975: 221). Green found that issue-specific groups were excluded until after decisions had been made (1987: 132). Hogg also suggests that NHS organisations may exclude issue-specific groups from discussions if they think that their input could be influenced by receipt of funding from the pharmaceutical industry (2007: 132).

Statutory public involvement institutions gather the views of interest groups and include interest groups within their membership. When Klein and Lewis examined the appointments processes for Community Health Councils, they found that groups for vulnerable people were particularly well represented in CHC membership. They proposed that this was a representation by proxy of 'the most vulnerable and perhaps least articulate members of the community' (Klein and Lewis, 1976: 38). Bates found that health administrators valued CHCs for their role in articulating the needs of vulnerable groups (1982: 97). Winkler reported that Community Health Councils gathered the views of local service users and interest groups, which she viewed as an extended form of consumerism (Winkler, 1987).

Representation of local communities, particularly local interest groups, is therefore a thread within the public involvement literature that warrants further examination in the

light of the role that coordinating representation might play in political management of the NHS.

Monitoring service quality

Monitoring the quality of services is a complex process for Ministers. Ministers are dependent upon health professionals to deliver health services and it is difficult to manage the activity of this highly-skilled professional group (Harrison and Pollitt 1994: 10).

The activities of statutory public involvement institutions described in the literature include activities that could be regarded as monitoring services, although they are not described in those terms. Klein and Lewis describe the importance of the rights to visit services as they provide 'the time and opportunity to inquire into, and form a judgement about, the state of the local health services' (1976: 122). They also refer to problems experienced by Darlington CHC, which had had difficulties gaining access to or information about local services and it later transpired that there were significant problems at the Darlington Memorial Hospital, giving rise to an inquiry by the Northern Regional Health Authority (Klein and Lewis, 1976: 130-131). The ability to visit and report on services suggests that statutory public involvement institutions may play a role in political management of the NHS by identifying and reporting problems.

Statutory public involvement institutions have also identified problems through concerns raised by health service users. Whilst they did not have a statutory role in complaints management, Community Health Councils provided support to complainants and all of the successive institutions have gathered feedback from service users. Hirschman's notion of voice was that consumers 'express their dissatisfaction directly to management or to some other authority to which management is subordinate or through general protest to anyone who cares to listen' (1970: 4). It is difficult for patients who are dependent on the NHS to make complaints, as they may fear that it will jeopardise the doctor-patient relationship (Hogg, 1999: 32). Statutory public involvement institutions provide a means for people to voice concerns, particularly those for whom private healthcare is not an option (Bates, 1982: 98). The public involvement in health literature demonstrates that statutory public involvement institutions play an active role in gathering feedback about local health services.

The combination of statutory rights (to visit services and to request information about them) and gathering feedback enables statutory public involvement institutions to play roles in monitoring service quality. This role may be an important one for Ministers

seeking to identify and act on problems before they become disasters (Alaszewski and Brown, 2012: 115-116).

Statutory public involvement institutions have tended to be discussed in the same terms as NHS-led involvement and interest group engagement. As statutory bodies, however, they are an alternative to these other forms of public involvement and need to be considered in terms of their statutory powers, as the statutory powers are their distinctive feature. Rather than considering statutory public involvement institutions in terms of consumerism or democratic engagement, this study draws on strands in the current literature that relate to the statutory powers of the institutions: managing local representation; and monitoring service quality. These elements are considered in terms of approaches to interest group management and public service oversight from the wider political science literature to form the basis of the theoretical framework for this study.

Chapter summary

This chapter reviewed the literature on public involvement in health services. It opened with an introduction to the underlying theme of the balance between state, professional and public interests in the politics of health services literature. The discussion of the literature on public involvement in the NHS took a chronological form, demonstrating how research interests have shifted over time. During the 1970s and 1980s there was an interest in statutory public involvement institutions as new organisations, with studies of their membership profile and the way in which they related to health authorities. In the 1990s, the literature reflected the creation of new NHS-led mechanisms for public involvement, such as citizens' juries, with research interests in consumerism and whether public involvement activities might address a perceived democratic deficit in the NHS. Since 2000, there have been several changes to statutory public involvement institutions, which have been the focus of academic interest. Alongside the changes to statutory public involvement institutions, there has been an increase in interest group influence and NHS-led activity, which have also been the focus of academic study. The chapter concludes by suggesting that statutory public involvement institutions are an alternative to the other forms of engagement and need to be considered in terms of their statutory powers. Whilst there is little explicit discussion of the statutory powers in the current literature, two key themes emerge that relate to those powers: managing local representation; and monitoring

service quality. These themes are reflected in the next chapter within the theoretical framework for this study.

Chapter Three: Research framework

This chapter presents the research design for this study, beginning with the research question, then the theoretical approaches and closing with the methods for the study. This research draws upon the indications in the existing literature of a potential role for statutory public involvement institutions in managing local representation or monitoring service quality. It questions the roles that the institutions may have played in political management of the NHS between 1974 and 2010. Two theoretically-derived approaches to examining the roles of the institutions are framed broadly as a 'sheepdog' and a 'watchdog'. A 'sheepdog' rounds up local representation, including potential opponents to change, and a 'watchdog' alerts actors to problems before they become disasters. This chapter discusses the theoretical background and operationalisation of each of these models. The final section discusses the methods selected to research the question using the two theoretically-derived approaches and the implications of the methods and sources used. This includes a review of the issues involved in analysing documents that were not created for research into statutory public involvement institutions, such as evidence presented to public inquiries.

3.1 Research question

Each time Secretaries of State have abolished statutory public involvement institutions, they have had the opportunity not to replace them. The abolitions, however, have been followed in each case by state funding of new institutions. In the light of the growth of alternatives to the statutory public involvement institutions as mechanisms to engage the public in decisions about health services, this ongoing investment can be seen as a puzzle. This puzzle provides the starting point for engaging with the current literature and developing the research question (Hancké, 2009: 15). Ongoing state funding and investment in redesign of the institutions suggests that national politicians responsible for the NHS have seen statutory public involvement institutions as playing a role, or roles, beyond that provided by either self-generating interest groups or NHS-led involvement. The existing literature on the broader politics of health, as discussed in Chapter Two, includes indications that the institutions may play roles in managing local representation and monitoring the quality of services. Managing interest groups, particularly where the groups oppose reforms, presents a major challenge to politicians (Pierson, 1994: 19). Ministers also find it difficult to manage the activities of expert health professionals and need timely intelligence on locally-delivered health services to help them to avoid disasters

(Alaszewski and Brown, 2012: 39, 115). The suggestions of managing local representation and monitoring services within the existing literature may be indications of roles played by statutory public involvement institutions in political management of the NHS.

Statutory public involvement institutions may be seen as a distinctive form of public involvement owing to their statutory powers. The powers granted to statutory public involvement institutions have included privileged consultation rights, such as the ability to reach local agreement on hospital closures, rights to enter and inspect NHS premises and the ability to refer issues directly to the Secretary of State responsible for health services. These powers could be seen as a puzzle in the context of public involvement if such involvement is understood purely in the terms of some of the themes within the public involvement in health literature, such as consumerism or addressing a democratic deficit. The powers also highlight that the institutions are a very particular form of public involvement, distinct from self-generating groups or consultation led by NHS personnel. This suggests that the growth of self-generating interest groups and NHS-led forms of involvement has not provided a direct alternative to statutory public involvement institutions.

The nature of the statutory powers could indicate that statutory public involvement institutions play a more formalised role in Ministerial management of the NHS than that described in the existing literature on public involvement in health services. One dimension to disentangling the puzzle of ongoing investment is therefore to consider whether the statutory powers granted to the institutions are indicative of roles Ministers wish them to fulfil. This study takes concepts from the broader political science literature and considers whether statutory public involvement institutions have played a role in Ministerial management of health service politics. Framed as a research question: **what role(s) have statutory public involvement institutions played in political management of the English NHS, 1974-2010?**

This research question is specific to the institutions within the National Health Service, but it also links to the broader issues of the role played by citizens in public service governance and the tools available to political actors overseeing complex services. The research question can be broken down into several parts. The first part is the potential role or roles; as discussed below, the potential roles explored in this study draw upon issues of managing interests and managing expertise within the political science literature. The second element in the question, the statutory public involvement institutions, refers to the succession of institutions in the NHS in England: Community

Health Councils; Patient and Public Involvement Forums; and Local Involvement Networks. For the purposes of this study, political management of the NHS refers to the nationally coordinated processes that enable Ministers and other nationally-elected politicians to oversee the health service and to facilitate reforms. The focus of this research is on the NHS in England during the period 1974 to 2010. The timeframe from 1974 covers the period from the establishment of Community Health Councils to the consultation in 2010 on the replacement of Local Involvement Networks with local Healthwatch.

Two theoretically-informed approaches form the basis of potential roles and the sub-questions in this study. The first considers the role that statutory public involvement institutions may have played in managing interests. It uses a 'sheepdog' analogy: a sheepdog may round up sheep to ensure that they are all accounted for, but it may also keep the sheep penned in to enable the farmer to manage them, such as by shearing the stock or undertaking medical procedures. Drawing on the public involvement in health literature, a sheepdog may ensure that vulnerable groups are represented (Klein and Lewis, 1976: 38; Klein, 1984: 30). Considered from a welfare state retrenchment perspective, a sheepdog may manage the involvement of more dominant groups to prevent mobilisation of opposition to reforms (Pierson, 1994: 19). The first sub-question considers the two dimensions to the sheepdog role: **do the institutions act as 'sheepdogs' rounding up participants and managing potential opposition?** The second sub-question uses a 'watchdog' analogy in the context of managing expertise in health services. Participants in statutory public involvement institutions have often referred to themselves as 'watchdogs' (as an example, see Gerrard, 2006: 79), but have not provided a theoretical basis for the 'watchdog' role. Considered from the perspective of the legislative oversight literature, statutory public involvement institutions may gather intelligence about local services and alert political actors to problems before they become disasters. This provides the second sub-question: **do the institutions act as 'watchdogs' preventing disasters in the NHS?**

The canine analogies in the two sub-questions are based on the theoretical frameworks described below, but also draw upon the language used by statutory public involvement institutions to describe their role:

'Community health councils are the watchdogs of the National Health Service. Haringey CHC liked the image and chose a dog's head for badges and publicity material when they meet people at Wood Green Shopping Centre during the [awareness] Week. What sort of dog? Alsatian. – too fierce. Poodle? – well...

Compromise? “A sort of labrador” with a CHC telephone number on its collar.’
(Association of CHCs for England and Wales, 1983c: [unpaginated])

The volunteers who had given their time wanted to be seen to have a definite role, rather than being a ‘poodle’. An interpretation of this third dog could be to see statutory public involvement as a form of symbolic politics (Harrison and McDonald, 2008: 122). Edelman suggests that participation mechanisms, such as voting, may be ritual acts that come to symbolise involvement even when the general public have limited influence over policy (1985: 2-3). Considered from this perspective, Ministers may wish to be seen to provide a mechanism that symbolises participation without giving a more definite role. This study considers the potential of the sheepdog and watchdog roles, but with the underlying possibility that statutory public involvement institutions may prove to be poodles.

The next two sections of this chapter consider the theoretical underpinnings and operationalisation of the sheepdog and watchdog roles for statutory public involvement institutions in political management of the NHS. This leads into a discussion of the research design and methods.

3.2 Sheepdog and watchdog: theoretical framework

The theoretical approaches underlying the sheepdog and watchdog roles are drawn from within the political science literature. This section presents the concepts underlying the sheepdog and watchdog roles in turn. It then discusses the potential reasons why Ministers might choose to work with statutory public involvement institutions, including the risks a Secretary of State would need to consider in working with groups of volunteers to support political management of the NHS. It also considers whether the sheepdog and watchdog can be combined and issues around the activity of sheepdogs and watchdogs that could lead to the decision to abolish and replace statutory public involvement institutions.

Sheepdog theoretical framework

Issue-specific interest groups have grown up alongside the development of the National Health Service, with a growth in the number of patients’ organisations particularly since the 1970s (Wood, 2000: 39). For the purposes of this study, ‘interest groups’ refers to patient associations, community groups and other groups with an interest in health services, such as Leagues of Friends for NHS institutions. Interest groups supporting

particular aspects of the NHS have become prominent social actors (Pierson, 1994: 29). These groups are supportive of developments at times of welfare state expansion. The combination of ageing populations and the development of more sophisticated medical technologies, however, increase health service costs and mean that mature welfare states face austerity rather than the expansion of public services (Pierson, 2001: 103). In a climate in which resources are tight, difficult decisions have to be made about the allocation of resources. With changes to health services, there is the risk that better-resourced groups will be heard to voice opposition, whereas the views of less dominant groups, often representing vulnerable communities, may not be heard. Changes to health services may include the closure of services. Closures are unpopular with existing interest groups and, in the case of hospital closures, may lead to the development of new groups specifically to oppose the changes. Pierson suggests that whilst voters may resent paying taxes, they respond more strongly to perceived service losses than they do to reductions in the tax burden (1994: 2). Organised opposition to reform can slow down proposed changes (Korpi and Palme, 2003). To reduce delays to changes, therefore, one of the political tactics that has been identified in the welfare state retrenchment literature is to reduce the mobilisation of opposition to reform (Pierson, 1994: 19). Whilst Pierson was writing specifically about welfare state retrenchment, his discussion of tactics can be applied to management of potential opposition to reforms more generally. Rounding up interest groups may moderate their participation, or it may rig the system so that vulnerable groups are represented and the issues raised are only those that are of concern to the wider population rather than well-resourced groups (Klein, 1984: 30).

One of the problems for political actors seeking reforms is that major social policy programmes, such as delivery of health services, affect large numbers of people who either participate in or are represented by well-organised groups (Kitschelt, 2001: 267). Wood's research into patient groups in Britain suggests that politicians may see issue-specific interest groups as only being concerned with the needs of "their" members, rather than taking a broader approach to the services needed across the community or the broader health service (2000:13). When it comes to implementation of health services policy, it is often the activity of local groups that can help or hinder developments, as NHS services are delivered locally and attract the support of local groups. The local services tend to be very tangible, such as the presence of a local hospital or a service for people with a particular health problem, making local mobilisation more likely if services are perceived to be at risk. Ministers at points of reform may have therefore seen local issue-specific interest groups as a threat to policy implementation and so sought mechanisms to

manage participation by issue-specific groups in local health service consultation processes. As discussed in Chapter Two, Klein and Lewis found that the appointment processes for Community Health Councils were designed to ensure that representatives of groups for vulnerable people were included as members, alongside representatives of well-resourced groups (1976: 38). This may have been part of a sheepdog structure to moderate the input of groups that have more powerful voices. Statutory public involvement institutions were designed to have privileged consultation rights, so the structured representation of interest groups in their membership may have created a means for intermediation between interest groups and local health services. In this sense, they may be understood as a form of corporatism at a local level to manage representation of interests and prevent potential mobilisation of opposition by issue-specific interest groups.

Schmitter distinguishes between self-generating corporatism as 'societal corporatism' and collaborations developed by the state as 'state corporatism' (1974: 103). A form of societal corporatism would be a cartel to protect the trade interests of a group of producers. State corporatism would be an association for interest intermediation created by the state to shape the relationship between member organisations and the state. Schmitter initially described the activity of corporatist associations as a form of 'interest representation', but he later revised this to 'interest intermediation':

'By switching to the more awkward and less frequently used expression "interest intermediation", I mean to emphasise that these associations not only may express interests of their members, and/or play an important role in teaching their members what their interest "should be", but also often assume or are forced to acquire governmental functions of resource allocation and social control. Representation (or misrepresentation), hence, may be only one of the activities of these associations, occasionally not even the most important one.' (Schmitter, 1977: 36).

Schmitter's assertion that corporatist associations play an 'important role in teaching their members what their interest "should be"' suggests that a corporatist interpretation of statutory public involvement institutions could be that they would direct their issue-specific member organisations away from mobilising opposition to changes. The extension of Schmitter's justification for the shift in terminology to encompass the expectation that corporatist associations would 'acquire governmental functions of resource allocation and social control' sits with a desire of national elected politicians to avoid taking blame for unpopular decisions about health service allocation. Strategies for blame avoidance are discussed below and incorporated into the operationalisation of statutory public involvement institutions as a sheepdog rounding up potential opposition to reforms.

Schmitter proposes nine characteristics of corporatism, which he states can be applied both to state corporatism and to societal corporatism (1974: 103-104). Three of these characteristics relate to an interest intermediation role: the corporatist associations are singular bodies (in the case of statutory public involvement institutions, a single representative of issue-specific groups at a local level); they are non-competitive, as they hold singular rights; and they are hierarchically ordered. Corporatist associations are also described by Schmitter in terms that reflect their role in structured consultation: they have a limited number of members; there is compulsory representation of particular communities; the state grants monopoly consultation rights in return for intermediation; and there are controls set by the state on leadership selection and interests articulation. The remaining two characteristics reflect a state-determined remit: corporatist associations are functionally differentiated, having a remit that covers a particular function; and they are recognised by the state for the purposes of intermediation in relation to that function. This grouping of the elements in Schmitter's model produces three characteristics when applied to local corporatist bodies: mediating between local interests; structuring consultation on local services; and considering issues within a state-determined remit. These three characteristics are incorporated into the operationalisation of the sheepdog role in Section 3.3 and Figure 3.1 below.

Associations that have these corporatist characteristics may be able to manage opposition to reforms. Discussions of corporatism tend to focus on national peak organisations, with a national intermediation role. Cawson suggests that corporatism is a political structure associated with the centre, whereas competitive politics are more significant at the local level (1985: 134). The local activity of statutory public involvement institutions could be interpreted as placing difficult decisions about health service reforms at a convenient distance from Ministers. Schmitter's statement on the change from interest representation to interest intermediation mentioned that corporatist associations may be 'forced to acquire governmental functions of resource allocation' (1977: 36). Involving interest groups in the difficult decisions may make it harder for the interest groups to oppose changes in which they have been involved. Transferring responsibility for local resource allocation decisions to local corporatist structures could also be a way to shift blame from national politicians to local groups.

Blame avoidance is described by Weaver as the primary motivator for elected politicians, as voters are more likely to respond negatively to losses than they are to respond positively to gains (1986: 317). There is a parallel here with the use Harrison and Mort identified of public involvement as a means to legitimise decisions, a tactic which

could be transferred into avoiding blame for a decision if it proved to be unpopular (1998: 66). If opposing a measure has little chance of success, a politician may feel that they are less likely to be blamed by voters if they portray themselves as powerless to influence the decision (Weaver, 1986: 379). Weaver identifies eight blame-avoiding strategies, ranging from keeping the issue off the agenda to seeking consensus, so that all participants cover for colleagues (1986: 384-389). One of these strategies is 'passing the buck': if a blame-generating decision has to be made, politicians are likely to delegate that decision to someone else (Weaver, 1986: 392). Weaver draws on work by Fiorina for his 'passing the buck' strategy. Fiorina suggested in a 1982 paper that delegation to regulatory authorities is a deliberate attempt to shift the political costs of decisions and he later proposed that rational actors may choose the uncertainty of a delegated decision over the certainty of retaining responsibility for an unpopular decision (1982: 46; 1986: 38). The creation of state-funded local institutions provided national politicians with the opportunity to delegate local decisions that were likely to have an unpopular outcome.

Considered from the perspective of managing interest group involvement, do statutory public involvement institutions act as 'sheepdogs' rounding up participants and managing potential opposition to NHS reforms? The theoretical basis for this question is taken from the need expressed in the welfare state retrenchment literature for national politicians to manage opposition to reforms, modelled through the characteristics of state corporatism and the strategy of blame avoidance. It also draws upon elements in the literature on public involvement in health literature that refer to representation of less well-resourced groups through statutory public involvement institutions (Klein, 1984: 30). On the basis of the corporatist association characteristics, if statutory public involvement institutions managed opposition they would mediate between local interests, structure consultation on local services and consider only a state-determined range of issues. Adding an explicit role to enable national politicians to avoid blame for unpopular decisions, the statutory public involvement institutions would be granted delegated responsibility for unpopular local decisions.

Watchdog theoretical framework

The second sub-question considers whether statutory public involvement institutions may alert national politicians to problems before they become disasters. This theoretical approach comes from the legislative oversight literature, which treats political actors as principals facing the challenge of managing agents who may hold greater

expertise than the principals on their specific areas of work. To manage expert agents, political principals need information on the agents' activities. The need for feedback to improve services is a core element in the consumerist literature, but in this case the theory is drawn from the literature on preventing disasters. Ministers seek to avoid disasters in the NHS as the electorate and the media may criticise the Government for not having acted to prevent the problem (Alaszewski and Brown, 2012: 139). If disasters cannot be avoided entirely, Ministers need to receive information quickly, so that they can be seen to act without being forced into a position in which there is little scope for a rational policy response (Alaszewski and Brown, 2012: 138). The legislative oversight literature examines mechanisms for gathering information, or 'the "watchdog" function of legislatures which monitors the implementation and administration of laws and policies by state agencies' (Hagens, 1974: 170). The language and examples used in much of the legislative oversight literature reflect the systems in the United States and the role of Congress. For the purpose of this study, these are the political oversight mechanisms used by elected politicians to oversee the NHS in England.

Considering Ministers as principals overseeing the work of agents with high levels of expertise, the Ministers need independent intelligence on the agents' activity. Principal-agent models of the relationship between politicians and expert agents tend to suggest that oversight may be most effective when it is least apparent (Ogul and Rockman, 1990: 6). McCubbins and Schwartz challenge the notion that Congress may be neglecting oversight responsibility if it does not develop overt oversight mechanisms (1984: 165). They nominate a distinction between overt 'police-patrol oversight' and less apparent 'fire-alarm oversight'. In the form of a police patrol, oversight would be a comparatively centralised process, with samples of activity assessed to discourage violations and mechanisms to identify problems through surveillance (McCubbins and Schwartz, 1984: 166). With a fire-alarm oversight system, the principal would create 'rules, procedures and informal practices' to enable citizens and interest groups to alert the principal to any problems (McCubbins and Schwartz, 1984: 166). Thus, the police patrol is a professionalised process, whilst fire alarms depend upon third parties to gather information.

McCubbins and Schwartz suggest that police patrols tend to be the assumed legislative oversight mechanism in much of the literature (1984: 170). On the analogy of actual police patrols, this form of oversight consists of surveillance that will either detect and remedy problems or discourage violations (McCubbins and Schwartz, 1984: 166). Personnel within police patrols are not directly involved in managing services, so do not

have the same incentive to shirk or to provide misinformation as expert agents would do. McCubbins and Schwartz indicate that information collection methods would include: reading documents; commissioning scientific studies; conducting field observations; and holding hearings to question officials and affected citizens (1984: 166).

Engagement with police-patrol oversight takes a great deal of time for political principals, including detecting and remedying violations that do not cause harm to potential supporters or voters and so are unnoticed by them (McCubbins and Schwartz, 1984: 168). A second downside of police-patrol oversight is that it is impossible to create a system that is comprehensive, so violations will still slip through (1984: 168). Thirdly, many of the costs of a police patrol, whether time or financial cost, are borne by political principals, whereas the major costs of fire-alarm oversight are borne by voluntary third parties (McCubbins and Schwartz, 1984: 168).

Effective fire-alarm oversight depends upon mechanisms that enable citizens and interest groups to notify principals of problems. Fire-alarm oversight does not suggest a lack of activity by the political principal, but an investment in the statutory provisions that enable a fire alarm to be effective – extending the analogy, Bawn proposes that the principals are ‘dispensing fire extinguishers and establishing guidelines for a fireproof environment’ (1997: 104). A fire alarm may be a preferred mechanism from an elected politician’s perspective as: firstly, issues that cause harm are more likely to be raised, rather than procedural violations, so the time costs to politicians are low; secondly, the costs of monitoring are borne by interest groups, so the resource costs are lower for the politician than maintaining a regulator to provide a police patrol; and, thirdly, a political actor can receive credit from potential supporters if the politician is seen to intervene in response to a public concern, gaining a beneficial response from any adverse publicity about the failing service that has been generated by the interest group (McCubbins and Schwartz, 1984: 167). This third dimension is attractive from the perspective of relationships with the electorate, as it means that the politician could be seen to act to prevent a problem from becoming a disaster.

In their model of fire-alarm oversight, McCubbins and Schwartz propose that fire alarms are local rather than centralised bodies. McCubbins and Schwartz identify specific rights that would be needed by citizens and interest groups to enable them to act as fire alarms: firstly, access to information; secondly, access to decision-making processes; thirdly, standing to challenge administrative decisions or to bring alleged violations to the legislature’s attention; and finally, the ability to facilitate ‘collective action by comparatively disorganised interest groups’ (1984: 166). Most fire-alarm oversight mechanisms depend

upon feedback from independent pressure groups, which may cause bias as problems that are a concern for well-organised groups may be more likely to be voiced (Hopenhayn and Lohmann, 1996: 209). Whilst McCubbins and Schwartz refer to facilitating 'collective action' within their model, the collective action is a form of moderation or filtering, assessing the issues that are of greatest general concern and focussing on these rather than those issues that are of concern to well-resourced groups (McCubbins and Schwartz, 1984: 166). By funding statutory public involvement institutions in the NHS, political principals may have created mechanisms that would voice the concerns of less-organised groups and extend their interests beyond an issue-specific approach.

If principals are to learn from fire-alarm oversight, they have to be sure that citizens or interest groups that voice concern are telling the truth (Bawn, 1994: 139). The legislative oversight literature uses descriptors such as 'false alarms' and 'lying' (Lupia and McCubbins, 1994: 100). In essence, when applying the model to the NHS, elected politicians need to be sure that they are not being misinformed by their sources. Lupia and McCubbins identify two conditions under which principals can trust fire alarms: firstly, where there are penalties for lying; and secondly, where the legislators perceive the citizen or interest group to have similar preferences to their own (1994: 111).

McCubbins and Schwartz suggested in their original paper that political principals can choose between three general options for oversight mechanisms: police-patrol oversight alone; fire-alarm oversight alone; or a combination of both police-patrol and fire-alarm methods (1984: 167). When Lupia and McCubbins revisited the model, they indicated from a review of the literature that police patrols may never be comprehensive enough to enable political principals to manage the expertise of agents (1994: 97-98). A combined model may therefore be attractive to Ministers overseeing the National Health Service. This use of a combined model could contribute to explaining the ongoing investment in re-shaping and funding statutory public involvement institutions if they are acting as fire alarms alongside changing systems of police-patrol oversight.

Considered from the perspective of politicians' need to be alerted to problems before they become disasters, do statutory public involvement institutions act, to use the phrase current in descriptions used by members of the institutions, as 'watchdogs' alerting Ministers to problems in the NHS before they become disasters? In this context, the term 'watchdog' is used to refer to fire-alarm-style oversight rather than regulators, or the professional police patrol. McCubbins and Schwartz identified four institutional roles that interest groups need to be able to fulfil if they are to act as what they refer to as 'fire

alarms' (1984: 166). These are used here as the basis for the operationalisation of a role for statutory public involvement institutions as watchdogs helping to prevent disasters.

Political choice of sheepdog and watchdog functions

Systems to round up participants (sheepdogs) or to provide alerts (watchdogs) can be kept separate, or they can be combined. When overseeing participation and minimising opposition to reforms, a Secretary of State can choose from a range of options: working directly with interest groups; encouraging NHS personnel to involve members of the public in decision-making processes; or creating a state-funded structure for involvement. Each of these forms of involvement is associated with risks. Working with interest groups may bias activity in favour of better-resourced groups, potentially leading to punishment from the wider electorate if a particular group is seen to be favoured. When NHS personnel lead on involvement activity, whether as specific consultations or more recently through membership of NHS Foundation Trusts, they may use it to legitimise plans that do not match national policy (Harrison and Mort, 1998: 67). Given the alternative of NHS-led consultation or working with issue-specific interest groups, creating a statutory public involvement institution (or sheepdog) could provide Ministers with a means to structure participation whilst continuing to keep difficult decisions at the local level. In terms of avoiding disasters in the NHS, a Secretary of State can choose between: greater regulation; alerts provided by independent interest groups; or a combination of regulation and local voluntary intelligence. By combining an alert mechanism (or watchdog) with a structured form of public involvement (or sheepdog), a national politician has the potential of a more vigilant watchdog, drawing on expertise from members in a range of local interest groups and only raising issues that are a broad concern.

Statutory public involvement institutions provide an opportunity for national politicians. Depending upon particular political preferences, they can be utilised as a sheepdog or as a watchdog. As a sheepdog, they ensure that no one interest group becomes the dominant voice and they may potentially take the blame for unpopular local decisions. At times when interest groups are regarded with some suspicion, the sheepdog is a valuable tool to moderate influence and to ensure that less well-resourced groups are represented. When governments are encouraging direct participation by interest groups, the sheepdog role is of less value to Ministers.

As part of a watchdog, local volunteers who have a passionate interest in services can observe the local NHS over time in a way that would not be affordable with a

professional oversight mechanism. The extent to which a watchdog is valued will depend upon whether Ministers feel that problems are likely to be visible (such as cultural behaviours or cleanliness) or whether Ministers take the view that a problem will only become apparent through statistical comparison between services. At times when governments believe that problems with health services could be observed by volunteers, statutory public involvement institutions may provide a structured means to learn from the volunteers' insights. When police-patrol oversight is the predominant model, watchdogs may have less value.

The value of statutory public involvement institutions to Ministers also depends upon the extent to which they are prepared to take the risk of being dependent upon volunteer-led organisations. Unlike contracted members of staff, volunteers have choices about the priority they give to different aspects of their role. Including volunteers in processes that form part of a Secretary of State's political management of the NHS requires the Secretary of State to trust that they will fulfil the role expected, or that there will be no backlash from the outcome if they do not do so. If a national politician wants to avoid blame for an issue delegated to a statutory public involvement institution, they have to be sure that the institution will be taken sufficiently seriously to take the blame and to be confident that most of the delegated decisions would not put other plans at risk (Weaver, 1986: 379). If a group of volunteers is to have the authority to take the blame for unpopular decisions, it needs to be seen to have related powers.

Once volunteer-led organisations have been established, they can be hard to abolish in a meaningful sense. As individuals, volunteers give time, passion, commitment and, subject to the recruitment criteria, expertise. This commitment means that statutory public involvement institutions may achieve a great deal with limited financial resources, but it also means that the institutions are hard to abolish in a true sense, as individuals who care about NHS services will volunteer to be part of the next institution, or use their skills within other voluntary organisations. The ongoing investment in statutory public involvement institutions may therefore include an element of path dependency, or self-reinforcing direction, as the volunteers who commit their time cannot be abolished (Pierson, 2004: 10-11).

The creation of statutory public involvement institutions provides Ministers with organisations that are dependent on state funding and subject to top-down reform. In this sense, they differ from the self-generating interest groups and NHS-led involvement mechanisms. If the statutory public involvement institutions fail to operate as Ministers expect them to do, a Secretary of State can reform the institutions. Considered from the

perspective of sheepdog and watchdog roles, a sheepdog would cease to be valued by Ministers if it used its ability to round up interests in a rogue fashion, rounding up opposition rather than intermediating. In the case of the watchdog, there may be a political preference for police-patrol oversight, such as improved technologies for gathering and analysing statistical data, which would reduce the value of a watchdog. If statutory public involvement institutions undertake roles in political management of the NHS, then shifts in the value placed by Ministers on those roles are likely to form part of any changes to the institutions. This may include separating the sheepdog and watchdog roles, or giving differing emphasis to each role. Political actors have choices in the extent to which they utilise either the sheepdog or the watchdog role, including the choice of whether to fund them at all.

3.3 Operationalisation of sheepdog and watchdog roles

This section discusses the operationalisation of the theories underlying the sheepdog and watchdog roles. The process of operationalising theory converts aspects of a theoretical approach into the operational findings that would be expected to provide evidence to support the theory (Manheim and Rich, 1986: 7). In each case, the institutional role suggested from the theory is considered in terms of the elements a state would determine, the likely statutory documentation or powers that would show that this is the case and operational findings, such as reports, which would provide evidence of a political role as a sheepdog or as a watchdog.

Operationalisation of sheepdog role

Four institutional roles were identified in the discussion of theory to explore whether statutory public involvement institutions act as tools to round up participants and manage potential opposition, the sheepdog role in political management of the NHS. The first three of these came from a corporatist approach to interest group management and the fourth from the notion in the blame-avoidance literature that politicians seek to delegate unpopular decisions. These institutional roles form the starting point for Figure 3.1.

Each of the potential institutional roles is operationalised in Figure 3.1. The institutional roles are listed in the left-hand column. These are taken from the discussion of the theoretical basis for the possibility that statutory public involvement institutions round up participants and manage potential opposition. The second column outlines what it is

that the state would determine for each of the institutional roles in the sheepdog model. This relates closely to the third column, summarising the statutory evidence that the institutions have the relevant powers to undertake each of the institutional roles. The right-hand column is headed 'operationalisation' and summarises the likely evidence that statutory public involvement institutions fulfilled these institutional roles in practice.

Figure 3.1: Sheepdog – roles in rounding up participants and managing potential opposition			
Institutional role	State determines	Statutory evidence	Operationalisation
Mediate between local interests, including vulnerable groups	Intermediation role to be undertaken by statutory public involvement institutions	Statutory membership requirements, processes to involve vulnerable groups and consultation responsibilities	Reports of interests being referred to institutions to mediate on issues; Accounts of institutions forming consensus views
Structure consultation on local services	Consultation rights and responsibilities	Statutory consultation rights or guidance to NHS personnel on consultation	Reports of consultation role undertaken or state expectation of role
Consider only state-determined range of issues	Remit (e.g. single hospital or health and social care)	Institutional design and breadth of statutory rights	Reports of institutions being prevented from taking broader or alternative remit
Take responsibility for unpopular local decisions	Decision-making powers or rights to agree proposals	Statutory powers or guidance on taking politically difficult decisions	Accounts of institutions blamed for delegated decisions; Ministerial comments on role

Taking each of the institutional roles in turn, if the institutions mediated between interests and ensured representation of vulnerable groups, the state would determine the intermediation role to be undertaken by statutory public involvement institutions. This would include determining the types of interest groups for whom the institutions would act as mediators and the issues on which they would mediate. The statutory powers to enable this would be statutory membership requirements, processes that ensured the representation of vulnerable groups and consultation responsibilities. Evidence of statutory public involvement institutions mediating between interests would come from reports of activities, including reports from issue-specific interest groups. Expected operationalisation of mediating between interests would include reports of interest groups being referred to statutory public involvement institutions, rather than approaching those involved in decision-making processes directly, or of statutory public involvement institutions working with local interest groups in order either to reach a consensus or to implement the output of a consensus that has been reached elsewhere.

The second of the institutional roles is to structure consultation on local issues. The state would determine the consultation rights and responsibilities of statutory public involvement institutions. This might take the form of statutory consultation rights or guidance to NHS personnel on how to consult. If the institutions structured consultation in ways that manage public opposition, this would be apparent in reports of the role that the institutions had undertaken or in comments from Ministers or other state representatives about their expectation of the institutions and whether that expectation has been fulfilled in particular cases.

If statutory public involvement institutions were expected to manage opposition by considering only a state-determined range of issues, this would be apparent in the state-determined remit. In the context of managing opposition to local changes in health services, the breadth of the remit would be significant, such as whether particular NHS services are included and whether the range of issues on which the organisations have a statutory right to be consulted extend to social care. The statutory evidence for this would be the institutional design and breadth of statutory rights. At an operational level, if the statutory public involvement institutions were expected to manage opposition by keeping to a narrow agenda, evidence of state expectations of this role could be found in reports of the institutions being prevented from taking a broader remit, or blamed for having done so.

The fourth of the institutional roles is taken from the literature on political blame avoidance. Considered from this perspective, statutory public involvement institutions take responsibility for unpopular decisions that are delegated to them. If this were the case, the state would determine decision-making powers or delegate powers to agree proposals. The statutory evidence of this would be statutory powers or guidance from Ministers on taking politically difficult decisions. In practice, this would lead to accounts of the statutory public involvement institutions being blamed for taking the decisions delegated to them, or there would be evidence of the deliberate delegation of difficult decisions in Ministerial comments on the role.

This operationalisation of the sheepdog role is used as the basis of the empirical study of the successive statutory public involvement institutions in Chapters Four and Five.

Operationalisation of watchdog role

On a similar model to the discussion of the sheepdog, the operationalisation of preventing disasters, or the watchdog role, commences in the left-hand column of Figure

3.2 with institutional roles, extending into what the state determines in relation to each role, the statutory evidence for the state-determined role and potential operational findings.

Figure 3.2: Watchdog – roles in preventing disasters

Institutional role	State determines	Statutory evidence	Operationalisation
Gather intelligence about local services	Access to information, including complaints; Access to enter and inspect services	Statutory rights to access information and to inspect services	Reported state expectation of inspection and gathering information
Influence decisions about local services	Consultation rights	Statutory consultation rights or guidance to NHS personnel on consultation	Reports of involvement or state expectation of involvement
Challenge local decisions and refer problems	Rights to refer unresolved issues to higher authority	Statutory rights to challenge local decisions or practice and to refer unresolved issues	Report of state expectation that would challenge decisions and refer issues
Filter significant issues from problems raised by interest groups	Mediation role in working with interest groups	Statutory rights to work with interest groups or include them as members	Reports of interests referred to institutions to mediate on issues; Accounts of support for vulnerable groups' interests

The first of the institutional roles, as outlined in Figure 3.2, is to gather intelligence on local services. In order to do this, the state determines the rights that statutory public involvement institutions have to receive information from complaints and other sources and to enter and inspect services. Evidence for this from a statutory perspective would be the rights to receive information and to inspect services. If statutory public involvement institutions either use these tools to prevent disasters or are expected to do so, this should be evident operationally in examples either of Ministers expressing the expectation that the institutions should gather information in order to report problems before they become disasters.

The second aspect of the watchdog role is access to decision-making processes (McCubbins and Schwartz, 1984: 166). In the context of statutory public involvement institutions, this is expressed in Figure 3.2 as a role in influencing decisions about local services. In order to ensure that local groups of voluntary members of the public are able to influence decisions about local services, the state would need to grant consultation rights, which would be included in statutory rights or guidance to NHS personnel on consultation. Operational evidence of influence on decisions about local services would be apparent from reports on involvement (particularly reports that have not been written by

the statutory public involvement institutions themselves) and expectations of influence and involvement expressed by Ministers or other representatives of the state.

The third institutional role in preventing disasters is the ability to challenge local decisions or practice in the interests of the local community. In order to do this, institutions need to have state-determined rights to refer unresolved issues to a higher authority. This would be reflected in statutory rights to challenge local decisions or practice and to refer unresolved issues to a higher authority. Examples of challenging local decisions or practice would be apparent in reports of specific cases; if Ministers responsible for health services expect statutory local involvement institutions to challenge local decisions and refer issues, this would be apparent in comments made either when issues have been referred or when local institutions have failed to report unresolved issues.

Fourthly, institutions involved in preventing disasters would mediate between local issue-specific groups, filtering issues to ensure that significant issues and the concerns of less powerful interest groups were raised, rather than the concerns of the most vocal groups. If the state expected such a mediation and filtering role to be taken, this would be seen in statutory membership requirements and responsibilities to involve and consult other issue-specific groups. Operational evidence of mediation would include reports of issue-specific groups being referred to statutory public involvement institutions to mediate on issues and accounts of statutory public involvement institutions promoting the concerns of less powerful groups or issues relevant across the local population.

In McCubbins' later work with Lupia, he tackled the issue of ensuring that interest groups who raise alarms are not deliberately providing misinformation. As outlined above, Lupia and McCubbins found that to prevent misinformation, politicians need to ensure that there are penalties for providing misinformation or the politicians need to be confident that the interest groups have similar preferences to their own (1994: 111). This element has not been incorporated directly into the operationalisation of a watchdog, or fire-alarm oversight, but forms one of the elements to be considered in accounts of public involvement and rationales given for changes to statutory public involvement institutions.

This operationalisation of the watchdog role is incorporated with the sheepdog within the research design discussed below.

3.4 Research methods

This section reviews the methodological choices made in developing the research. It opens by discussing the process of refining methods, followed by the selection of archival sources and the methods chosen for data analysis.

Refining methods

The research question and sub-questions were refined initially on the basis of elite interviews. Six potential interviewees were identified, selected on the basis of their knowledge of the successive statutory public involvement institutions. In each case, the potential interviewees held positions at a national level where they were interacting between local statutory public involvement institutions, the Department of Health and Ministers. Five of the six individuals identified agreed to be interviewed. As these were elite interviews, the questions asked varied slightly, on the basis of the particular experience of the interviewees. The interviewees were asked about their experience of the relationship between local statutory public involvement institutions, the Department of Health and Ministers. They were also asked about their views on the changes to statutory public involvement institutions and to provide any suggestions for data sources.

The elite interviews confirmed that the broader question of the role played by statutory public involvement institutions in political management of the NHS was a valuable topic and not a question that those heavily involved in the institutions had considered previously in any detail. As these were exploratory interviews, they were not intended to act as data sources; where material from the interviews has been used in the dissertation, this is acknowledged and attributed.

Operationalisation of the sheepdog and watchdog models indicated that documentary sources would provide the materials needed to examine each dimension of the two potential roles played by statutory public involvement institutions. Documentary sources also had the advantage in a study covering the period from 1974 to 2010 of providing data that were not dependent upon interviewees' distant memories. The sources relevant to operationalisation of the sheepdog model are largely found in the archives of the statutory public involvement institutions themselves and contemporary records in accounts by other organisations of the institutions' activities. The watchdog model is slightly different, as it is assessing Ministerial expectations of whether the statutory public involvement institutions provided intelligence in time to prevent a disaster or were expected to have done so. Lewis and Klein mentioned in their study that a lack of

information provided to Darlington Community Health Council was of interest as Darlington Memorial Hospital was later the subject of an inquiry by the Northern Regional Health Authority (1976: 131). This reflection on the regional inquiry suggested that public inquiries, which only arise when there has been a serious failure, would be likely to indicate if statutory public involvement institutions had either raised an alarm or failed to do so.

Archival sources

Archival sources tend to be associated with research by historians. Early researchers in the social sciences, however, made extensive use of documentary archives: Marx analysed reports from factory inspectors, Weber appraised religious pamphlets and Durkheim reviewed official statistics on suicide (Scott, 1990: 1). The extent of material available in archives varies. Researchers are dependent upon materials having been deposited in the first instance and then retained. Not all official documents are published and those that are retained in open archives may be a small selection of the original material (Scott, 1990: 63). Survival of material also depends upon it taking on a non-transient form. Back in 1990, Scott warned that the development of electronic sources could reduce the amount of material available in archives, as the content might not be printed out or stored in a form in which it would remain accessible (1990: 196). As discussed below, two of the electronic archives used for this research were taken offline during the course of the study, reducing opportunities for replication and future research.

The state-determined rights of statutory public involvement institutions were examined through legislative documentation and guidance notes. Acts of Parliament can be accessed online. Statutes are also available online whilst they are in force²²; once they are no longer in force, printed copies have to be tracked down through paper archives. Health service circulars and other guidance notes have been issued online since 1997 and can be traced either through the Department of Health website²³ or through the National Archives²⁴. Prior to 1997, guidance notes were not stored electronically and need to be traced through paper archives. The Patients' Association archive at the Wellcome Trust proved to be a particularly valuable source for copies of guidance notes relevant to Community Health Councils. Secondary source accounts of public involvement,

²² <http://www.legislation.gov.uk> [Accessed June 2012]

²³ <http://www.dh.gov.uk> [Accessed June 2012]

²⁴ <http://www.nationalarchives.gov.uk> [Accessed June 2012]

particularly those by Gerrard and Hogg, were used to identify guidance notes and legislative materials to be traced. A list of the archives used is presented in the Appendix.

The archives and documents selected to examine the potential role of statutory public involvement institutions as sheepdogs were resources that would contain contemporary accounts of activities. These included newsletters and reports produced by the statutory public involvement institutions, but also comments from Ministers recorded either in their own publications, such as diaries, or in Parliamentary sources including Hansard and inquiries by Select Committees. Materials on or by Community Health Councils during the period 1974 to 2003 were predominantly printed publications, in some instances produced as typescript rather than formally published. Copies of the journal *CHC News* are held at the Wellcome Trust. One of the elite interviewees²⁵ for this study indicated that an archive of material from the Association of CHCs for England and Wales had been deposited at the Wellcome Trust and at Oxford Brookes university library. Initial enquiries at the Wellcome Trust suggested that they did not hold the archive; close examination of the catalogue, however, revealed that the archive had been deposited as a set of image files on a CD-ROM which had been mis-catalogued as an audio compact disc²⁶. The materials in the Association of CHCs for England and Wales archive are images of newsletters and reports published by the Association. The Patients' Association archives for 1974 to 1982 included some early publications that were missing from the formal archive of the Association of CHCs for England and Wales, the combined archives providing what seems to be a comprehensive set of newsletters throughout the period from 1974 to 2003 as well as a substantial body of reports produced through the life of the Community Health Councils. To complement the national perspective provided by the Association of CHCs for England and Wales, annual reports and other publications from individual Community Health Councils were traced through the King's Fund library, the Wellcome Trust, local authority archives and hospital archives (notably the Tower Hamlets CHC archive held at the Royal London Hospital).

Materials from Patient and Public Involvement Forums were initially collated on a knowledge management system held by the Commission for Patient and Public Involvement in Health²⁷. This system was shut down once the Commission was closed in 2008 and the digital archive transferred to the website for Local Involvement Networks (the

²⁵ Malcolm Alexander, formerly Director of the Association of CHCs for England and Wales

²⁶ This has since been re-catalogued as an electronic resource at my request, reference: Wellcome Trust library Closed Stores Computer Media 55

²⁷ Source: interview with Sharon Grant, formerly Chair of the Commission for Patient and Public Involvement in Health

LINks Exchange)²⁸. There was no operational search function for the archive within the LINks Exchange website and the documents tended to have been uploaded with generic titles, such as 'report', which did not indicate the nature of the document, the source or the date. The archive was withdrawn without notice in January 2011; on enquiry, the contractor operating the site for the Department of Health indicated that the material was over three years old and did not fulfil the criteria for the current site²⁹. All of the materials collected by the Commission for Patient and Public Involvement in Health from individual PPI Forums had been included in the archive on the LINks Exchange. For the purposes of this study, documents had been downloaded prior to the closure of the archive, but the resource is no longer available to researchers. Some websites maintained by NHS organisations and local authorities have retained reports from the PPI Forums in their area. The Commission for Patient and Public Involvement in Health website was archived by the National Archive. The most complete snapshot of the Commission's website was taken on March 13 2008³⁰. The archived website includes copies of *Forum Focus*, the magazine for PPI Forums, and reports produced by the Commission. The materials from the Commission's archived website provide a national overview of activity, including the national summaries produced by the Commission of annual reports from PPI Forums.

Local Involvement Networks, unlike their predecessor organisations, did not have a national association or commission to act as a coordinating body. Until August 2009, the Local Involvement Networks received guidance and support for the NHS Centre for Involvement. The NHS Centre for Involvement had been established on the basis of a three-year grant at the point of the decision to close PPI Forums. It was set up predominantly to collect evidence and encourage best practice for NHS-led public involvement. Guidance materials and electronic newsletters were produced for LINks by the NHS Centre for Involvement, which were available centrally on the centre's website until July 2011³¹. The website closed in July 2011, two years after the closure of the NHS Centre for Involvement, and was not copied for inclusion in the National Archives. Copies of the materials from the NHS Centre for Involvement had been downloaded from the website for the purposes of this study and are available as attachments on websites for some of the individual Local Involvement Networks. Annual reports and newsletters from individual Local Involvement Networks were deposited on the LINks Exchange website³². An email newsletter for LINks was also issued by the Department of Health after the

²⁸ <http://www.lx.nhs.uk> [Accessed June 2012]

²⁹ Email correspondence, January 2011

³⁰ <http://webarchive.nationalarchives.gov.uk/20080313140813/http://www.cppih.org/> [Accessed June 2012]

³¹ <http://www.nhscentreforinvolvement.nhs.uk/> [Accessed July 2011 – no longer available]

³² <http://www.lx.nhs.uk> [Accessed June 2012]

closure of the NHS Centre for Involvement, with copies stored on the LINks Exchange website.

The archives available for the successive statutory public involvement institutions reflect the transience of the material. By contrast, the material gathered for public inquiries is managed carefully and the issue is one of researcher access rather than the archival retention of material. Four public inquiries were selected to examine activities and expectations of statutory public involvement institutions as watchdogs alerting political actors to problems before they become disasters. The inquiries were selected to reflect the institutions over time, but also as three of the four inquiries could be seen as turning points in public involvement.

The first public inquiry selected was the inquiry into the Ely Hospital, Cardiff, in 1969. This inquiry preceded the creation of the first statutory public involvement institutions, but has been credited with inspiring the need to have Community Health Councils as independent bodies that could enter and inspect hospitals (Hogg, 2009: 16; Klein and Lewis, 1976: 15; Klein, 2006: 70). The Ely Hospital Inquiry was one of the first public inquiries to be published in full. The report itself is therefore available as a publication. Transcripts of hearings and evidence relating to the Ely Hospital are held at the National Archives in Kew, but a fifty-year closure was placed on the documents in 1974, so the evidence and transcripts will not be made available to the public until January 2025³³. The sources used for this study were the report of the committee of inquiry, responses to the report in Hansard and the published diaries of Richard Crossman, the Secretary of State when the Ely Hospital Inquiry was concluded.

Following the establishment of Community Health Councils, the first major public inquiry examined problems at Normansfield Hospital in Teddington, Surrey. This was selected to examine the role played by the local Community Health Council and comments on that role made by Ministers at the time, including the Secretary of State David Ennals. The main source is the published report by the Committee of Inquiry. The archived transcripts from the hearings and evidence presented to the inquiry are housed at the London Metropolitan Archive³⁴. The hard-copy materials became open to the public in

³³National Archives piece reference BD 18/2527
<http://www.nationalarchives.gov.uk/catalogue/displaycataloguedetails.asp?CATLN=6&CATID=5006654&j=1> [Accessed June 2012]

³⁴ Files at the London Metropolitan Archive relating to the involvement of the local Community Health Council in inspecting Normansfield Hospital, Teddington: H29/NF/F/06/008; H29/NF/F/07/007; H29/NF/F/07/008 [Accessed May 2009]

2009 and were used alongside the published report to examine the role played and any expectations expressed of the Community Health Council.

The third public inquiry selected for examination was that into the Bristol Royal Infirmary. This was selected as the Bristol Royal Infirmary Inquiry was later cited by Alan Milburn in his rationale for the transition from Community Health Councils to PPI Forums (Gerrard, 2006: 270-271). Unlike the earlier public inquiries, the report into the Bristol Royal Infirmary was published online with the evidence and transcripts from the hearings³⁵. The online materials and comments from Ministers were used as the sources to consider the role played by Community Health Councils and how this was interpreted for the future of public involvement.

The last of the public inquiries was selected as it included evidence on the role of both PPI Forums and Local Involvement Networks, with the expectations of Ministers and others in relation to their role. This was the public inquiry into events at the Mid Staffordshire NHS Foundation Trust. As the public inquiry was the culmination of a series of inquiries, including a Healthcare Commission investigation, an independent inquiry by Robert Francis and several specialist inquiries (including an inquiry into the role played by the Staffordshire Local Involvement Network), the documents from the earlier series of investigations were included in this study. Documentation for the Mid Staffordshire NHS Foundation Trust public inquiry was published online, including evidence presented to the inquiry and transcripts of the hearings³⁶.

Data analysis

The selected archival materials formed the primary sources for this study, but were not created specifically for this research programme. The analysis of the sources was therefore a form of secondary analysis, pulling together materials from a range of sources into one collection and then analysing the materials in the terms of this study. The writers of newsletters and reports for the statutory public involvement institutions would have been aware that they were writing for an audience that might have an academic interest in their activities, but witnesses called by public inquiries would be unlikely to have thought of their contributions as being used as a source for research into public involvement. There are ethical issues involved in secondary analysis, as a secondary analyst may not be aware of the conditions under which subjects gave their original consent (Homan, 1991: 90).

³⁵ <http://www.bristol-inquiry.org.uk/index.htm> [Accessed June 2012]

³⁶ <http://www.midstaffpublicinquiry.com/> [Accessed June 2012]

Contributors to public inquiries in the era of transcripts being placed online could be reasonably expected to be aware that their evidence is public and may be reanalysed. In the case of a single transcript and original evidence being held in a paper archive, however, witnesses may not consider it likely that their contributions would be reanalysed outside the context of the particular inquiry. In terms of moral principles, the participants have not been granted autonomy in the case of secondary analysis, but a researcher can ensure that no harm or injustice results from the reanalysis of their input (Beauchamp *et al.*, 1982: 18-19). Where witnesses might not reasonably have expected their words to reach the public domain, in the case of the transcripts and written evidence for the Normansfield Hospital inquiry, person-identifiable information has been excluded from the account in this study on ethical grounds.

Documentary sources were assessed to ensure that they were authentic and credible before being analysed (Scott, 1990: 6). In common with other data sources, documentary material needs to be reliable and valid if it is to be used in a research study. The reliability of data when using documentary sources depends upon the findings being independent of the particular documentary account; and the documentary sources can be considered valid if they provide appropriate evidence to support the claims made (Prior, 2003: 149). To support reliability of the analysis, accounts of the same event in different sources were cross-referenced. In the case of the public inquiries, the formality of the legal hearings should mean that the participants aim to be reliable witnesses. Documents used to validate the claims made are cited in the text and included in the bibliography.

In qualitative research, King, Keohane and Verba suggest that the aim of the research is to make inferences about the world on the basis of empirical information and that the conclusions, whilst uncertain, need to be based on a method that is open to scrutiny (1994: 7-9). The examination of archival sources for this study was based on operationalisation of two theoretically-driven perspectives, as presented in Figures 3.1 and 3.2. With both perspectives and both sets of archival resources, materials were read and coded manually. Throughout the process, the materials were appraised for examples of instances that did not fit the theoretical approaches (Prior, 2003: 154). Elements in the text that either supported or did not match the theoretical approaches were constructed into chronological narratives, to establish any changes in Ministerial expectations or the activities performed in each role over time. The historical narratives are presented as Chapters Four, Five and Six, with the narrative of the history of the institutions focussed on the sheepdog role spanning Chapters Four and Five and the public inquiries as a separate sequence in Chapter Six. These narratives explore whether it can be inferred that the

statutory public involvement institutions undertook either a sheepdog or a watchdog role or whether they were expected to do so by Ministers.

The research design for this study framed an empirical puzzle as a research question and drew upon alternative theoretical approaches in the sub-questions to consider roles that statutory public involvement institutions might have played in political management of the NHS between 1974 and 2010. The analysis of archival materials constantly referred back to the main question and contributed to reflections on the precise question and sub-questions. As sources were identified that covered the full timeframe of the question, shifts over time could be explored. In particular, the data were analysed to assess whether sheepdog or watchdog roles were apparent at different points in time. The question and approaches build on the existing public involvement literature by considering the potential roles that statutory public involvement institutions may have played in political management of the NHS.

Chapter summary

This chapter presented the research framework for the study. It opened with the research question: what role(s) have statutory public involvement institutions played in political management of the English NHS, 1974-2010? Two possible roles were identified as: a 'sheepdog' rounding up interests and managing potential opposition; or a 'watchdog' providing intelligence to prevent disasters. The theoretical basis for each of these approaches was discussed and operationalised in terms of the materials that might be found if either approach were supported empirically. The closing section discusses the research methods, including the issues around the usage of archival material and the process used for qualitative analysis of the sources.

The next three chapters present the historical narratives that emerge from the archival sources. This sequence opens in Chapter Four with the role that Community Health Councils may have played as 'sheepdogs' between 1974 and 1997.

Chapter Four: Sheepdog? Rounding up participants, 1974-1997

The sheepdog role in political management of the NHS, as outlined in Chapter Three, consists of four main attributes: mediating between local interests, including ensuring representation of vulnerable groups; structuring consultation on local services; considering issues within a state-determined remit; and taking responsibility for unpopular local decisions. A sheepdog both rounds up participants and pens them to manage their activity. This chapter takes the form of a historical narrative, discussing whether the CHCs undertook a sheepdog role in political management of the NHS during the period from 1974 to 1997 and any changes to that role over time.

The chapter opens with the establishment of CHCs in 1974, including a detailed account of the policies and processes surrounding the appointment of members, to establish the relationship between CHCs and local interest groups. The first section considers the period to 1979 and includes the Ministerial allocation to CHCs of rights to agree the closure of local hospitals. The second section reviews CHCs during the first decade of Conservative governments, up to the creation of the internal market in the NHS. The third historical section considers CHCs as potential sheepdogs in the period from 1989 to 1997. The chapter closes with a review of the extent to which Community Health Councils either had the powers to act as sheepdogs or undertook a sheepdog role in political management of the NHS during the period from 1974 to 1997.

4.1 Development of Community Health Councils, 1974-1979

Community Health Councils first emerged as a concept in plans for NHS reorganisation by Keith Joseph, Secretary of State for Social Services within Edward Heath's Conservative government of 1970. Joseph initially proposed that each Area Health Authority should establish a Community Health Council, with members appointed 'after consultation with a wide range of interested local organisations' (Secretary of State for Social Services, 1971a: §17). When Community Health Councils were formally introduced in legislation in the *NHS Reorganisation Act 1973*, the responsibility for establishing, staffing and funding the councils was placed with the Secretary of State (*NHS Reorganisation Act 1973*, Part I Section 9). This centralised accountability emerged in the course of debate on the *NHS Reorganisation Act 1973* (Gerrard, 2006: 44). The ability of the Secretary of State to modify statutory public involvement institutions may not have formed part of Keith Joseph's original concept, but provided a tool for his successors.

Membership of Community Health Councils

The *NHS Reorganisation Act 1973* introduced the most significant restructuring of the NHS since it was founded in 1948. A Labour government came into office in the month before the new structure was due to take effect. The incoming Secretary of State for Social Services, Barbara Castle, and the Minister for Health, David Owen, took the decision to retain the reorganised structure, incorporating Community Health Councils:

'When the Labour government took office in 1974, three weeks before the appointed day for reorganisation, a basic decision was taken to strengthen and enhance the role of the Community Health Council. The reorganised structure of the health service had never seemed to be satisfactory and the Labour Party in opposition had been very critical of it during its lengthy passage. Yet it was felt, and subsequent events wholly vindicated the judgement, that to tamper with the reorganisation only three weeks from the appointed day would have run a very severe risk of damaging patient care.' (Owen, 1976: 18)

The Labour government retained the appointment system for Community Health Council members that had been outlined in the *NHS Reorganisation Act 1973*. This has been described by Klein and Lewis as a 'uniquely eccentric system for choosing the membership' (1976: 27). The *NHS Reorganisation Act 1973* stipulated that half of the members of Community Health Councils should be appointed by local authorities, a third by local voluntary organisations and the remaining sixth by Regional Health Authorities. Each of these three appointment mechanisms seems to meet a slightly different political need in ensuring collective participation by different elements in the local community. The local authority appointees represented the local electorate; albeit, as Klein and Lewis point out, 'in some undefined way' (1976: 19). The Act required voluntary organisations to collaborate on the selection of their nominees, creating a mechanism that involved interest groups directly in the appointment process. Regional Health Authorities were expected to use their sixth of appointments 'to honour the Secretary of State's obligation to allocate places on CHCs to certain organisations in order to ensure continued representation of special interests in particular institutions, such as miners' rehabilitation centres, denominational hospitals and seamen's hospitals' (Department of Health and Social Security, 1974a: §15).

Regional Health Authorities acted as the establishing bodies for Community Health Councils, initiating arrangements to set up a CHC for each Area Health Authority in their region. The Community Health Councils had a remit to be consulted on and to inspect the NHS services across the geographical patch covered by an Area Health Authority. As most of the consultations on local service developments would take place between the Community Health Council and the Area Health Authority, the establishing role of the

Regional Health Authority placed the selection of members at a slight distance from day-to-day activities. Instructions outlining the Regional Health Authorities' role in establishing Community Health Councils were included in health circular HRC (74) 4, issued in January 1974. The circular clarified details within the *NHS Reorganisation Act 1973*, such as the number of members in a Community Health Council, as 'the Secretary of State expects that the great majority of Councils will have between 18 and 30 members' (Department of Health and Social Security, 1974a: §7). Much of the detail in the circular is concerned with the process by which voluntary organisations should be selected to participate in the nomination of Community Health Council members:

'§12 Any voluntary organisation active in a CHC's district (whether or not its office is situated in that district) or with a particular interest in a health service institution within that district can apply to take part in appointing members to the CHC. ... To this end RHAs [Regional Health Authorities] should draw up, with the primary assistance of the AHA [Area Health Authority], and in consultation with such co-ordinating bodies as local Councils of Social Service, Age Concern or Old People's Welfare Committees and local authorities' Voluntary Bodies Liaison Committees, a provisional list of voluntary organisations which might be invited to take part. ... §13 In addition to these consultations the RHA must advertise in the local press inviting voluntary organisations to apply.' (Department of Health and Social Security, 1974a)

Making the Regional Health Authorities responsible for collating and updating a list of voluntary organisations meant that the detail of which voluntary organisations could participate was devolved from a national level, but that there was the potential that a Secretary of State could intervene if there were difficulties with the selected list of organisations. The inclusion of local Councils of Social Service and local authorities' Voluntary Bodies Liaison Committees in the consultation on the initial list ensured that organisations concerned with broader welfare issues, not just health services, would be considered as part of the process of drawing up the list.

Only by being on the list could voluntary organisations participate in the selection, from their number, of organisations that would be represented on the Community Health Council. An appendix to circular HRC (74) 4 provides a model advert to be placed in the local press to invite voluntary organisations to apply to be included on the list. The model advert underlines that the participants in the list are organisations with local interests, rather than national interests, in health services: 'Voluntary organisations active in these districts with a strong active interest in health matters, or which provide a service for NHS patients, or which have a special interest in a particular NHS institution or institutions in these districts, are invited to apply for inclusion in the list of voluntary organisations which are to be asked to appoint members to the appropriate Community Health Councils'

(Department of Health and Social Security, 1974a: Appendix 4). The requirement that the voluntary organisations should be 'active in these districts' barred most national voluntary organisations, as few national organisations in the 1970s were sufficiently established to have local branches across the country. It also effectively barred disease-specific groups, which tend to be national organisations as for most medical conditions there are insufficient numbers of people affected in any given locality to set up a specific local organisation (Hatch, 1984: 106).

On the behalf of the Department of Health and Social Security, the National Council of Social Service drew up guidance on how Councils of Social Service or other coordinating bodies could develop the list of voluntary organisations for their Regional Health Authority (National Council of Social Service, 1974). The National Council of Social Service advised that it was important for voluntary organisations to be as closely involved as possible in the development of the list. The rationale given for this was to ensure that the organisations selected were representative of the full range of health-related needs of the local community. Involving voluntary organisations in the compilation of the list would also, however, have given a degree of legitimacy to the selection process and mean that organisations that had been involved would be more likely to support the selection. To ensure breadth of organisations involved in the Community Health Councils, the National Council of Social Service suggested that 'categories of interest' could be used as a basis on which to discuss allocation of places (National Council of Social Services, 1974: §9). The categories given as examples in the guidance notes were: children; the old; mentally ill or handicapped; physically handicapped; and a general category. Whilst the guidance from the National Council of Social Service was not a statutory document, the proposed 'categories of interest' were widely used by Regional Health Authorities (Klein and Lewis, 1976: 38).

Once the list had been completed, the Regional Health Authority was responsible for inviting the organisations on the list 'to agree amongst themselves how the places to be filled by them should be allocated' (Department of Health and Social Security, 1974a: §14). In the event that the voluntary organisations could not reach a unanimous agreement on the allocation of places, the Regional Health Authority was empowered to 'select the organisations which individually or jointly are to appoint members' (Department of Health and Social Security, 1974a: §15). Requiring the organisations to agree representation, with the threat of the choice being made for them, ensured a degree of collaboration between the voluntary organisations that could form the basis of an intermediation role by the Community Health Council.

The extent to which the appointment process resulted in representation of a range of local interests can be seen in the 1975 survey by Klein and Lewis of Community Health Council members. Their study was the only attempt to undertake a comprehensive survey of CHC members and they received 3,796 completed questionnaires, representing nearly two thirds of Community Health Council members (Klein and Lewis, 1976: 28). As discussed in Chapter Two, Klein and Lewis found that the CHCs were predominantly from middle class, professional backgrounds (1976: 157). The researchers used the five categories suggested by the National Council of Social Service to analyse the representation within CHC membership. They found that the efforts to represent more vulnerable groups within CHC membership seemed to have been effective:

'In the outcome, the system of fancy franchises invented to choose voluntary sector representatives, appears to have worked. The special care groups like the mentally handicapped and the physically disabled are well represented. One-tenth of CHC councillors are members of organisations concerned with mental health, while one-quarter of them are members of organisations concerned with the elderly. Mere membership does not imply active involvement and interest. The high proportion of voluntary organisation members on CHCs who hold some position in those organisations is therefore particularly noteworthy, since this implies a more than average degree of commitment. For instance, in the case of members of organisations concerned with the physically disabled, almost two-thirds hold some office.' (Klein and Lewis, 1976: 38-39)

As Klein and Lewis found, the categories proposed by the National Council of Social Service (notably, mental health, physical disability and old age) were well-represented as interest groups within Community Health Councils. The proportion of members who held office in voluntary organisations also suggested not only that they were actively engaged, but that they were likely to have the knowledge and skills to be able to challenge NHS officials. Whilst a third of the members had been appointed by voluntary organisations, 85 percent of the CHC members were connected to a voluntary organisation and 20 percent of the CHC members were linked to four or more such groups (Klein and Lewis, 1976: 38). This suggests that the local authorities and Regional Health Authorities had also been using their places to appoint people with voluntary sector experience. Klein and Lewis suggested on the basis of their survey data that the role of the Regional Health Authority in ensuring appointees for vulnerable groups was largely redundant, as such groups were represented in the nominations made by voluntary organisations (1976: 162).

Having inherited a system that managed local interest group representation, David Owen suggested to Community Health Councils that they might act as a catalyst for action

with the voluntary sector, where a CHC identified problems (CHC News³⁷, 1976a: 8). He also advised MPs that when voluntary organisations in their constituencies wanted to raise issues with local NHS services, they should do so through the Community Health Council (Malin, 1978). The complex appointment processes for CHC members remained largely unchanged throughout the life of the Community Health Councils. The selection processes ensured that vulnerable groups were represented and relationships were established that provided the basis for intermediation – and the example of David Owen, as Minister for Health, referring groups to the CHC demonstrates that at this early stage Community Health Councils were expected to take an intermediary role. The issue on which the early CHCs undertook their most complex intermediary role was the closure of hospitals.

Community Health Councils and hospital closure rights

In 1974, the incoming Labour government had to contend with the immediate fiscal austerity of the oil crisis, combined with the implementation of two national strategies that had implications for the number and location of hospitals. The first of these national strategies was Enoch Powell's 1962 hospital plan, which created large District General Hospitals in place of small community hospitals (Webster, 2002: 45). Additional funding for the District General Hospitals had come to an end in 1972 (Ham, 2009: 17). The programme was still in progress, however, and unpopular decisions needed to be made on the closure of local hospitals, with the transfer of patients to the new District General Hospitals. The second national strategy arose from a Green Paper issued for consultation by Richard Crossman in 1970, which proposed 'that the basic determinant of area health authority budgets will be the population served by the area, modified to take into account relevant demographic variables' (Department of Health and Social Security, 1970: §79). Whilst the calculations had not been completed at the point when Labour came into power, it would have been apparent to civil servants and members of the incoming Government that the latter strategy would result in more hospital closures. When the Resource Allocation Working Party (RAWP) reported on a needs-based distribution of NHS services in 1975, it concluded that there were disproportionately high numbers of hospitals in

³⁷ *CHC News* had an editorial team that was initially hosted by the King's Fund and then transferred to the Association of Community Health Councils for England and Wales (ACHCEW) once ACHCEW had been established. The editorial team always retained a degree of independence from ACHCEW; where there is no named author for an item in *CHC News*, therefore, the author is given as *CHC News*.

London and Oxfordshire, so services would need to be closed in these areas and new hospitals opened in less well-served parts of the country (Webster, 2002: 84-87).

The Labour government needed to find a way to facilitate the hospital closures without blame for loss of local hospitals being apportioned to the Secretary of State. As discussed in Chapter One, the 1974 reorganisation of the NHS reduced the independence of prestigious teaching hospitals and accountability for the nationalised hospitals was held by the Secretary of State. Under the initial Statutory Instruments for Community Health Councils, Area Health Authorities had a statutory duty to consult the local CHC 'on the proposals which the authority may have under consideration for any substantial development of the health service in the Council's district and on any such proposals to make any substantial variation in the provision of such services' (*National Health Service (Community Health Councils) Regulations 1973*). This duty required Area Health Authorities to consult Community Health Councils on major changes, but it did not provide strong incentives for Area Health Authorities to consult in a meaningful way.

The consultation arrangements in relation to hospitals changed as part of *Democracy in the National Health Service*, launched by Barbara Castle and David Owen in May 1974. This was largely a consultation document, but it included a strengthening of the role of Community Health Councils in relation to hospital closures that was explicitly not a matter for consultation:

'CHCs should have a special responsibility in relation to hospital closures. The Government is currently reviewing the procedures for consultation on proposed closures. But the establishment of CHCs enables it to make one change in the present arrangements without further delay. Guidance already issued to health authorities makes it clear that CHCs should be consulted about all hospital closures. At present all closures are subject to specific authorisation by the Secretary of State. In future where the CHC accepts the proposed closure this authorisation will not be required. If a CHC wishes to object to closure then it will be expected to make a detailed and constructive counter-proposal, with full regard to the factors, including restraints on resources, which have led the health authority to propose the closure.' (Department of Health and Social Security, 1974b: §23e)

This section is quoted in full, as the text gives an interesting placement of responsibility. Community Health Councils are described as having a 'special responsibility' in relation to hospital closures, whereas the Secretary of State is described as just having had a role in the 'specific authorisation' of the closure. Whilst the Secretary of State is purely an authority figure, the Community Health Council takes a responsibility, and by implication part of the blame, for agreeing to the closure of a hospital within its district. The requirement to make 'a detailed and constructive counter-proposal' that took account, explicitly, of resource issues, was a stringent requirement to make of a group of volunteers

supported by a couple of members of staff. In practice, authors have suggested that the powers may have meant that the Community Health Councils were unlikely to be able to do more than delay closures in most instances (Hogg, 2009: 61; Klein, 2006: 84). As a mechanism that changed decision-making processes, however, the power granted to CHCs enabled Ministers to avoid blame for hospital closures.

David Owen described Community Health Councils as 'very realistic about lack of money' and 'a way of bringing voluntary bodies to a closer relationship with the NHS' (CHC News, 1976a: 1). He assured Community Health Councils that Ministers would read their counter-proposals to hospital closures carefully, provided that CHCs developed a reasoned case with an alternative proposal that included the costs involved (David Owen, in: CHC News, 1976b: 1). In his book *In sickness and in health*, Owen wrote positively about the extent to which Community Health Councils were agreeing to hospital closures:

'The decision to allow closures of hospitals to take place if Community Health Councils and the Area Health Authority and the Regional Health Authority all agreed was much criticised. It was said the councils would never agree to any closures. Yet, up and down the country, Community Health Councils are agreeing. And what is interesting, though not surprising, is that they tend to agree in those districts which have the fullest exchange of information. It is when a closure can be put into its wider context – that, by making the change, services can be improved, or, by making a saving, a cut-back can be stopped – that people will understand and recognise the case for rationalisation. They will oppose if just told a hospital is to close, if they do not feel part of the process of decision-making and if it is not explained. If they are not led to see the problems of the health service in the round then the local instinctive reaction, which is to keep what one has, will become the dominant voice. Community Health Councils have the opportunity to work constructively towards transforming the relationship between the health service and the people living in the district.' (Owen, 1976: 24)

Whilst David Owen presented the opportunity for local consultation as being of benefit to the local community, it was also a benefit to the Minister just to be the final arbiter in difficult cases, rather than having to take personal responsibility for agreeing to the closure of each hospital. His statement that Community Health Councils 'will oppose if just told that a hospital is to close' reflects the mood of public opinion, as protecting existing services is 'the local instinctive reaction'. He was not alone amongst Ministers in advising CHCs to balance economic realism with local deliberation. David Ennals, successor to Barbara Castle as Secretary of State, advised Community Health Councils that they needed to be realistic, but that he felt that the economic restraint might lead to 'a new spirit of cooperation' (CHC News, 1976c: 1). David Ennals also advised health authority personnel that he would not act as an alternative to agreeing closures with the relevant Community Health Council (CHC News, 1977d: 6-7).

The Ministerial emphasis on resource constraints and the need to follow due process suggests that granting Community Health Councils the power to approve or contest hospital closures was a valuable mechanism from a Ministerial perspective. The involvement of the public through Community Health Councils may have been seen as legitimising the difficult choices that needed to be made over local resource allocation. The process placed opposition to hospital closures within a consultation framework with the Community Health Councils, which was easier for NHS managers to contain than a public demonstration. Considered in terms of the sheepdog role, transferring authorisation to groups of local volunteers decentralised the decision-making, potentially shifting blame for hospital closures away from the Secretary of State.

Whether or not the power provided a means for Ministerial blame avoidance in practice depended upon the activities undertaken both by health authorities and by Community Health Councils. In the mid-1970s, Community Health Councils focused a great deal of energy on responding to, re-shaping or opposing proposals to close local health services. During the period January 1976 to March 1978, there were 191 proposals for closures or part-closures of NHS services. Of these, 164 were agreed locally and 27 went to the Secretary of State, who approved all but one closure, that of St Nicholas' Hospital in South East London (CHC News, 1978a; 1978f). Most of the closures approved by the Secretary of State were small maternity hospitals (CHC News, 1978d: 11). The requirement to produce detailed counter-proposals demanded time and effort; some CHC members questioned how they could be expected to produce counter-proposals when they had to depend upon information that had been supplied to them by the Area Health Authority – the body proposing the closure (Gordon, 1978: 10).

Much of the discussion within *CHC News* focuses on successes in changing local plans, such as intervening to save a village surgery in West Cumbria and negotiating to retain a GP-led hospital in Dartford in return for losing 32 beds in an acute hospital in the district (1977a: 5; 1978e: 5). One of the most significant counter-proposals to be accepted at a local level was a rejection by North Kensington, Chelsea and Westminster CHC of plans to expand St Mary's Hospital, Paddington, at the expense of local services. The CHC agreed to some of the closures, but in return for a reduction in the plans for St Mary's reached agreement with the health authority on the creation of a new community hospital within existing premises. This was a successful outcome for the CHC, but 'the CHC has made it plain that the whole exercise has stretched its own resources to the limit, with staff and members working flat-out for the three-month period' (CHC News, 1979a: 12).

Rather than writing in *CHC News* about successful opposition to a hospital closure, Ross and McCarthy from North West Herts CHC reported on the consultation process that they went through to determine whether St Albans or Hemel Hempstead should be the site of a District General Hospital. Both towns had been promised a District General Hospital following the 1962 hospital plan, but the funds were no longer available to provide two large hospitals. North West Herts CHC placed advertisements in local papers requesting views on whether there should be a medium-sized hospital in each town or a District General Hospital in one town and a supporting service in the other. The results of the consultation were inconclusive, so the CHC members took a vote and recommended a District General Hospital in one town and a supporting service in the other, an outcome that was similar to the recommendation later made by the Area Health Authority. This recommendation did not make the Community Health Council popular, and the CHC was 'roundly condemned by opponents of the recommendation for having ignored public views' (Ross and McCarthy, 1978: 4). As such, the Community Health Council bore the brunt of the opposition, rather than the opposition being directed towards the Secretary of State or the health authority. This suggests that the powers allocated to the CHC had enabled Ministers to avoid blame.

Development of a national association

The *NHS Reorganisation Act 1973* granted powers to the Secretary of State to establish a national body for Community Health Councils. Considered from a corporatist perspective, a classic model is that a national peak organisation would represent the interests of local members to national politicians. In the case of statutory public involvement institutions, the focus was on the development of the powers of the local bodies to coordinate interest intermediation. In a health circular issued in January 1974, the Secretary of State, Keith Joseph is described as considering 'that it is for the Councils themselves to decide, when they have settled down, whether they want a national association and to propose, in the light of their own experience, what should be its form and functions' (Department of Health and Social Security, 1974a: §41). Such an approach suggests that a national organisation was not an assumed part of the structure for local statutory public involvement institutions.

In February 1975, the Nuffield Centre for Health Service Studies hosted a meeting in London for Community Health Councils. David Owen announced at the meeting that he intended to form a steering group to prepare proposals for a national association for

Community Health Councils (Hogg, 2009: 32). The Government also provided initial funding for a publication for Community Health Councils, *CHC News*, and an information service to be hosted by the King's Fund (Gerrard, 2006: 41-42). David Ennals, as Secretary of State, announced in May 1977 that the Department of Health and Social Security would fund *CHC News* and the information service on an ongoing basis. He also agreed to provide funding to cover the operation of a national association in the first year, after which he would expect the organisation to be funded through subscriptions from Community Health Councils. By contrast with this active support from Labour Ministers, key Conservative Members of Parliament were opposed to the establishment of a national association. Most notably, Patrick Jenkin and Gerard Vaughan, future Secretary of State and future Minister for Health respectively, were amongst six signatories to a motion calling for the annulment of regulations for the establishment of a national association of Community Health Councils (CHC News, 1977f:1).

The first Annual General Meeting of the Association of Community Health Councils for England and Wales (ACHCEW) took place on 15 June 1977. From the outset, the association strived to be as democratic as possible, with all decisions going to a full Standing Committee, consisting of representatives from each region. Policy issues were discussed as resolutions at the Annual General Meeting, with special meetings called when there were key matters to be debated. It was, therefore, very much a membership organisation rather than a corporatist-style national peak organisation that would ensure local implementation of national decisions.

Community Health Councils had the right to be consulted individually and ACHCEW did not compile responses to consultations on their behalf. There is evidence in ACHCEW's annual reports that Ministers in the Labour government expected the Association to act as an intermediary and that ACHCEW declined to undertake this role. The first annual report, for 1977 to 1978, states that:

'certain questions have been brought to the attention of the Association by the Department of Health. In every case it has been made plain the individual CHCs have the right to be consulted and the Association is not an intermediary, and that remains policy.' (ACHCEW, 1978a: unpaginated [2])

The autonomy and rights of individual Community Health Councils were important to members; ACHCEW, as an organisation dependent upon the fees of CHCs who chose to join, was not in a position to act as an intermediary. In the 1978 to 1979 annual report, ACHCEW clarified its role as 'an information gatherer, a test-bed for new ideas, and an advocate of CHCs to Government and to national bodies of every kind' (ACHCEW, 1979a:

2). Taking on the role of an advocate to Government was not quite the style of mediation that Ministers seemed to have in mind. *CHC News* carried a report in 1978 of an interview with David Ennals on Radio Medway. As reported by *CHC News*:

‘David Ennals said that while he is unable to see deputations from individual CHCs, he is willing to see representatives of the national body speaking on their behalf. The Secretary of State has thus proposed a role for ACHCEW interposing it between CHCs and the Government, as if it were a kind of national CHC.’ (CHC News, 1978g)

Retaining its editorial independence from ACHCEW, the reporting style is representative of the approach taken in *CHC News*, as is the editorial team’s action in asking Mike Gerrard, Secretary of ACHCEW, to respond to the report. Gerrard’s response was that ACHCEW had not undertaken the role of an intermediary and that ‘if performance of their statutory duties necessitates CHCs making direct representations to him, and the issues merit his personal involvement, Mr Ennals has a clear obligation to put himself at their disposal’ (CHC News, 1978g: 10). This interchange seems to epitomise differences in perspective between Ministers and ACHCEW personnel on the role that ACHCEW played in relation to Governmental relationships with Community Health Councils.

From mediation to mobilisation

By the late 1970s, many members and staff of Community Health Councils were disenchanted with the role that they had played in consultations on the closure of services. Tom Heller, a member of Norwich CHC, felt that Community Health Councils had deliberately been placed in a difficult position, as ‘the administration can legitimise unpopular decisions by claiming that they have been considered by the CHC while on other occasions dismissing the protests of CHCs because “they do not properly represent the population at large” ’(Heller, 1977: 6). Jeanette Mitchell was Secretary of Brent CHC, which had had a particularly difficult experience with the consultation on the Willesden General Hospital. She suggested that the right to be consulted on hospital closures might be a step backwards in public participation in the NHS:

‘While prior to reorganisation NHS users had not been particularly known for their militancy, it was not difficult for the Government to predict in the early seventies that its plans to close hospitals on an unprecedented scale over the coming decade would be met with resistance. The introduction of the formal consultation procedure has ensured that these battles take place on ground that is familiar to health service managers but also alien to most local people – including CHC members.’ (Mitchell, 1979: 5)

Jeanette Mitchell's comments suggest that the consultation rights granted to Community Health Councils had turned the CHCs into a tool for blame avoidance. As she indicated, the incoming Labour government had faced the prospect of having to close hospitals 'on an unprecedented scale' and the consultation process ensured that 'battles' could be managed as they took place on terms that were familiar to NHS administrators.

Some Community Health Councils started to mobilise opposition to reforms. Oxfordshire CHC spent £1,000 on publicity in three local papers to alert local people to the threatened closure of Cowley Road Geriatric Hospital in Oxford. The Community Health Council had referred the proposed closure to the Secretary of State and decided 'to make as big a stir as possible, so that the final decision will at any rate be made in the context of public debate' (CHC News, 1979a: 12).

In terms of a sheepdog role in political management of the NHS, CHCs during the 1970s had the powers to mediate between local interests, with representatives of vulnerable communities included in their membership, had local consultation rights and were granted a remit to consider health service issues across an allocated geographical area. They were also taking some of the blame for local hospital closures. At this early stage, they had the full set of sheepdog characteristics and seem to have been valued by Ministers for their sheepdog role. Some of the CHCs, however, suspected that they were being treated as tools to legitimise unpopular decisions and had started to mobilise opposition. It was in this context of increasing opposition to national government policy and ongoing austerity, resulting in contentious hospital closures, that Margaret Thatcher's Conservative government took office in 1979.

4.2 Changes to Community Health Councils, 1979-1989

As the new Secretary of State for Social Service and Minister of Health, Patrick Jenkin and Gerard Vaughan inherited a situation of industrial unrest in the NHS and ongoing public concerns about hospital closures. Whilst Community Health Councils had been invented by the Conservative party, the implementation and extension of powers to include consultation on hospital closures had taken place under Labour. As Jenkin and Vaughan had both signed a motion calling for Community Health Councils not to be granted the right to create their own association, there was some anxiety amongst Community Health Councils about the new working relationship.

The first few years of the Conservative government saw a series of challenges to the Community Health Councils. At a local level, the consultation rights were challenged

by health authorities. This was followed by a national challenge, as discussed in Chapter One, that CHCs could be abolished as part of a reduction in the layers of bureaucracy outlined in *Patients first*. Once the ongoing existence of CHCs had been assured, the Association of Community Health Councils for England and Wales came under threat and *CHC News* lost its grant. Hogg suggests that after 1985 the Community Health Councils were 'ignored, not worth the effort required to abolish them' (2009: 44). This section considers CHCs in terms of their sheepdog role in the period from the election of a Conservative government in 1979 to the announcement of the internal market in the NHS.

Local challenges to hospital closure rights

With the change of Government, Community Health Councils found that Area Health Authorities tried to avoid going through formal consultation on hospital closures, by claiming that the changes were temporary or necessitated by financial crises in the district. Concerns about the erosion of consultation rights generated an emergency debate at the Association of CHCs for England and Wales 1979 Annual General Meeting. The Standing Committee of ACHCEW sought a meeting with the Secretary of State to discuss the issue, but were referred instead to Gerard Vaughan. Dr Vaughan agreed that a 'temporary' variation in health services could be 'substantial', which therefore meant that it was subject to agreement with the Community Health Council (ACHCEW, 1979b: 1). Following the meeting, a letter was issued from the Department of Health and Social Security advising health authorities that 'consultation should take place other than where emergencies (such as the outbreak of infection) cause a hospital, ward or department to be closed without delay' (ACHCEW, 1980: unpaginated [1]).

In practice, Patrick Jenkin rejected a higher proportion of disputed closure proposals than his predecessor David Ennals had done, effectively agreeing with Community Health Councils' opposition to the closures. In the first eighteen months of the Conservative government, six disputed closures were approved by the Secretary of State, three rejected and one converted into a 'change of use' of the premises; by comparison, in the last twenty months of the Labour government, twenty closures were approved, two rejected and one converted to a change of use (*CHC News*, 1981b). In a survey of CHCs' activity in 1980, Farrell and Adams found that 43 percent of Community Health Councils had opposed closures during the year, a sixth of whom had put forward counter-proposals (Farrell and Adams, 1981: 9).

When the Conservative government took office in 1979, the contentious nature of existing proposals for hospital closures may have meant that approval of closures by Community Health Councils was a valuable tactic that shifted blame away from Ministers. The new Ministerial team was unsure about the value of Community Health Councils, however, and used the *Patients first* consultation exercise as an opportunity to gather views on the CHCs. Prior to the outcome of the *Patients first* consultation, the Department of Health and Social Security announced its intention of moving away from a policy of developing large District General Hospitals, so retaining more of the local hospitals that had been at risk (CHC News, 1980c: 11; Webster, 2002: 122). Regardless of the outcome of *Patients first*, therefore, the right to agree or dispute a hospital closure was less valuable.

National consultations on CHCs

At the end of 1979, Ministers launched the *Patients first* consultation. *Patients first* proposed the removal of Area Health Authorities as a layer in the NHS structure, to be replaced by an upgrading of the more localised District Management Teams into District Health Authorities. This formed part of an attempt to reduce bureaucracy and devolve authority in the NHS (Klein, 1984: 18). Respondents to *Patients first* were asked to consider whether Community Health Councils would still be needed with a more localised health authority structure:

‘In future authority members will be less remote from local services than many necessarily are today, and will be more closely in touch with the needs of the community. The need for separate consumer representation in these circumstances is less clear; next year the councils will cost over £4 million. The Government will welcome views on whether Community Health Councils should be retained when the new District Health Authority structure has been implemented.’ (Department of Health and Social Security and Welsh Office, 1979: 14 §26)

The *Patients first* consultation was effectively the Conservatives’ response to the Royal Commission on the NHS, which had been set up by the preceding Labour government. The Royal Commission had supported the ‘experiment’ of CHCs, but also identified confusion within the NHS about the role CHCs played both in consultation and in representation of the public (Royal Commission on the NHS, 1979: §11.11). As members of Community Health Councils commented, the issue of the future of CHCs was the only truly consultative part of *Patients first* (CHC News, 1980a: 3).

Patrick Jenkin, Secretary of State, came to speak to a special meeting of the Association of CHCs for England and Wales at the mid-point of the *Patients first*

consultation. He indicated that it was a genuine consultation and that the Department had not pre-determined whether Community Health Councils would continue. He presented the reasons why CHCs might be retained as the roles that they played in making 'a sensible reconciliation of consumer viewpoints', providing a critical voice that was independent of professionals and monitoring services (CHC News, 1980b: 1). In effect, he suggested to the CHCs that their value lay in the statutory roles that form the basis of the sheepdog and watchdog analogies. After Mr Jenkin left the meeting, the CHC representatives agreed that 'the fight for the survival CHCs should be seen as part of the struggle for more democracy and accountability in the NHS' (CHC News, 1980b:1). The Secretary of State had not described the Community Health Councils in terms of their role in increasing democratic input into the NHS, however, which suggests a disconnect between the role of CHCs as seen by the Ministerial team and the activity in which CHC members felt that they were engaged.

The question left hanging over the future of Community Health Councils generated a great deal of support for CHCs. The future of CHCs generated more responses than any other issue in *Patients first*. Members of the public and all political parties registered their support for CHCs; of nearly 5000 comments relating to Community Health Councils, over half were from members of the public, many of whom felt that their views carried more weight when expressed through their local CHC (Hogg, 2009: 42-43). The *Patients first* consultation therefore confirmed the popularity of Community Health Councils. In response to the findings, the Department of Health and Social Security announced that Community Health Councils would be retained, with one council in each District Health Authority area, but that there would be a further consultation on the membership and roles of CHCs (Department of Health and Social Security, 1980: §21).

Ministers launched the consultation on CHCs specifically in January 1981. *Community Health Councils in England*, alongside a companion document *Community Health Councils in Wales*, proposed reforms to Community Health Councils and queried the need for the Association of Community Health Councils for England and Wales (Department of Health and Social Security, 1981a). The consultation document stated that 'Ministers see CHCs as local bodies, representing the interests of their local population in the health services, and not as having a role in the formation of policies at a national level' (1981a: §3). Continuing on the theme of a local role, *Community Health Councils in England* supported the right of local CHCs to approve hospital closures, as 'Ministers support this role of CHCs as a valuable aid to local decision-making' (1981a: §12). Community Health Councils were therefore valued by Ministers when they managed

consultation locally, but not as a means to raise issues nationally. Responding to the consultation, individual CHCs objected to being seen as having a specifically local role. *CHC News* proclaimed optimistically, on the basis of the objections of CHCs to being restricted to a local role, that 'we won't be muzzled' (CHC News, 1981c: 1).

If Community Health Councils were not to have influence at a national level, this placed a questionmark over the value of a national association. As stated in the consultation document:

'The Association has now been in existence for several years, though not all CHCs are members. The need for the CHCs to have a national association at all is still sometimes questioned. Ministers suggest that CHCs take the opportunity to consider whether the Association should continue.' (Department of Health and Social Security, 1981a: §43)

ACHCEW had actively refused to provide an intermediary role between Ministers and individual Community Health Councils, which may have contributed to questioning ACHCEW's future.

By the time that feedback on the consultation was received, Norman Fowler had replaced Patrick Jenkin as Secretary of State and alternative mechanisms to reduce the mobilisation of Community Health Councils were being put in place with threats to remove the Departmental funding for *CHC News*. The response to the consultation, health circular HC (81) 15, reduced the number of members of a Community Health Council from between 24 and 30 members to the range of 18 to 24 members, stating that 'the Secretary of State expects most CHCs to be at or near the lower end of this range' (Department of Health and Social Security, 1981b: §3). The appointment processes (with half of members appointed by local authorities, a third by voluntary organisations and a sixth by Regional Health Authorities) remained unchanged 'for the time being' (1981b: §4). A new membership criterion excluded former NHS employees who had been dismissed for 'reasons other than redundancy' (1981b: §6). At a first glance, this may appear to be an attempt to prevent NHS personnel dismissed as whistleblowers from colluding with Community Health Councils. Correspondence in *CHC News*, however, suggests that the clause was included at the request of the North Western Association of CHCs, who had protested to the Secretary of State that a sacked Secretary of Rochdale CHC (who, as Secretary, was employed through the NHS) had been returned to the same CHC as a member by the local authority (CHC News, 1982a). Other than restricting numbers of members and confirming that there would be no increase in funding, the formal response to the consultation left CHCs and the Association of Community Health Councils for England and Wales intact (Department of Health and Social Security, 1981b: §13). If

Ministers aimed to reduce the ability of Community Health Councils to be involved in national issues, the tactic they chose was a less formal reduction in national roles.

Lessening national roles

The description of CHCs in *Community Health Councils in England* as 'local bodies' and 'not having a role in the formation of policies at a national level' provided a strong indicator that Ministers did not welcome activity that might mobilise national influence (Department of Health and Social Security, 1981a: §3). During the protracted consultation on *Community Health Councils in England*, the Community Health Councils continued to raise issues that Ministers might wish to see buried. In particular, individual Community Health Councils and ACHCEW drew attention to *The Black report*. Sir Douglas Black had been commissioned by the previous Labour government to chair a committee reviewing inequalities in health. The committee found that, despite the NHS being accessible to all, the gap between the health of the wealthier classes and the health of the poorer classes was widening (Black *et al.*, 1980: 198). This did not fit with the Conservative administration's emphasis on personal responsibility for health. In his introduction to *The Black report*, Patrick Jenkin indicated that the costs involved in increasing equality of health were 'quite unrealistic', so he could not endorse the report's recommendations; instead, he was 'making the report available for discussion, but without any commitment by the Government to its proposals' (Black *et al.*, 1980: 31). The extent to which the report was made available was exceptionally limited: the report was issued on the Friday before the August Bank Holiday and just 260 copies of the duplicated typescript were produced (Townsend, Whitehead and Davidson, 1992: 3).

Over time, medical journals and trades unions began to spread information about the content of *The Black report*. One of the first journals to summarise the report was *CHC News*. Individual Community Health Councils began to take action to campaign for the report to be recognised: eleven CHCs from the ten areas identified in *The Black report* as having the poorest levels of health coordinated a campaign, working with voluntary organisations and their local Members of Parliament (CHC News, 1981a: 1). The Association of Community Health Councils for England and Wales organised a national conference on the report, including one of the authors, Peter Townsend, as a speaker. As an action arising from the conference, the participants passed a resolution deploring the response of the Government to *The Black report* and calling for a Parliamentary debate on the report's findings (CHC News, 1981d). As an activity during a period when the national

role of CHCs and the existence of ACHCEW were matters of public consultation, these were brave stances to take on as contentious an issue as the Conservative government's near-suppression of *The Black report*.

Ministers started to reduce the ability of CHCs to mobilise opposition before the formal response had been made to *Community Health Councils in England*. At the 1981 Annual General Meeting of ACHCEW, civil servants informed the officers of the association that Ministers were considering ending the grant that was provided to fund *CHC News* and the information service for Community Health Councils. Having received positive responses to the role of Community Health Councils in the responses both to *Patients first* and the subsequent consultation on CHCs, Ministers shut off the funding at a vulnerable point: 'In this way, Ministers were able to terminate a commitment made by their predecessors, silence a persistent critic, and reduce the operational capacity of CHCs by removing their information and communication mechanism at a stroke' (Gerrard, 2006: 118). The tactic of removing communications weakened the CHCs' ability to mobilise activity. Whilst the membership structure stipulated for Community Health Councils had created CHCs as bodies that could round up interests, their statutory dependence meant that if they proved to be rogue dogs rounding up opposition their activity could be curtailed.

Initially, ACHCEW continued to produce *CHC News* on a subscription basis, but Community Health Councils' budgets were determined by their relevant Regional Health Authority, so resources for the CHCs were tight and the plans to expand other activities, such as training, did not yield sufficient income to cover the costs of the newsletter and the associated information service. By January 1984, the shortfall in funding was putting ACHCEW at risk (ACHCEW, 1984a). *CHC News* was closed, but ACHCEW was still financially vulnerable (Gerrard, 2006: 143). Kenneth Clarke, the new Minister for Health, agreed, after much discussion, to pay up to £27,500 to clear ACHCEW's projected deficit for the financial year (ACHCEW, 1984b:1). During the discussions about ACHCEW's financial position, Kenneth Clarke expressed a desire for the association to take on a 'postbox' function, transferring communications between the Department of Health and Social Security and the Community Health Councils; he also 'indicated to the ACHCEW deputation that the DHSS saw no reason to fund another "campaign"' (ACHCEW, 1984b: 1). Kenneth Clarke had been heckled at a conference organised by ACHCEW and presented with a pair of rose-tinted spectacles to demonstrate that Ministers were not seeing the real effects of cuts to the NHS, so he would have been personally aware of ACHCEW's ability to mobilise opposition (CHC News, 1983d). The terms he offered for

supporting ACHCEW were that it would act as a modest intermediary and not a campaigning body.

Cutting *CHC News* and reducing the power of ACHCEW limited the means for co-ordination between Community Health Councils and reduced the risk of national mobilisation, but meant that political actors still had the tools for local management of interest groups. In the meantime, management techniques were being explored by the Conservative government as a means to manage the ever-increasing costs of the National Health Service.

General management and changes to consultation

Roy Griffiths, managing director of the supermarket chain Sainsbury's, was invited by the Thatcher government to conduct a review of the National Health Service. The review took the form of a rapid and informal collection of information, used as the basis for general observations and specific recommendations (Klein, 2006: 117). The Griffiths report, as discussed in Chapter One, presents the problem in the NHS as lack of clarity about who is in charge. The fundamental direction behind the recommendations was that general management of the NHS should be improved at all levels.

Community Health Councils receive brief, but explicit, comment in the Griffiths report. It states that feedback is needed from users of health services, in order to judge the quality of the service that is being delivered, and that user feedback 'can be derived from CHCs and other methods, including market research and from experiences of general practice and the community health services' (Department of Health and Social Security, 1983: Recommendation 13.1). Within the new managerial approach in the NHS, Community Health Councils were treated in Griffiths' plans as one of a range of information sources rather than having a unique contribution to make. The Griffiths report states specifically that judgements about Community Health Councils had not formed part of the review, but that the inquiry team 'have been impressed with the grass-roots work of some of the CHCs' (Department of Health and Social Security, 1983: General observation 30).

With the general management model of consumerism, feedback on the quality of services was interpreted by NHS personnel. Whereas the previous Labour government had decentralised the difficult decisions on closure of hospitals, attempts to reduce the costs of health services were coordinated through a new management structure. Ministers

could avoid blame for local decisions through the management structure and did not need to use Community Health Councils to take the blame for hospital closures.

The role of Community Health Councils in agreeing local hospital closures was eroded after the introduction of general management into the NHS. The Richmond and Twickenham CHC reported in 1984 that the consultation processes in Greater London were being progressively squeezed, with health authorities expecting to be able to conduct a consultation exercise in six weeks rather than three months (ACHCEW, 1984c: 14). The Community Health Councils continued to view preventing the closure of a hospital as a success. Between May 1979 and the end of June 1985, 50 hospital closures were opposed by CHCs, of which the Minister approved 45 for closure (HC Deb (1985-86) 84 col. 570/571).

In 1985, Community Health Councils lost the right to approve a hospital closure (Hogg: 2009: 62). Whilst the Community Health Councils retained their statutory rights to be consulted on significant changes, District Health Authorities could approve closures that they could justify as being in the interests of the local community. The health authorities still had a statutory duty to consult Community Health Councils on substantive changes to services, including proposals to close hospitals. In its annual report for 1986/87, Tower Hamlets CHC reported that in practice many Community Health Councils were unable to develop alternative proposals when faced with a proposed hospital closure, 'however, it is this CHC's intention to submit alternative proposals whenever appropriate' (Tower Hamlets CHC, 1987).

Alongside the reduction in CHC consultation rights and the growth of consumerism, the 1980s saw a growth in the direct involvement of voluntary organisations, including disease-specific associations. The most significant statutory change was the development of joint consultative committees, which were the main forum to enable local authorities and health services to plan services jointly. Voluntary organisations were given the right to elect three members for each local committee. In the establishing guidance, Ministers welcomed the contribution that voluntary organisations could make directly:

'Voluntary organisations have a valuable contribution to make to the development of health and personal social services and related services in the housing and education fields. Ministers wish to encourage the participation by voluntary organisations in the planning and operation of these services.' (Department of Health and Social Security, 1984: §1)

The 'valuable contribution' to be made by voluntary organisations included acting as providers of services. Unlike Community Health Councils, individual voluntary

organisations were not seeking to represent views across the community, but might be able to make direct contributions to the range of services planned locally. The specific reference to Ministers encouraging voluntary organisations to participate ‘in the planning and operation’ of local services suggests that this is a different form of involvement. With the development of the internal market in the 1990s, the involvement of voluntary organisations as potential providers rather than as interest groups became more significant.

During the 1980s, Community Health Councils overcame the formal challenges of the *Patients first* and *Community Health Councils in England* consultations. Cuts to *CHC News* and the information service meant that the national support available to local CHCs was reduced. In terms of their sheepdog role, they retained the appointment mechanisms that ensured representation of local groups for vulnerable communities, but their consultation rights were eroded, so that CHCs lost the right to agree hospital closures and they became a means to gather consumer views rather than the representatives of the local community. They also demonstrated their ability to round up opposition to national policy, potentially making them less valuable to Ministers as sheepdogs.

4.3 CHCs in the NHS internal market, 1989-1997

On coming to power in 1979, the Conservative government attempted initially to cut costs in the NHS by reducing the tiers of bureaucracy and then by introducing general management. It was clear by the late 1980s that a more radical approach was needed to curtail costs (Pierson, 1994: 134). This took the form of an internal market, in which roles of providing and purchasing services were split so that providers could compete for funding.

Introduction of internal market

The NHS internal market was introduced in the White Paper *Working for patients* (Secretaries of State for Health, Wales, Northern Ireland and Scotland, 1989). The White Paper continued to recognise managers as responsible for the effective use of NHS resources (1989: 40). Community Health Councils in England are mentioned briefly: ‘The interests of the local community will continue to be represented by Community Health Councils, which act as a channel for consumer views to health authorities and FPCs [Family Practitioner Committees]’ (1989: 66). Acting as a channel for ‘consumer views’ did

not present Community Health Councils with a very powerful role in the new internal market. As fund-holding General Practitioners were able to choose the specialist services that they purchased on behalf of patients, the relationship with Family Practitioner Committees was important. It meant that Community Health Councils would be able to advise on services to purchase. The Community Health Councils retained their statutory rights to be consulted on service change and to visit health services, but they seem to have been overlooked as active participants in the new market.

The Government encouraged NHS bodies to seek the views of their service users directly, on a Hirschman-style model of responding to feedback to improve customers' experience of services (Hirschman, 1970). NHS organisations started to use new models of consultation with the public, such as health panels and citizens' juries, which did not involve Community Health Councils. The voluntary sector also benefited from the guidance *Local voices*, which encouraged discussions with voluntary organisations about the services to be purchased locally (NHS Management Executive, 1992). With greater direct engagement by NHS managers with individual patients and with voluntary organisations, it was hard for Community Health Councils to sustain a role as representing the public interest (Hogg, 2009: 48).

Ministers expected Community Health Councils to play a role in purchasing and developing health services, despite their exclusion from the membership of joint consultative committees to develop services across health and social care. Stephen Dorrell, Parliamentary Under Secretary of State, wrote to the Chairs of Regional Health Authorities and District Health Authorities in 1992 advising that health authorities 'should agree locally with CHCs how they should contribute' to assessment of priorities, purchasing and standards-setting for services (Gerrard, 2006: 164). Whilst this did not provide health authorities with specific guidance, the letter gave Community Health Councils a tool that they could use to negotiate a local role in the purchasing process.

Challenging national policy

The Association of CHCs for England and Wales continued to coordinate national activity by the CHCs. In the 1990s, ACHCEW opposed the introduction of the Private Finance Initiative (PFI). The Private Finance Initiative was first introduced by John Major's government in 1992. It provided a controversial approach to capital funding, as private funding was used to build hospitals and provide services that were then rented back to the NHS, a process that was interpreted by critics as a form of privatisation (Pollock, 2004:

54). As Community Health Councils were all independent bodies, they reached differing conclusions on the value and ethics of the Private Finance Initiative. A briefing paper produced by ACHCEW in 1995 includes a range of views expressed by Community Health Councils. It is a very balanced report and concludes that 'the prospects for PFI depend very largely on the existence of feasible and attractive alternatives to privately-financed development' (ACHCEW, 1995b: 19).

The 1996 Annual General Meeting of ACHCEW adopted a resolution opposing the use of the Private Finance Initiative to fund capital projects in the NHS (Gerrard, 2006: 169). The resolution stated that the Private Finance Initiative had 'delayed or blocked many capital developments, that the cost to the NHS was substantial and that public sector investment in the NHS had been cut' (ACHCEW, 1996: 28). Following the Annual General Meeting, ACHCEW conducted a survey of Community Health Councils. Responses were received from 129 of the 207 Community Health Councils, which was a fair response, but indicated that ACHCEW was not in a position to coordinate universal input from local CHCs. The report on the survey acknowledges that CHCs would sometimes welcome PFI-financed initiatives as private finance had proved the only way to achieve some developments that had been needed for many years. One in ten (11 percent) of the respondents indicated that the Private Finance Initiative had facilitated projects that would not otherwise have taken place, whilst half (54 percent) stated that PFI had not enabled projects to take place (ACHCEW, 1996: 26). Whilst ACHCEW respected the right of individual Community Health Councils to form their own opinions, the national association feared that funding would flow on the basis of 'best return', rather than greatest need (ACHCEW, 1996: 28).

Where Private Finance Initiatives were proposed locally, Community Health Councils often had the contacts to provide a rigorous review of the proposals. In January 1997, South Birmingham Community Health Council received details of a proposal to replace the Selly Oak and Queen Elizabeth hospitals with a single PFI-funded hospital:

'Ursula Pearce, as Chair of SBCHC [South Birmingham Community Health Council], led discussion with a wealth of information, often drawn from financial and construction industry sources. A working group was set up and its discussions took on a seminar form with her and Shirley Hoole, Chair of the Acute Working Group, producing evidence based on then existing or planned projects around the country. Research by academics like Allyson Pollock and David Price was also taken into consideration. It became apparent to all that a PFI hospital was likely to have fewer beds and services and higher running costs over a long period.'
(Spilsbury, n.d. [2003]: 49)

The PFI build in Birmingham did not go ahead. As established organisations whose voluntary members had a range of professional skills, the CHC members were committed to the future of the NHS in their district and would seek out relevant information that could sway arguments.

Opposing the Private Finance Initiative was unlikely to make Community Health Councils popular with NHS managers or with Ministers. Their opposition, however, seems to have made little impression on the Conservative government.

Reviewing Community Health Councils

In 1995, Community Health Councils became a focus for Ministerial attention. Ministers commissioned a report from Insight Management Consulting to review the roles of Community Health Councils. A review of CHCs had been promised since the early 1980s, so Community Health Councils welcomed the move as evidence of Ministerial interest (Hogg, 2009: 53; Gerrard, 2006: 180-181).

At the same time as the review, restructuring of the NHS meant that the Regional Health Authorities – which acted as establishing bodies for Community Health Councils – were being abolished and so the location of CHCs within the NHS needed to be considered. The abolition of the Regional Health Authorities preceded the findings of Insight Management Consulting. The actions taken therefore reflect Ministerial views, in this case those of Stephen Dorrell who had just replaced Virginia Bottomley as Secretary of State for Health, rather than a response to advice from consultants. ACHCEW was invited to participate in a working group to consider how Community Health Councils would be established with the demise of Regional Health Authorities. Regional Health Authorities were merged into eight regional offices of the NHS Executive (Ham, 2009: 45-46). The remit of the working group was to consider how the regional offices of the NHS Executive would undertake the role of establishing Community Health Councils. Following the report of the working group, ACHCEW produced a response that called for an independent agency to act as the establishing body:

‘It is recognised that the scope of the Working Group’s remit was to make recommendations on the implementation of the decision that had already been taken by Ministers that, once RHAs [Regional Health Authorities] are abolished, the establishing functions for CHCs should be exercised by the NHS Executive through its regional offices. This recognition does not alter the Association’s existing position as agreed at the Association’s Special General Meeting on 7 February 1994 that “an independent agency should be set up to act as the establishing authority for CHCs”.’ (Association of CHCs for England and Wales, 1995a: 1)

The nature of ACHCEW as a membership organisation meant that the resolutions taken at either Annual General Meetings or Special General Meetings were binding, so representatives from ACHCEW were not empowered to negotiate an alternative solution. The remainder of the response from ACHCEW consists of expressions of concern about the powers, resources and independence of Community Health Councils. Using responses as an opportunity to raise concerns about the resources available to CHCs is a tactic that was frequently used by ACHCEW in the reports produced during the 1990s.

The Statutory Instrument that followed, *Community Health Councils Regulations 1996*, transferred the rights that had been held by the Regional Health Authorities to the Secretary of State. The Secretary of State was therefore empowered to 'vary the total membership and composition' of any Community Health Council, to determine the list of voluntary organisations to be involved in selecting the voluntary sector's third of members and to determine how the sixth of members who had been nominated by the Regional Health Authority should be appointed (*Community Health Council Regulations 1996*: 1(2)(c), 3(3)). In practice, this meant that the Secretary of State could authorise the regional office of the NHS Executive or any other body to act as the establishing body for Community Health Councils. The distinctive appointment mechanisms for Community Health Councils were retained: with half of members appointed by local authorities; a third of members nominated by local voluntary organisations; and the remaining sixth appointed by the regional office of the NHS Executive on the behalf of the Secretary of State. The regional offices were urged when establishing Community Health Councils to aim for a balance of representation in terms of race, age, sex and geographical localities (Hogg, 2009: 55-56). This was a different dimension to representation, with the members themselves being seen for the first time as reflecting the profile of the local community, rather than purely as individuals designated by their respective interest groups. It also meant that there was an attempt to have more direct participation by members of more vulnerable communities, rather than representation through groups supporting their interests. Whilst the transfer from Regional Health Authorities to regional offices of the NHS Executive was a relatively minor change, the centralisation of powers to the Secretary of State provided Ministers with the option of greater control, including determining parameters for the selection of members.

Insight Management Consulting presented their report on CHCs to Ministers in November 1996. The report developed a model for a 'notional CHC' (Gerrard, 2006: 170-179). Insight identified that Community Health Councils were undertaking a wide range of activities, including providing information services and supporting complainants. The

consultants recommended that CHCs should refocus their activity, concentrating on consultations and a targeted investigation function (Hogg, 2009: 53). Essentially, these were the statutory rights of CHCs, to be consulted and to enter and view NHS premises. Community Health Councils had been conscious of variations in their activities and had been debating standards for CHC activity during the 1980s and 1990s, commissioning reports on best practice and standards for CHCs (Hogg, 1987; Hogg, 1996). The Insight Management Consulting report provided Community Health Councils with an opportunity to reform themselves. The CHCs failed to agree, however, on a response to the specific proposals in the report and the actions to take. Christine Hogg, who had herself undertaken much of the standards-related activity for ACHCEW, reflected later that the most promising opportunity that CHCs had had to reform themselves had been lost (2009: 55).

In response to the general challenge posed by the Insight Management Consulting report, which was seen as narrowing the range of activity undertaken by Community Health Councils, Toby Harris, Director of ACHCEW, led on the compilation of *CHCs making a difference* (ACHCEW, 1997). This was described by Gerrard as 'a genuine compilation of the constructive and painstaking work of CHCs' (2006: 192). It was also something of a morale booster for CHCs, as over half of the CHCs were mentioned by name in the summaries of activity.

CHCs making a difference lists a broad range of activities undertaken by CHCs, including visiting health services, responding to consultations, training NHS personnel, providing information services, supporting complainants and providing advocacy support. Taken as a demonstration of the commitment of CHC members, it is an impressive array of activity. The report also includes examples of CHCs mobilising local opposition, often over a long timeframe:

'Croydon CHC finally persuaded its local health authority to accept the need for more beds at Mayday Hospital following two years of campaigning culminating in a public meeting, convened by the CHC, at which the Chief Executives of the health authority and Mayday Hospital were asked to explain why the hospital had been unable to cope with emergency admissions for the fourth winter running. Shortly after, the health authority ear-marked money for extra beds. Prior to this they had insisted that the problems were purely to do with the need for more efficient bed management.' (Association of CHCs for England and Wales, 1997: 13-14)

This example of a successful campaign demonstrates the value of continuity of local knowledge. The ability of Croydon CHC to demonstrate that emergency admissions had been a problem at Mayday Hospital for four consecutive winters would have had more weight with the health authority than a single instance of a problem. The CHC members

also knew who to invite to the meeting in order to get the required result. From an intermediary perspective, access to hospital beds during the winter is not a disease-specific issue, but an issue for the whole community that is more likely to be a problem for vulnerable groups, such as young children and the elderly, whom CHCs were set up to represent.

During the period of the internal market, Community Health Councils continued to represent vulnerable groups, but their mediation role was lessened as interest groups were becoming involved directly in local decisions. They retained their rights to be consulted, but NHS-led involvement, such as citizens' juries increased, lessening the significance of input from the CHCs. They continued to have a remit to comment upon health services across a geographical area, but also coordinated activity in opposition to national policy, notably on the Private Finance Initiative. Having lost the right to agree local hospital closures, they were less likely to be in a position to take the blame for unpopular local decisions.

Community Health Councils had much to celebrate in *CHCs making a difference*, but the emphasis placed on the breadth of activity did not accord with the proposal from Insight Management Consulting that the range of CHC activity should be reduced and focused on the statutory aspects of their role. The Community Health Councils had had positive experiences of working with Labour, both when they were in power during the 1970s and in opposition during the 1980s and 1990s (Hogg, 2009: 108). With unresolved issues about the focus of their role, Community Health Council members would have looked forward with interest to the outcome of the 1997 General Election.

4.4 Managing interests trends, 1974-1997

Taking Community Health Councils as potential sheepdogs to round up participants and manage potential opposition, the institutions played a stronger role in political management of the NHS in the 1970s than they did in the 1990s. The activities of Community Health Councils are considered over time against each of the sheepdog characteristics in Figure 4.1.

The first period, from 1974 to 1979, covers the early activity of Community Health Councils under Labour governments. The appointments mechanisms that had been set up by the preceding Conservative administration ensured that groups representing vulnerable communities were members of CHCs and Labour Ministers referred issue-specific groups to participate in health service discussions through their Community Health

Council, strengthening the local mediation role of CHCs. The early CHCs had statutory rights to be consulted on local services within a state-determined geographical area. Granting the CHCs the powers to agree to the closure of local hospitals seems to have provided Ministers with a valued blame-avoidance mechanism. Taken in the terms of the sheepdog model, Community Health Councils during the period 1974 to 1979 seem to have acted as sheepdogs and to have been valued by Ministers for this political role.

Figure 4.1: Sheepdog – assessment of role played by Community Health Councils (CHCs), 1974-1997			
Sheepdog characteristics	Early CHCs (1974-1979)	Middle period (1979-1989)	CHCs in internal market (1989-1997)
Mediate between local interests, including vulnerable groups	Appointments ensure vulnerable groups are represented in CHC; Issue-specific groups referred to CHCs	Reduced numbers of members, but appointments ensure vulnerable interests represented in CHC	Appointments ensure vulnerable groups are represented in CHC; Increasing direct involvement of voluntary sector
Structure consultation on local services	Right to be consulted on local changes	Right to be consulted on local changes; Griffiths report encourages CHC gathering of consumer views	Right to be consulted on local changes; Growth of NHS-led forms of consultation
Consider only state-determined range of issues	Remit granted for health services in geographical area	Remit granted for health services in geographical area; Criticised for national role in promoting <i>The Black report</i>	Remit granted for health services in geographical area; Varying CHC views on Private Finance Initiative (PFI) and ACHCEW opposition to PFI
Take responsibility for unpopular local decisions	Hospital closure rights; Examples of CHCs blamed for decisions	Hospital closure rights to 1985	Not sufficiently powerful to be blamed for local decisions

During the middle period, as presented in this chapter, from 1979 to 1989, the existence of Community Health Councils was challenged in the *Patients first* consultation and then the need for the Association of Community Health Councils for England and Wales was questioned in the *Community Health Councils in England* consultation. These consultations could suggest that the statutory public involvement institutions were not actively valued by the incoming Conservative government. In terms of mediation, the number of members in CHCs was reduced by statute, but the appointment processes continued to ensure that vulnerable groups were represented. The CHCs retained their statutory rights to be consulted on changes to services. In addition to the rights of CHCs to be consulted, NHS managers were encouraged to seek feedback from individual service users, although the NHS managers often sought this feedback through Community

Health Councils. CHCs had a state-determined remit and were criticised for their role in promoting *The Black report* on health inequalities, suggesting that they were seen to be beginning to round up opposition rather than mediating interest group involvement. The end of CHCs' rights to agree hospital closures meant that they were no longer acting as a means for Ministers to avoid blame for hospital closures. During the 1980s, therefore, the sheepdog role of CHCs was weakened.

The last of the three periods described in this chapter and summarised in Figure 4.1 covered the NHS internal market, 1989 to 1997. Community Health Councils retained their appointment structure and continued to include representatives of vulnerable groups. Their mediation role was reduced, however, by increasing Ministerial encouragement to NHS personnel to involve interest groups directly, particularly following the *Local voices* initiative (NHS Management Executive, 1992). CHCs retained their statutory right to be consulted, but NHS organisations were also experimenting with new forms of consumer consultation. The statutory public involvement institutions continued to be granted a state-determined remit, but to operate outside their remit as well as within it. The CHCs were no longer responsible for significant decisions, such as agreeing hospital closures and may not have been strong enough to enable Ministers to avoid taking the blame for unpopular decisions.

During the 1970s, there is evidence that Community Health Councils were valued in the sheepdog role. Over the course of the 1980s and 1990s, however, the powers that enabled CHCs to act as sheepdogs were reduced. In the case of hospital closures, the power to agree the closures was removed. The intermediation and consultation powers were effectively reduced through layering with other forms of involvement. 'Layering' of existing policies or institutions with new mechanisms is a recognised option for political actors if the existing tools no longer meet their needs (Hacker, 2004: 248). It is possible, therefore, that Community Health Councils no longer operated effectively in sheepdog roles, but that they were too popular or too difficult to abolish, so Ministers created new processes to work around the Community Health Councils.

The incoming Labour government of 1997 tackled the issue of abolishing Community Health Councils, choosing to replace them with Patient and Public Involvement Forums. The successive changes to statutory public involvement institutions are the subject of Chapter Five, which continues to consider whether statutory public involvement institutions play a sheepdog role in the political management of the NHS.

Chapter summary

Chapter Four opened by considering whether statutory public involvement institutions acted as ‘sheepdogs’ in political management of the NHS, rounding up participants and managing potential opposition. It covered the period from 1974 to 1997. During the 1970s, there is evidence that Labour Ministers valued the sheepdog role played by Community Health Councils, referring interest groups to them for mediation and granting powers to CHCs that meant they took the Ministers’ share of the blame for the closure of local hospitals. In the early 1980s, the Conservative government questioned the need for CHCs and progressively developed alternatives to their involvement as part of consumer input into general management of the NHS. Throughout the period covered by this chapter, CHC members were appointed through a statutory process which ensured that vulnerable groups were represented, maintaining a forum through which intermediation could take place. In practice, however, the powers that enabled CHCs to intermediate and manage potential opposition also enabled them to round up opposition to reforms, making them less valuable as sheepdogs.

The next chapter continues to consider whether statutory public involvement institutions carried out a sheepdog role in political management of the NHS, reviewing the series of institutions during the period from 1997 to 2010.

Chapter Five: Changing breeds: abolitions and replacements, 1997-2010

Community Health Councils outlived all the other institutions introduced in the 1974 NHS reorganisation. Whilst their existence had been challenged, particularly in the *Patients first* and *Community Health Councils in England* consultations, their fundamental appointments structure and statutory rights, to be consulted and to enter and view NHS premises, remained unchanged. *The NHS plan* in July 2000 brought the announcement that Community Health Councils were to be abolished and replaced by patients' forums, with the complaints functions that many CHCs had been undertaking transferred to Patients' Advice and Liaison Services (PALS). Patients' forums, or Patient and Public Involvement Forums to use the title that was adopted for the forums in practice, were themselves abolished and replaced with Local Involvement Networks (LINKs), to be replaced in their turn by local Healthwatch in April 2013. Given the series of abolitions, Ministers had successive opportunities not to replace abolished statutory public involvement institutions with new institutions. This chapter considers whether the successive statutory public involvement institutions were expected to undertake a sheepdog role in political management of the NHS and the sheepdog role was a factor in the series of reforms.

The chapter opens with a discussion of the Community Health Councils following the election of a Labour government in 1997. It considers the abolition of Community Health Councils in terms of a sheepdog role in political management of the NHS. The second section reviews the role of Patient and Public Involvement Forums (PPI Forums) and their national body, the Commission for Patient and Public Involvement in Health (CPPIH). Thirdly, the chapter considers Local Involvement Networks. The chapter closes with a discussion of the trends observable in the changes to statutory public involvement institutions and whether changing understandings of the sheepdog role played a part in the institutional reforms.

5.1 Last steps of the Community Health Councils, 1997-2003

Experience of working with Labour politicians in Government and in opposition suggested that Community Health Council members had cause to be optimistic with the landslide victory of Blair's Labour government in 1997. As Community Health Councils had struggled for Ministerial attention for much of the 1980s and 1990s, the new

Government was seen by many CHC members as an opportunity to raise the profile of public involvement in the NHS (Hogg, 2009: 108; Gerrard, 2006: 24). Several different theories have been proposed to explain the Labour government's decision to abolish Community Health Councils, including a desire to create a customer service function, objections by CHCs to the use of the Private Finance Initiative to fund health facilities and relationships between individual Ministers and the CHCs in their constituencies (Gerrard, 2006; Greer 2004a; Hogg, 2009). This section considers public involvement when Labour first came to power and examines the abolition of Community Health Councils in England in the context of a sheepdog role to support political management of the NHS.

Public involvement and New Labour

On coming to power, the Labour party began a programme of reforming and modernising the National Health Service. In place of local professional consensus on the treatments to be funded, the Labour party introduced the National Institute for Clinical Excellence (NICE). NICE provided guidance on the clinical value and cost-effectiveness of drugs and treatment regimes, to be used as the basis of funding decisions. The creation of NICE was followed by that of the Commission for Health Improvement, which was authorised to undertake clinical reviews of each NHS trust every four years. NICE and the Commission for Health Improvement were key elements in the first clinical governance structure across the NHS in England and Wales. The framework for clinical governance, *A first class service*, incorporated public involvement at all levels, from the expectation of NHS-led user involvement in local services to patient representatives sitting on NICE appraisal committees considering the merits of treatments (Department of Health, 1998). For the first time, public involvement was a core activity in the NHS. The Department of Health produced a paper on *Patient and public involvement in the new NHS* ['new' italicised in the title], which outlined the benefits of patient and public involvement and emphasised the increasing role of users and carers in the Department of Health's work programmes (Department of Health, 1999). In the foreword to *Patient and public involvement in the new NHS*, Parliamentary Under Secretary of State Gisela Stuart emphasised the importance of involving local people in decisions about local services as part of the modern NHS:

'Since 1997 we have been engaged in a widespread programme of reforms to modernise the services which the NHS delivers. Access to these services should be fast and convenient for the communities in which they are based. Fundamental to these reforms has been a commitment to give people at a local level the power to make decisions about the services that are needed. This means involving all the

key stakeholders locally, in partnership with Health Authorities and health professionals. Patients, carers, and the local public have a key role to play in this process.' (Department of Health, 1999: i; underline in the original)

The emphasis on direct involvement of 'all' key stakeholders is a shift, as Community Health Councils had been structured to be representative of the main interest groups and to act on the behalf of the local community in negotiations with NHS organisations. Expansion of public involvement into other areas of NHS activity and encouragement of health authorities to involve all stakeholders implicitly moved away from an interest intermediation role for the Community Health Councils. The activity of CHCs is illustrated in case studies of public involvement within *Patient and public involvement in the new NHS*, but CHCs receive little attention in the document.

With greater emphasis on a range of stakeholders, rather than interest intermediation, Community Health Councils had started to describe their membership in terms of their demographic profile, rather than the interest groups they represented. Whereas annual reports in the 1980s had listed the groups that the members represented (as an example, Tower Hamlets CHC in 1987 listed the very local organisations that were represented, including Tower Hamlets Welfare for the Mentally Handicapped and the League of Friends of Mildmay Mission Hospital), CHCs listed age groups represented, the numbers of people who were patients and the specialisations of the interest group experience contributed by individual members (as an example, Rochdale CHC, 2003: 3). In response to the requirement from 1996 that establishing bodies should consider the membership profile of CHCs, individual Community Health Councils were beginning to represent their activities in ways that met a change in the agenda that recognised demographic representativeness and inclusion of members from vulnerable communities, rather than representatives from groups for vulnerable communities.

Community Health Councils were in a mood for reform, but the long period outside the spotlight of Ministerial attention had allowed problems within the Association of Community Health Councils for England and Wales and across the CHC movement to simmer (Hogg, 2009: 109). Donna Covey was appointed as Director of ACHCEW in 1998. She took an energetic stance in raising the profile of Community Health Councils. Covey set up an All-Party Parliamentary Group on CHCs, which in 1999 had 240 MPs as members, many of whom had previously been members of CHCs (Hogg, 2009: 110). She also set up an independent Commission on the NHS, chaired by Will Hutton. The Commission on the NHS organised a randomised public poll and found that 63 percent of the population regarded the NHS as the most important institution in the country, with the

next highest scores for Parliament (12 percent) and the police (11 percent) (Hutton, 2000: 1). Such findings were used in reports and media releases to raise the profile of ACHCEW. The independent Commission on the NHS also recommended that Community Health Councils should be strengthened and that public involvement should be represented by CHCs as they could work across a broad range of interests, not the 'ginger group' activity of issue-specific voluntary organisations (Hutton, 2000: 93, 96).

Whilst ACHCEW was continuing to emphasise the value of intermediation between interest groups, voluntary sector organisations themselves were becoming more influential. A compact was set up between Government and the voluntary sector to encourage partnership working (Secretary of State for the Home Department, 1998). The Government also wanted to hear consumer views directly and organised 'the biggest ever listening exercise', including a 'census day' for the NHS on 31 May 2000 (Hogg, 2009: 110). To support the census day, 12 million survey forms were distributed through shops, pharmacies and NHS services. Alan Milburn, Secretary of State for Health, launched the census day and promoted it as an opportunity for individuals to have their views heard:

'We now have a once in a lifetime opportunity to use the extra resources that this Government is putting into the NHS to create a 21st century NHS where the needs of the patient come first. The time has come to have an NHS where the patients are listened to and not talked at, which is why we are launching this huge national public consultation exercise that will involve staff as well as patients. ...This is a genuine commitment to not just consult, but to listen and act upon the views of the public.' (Alan Milburn, in: Department of Health, 2000a)

Feedback from the census day was provided to the modernisation action teams, each of which, to quote the press release, 'has at least one representative of a patient organisation on it' (Department of Health, 2000a). It was against this context of increasing involvement by issue-specific voluntary organisations in national policy and direct consultation of the public that ACHCEW and the CHCs learned that they were to be abolished.

Abolition of Community Health Councils in England

The Conservative governments in the 1980s had consulted on whether Community Health Councils were needed, but the strength of support was such that they did not disband them. The Labour government, however, was prepared to risk any unpopularity arising from abolishing Community Health Councils (Hogg, 2009: 112).

The NHS plan presented three elements from the work undertaken by Community Health Councils to be transferred to other organisations. The complaints work, which was

not a statutory function of the CHCs, was to be transferred to a new category of paid officials within NHS trusts, the Patient Advocacy and Liaison Services (later renamed, after much debate with interest groups, Patient Advice and Liaison Services) (Secretary of State for Health, 2000: 92). As discussed in Chapter Six, depriving statutory public involvement institutions of intelligence gleaned from complaints lessened their ability to act as watchdogs and alert authorities to problems before they became disasters. Secondly, the power to refer major planned changes to the Secretary of State was to be transferred 'from unelected community health councils to the all-party scrutiny committees of elected local authorities', although successive statutory public involvement institutions could still refer issues to the Secretary of State through the local authority Overview and Scrutiny Committee (2000: 94). Thirdly, the representation and consultation role, including 'the right to visit and inspect any aspect of the trust's care at any time' was to be transferred to 'Patients' Forums' (later known as Patient and Public Involvement Forums) (2000: 94). The statutory aspects of the Community Health Councils' activity, therefore, were being passed on to the new PPI Forums. As groups of volunteers with statutory powers, it is the PPI Forums that formed the successors to Community Health Councils as statutory public involvement institutions.

In case there was any doubt about a role remaining for CHCs, the section of *The NHS plan* on 'changes for patients' closed with confirmation that Community Health Councils would be abolished:

'This is a package of radical reform. It will enhance and encourage the involvement of citizens in redesigning the health service from the patient's point of view. As a result Community Health Councils will be abolished and funding redirected to help fund the new Patient Advocate and Liaison Service and the other new citizens empowerment mechanisms set out above.' (Secretary of State for Health, 2000: 95)

'Redesigning the health service from the patient's point of view' is a very different form of consultation from the intermediation between interests that the Community Health Councils provided in their sheepdog role. The reference in the text is to 'the patient's view' in the singular, suggesting that this redesigning is less of a deliberative process and more a collation of individual views to be incorporated by NHS personnel into plans for service development. The rationale given within *The NHS plan* for the change is that Community Health Councils had combined distinct functions and that 'it is time to modernise, deepen and broaden the way that patient views are represented within the NHS' (Secretary of State for Health, 2000: 93).

Viewed in terms of the sheepdog role, the Labour government was shifting from public involvement as intermediation between interest groups to a greater degree of direct engagement with patients and citizens. Whilst half of CHC members were appointed by local authorities, a third by voluntary organisations and a sixth by the NHS, most of the members were representatives of interest groups. The new PPI Forums were intended to attract new members who were not already involved in voluntary groups or civic activity. As envisaged at the time of *The NHS plan*, half of the members would be 'drawn from local patients groups and voluntary organisations' and 'the other half of the Forum's members will be randomly drawn from respondents to the trust's annual patient survey' (Secretary of State for Health, 2000: 94). This suggests a half-way house between interest intermediation and a membership intended to represent current users of hospital services. In practice, as outlined in the discussion of Patient and Public Involvement Forums below, the mix of interest representation and patients appointed as individuals was not implemented.

In terms of the state-determined remit, a much narrower role was imposed by the state: Community Health Councils covered health services across a geographical area, whereas Patient and Public Involvement Forums were limited to activity with a particular NHS trust, whether a hospital or a Primary Care Trust. The PPI Forums were therefore seen as needing to have a closer relationship with NHS trusts. Alan Milburn later suggested that this close relationship with NHS trusts had been seen as a solution to problems identified by the Bristol Royal Infirmary inquiry (which was then in progress):

'I took the decision to abolish CHCs because I took the view that patients needed to have a voice inside the National Health Service. As you know this was the point that was made very forcibly by Professor Sir Ian Kennedy in his inquiry into the tragic events at Bristol Royal Infirmary. ...I could never understand the argument of those who said that the proposal to abolish CHCs would somehow weaken patients' presence in the NHS. In fact, the reforms that I put in place – both organisationally in terms of patients' forums etc., and institutionally in terms of patients being able to express a choice about where they are treated, when and by whom – represented a real strengthening of patient power in the Health Service.' (Alan Milburn, in: Gerrard, 2006: 270-271)

The emphases in Milburn's account are on placing involvement within the NHS and on the involvement of individual patients, rather than the involvement of interest groups or mechanisms to manage interest groups. A remit within the NHS placed the Patient and Public Involvement Forums in a position where they might influence the attitudes of health professionals within specific institutions. In the period leading up to the abolition of Community Health Councils, there had been a series of events resulting in public inquiries that revolved around the attitudes of health professionals: over-confidence of staff using

new surgical techniques resulting in the deaths of babies at Bristol; and ethically-questionable retention of organs from dead children at Alder Hey (Secretary of State for Health, 2001; Royal Liverpool Children's Inquiry, 2001). As a solution to a political problem, restricting the remit of statutory public involvement institutions to a specific NHS trust may have been seen as a means to develop more patient-centred attitudes towards clinical practice.

Considered in terms of the sheepdog role, the abolition of Community Health Councils may have been a means to limit mobilisation of opposition. Whilst the CHC movement was fragile, it could mobilise on specific issues. Since 1998, Community Health Councils had been working with ACHCEW to produce Casualty Watch reports: the majority of CHCs took part in Casualty Watch (in 2000, 176 of 181 Community Health Councils took part), visiting Accident and Emergency units during the same 24 hour period and monitoring how long people had to wait before they were seen (ACHCEW, 2000a). The data from the Casualty Watch visits were compiled very rapidly and produced reports that drew media attention to shortcomings in health services. Abolishing CHCs and ACHCEW therefore muzzled a voice that could be oppositional.

The Community Health Councils demonstrated their ability to mobilise opposition in their response to the announcement that they were to be abolished. They objected to the new proposals on the grounds that they lacked special provision for representation of vulnerable groups and that the new PPI Forums would be too close to NHS trusts for their inspections to be seen as objective (ACHCEW, 2000b: unpaginated [1]). Parliamentary contacts of the Community Health Councils were drawn into the debate, with the result that the arrangements for the replacement of CHCs did not appear as planned in the *Health and Social Care Act 2001*, but were delayed and incorporated into the *NHS Reform and Health Care Professions Act 2002*. Wider duties requiring NHS organisations to consult the public were included in the *Health and Social Care Act 2001*, as discussed below, which duplicated the rights of Community Health Councils to be consulted in their last months of existence. The Parliamentary debates on the nature of the Patient and Public Involvement Forums clarified their statutory powers and led to the inclusion of a national body, the Commission for Patient and Public Involvement in Health (CPPIH) in the legislation.

With devolution of responsibility for the National Health Service in Wales to the National Assembly for Wales in 1999, decisions relating to Community Health Councils in Wales were handled by the National Assembly. In April 2000, a new federal model for Community Health Councils was established, enabling CHCs to collaborate regionally

(Assembly Secretary for Health and Social Services, 2000a: §7.5). Jane Hutt, Assembly Secretary for Health and Social Services, announced on 12 July 2000 that she had commissioned a review of CHCs (Assembly Secretary for Health and Social Services, 2000a: §7.5). Jane Hutt's response to *The NHS plan*, when it came out on 27 July, was to frame it as being 'for England' and that 'ideas' within it needed to be shaped into 'an approach that is right for us' (Assembly Secretary for Health and Social Services, 2000b: §1-5). *The NHS plan* was a wide-ranging document and Hutt's only specific example of an area of activity that might be different in Wales was the proposed abolition of Community Health Councils (Assembly Secretary for Health and Social Services, 2000b: §6-7). The decision to retain CHCs in Wales was announced within *Improving Health in Wales*, the plan for the NHS in Wales (National Assembly for Wales, 2001).

The situation in Wales differed from that in England when considered in terms of interest group management. With a smaller national population, fewer people were likely to get involved in activities and there was the potential for individual interest group representatives to be very influential. The Welsh review of CHCs concluded that 'CHCs' strengths lie in their statutory status and their ability to represent the interests of the public, free from any vested interest' (Health and Social Services Committee, 2001: 45). There was therefore perceived to be a need for intermediation between interest groups, to avoid dominance by any of the issue-specific groups. The Welsh Community Health Councils also had a reputation for adopting a less oppositional style than CHCs in England³⁸. They were therefore less likely to mobilise opposition.

Changes to consultation and referral rights

The *Health and Social Care Act 2001* Section 11 introduced a duty for the NHS to consult the public on decisions relating to planning, providing and potentially changing health services, a process which became known as Section 11 consultations. Rather than a privileged right of the Community Health Councils to be consulted, the new duty referred to consulting 'persons to whom those services are being or may be provided' and that patients and potential patients should be consulted or involved 'directly or through representatives' (*Health and Social Care Act 2001*, Section 11). This places the decision on who should be consulted with the NHS organisation, rather than giving statutory public involvement institutions a statutory right to be consulted. The reference to the consultation

³⁸ Source: Interview with Malcolm Alexander, former Director of the Association of Community Health Councils for England and Wales

as 'directly or through representatives' means that individual users of health services or their representatives, such as voluntary organisations, may be consulted. The withdrawal of a statutory right to be consulted weakened the position of Community Health Councils in their last months and the position of their successors. Whether or not the statutory public involvement institutions were included in the Section 11 consultations depended upon local influence, rather than nationally-granted rights.

Connected to rights to be consulted, Community Health Councils had the right to refer disputed plans to the Secretary of State. This right was transferred to the Overview and Scrutiny Committees within local authorities:

'In any case where an Overview and Scrutiny Committee considers that the proposal would not be in the interests of the health service in the area of the committee's local authority it may report to the Secretary of State in writing who may make a final decision on the proposal and require the local NHS body to take such action, or desist from taking such action as he may direct.' (*Local Authority (Overview and Scrutiny Committees Health Functions) Regulations 2002*)

Successors to CHCs were able to refer problems to the Secretary of State through their Overview and Scrutiny Committee (or through the Commission for Patient and Public Involvement in Health in the case of PPI Forums), but did not have the right to refer problems directly. When Community Health Councils objected to proposals for health service changes, as discussed in Chapter Four, they were expected to provide a costed alternative proposal when referring a case to the Secretary of State. As part of the broader Section 11 consultation, statutory public involvement institutions might choose to generate alternative proposals, but this was neither an automatic right nor a requirement. Successors to Community Health Councils were granted rights to refer unresolved issues to the Overview and Scrutiny Committee of the relevant local authority, but they were then dependent on the determination of the committee as to whether an issue should be referred on to the Secretary of State.

Discussion in Chapter Four suggested that the right to be consulted, particularly once extended by the 1974 Labour government into a right to agree local hospital closures, provided evidence of the blame-avoidance aspects of the sheepdog model. In 2000, the Blair government announced the largest real-terms increase in funding that the National Health Service had seen (Secretary of State for Health, 2000). This did not mean, however, that difficult decisions did not need to be made, as additional funding was conditional on modernisation. Health services were also becoming more costly, with new technologies and more people living longer with complex health service needs. Reflecting in 2003 on the experience of Central and South Birmingham CHCs, David Spilsbury

commented that ‘in most cases, the general public objected to change’ and that ‘there were many instances where the CHC’s intervention proved necessary and welcome to improve the situation’ (n.d. [2003]: 46, 47). As sheepdogs, the Community Health Councils had acted as mechanisms to manage opposition to change. With the loss of privileged consultation rights and the transfer to Overview and Scrutiny Committees of the right to refer proposals to the Secretary of State, successors to Community Health Councils were in a weaker position and less likely to act as tools to shift blame for changes away from Ministers.

5.2 Patient and Public Involvement Forums, 2003-2008

Community Health Councils were replaced with PPI Forums in December 2003. The PPI Forums were established by the Commission for Patient and Public Involvement in Health (CPPIH). As CPPIH played a fundamental role in setting up the Patient and Public Involvement Forums (PPI Forums) and setting the parameters for their activity, this section opens by considering the role played by the Commission for Patient and Public Involvement in Health. The section continues with a review of the nature of the membership of PPI Forums, the activity of the Forums (particularly in terms of whether they played a sheepdog role) and the abolition of both CPPIH and the PPI Forums.

Commission for Patient and Public Involvement in Health (CPPIH)

The Commission for Patient and Public Involvement in Health was set up in January 2003 as an independent, non-departmental public body, sponsored by the Department of Health. It was given statutory duties to appoint members of the PPI Forums and to facilitate the co-ordination of activity by PPI Forums, including making arrangements for staff to support the volunteers in each Forum (*NHS Reform and Health Care Professions Act 2002* Section 15(2); *Commission for Patient and Public Involvement in Health (Functions) Regulations 2002*). The Commission was also given wider responsibilities for promoting patient and public involvement within the NHS and to act as a national voice for the public. Prior to their dissolution, the Community Health Councils had campaigned hard for a national organisation that would be able to have a national voice (Hogg, 2009: 120).

The name for the Forums in legislation was ‘Patients’ Forums’. More inclusively, but confusingly, the CPPIH referred to the Forums as ‘Patient and Public Involvement

Forums', which is the title used here for consistency with documentation produced by the CPPIH and the PPI Forums themselves. Members of staff from the Community Health Councils were disappointed to find that CPPIH had decided to ask voluntary and non-profit organisations to tender to act as forum support organisations, rather than employing staff directly to provide support to the PPI Forums. People who had been employed to support CHCs had expected to have an opportunity to be appointed to posts supporting the new Forums and the decision to contract-out support for the PPI Forums alienated ACHCEW and the CHCs during their final months of operation (Hogg, 2009: 128).

As a national organisation that coordinated communication and provided a national voice for patients and the public, the Commission for Patient and Public Involvement in Health acted as the peak organisation and intermediary on the behalf of the individual Patient and Public Involvement Forums. The Commission had the potential to act as an intermediary with national issue-specific organisations, but this aspect of its role did not have sufficient time to flourish, particularly as the decision was taken to abolish the Commission for Patient and Public Involvement in Health as part of the Department of Health's review of arm's-length bodies in July 2004. Mechanisms were considered for alternative support structures for the PPI Forums after the abolition of CPPIH, but successive extensions were given to the life of CPPIH and it continued for the duration of the PPI Forums.

The Commission for Patient and Public Involvement in Health was successful in recruiting and sustaining sufficient volunteers for the PPI Forum network, including meeting the initial deadline of 4,000 members for 572 PPI Forums by 30 November 2003 (Hogg, 2009: 134). Members were recruited as individuals, rather than as representatives of interest groups. This marked a shift away from the local intermediation role and changed the nature of representation of vulnerable groups.

Members of Patient and Public Involvement Forums

The first references to the membership structures for the PPI Forums, as discussed above, came in *The NHS plan*, which stated that half of the members would be 'drawn from local patients groups and voluntary organisations' and half 'randomly drawn from respondents to the trust's annual patient survey' (Secretary of State for Health, 2000: 94). This would have given a mix of interest group representation with participation by individual patients. Whilst this was not the model that was implemented, it gives an indication that from the outset there was a wish to bring new participants into public

involvement. Within the Statutory Instrument for the membership of the PPI Forums, they were expected to have at least seven members, the majority of whom would be current or former patients of the NHS trust to which they were attached and at least one of whom would be a member or representative of a voluntary organisation (*Patients' Forums (Membership and Procedure) Regulations 2003*). In the case of PPI Forums for Primary Care Trusts, the regulations stipulated that in addition to the seven patients or former patients, the PCT-based PPI Forums needed to include a representative from the PPI Forums for each of the NHS trusts (principally hospitals, but also trusts for mental health and ambulance services) within the district of their Primary Care Trust. At the discretion of the Commission, a PCT-based PPI Forum could also include a representative of any body 'which represents members of the public in the Primary Care Trust's area in matters relating to their health' (*Patients' Forums (Membership and Procedure) Regulations 2003*).

Prior to the establishment of the Commission for Patient and Public Involvement in Health, Ministers had indicated that they wanted to encourage people from communities who had not traditionally been involved to be a part of the PPI Forums:

'We want to ensure not only that people respond to an advertisement but that we seek out people from communities who, traditionally, have not put themselves forward. That is easier said than done. In many cases, people will need encouragement, support, training, advice and back-up to come forward and feel that they can be part of the Patients' Forum. That is very different and a much more proactive approach – not simply issuing an advertisement, waiting for people to apply and allowing a very self-selecting group to come forward to be part of our public involvement, but going out to deprived, marginalised, excluded communities that, traditionally, have not been part of running our services and making those decisions.' (Hazel Blears, Parliamentary Under Secretary for Health, HC Deb (2001-02) 386 col. 321)

Encouraging people who are not part of 'a very self-selecting group' to be involved does not treat statutory public involvement institutions as a 'sheepdog to manage local interest groups' participation in decision-making processes.

The Commission for Patient and Public Involvement put a great deal of energy into recruiting people who did not have experience of involvement in voluntary organisations or other civic activity; they avoided the 'usual suspects' (Hogg, 2009: 5). The Commission developed a recruitment campaign that was deliberately aimed at people who had not previously been involved. As illustrated in Figure 5.1, the campaign used the image of a runner in a superchicken suit and presented the message, 'ordinary people only – experts and chickens need not apply'. The implication was that the Commission was trying to attract ordinary users of health services, rather than people who were involved in voluntary organisations (who might, in terms of the superchicken image, have undertaken

fundraising activities in fancy dress) and those who might regard themselves as ‘experts’ in public involvement.

The strategy was successful in bringing people into PPI Forums who had not been involved in voluntary organisations or CHCs previously. Of the members of PPI Forums: a third had not volunteered previously; a third had volunteered previously, but not in health; and a third had volunteered in health in the past (Martin, 2008: 45). Within the third who had volunteered in health, most had been involved in Community Health Councils – with perhaps a quarter of the overall membership being people who had been either CHC members or staff supporting CHCs³⁹. The Commission was successful in both recruiting and retaining PPI Forum members. Despite the uncertainties with the abolition of CPPIH and later the abolition of the PPI Forums, there were still 4,250 members in place towards the end of 2007, of whom over 2,500 had been members of PPI Forums for over two years (CPPIH, 2007a: 21). The ratio of men and women was similar to that in the general population, with 48 percent male and 52 percent female members (2007a: 21). The Forum members also had 6 percent of members who classed themselves as Asian, 4 percent who classed themselves as black or African and 3 percent regarded themselves as white but not British (2007a: 21). The Commission did not report the age profile of the members; Hogg alludes to 55 percent of members being over 65 years of age and only 10 percent under 45 years, although she does not cite her source (2009: 147). In terms of bringing in new volunteers, the Commission’s finding that a third of the PPI Forum members were new to volunteering and a third had not volunteered in health previously indicated that it was very successful (Martin, 2008: 45).

The PPI Forums did not formally represent interest groups or mediate between them, so they did not report their membership in terms of the affiliation of PPI Forum members to interest groups. Representation of vulnerable groups was discussed in terms of numbers of people from different communities, rather than interest groups representing vulnerable groups. They were not formally set up with an intermediation remit. In practice, as discussed below, the PPI Forums worked closely with interest groups.

³⁹ Source: Interview with Leslie Forsyth, formerly Director of Operations for the Commission for Patient and Public Involvement in Health

Figure 5.1: Recruitment flyer for PPI Forum Members



The flyer is a recruitment advertisement for Patient and Public Involvement (PPI) Forum Members. It features a central image of a yellow chicken mascot wearing a purple and red striped skirt and a white bib with the number '526'. The chicken is running on a paved surface. The flyer is divided into several sections with text and graphics.

make time for health

People often do amazing things for health - running a marathon in a superchicken suit for one!

Now there's another way to make an impact by joining your new local forum for health.

Ordinary people only - experts and chickens need not apply.

Patient and Public Involvement (PPI) Forum members will be champions for health and make the views of patients and the public heard.

That's why we need people like you - people who know their communities and will give their time to make a real difference.

Can you help to bring better health to your community?

Please call **0845 120 7115** or visit www.maketimeforhealth.org for more information and an application pack.

Or write to
Make Time for Health
PO Box 11442
Birmingham
B2 4WP

General enquiries **0845 120 7111**
PPI Forum Membership Recruitment Line
0845 120 7115

Lines are open
8am to 10pm Monday to Friday
9am to 5pm Saturday and Sunday
Minicom 0845 120 7113

**Care about health?
Apply now -
no fancy dress required**

make time for health

Commission for Patient and Public Involvement in Health

Commission for Patient and Public Involvement in Health

Activity by PPI Forums

The PPI Forums worked on projects with local voluntary organisations, monitored existing services and mobilised opposition to changes. Not having the consultation responsibilities of Community Health Councils, they were able to generate petitions and set up campaigns without having to take responsibility for agreeing hospital closures or producing a costed alternative to disputed proposals.

When the PPI Forums undertook activity that had national significance, they referred issues to the Secretary of State through the Commission for Patient and Public Involvement in Health, rather than through local Overview and Scrutiny Committees. In this sense, the CPPIH undertook the national intermediary role that the Association of Community Health Councils for England and Wales had rejected. The activities on which CPPIH acted as an intermediary for the PPI Forums tended to relate to the needs of minority groups:

‘The London Network of Mental Health PPI Forums and the London Ambulance PPI Forum were successful in their request to the Secretary of State for Health to extend the consultation on the race equality implications of the proposed Mental Health Bill. In November 2005, the Forums agreed to ask the Chair of the Commission, Sharon Grant, to write to the Secretary of State for Health requesting further consultation on the Race Equality Impact Assessment of the Mental Health Bill. The Forums raised concerns that the proposed Bill would have detrimental implications for black and minority ethnic communities.’ (Commission for Patient and Public Involvement in Health, 2006: 6)

In its commentary on this case, CPPIH alluded to the need for time to build up the networks to develop more of this type of activity (2006: 6). The eleven PPI Forums for mental health trusts in London went on to produce *“Unheard voices”: listening to refugees and asylum seekers in the planning and delivery of mental health provision in London* (CPPIH, n.d. [approx 2006]). The *“Unheard voices”* report was praised by the All Party Parliamentary Group on Refugees and welcomed both for its content and its recommendations (CPPIH, 2007a: 8). The report was published and presented by the Commission on behalf of the PPI Forums, reflecting the Commission’s national intermediary role.

Ministerial comments and the actions of CPPIH supported the recruitment of individuals who were not associated with interest-specific voluntary organisations; nonetheless, the PPI Forums worked with local and national voluntary organisations. Whereas the membership structure for Community Health Councils had restricted direct involvement to local voluntary organisations or organisations with specific interests in local NHS institutions, the PPI Forums did not have allocated relationships with local groups

and could call in national voluntary organisations to contribute towards specific activities. In Milton Keynes, the Primary Care Trust PPI Forum brought in support from a national programme operated by Age Concern to strengthen their opposition to the closure of a local podiatry service:

‘Milton Keynes PCT PPI Forum helped to halt the closure of a podiatry service in Milton Keynes, after responding to the consultation initiated by the Milton Keynes Primary Care Trust. ... The Forum discussed the issue with various local voluntary and statutory organisations and found that many felt that the podiatry services were needed. The Forum called in Age Concern, which offers advice on podiatry programmes around the country, to ask their opinion on how the closure of the service would affect patients. Together they met with the PCT to ask them to reconsider the steps they were taking. The Forum made the case that the costs saved from withdrawing podiatry services were negligible but the effect on the public was huge. As a result, Milton Keynes PCT agreed to withdraw their proposals and to fill some of the existing vacancies in order to create a proper and efficiently run service.’ (Commission for Patient and Public Involvement in Health, 2007a: 11-12)

The example from Milton Keynes demonstrates that the PPI Forums worked with interest groups both locally and nationally. It also shows that the PPI Forum was able to coordinate opposition to a service closure. Within the newsletter for PPI Forums, *Forum Focus*, there is a wide range of examples of PPI Forums mobilising opposition. Redbridge Primary Care PPI Forum held a public meeting, attended by 150 members of the public, two Members of Parliament, three local councillors and the Chair of Redbridge PCT, to raise concerns about changes to local services, including downgrading of the local Accident and Emergency service. This meeting resulted in the MPs leading petitions to oppose the changes (CPPIH, 2007b). Derbyshire County PPI Forum started a petition to save Heanor Minor Injuries Unit from closure, leading the activity of local residents and community groups (CPPIH, 2007c).

There are also examples of PPI Forums working with a range of agencies to find funding to retain or reopen services. The Poole Hospital PPI Forum lobbied the trust’s Executive Committee to consider re-opening a hydrotherapy pool and worked with the League of Friends and physiotherapy department to raise the funds for the pool (CPPIH, 2007d). The Mid Staffordshire General Hospitals NHS Trust PPI Forum and the Cannock Chase PCT PPI Forum set up a working group to improve public transport between the Mid Staffordshire General and Cannock Chase hospitals. Their activity was spurred by comments from patients that they could not get to their appointments on time due to poor public transport. The PPI Forums persuaded the local council and the Arriva bus company to invest jointly in a bus service running between the two hospitals (CPPIH, 2007e). This was a very laudable activity, but at the Mid Staffordshire General Hospital, shortly to

become the Mid Staffordshire NHS Foundation Trust, there were more significant issues that needed to be identified in 2006 to 2007, which are discussed in Chapter Six. The creation of the new bus services demonstrates, nonetheless, the ability of PPI Forums to collaborate with each other and with other organisations to identify sources of funding for services.

The appointment of individuals rather than representatives of organisations as members of PPI Forums meant that the Forums did not have a formal sheepdog role in the sense of mediating between local interest groups. The examples above demonstrate that they would mobilise activity, including involving national organisations in the case of the podiatry services in Milton Keynes. Without a specific interests intermediation role, PPI Forums worked with interest groups in a far less structured fashion than Community Health Councils had done. In evidence presented to the House of Commons Health Committee for its 2007 inquiry into public involvement in the NHS, the Health Advocacy Partnership suggested that the low numbers of people involved in each PPI Forum 'often result in Forums being exposed to "political", "interest", and even personal agendas' (House of Commons Health Committee, 2007b: Ev102). Considered from an interests intermediation perspective, the PPI Forums, with a legal minimum of seven members and an average of eight members (CPPIH, 2006:12), were not in a position to moderate the influence of interest groups or to manage potential opposition to reforms.

Abolition of PPI Forums

The Department of Health announced in July 2004 that the Commission for Patient and Public Involvement in Health was being abolished, following a review of arm's-length bodies. This placed the PPI Forums in a vulnerable position. The PPI Forums were still newly established, having started to operate in December 2003. The Department of Health considered options for the support of PPI Forums after the closure of CPPIH (Hogg, 2004). The future of public involvement became incorporated into the consultation on the future of health services that culminated in the White Paper *Our health, our care, our say* in January 2006. *Our health, our care, our say* presented a more integrated approach to health and social care services, including encouraging social care as well as health professionals to involve the public (Secretary of State for Health, 2006: 159). This integrated approach did not match the trust-specific remit of the PPI Forums within the NHS.

Our health, our care, our say pledged the completion of ‘our existing fundamental review designed to strengthen the arrangements for ensuring a strong local voice in health and social care by April 2006’ (Secretary of State for Health, 2006: 160). This ‘fundamental review’ took the form of an expert panel. Neither the Commission nor the PPI Forums were represented within the expert panel, although they were able to provide evidence for consideration. The expert panel was co-chaired by Harry Cayton, National Director for Patients and the Public at the Department of Health, and Ed Mayo from the National Consumer Council. The organisations represented covered both health and social care, including the Healthcare Commission, the Local Government Association and the Commission for Social Care Inspection. Rather than individual patient groups, the voluntary sector was represented by two membership organisations for voluntary organisations, the Long-Term Conditions Alliance and the National Council for Voluntary Organisations. The two membership organisations were effectively being used as national intermediaries for the voluntary sector.

The expert panel announced its recommendations in May 2006. The panel considered some of the broader issues around public involvement, including whether the pledge of greater individual choice for patients meant that they would still need to have the support of collective voice (Department of Health, 2006a: 2). The recommendations included the need for a stronger national voice as well as a stronger voice in local service planning, operating across both health and social care (2006a: 4, 5, 8). The panel felt that a more flexible approach needed to be taken to what it meant for people to be involved, so that people could contribute when they were able to do so rather than having the regular commitment of committee meetings, and there would be a mixture of individuals and organisations engaged in what the panel described as ‘local involvement networks’ (2006a: 5). In terms of powers, the panel felt that the new organisations should have the statutory powers of the PPI Forums, although they were not convinced that the organisations themselves should be statutory (2006a: 7). These were recommendations from an expert panel, rather than a binding commitment. As a panel that had been co-chaired by the National Director for Patients and the Public, however, the findings were likely to have weight.

In July 2006, the Department of Health announced the abolition of PPI Forums and their replacement with Local Involvement Networks (LINKs). In keeping with the direction of *Our health, our care, our say* and the recommendations of the expert panel, the Local Involvement Networks would operate across social care as well as health care. The proposals for LINKs were outlined in *A stronger local voice* (Department of Health, 2006b).

The document, issued 'for information and comment' rather than consultation, introduced: more explicit duties for Overview and Scrutiny Committees and commissioners; clearer roles for public involvement in regulation; the new Local Involvement Networks; and the option for national voluntary organisations to work together to create a networked body at national level that would liaise with the Government. The creation of Local Involvement Networks was therefore part of a broader package of reforms that integrated public involvement across health and social care.

Ann Keen, who oversaw part of the implementation of Local Involvement Networks, described the transition from PPI Forums to Local Involvement Networks in terms of changing the remit to cover both social care and health:

'The Government wants everyone to be able to have their say about local health and social care services and have the ability to influence how they are run. A patients' forum can scrutinise health services, but not social care services run by local councils. Forums could be more representative – they only have a few thousand members across England, when the NHS has tens of millions of patients. LINKs will build on the good work of the forums and will have similar powers to hold local services to account. However, they will be larger and will aim to represent everyone in the community. Importantly LINKs will cover all publicly-funded services in an area – no matter who provides them – and should provide a one-stop shop for care professionals who want to talk to the community and *vice versa*.' (Ann Keen, Parliamentary Under Secretary for Health, in: Commission for Patient and Public Involvement in Health, 2007f)

Considered in terms of the sheepdog role, part of the value to Ministers of state-sponsored institutions is that the remit of the organisations can be changed to address perceived political issues. As presented by Ann Keen, and drawing on the recommendations of the expert panel, a problem to be addressed was that individuals use both health and social care services and so they need a single mechanism to hold those services to account.

Keen also referred to a desire for the public involvement institutions to be more representative of the population as a whole. When asked to present evidence on the changes to the House of Commons Health Committee's 2007 inquiry into public involvement in the NHS, the Department of Health used the unrepresentative membership of PPI Forums as a rationale for the transition to LINKs:

'The Department of Health believes that PPIFs [PPI Forums] fail to represent their communities. First, too few people are members of forums. The average for the country is 8 per forum. Moreover, those people who are members tend to be older adults, often retired. There are relatively few participants from non-white backgrounds. This means that the views of working adults, those with young families and from black and minority ethnic groups are poorly represented.' (House of Commons Health Committee, 2007a: 28)

The Commission for Patient and Public Involvement in Health had taken steps to recruit people from a wide range of backgrounds. People who were prepared to commit to being members of a Forum, with the associated expectations that they would attend meetings and inspect services, would be likely to be unrepresentative of the community at large, as they had both time and sufficient interest in health services to participate. Community Health Councils had also been criticised for being unrepresentative of the population (House of Commons Health Committee, 2003: 4). As state-sponsored forms of participation, the state was in a position to define and re-define the nature of the representation, whether of interest groups or of a sample of the population.

The PPI Forums did not have the interest group structure or the powers to moderate opposition to reform. As the examples of activity showed, the PPI Forums mobilised opposition, by convening events, setting up petitions and drawing the attention of interest groups to proposed changes. Bringing voluntary organisations into Local Involvement Networks provided an arena in which interest intermediation could take place. The closure of the PPI Forums at a time when major changes were about to take place within the NHS may also have been a tactic by Ministers to prevent mobilisation of opposition to the new commissioning arrangements. Sharon Grant, Chair of the Commission for Patient and Public Involvement Health, told the House of Commons Health Committee that it was the wrong time to have a gap in public involvement in the NHS:

'The point is that that two years is going to be a critical two years in the context of system reform, particularly in the context of commissioning, which it is said that LINKs are going to be focusing on. By the time LINKs get to be functioning, one is concerned that a huge number of huge commissioning decisions will have been made and contracts will be let which are for five or ten years and from which the public has been by and large excluded' (Sharon Grant, Commission for Patient and Public Involvement in Health, in: House of Commons Health Committee, 2007a: 49).

The transition from PPI Forums to Local Involvement Networks created a hiatus in the local co-ordination of the public at a time that might have smoothed local commissioning of services.

Patient and Public Involvement Forums do not seem to have been considered by Ministers as having a sheepdog role for political management of the NHS, or if they did so it was a limited role in representing vulnerable groups through the direct participation of people from vulnerable communities. As discussed in Section 5.4 below, they were the statutory public involvement institutions whose powers were least closely matched to a sheepdog role. They had a limited capacity to act as interest intermediaries, as interest

groups were not included as members or represented formally within the PPI Forums. The replacement of rights for statutory public involvement institutions to be consulted with a wider duty of NHS organisations to consult meant that the PPI Forums were not in a position to structure or to be guaranteed local consultation. The PPI Forums had a state-determined remit: in this instance, it was a narrow remit associated with a particular NHS trust following concerns about the culture in hospitals, particularly following the Bristol Royal Infirmary inquiry. As they did not have direct responsibilities within consultation, such as the early right of Community Health Councils to agree closures of local hospitals, PPI Forums were too weak to take blame on the behalf of Ministers. Lacking an interest intermediation role, the PPI Forums helped to coordinate opposition to health service changes. An element in the timing of their abolition, as Sharon Grant suggested, may well have been to ease reforms as the new commissioning arrangements came into place. Their successors, Local Involvement Networks, provided a different model again of statutory public involvement.

5.3 Local Involvement Networks, 2008-2010

The transition from a centrally-managed recruitment mechanism for the PPI Forums to the looser model of Local Involvement Networks (LINKs) was a major change. To contextualise LINKs' activity, this section opens with a discussion of the creation of LINKs, including the statutory powers that were allocated to them. In the discussions leading up to the creation of LINKs, Ministers and Department of Health officials emphasised that LINKs were different from PPI Forums and that referring to them as having 'members' might be misleading (Department of Health, in: House of Commons Health Committee, 2007b: Ev2). The second part of this section considers how the participation in LINKs was analysed and presented in practice by the Department of Health. This leads into a discussion of the activity of LINKs and the section closes with the 2010 proposals to replace LINKs with local Healthwatch in 2013.

Creation of LINKs

Funding for Local Involvement Networks was distributed from the Department of Health to local authorities. The remits for LINKs were matched to local authority boundaries, covering both the NHS-funded and social care services across the local authority area. The local authorities were expected under the *Local Government and*

Public Involvement in Health Act 2007 to appoint a host organisation that would provide support for the LINK in their area (Department of Health, 2007a). The Department of Health provided guidance to local authorities based on the experience of seven early adopter sites for the LINK model (Department of Health, 2007b; NHS Centre for Involvement, 2007). The Local Involvement Networks had rights to ‘enter and view’ premises for social care as well as premises in which NHS-funded care was taking place, as opposed to just NHS premises; they could refer both social care and health issues to their local authority’s Overview and Scrutiny Committee; and they had rights to receive responses within 20 working days to any report or recommendation they made (*Local Involvement Networks Regulations 2008*).

In 2006, the Department of Health had issued a call for tenders to provide a resource centre that would advise health professionals on how to develop NHS-led involvement mechanisms. The successful tender was a joint application from the Centre for Public Scrutiny, the Long-Term Conditions Alliance and Warwick University. The partnership was funded for three years to create the NHS Centre for Involvement, based at Warwick University. Local Involvement Networks were established without a national body, but the NHS Centre for Involvement was commissioned, within its existing funding, to provide guidance to the Local Involvement Networks⁴⁰. The NHS Centre for Involvement issued e-bulletins to local authorities, to LINKs and to interested individuals, providing some coordinated information flow. The NHS Centre for Involvement also developed a series of guides for LINKs, on key matters such as interpretation of the *Local Government and Public Involvement in Health Act 2007*, understanding health and social care structures and codes of conduct for visiting and inspecting services (NHS Centre for Involvement 2008a, 2008b, 2008c). Whilst the decision had been taken not to have a national organisation in place of the Commission for Patient and Public Involvement in Health, the NHS Centre for Involvement, until the end of its three-year grant in 2009, provided some support for communications and consistent guidance during the period when LINKs were being established. The Department of Health also provided a web-based forum for Local Involvement Networks, operated by the Department’s health information website NHS Choices, through which the LINKs could exchange ideas and documents⁴¹.

The expert panel and *A stronger local voice* both suggested that there was a role for a national intermediary organisation working with the national interest-specific voluntary

⁴⁰ Source: Interview with Jonathan Tritter, former Director of the NHS Centre for Involvement

⁴¹ Website for LINKs, The LINKs Exchange <http://www.lx.nhs.uk> [Accessed June 2012]

organisations. With this agenda in mind, the Long-Term Conditions Alliance changed its name to National Voices and worked to expand its membership (Taggart, 2007; National Voices, 2009: 1). The Long-Term Conditions Alliance had had a membership base of national patient organisations for people with long-term health conditions, so it expanded its remit to include associations covering acute health conditions and wider social issues. National Voices built relationships with the Local Involvement Networks, but it was developing a role with national issue-specific organisations, rather than acting as a national body for LINKs. Once the NHS Centre for Involvement closed in August 2009, therefore, there was no central point for guidance or support to the Local Involvement Networks.

Participants in LINKs

The Department of Health emphasised from the outset that ‘LINKs will be open to all, there will be no set membership’ (Department of Health, 2007f). In evidence to the House of Commons Health Committee, the Department of Health indicated that ‘the term “membership of a LINK” may be misleading’ and that ‘the key issue is that LINKs are able to reach out to and hear from as wide a range of people as possible rather than relying on the views of a small group of heavily “involved” people’ (House of Commons Health Committee, 2007b: Ev2). When guiding local authorities on the establishment of LINKs, the Department of Health advised that ‘it is important to remember that LINKs are not merely groups of individuals, but are primarily networks that will bring together diverse groups in the area and representatives of other networks’ (2007b: 4). The accounts of participants oscillate between exclusion of groups of “involved” people and inclusion of those individuals through their membership of voluntary organisations and other networks. When establishing a LINK, the Department of Health emphasised the value of mapping out the existing networks, to see how the Local Involvement Network would fit with existing feedback systems in local health and social care services (Department of Health, 2007e).

Despite indicating that ‘membership’ was not a helpful term when referring to Local Involvement Networks, Ministers were keen to demonstrate that the transition to LINKs had resulted in involvement of more people and a more diverse range of people than PPI Forums had demonstrated. Shortly before the closure of the PPI Forums, the Secretary of State for Health, Alan Johnson, visited the Hull PPI Forum in his capacity as their local MP. He stressed that LINKs would incorporate the experience of existing PPI Forum

members, but would also increase the number of people involved in influencing local health and social care services:

'LINKs are about linking together health and adult social care services, about providing a greater opportunity for involvement and greater flexibility. The Department of Health would not want to lose the expertise of present Forum members, but the idea of LINKs is to promote much wider involvement.' (Alan Johnson, Secretary of State for Health, in: Commission for Patient and Public Involvement in Health, 2007g: 9).

As Ministers and civil servants had presented the transition as a means to increase the number of participants in state-sponsored public involvement, they needed to be able to demonstrate that more people were involved in LINKs than had been involved in PPI Forums. In effect, despite the looser structures, details were needed of the number of members.

Without a national organisation for LINKs, either as a membership organisation or an institution with the non-departmental public body status of the Commission for Patient and Public Involvement in Health, the Department of Health took a more direct role in receiving and analysing the annual reports of Local Involvement Networks, rather than receiving information that had been analysed for the Department. In 2009, the Department presented an analysis of the 2008-2009 LINKs annual reports as a Powerpoint presentation on the LINKs Exchange website (Commissioning, Analysis and Intelligence Team, 2009). By 2010, the analysis of the 2009-2010 annual reports had reached the status of a formal document published by the Department of Health, which included comparisons between the first and second year of LINKs operation (Commissioning, Analysis and Intelligence Team, 2010 [Updated February 2011]).

To illustrate the breadth of involvement, the Commissioning, Analysis and Intelligence Team at the Department of Health considered the numbers of individuals and groups involved in LINKs. For the 2009 annual reports, the LINKs were asked to supply data on the number of non-white and disabled members. Most of the LINKs did not supply this information; 146 of the 150 LINKs had supplied annual reports to the Department of Health, of which 57 provided information on non-white members and 52 supplied data on disabled members (2010 [updated February 2011]: 8). The loose nature of the Local Involvement Networks meant that individual LINKs gathered information about their participants differently and they may not have been able to demonstrate their representativeness in terms of the numbers of non-white or disabled people involved.

On the basis of the data in the annual reports, the team at the Department of Health estimated that the average LINK in 2008-2009 had, to use the terminology in the

summary, 201 'members' and that in a typical LINK 69 percent of the members were individuals and 31 percent of the members were groups (Commissioning, Analysis and Intelligence Team, 2009: slides 6-7). The analysis of 2009-2010 reports included a distinction between 'members', who had made a commitment to take part regularly in the LINKs' activity, and 'participants', who might be interested in a single issue (2010 [updated February 2011]: 12). The number of members estimated in 2009-2010 was 69,600, which is cited as 'more than treble the total number of members in 2008-2009' and an average of 483 members (both individuals and groups) in each LINK (2010 [updated February 2011]: 12). If the LINKs were intended to involve people from groups who were rarely engaged in public involvement activities, the data from the annual reports did not enable the Commissioning, Analysis and Intelligence Team to establish whether representatives of more vulnerable or less engaged groups were participating:

'There is an indication that LINKs engaged with seldom heard groups, but it is difficult to assess the level at which this happened. There was a lack of consistency in the data and many LINKs gave no data on diversity of membership.' (Commissioning, Analysis and Intelligence Team, 2010 [updated February 2011]: 13)

In sheepdog terms, the Local Involvement Networks did not have the structured interest intermediation that had been put in place for Community Health Councils. The tacit expectation seems to have been that by including more individuals and more groups, the involvement would become more representative by virtue of engaging more people. Whether or not the LINKs mediated engagement, either with established or excluded groups, is considered in the discussion of individual LINKs' activity below.

With a state-funded model of engagement, Ministers are able to change the remit, in this case the extension to cover social care as well as health services across a local authority area. The summary by the Commissioning, Analysis and Intelligence Team included examples of activity in social care, with case studies of improvements to the treatment of elderly people by care agencies in Lancashire and advising on training standards for carers looking after people with neurological conditions in York (2010 [updated February 2011]: 29, 30). The team at the Department of Health suggested from their reading of the annual reports that 42 percent of engagement by the LINKs related to social care rather than health activity (2010 [updated February 2011]: 13). In this sense, the remit had been modified to address the problems experienced by people in their own homes and in care services, rather than just when they were receiving health services.

The Local Involvement Networks were not granted powers to agree closures, nor did they have privileged consultation rights. The role individual LINKs played in

consultation activities in practice is discussed below. In terms of the general rights of LINKs, however, they were not given powers that would enable them to act as a blame-avoidance tool for Ministers. In considering the success of LINKs, the Commissioning, Analysis and Intelligence Team presented LINKs as saving money. They estimated that Sefton LINK had saved the NHS £346,000 per year by improving discharge arrangements, that Wakefield LINK had introduced cost savings of £242,000 per year by making suggestions to reduce the length of hospital stays and the number of cancelled operations, and that improvements to signage and communications instigated by Blackburn and Darwen LINK saved the NHS £115,000 per year by reducing the number of people who did not attend appointments that they either did not know about or that were at locations they could not find (2010 [updated February 2011]: 16-17). This suggests a justification of expenditure on LINKs in terms of overall cost savings to the NHS rather than as a means for greater engagement of the public.

Activity by LINKs

As Local Involvement Networks were given more freedom in their structure and communications than either PPI Forums or Community Health Councils had been, the style and content of their reports and internet presence varied considerably. Some LINKs were explicit about groups within their membership and how they worked with voluntary organisations to help them to reach people who are not usually engaged in discussions about health or social care services. Sutton LINK appointed an Outreach and Communications Officer as well as using its connections through the voluntary sector as a means to reach more people:

'We have reached out to groups who do not traditionally engage in consultation, through voluntary organisations and the work of our Outreach and Communications Officer. ... [examples of activity] Independence and Choice event for older people which included many vulnerable, frail adults who had not previously taken part in consultations. Enabling the views of users of mental health services to be heard by the Health and Wellbeing Overview and Scrutiny Committee. Working with new migrant communities (Polish, Albanian and Tamil) to identify their healthcare needs.' (Sutton LINK, 2009: 14)

Local Involvement Networks also used their position across health and social care to facilitate collaborative working and agree priorities for joint action. Lambeth LINK developed the Lambeth Living Well Collaborative to improve the experience of mental health and wellbeing across statutory and voluntary services:

'The Collaborative brings together service users and carers, members from Vital Link (a service user and carer mental health engagement group), local General Practitioners (GPs), members of community services and other local NHS organisations (hospitals, health centres, community services mental health teams) and the voluntary sector. The Collaborative recognises that no one organisation can provide all the elements that contribute to good mental health and wellbeing. Therefore, LINK members have put forward ideas on how those involved in the Collaborative could work differently to improve opportunities for people with long-term, serious mental illness.' (Lambeth LINK, 2011: 14)

As a state-sponsored organisation with a broad portfolio, Lambeth LINK was in a position to mediate between providers and service users to consider how matters 'could work differently' for people with mental illness in Lambeth. The mediation included working with statutory organisations and voluntary groups on their priorities. In facilitating the collaboration, Lambeth LINK took on a sophisticated intermediation role centred on the needs of local people with mental illness and their carers.

Local Involvement Networks were not granted privileged consultation rights, but were consulted under the terms of Section 242 of the *National Health Service Act 2006*. Like the consultations under the earlier *Health and Social Care Act 2001*, this placed a duty on service providers to consult rather than granting a right to statutory public involvement institutions to be consulted. The North Tyneside LINK used its right to request additional information to support local consultation on a proposed Emergency Care Hospital, following which it produced its own proposals:

'In 2009/10, several LINK members were involved in producing the final LINK Emergency Care Hospital Report, which was submitted as part of the formal consultation process. NHS North of Tyne (the commissioners of this project) have taken on board LINK members' concerns, requesting that Northumbria Healthcare do further work on some aspects of their plan to ensure that patients are appropriately served by the new hospital.' (North Tyneside LINK, 2010: 17)

The North Tyneside LINK was not, unlike the CHCs, under a legal obligation to produce an alternative proposal, but was able to combine its ability to request additional information with the consultation process in order to influence the commissioners funding the Emergency Care Hospital.

Outside the health arena, local authorities had not worked with either CHCs or PPI Forums as part of their development of social care plans. Torbay LINK learned shortly after it had elected a core stewardship group for the LINK that the local council was conducting a very short consultation on its budget over the Christmas period. The LINK used the opportunity both to comment on the significance of the local council budget for

the social care needs of vulnerable members of society and to raise its own profile in the media:

'The budget, for social care provided by the Care Trust, was likely to have most impact on care homes, who faced above-inflation cost increases; and the LINK was concerned about the impact on the quality of care. Press coverage of the LINK followed. Representations were made to the [Overview and] Scrutiny Committee, some changes were made to the budget, and the LINK continues to raise questions about the quality of the services now being provided; will continue to monitor the situation; and will seek earlier involvement in the budget process in future.' (Torbay LINK, 2009: 17-18)

The local council may have deliberately held a shortened consultation over the Christmas period in the hope that any changes to the budget would pass unscrutinised. The broader representational role of a LINK, with individual and organisational members, had the potential to have greater authority than individual comments on the social care budget would have done previously.

The examples of North Tyneside and Torbay LINKs present positive uses of the powers available to Local Involvement Networks. The ability of local LINKs to develop their own ways of working provided them with opportunities for innovative practice, but meant that there was not a single approach to their activity. As Hogg has observed, Community Health Councils were criticised for their inconsistencies, whilst LINKs were developed with the expectation that they would be different in each area (2009: 162).

Abolition of LINKs

Following the May 2010 General Election, a Coalition government was established by the Conservative and Liberal Democrat parties. The new Secretary of State for Health, Andrew Lansley, had been Shadow Secretary of State for six years and had radical ideas for the reform of the National Health Service. One of the first consultation documents from the new Government was on public involvement in health, circulated on 22 July 2010 (Department of Health & Communities and Local Government, 2010). This consultation proposed that Local Involvement Networks would 'become' local Healthwatch, a local organisation that would refer concerns about the quality of services to Healthwatch England within the Care Quality Commission, whilst maintaining a representative role for the public across health and social care (2010: 4, 5).

Consultation documents and guidance notes issued early in 2012 provide insights into the nature of representation within the new bodies. The national organisation Healthwatch England is a statutory committee of the Care Quality Commission, with a

maximum of 12 members. It is proposed that members will be 'representative of a range of interests' and appointed through a process to be developed by the Chair of Healthwatch England and the Care Quality Commission (Department of Health, 2012a: 10). The local Healthwatch groups will be corporate bodies carrying out statutory functions (Department of Health, 2012b: 12). The membership of local Healthwatch will incorporate local interest groups:

'To be truly representative of local communities the ambition is that local Healthwatch will be part of a system rooted in local expertise, harnessing the experience of the public, community and voluntary sectors and others at the local level, particularly those working with people and groups who have a difficult time getting their voices heard.' (Department of Health, 2012b: 10)

The local Healthwatch model moves away from the loose network of LINKs to 'identifiable bodies' with a recognisable corporate structure (Department of Health, 2012b: 13). This provides an opportunity for a more structured interest intermediation role. The explicit reference to 'local expertise' moves away from the 'ordinary people only' message that had been included in recruitment for PPI Forum members (Commission for Patient and Public Involvement in Health, n.d. [2003a]). As discussed in Chapter Six, local Healthwatch groups have a stronger role in the scrutiny of services and Ministerial re-assessment of the value of the watchdog role is likely to be a part of the transition from Local Involvement Networks to local Healthwatch.

Local Involvement Networks were too loose a structure to undertake formal interest intermediation, although they worked with and included interest groups within their networks. They worked with groups representing more vulnerable communities, but the diversity of operation meant that the Department of Health's Commissioning, Analysis and Intelligence Team were unable to quantify the extent of activity with vulnerable groups. As discussed in the review of trends below, the lack of consultation rights meant that LINKs were not in a position to take the blame for unpopular local decisions. With greater freedom to work with local interest groups, LINKs undertook a form of intermediation that connected services rather than balancing interests.

5.4 Managing interests trends, 1997-2010

The discussion of Community Health Councils in Section 4.4 suggested that CHCs were most valued in a sheepdog role in the 1970s and that, as they started to mobilise opposition rather than intermediate between interests, they were less valued by Ministers and their powers were reduced. This section considers the sheepdog roles played by the

successive statutory public involvement institutions, as summarised in Figure 5.2, and then reviews the transitions in the context of broader changes to interest group and NHS-led alternative forms of public involvement.

Figure 5.2: Sheepdog – assessment of role played by successive statutory public involvement institutions, 1997-2010			
Institutional role	Community Health Councils (1997-2003)	PPI Forums (2003-2008)	Local Involvement Networks (2008 – [2013])
Mediate between local interests, including vulnerable groups	Appointments ensure vulnerable groups are represented in CHC; High profile direct involvement of voluntary sector	Individual members, not interest groups; One voluntary sector representative per PPI Forum; Demographic representativeness	Encouragement of interest groups as members; Not structured mediation role; Demographic representativeness
Structure consultation on local services	Duty of NHS to consult the public, not specifically CHCs, from 2001	Duty of NHS to consult the public, not specifically PPI Forums; Right to request information; Right to response	Duty of NHS to consult the public, not specifically LINKs; Right to request information; Right to response
Consider only state-determined range of issues	Remit granted for health services in geographical area; ACHCEW coordinates Casualty Watch	Remit granted for specific health institutions	Remit granted for health and social care services across geographical area
Take responsibility for unpopular local decisions	Not sufficiently powerful to be blamed for local decisions	Not sufficiently powerful to be blamed for local decisions	Not sufficiently powerful to be blamed for local decisions

Community Health Councils, during their last years, were less valued by Ministers as interest intermediaries than they had been in the 1970s. As illustrated in Figure 5.2, their appointments mechanisms meant that they retained a structured membership that included representatives of vulnerable groups. The introduction of Section 11 consultations following the *Health and Social Care Act 2001* meant that CHCs no longer had privileged consultation rights and were not in a sufficiently powerful position to take the blame for locally unpopular decisions. They were, however, able to coordinate activity and opposition over time to national policies, such as the Private Finance Initiative. The Association of CHCs for England and Wales also coordinated CHCs' activity to produce swift comparisons between waiting times in Accident and Emergency units as part of the annual Casualty Watch. This coordination at local and national levels meant from a Ministerial perspective that they were, to extend the sheepdog analogy, rogue dogs that were using their ability to round up interests as a means to round up opposition.

Of the statutory public involvement institutions, the PPI Forums were the least likely to be able to take on a sheepdog role. The response to the CHCs whipping up interest group activity seems to have been to take interest groups out of the equation and to focus on individual members rather than interest group representatives. As the members were recruited as individuals, they did not have interest group constituencies even if they happened as individuals to be members of interest groups. Instead of representation of interest groups, the Commission for Patient and Public Involvement in Health worked hard to recruit people who had not been involved in interest groups and to ensure demographic diversity of members. The PPI Forums did not have rights to be consulted, although they might be included in consultation exercises undertaken by NHS organisations. Their remit was associated with specific NHS trusts, so they could influence the culture in that trust, but they were too closely allied to the trusts to be a Ministerial tool to support radical changes that might involve the closure of the NHS trust with which they were associated. Like CHCs in the closing stages, PPI Forums were not sufficiently powerful to be able to take the blame for unpopular local decisions.

The abolition of the PPI Forums coincided with the introduction of commissioning arrangements that changed the balance of authority within the NHS, as budgets were devolved to Primary Care Trusts. This placed the lead for decisions about funding specialist (secondary care) services with generalist health practitioners in the community. An arena was needed for local interest groups' participation in decisions about local health services, that would provide an opportunity for input by interest groups for people who needed specialist care. There was also a move towards greater integration across health and social care; the trust-specific remit of the PPI Forums did not enable them to operate across health and social care. The interest intermediation and state-determined remit aspects of the sheepdog role could therefore be interpreted as factors in the transition from PPI Forums to LINKs.

Local Involvement Networks, as outlined in Figure 5.2, took a far looser form than either Community Health Councils or PPI Forums. Whilst they were encouraged to have interest groups as participants, it was not in a structured form to ensure inclusion of disadvantaged or vulnerable groups. Without formal powers to represent interest groups, they were not in a position to undertake formal interest intermediation, although many LINKs undertook liaison to improve coordination of local services. LINKs did not have statutory rights to be consulted and were not sufficiently powerful to be blamed for unpopular decisions.

Considered overall, there is less evidence of statutory public involvement institutions providing a sheepdog role in political management between 1997 and 2010 than there was in the 1970s. The risk for Ministers may have been that organisations which could intermediate could also round up opposition. The timing of the successive changes seems to have been intended to weaken the ability of statutory public involvement institutions to mobilise opposition at points when major reforms were going through. The Community Health Councils were abolished at the point of *The NHS plan* reforms; PPI Forums were abolished whilst new commissioning arrangements were being put in place; and Local Involvement Networks were abolished at a point of major reforms to the National Health Service, with a realignment of public health services within local authorities and the creation of a National Commissioning Board overseeing the NHS in England.

Klein suggested in 1984 that part of the value of Community Health Councils was that the membership structures ensured that vulnerable groups were represented:

'The constitution of Community Health Councils is instructive in this respect. It represents a deliberate attempt to rig the political market in favour of those with the least resources for participation. By ensuring the presence of members representing pressure groups for the mentally ill and the handicapped, among others, the constitution of CHCs gives a voice to those citizens least able to participate in political processes: that is, the most vulnerable.' (Klein, 1984: 30)

The political value of the ability of the sheepdog to round up and ensure the participation of more vulnerable groups depends upon the relative profile of direct interest group engagement and NHS-led forms of involvement.

Issue-specific interest groups were largely placed outside strategic decisions about NHS services during the 1970s and began to take a direct role at a local level with the development of joint consultative committees in 1984 (Department of Health and Social Service, 1984). Interest groups were consulted in their own right on local service developments from 1992 onwards, with the *Local voices* initiative (NHS Management Executive, 1992). Since the 1990s, many voluntary organisations have been contracted to provide services, as well as providing a collective voice to comment on the needs of people with the health condition or social problem that they represent (Neville, 2010). The charities that have been most likely to be contracted to provide services are often those that support vulnerable groups, such as older people or people with mental health problems. This complicates the nature of consultation with issue-specific groups at a local level and leaves a role for a more independent collective voice through statutory public involvement institutions.

The evolution of NHS-led forms of involvement in England has been bound up with consumerism and the desire to learn from service users in order to improve service provision. NHS personnel have developed mechanisms for consulting service users directly, rather than through interest groups, which are perceived to be 'not necessarily representative either of constituents or communities with whom they work' (Chambers, Drinkwater and Boath, 2003: 5). As discussed in Chapter Two, some of the NHS-led forms of involvement, such as citizens' juries and Foundation Trust membership, have been described in the literature on public involvement in health as outflanking the statutory public involvement institutions (Baggott, 2005: 538). The NHS-led mechanisms in England have included an increasing emphasis on choice mechanisms and learning through customer preference (Dowding and John, 2011). The choice mechanisms enable patients to indicate preferred options for where they will be treated and also to provide feedback on their experience of the services received. In addition to the individual-level choice mechanisms, NHS-led involvement includes deliberative institutions, such as the NICE Citizens Council, to provide a citizens' perspective on controversial treatment issues (Davies, Wetherell and Barnett, 2006). Ongoing investment in statutory public involvement institutions suggests that the range of NHS-led initiatives does not fully address political aspirations for public involvement in the NHS.

The sheepdog role is not a comfortable one. The state corporatist origins of the modelling for this theoretical approach describe a state-determined gathering of participants to undertake a range of activities that are also determined by the state. Schmitter uses the term 'intermediation' rather than 'representation' to describe the corporatist role as corporatist bodies 'also often assume or are forced to acquire governmental functions of resource allocation and social control' (Schmitter, 1977: 36). Like the herding dog of the analogy, a sheepdog both rounds up the sheep to ensure that they are accounted for and keeps them penned in the fold so that they can be managed. The model in this study used the blame-avoidance literature to generate the specific point on the statutory public involvement institutions taking responsibility for unpopular decisions (Weaver, 1986). The instance of blame-avoidance that emerged in this study was the role played by Community Health Councils in agreeing local hospital closures. Schmitter suggests that corporatist bodies may be involved explicitly in rationing decisions. In some cases, Community Health Councils helped to prioritise local service developments, but most were unwilling to take part in discussions about rationing (Hogg, 2009: 34, 163). Debates about rationing resources tend to be NHS-led activities, such as those through citizens' juries or NICE. In this study, the only extensive rationing activity identified in

examination of documentation produced by the successive statutory public involvement institutions was the involvement of Community Health Councils in hospital closures.

The Local Involvement Networks are due to be replaced with local Healthwatch in April 2013. Whilst there may be interest intermediation elements in the most recent transition, the next chapter suggests that it is also due to a reassessment of the watchdog role and an increase in its value to Ministers following the inquiry into the Mid Staffordshire NHS Foundation Trust.

Chapter summary

This chapter considered the changes to statutory public involvement institutions between 1997 and 2010, beginning with Community Health Councils and leading on to PPI Forums and then Local Involvement Networks. The institutions and changes to them were considered from the perspective of whether the institutions were expected to take on a sheepdog role in political management of the NHS. Sheepdog elements were found in the roles played by CHCs and by LINks, but were not part of the role expected of PPI Forums, other than some representation of vulnerable communities through the membership profile of the PPI Forums. The timing of the changes suggests that statutory public involvement institutions were expected to play a sheepdog role that managed opposition and if there was a risk that they would oppose reforms, a reframing of public involvement would take place to weaken the institutions at key times. The sheepdog role does not entirely answer the puzzle of the ongoing investment in funding and reforming statutory public involvement institutions, however. For additional insights into the puzzle, the next chapter assesses selected public inquiries to examine whether statutory public involvement institutions played a watchdog role in political management of the National Health Service.

Chapter Six: Watchdog? Alerting politicians to problems

This chapter considers whether statutory public involvement institutions may be understood to be playing a role in political oversight of the NHS. Seen in this light, the institutions would be watchdogs alerting Ministers to problems before they become disasters. Whereas the main mechanisms to be considered alongside the sheepdog role were NHS-led and direct interest group involvement in the NHS, changes to any oversight role played by statutory public involvement institutions need to be considered in conjunction with the more formalised regulators over the same time period. The chapter opens by considering the operationalisation of both the more formalised police-patrol oversight and the potential watchdog role played by statutory public involvement institutions, matching the powers of the successive institutions of both types against the operational elements in the forms of oversight. Expectations of how these powers may be used in practice are explored through four public inquiries. As public inquiries take place after disasters, questions asked of statutory public involvement institutions and comments on their performance provide insights into expectations of how problems should have been identified and rectified before they became disasters. The chapter concludes with a discussion of the extent to which statutory public involvement institutions may have fulfilled a watchdog role over time.

6.1 Public involvement institutions as oversight

In common with other public services, the NHS has been subject to a range of different schemes to improve performance and to protect the public against the failure of services (Hood *et al.*, 1999). Politicians are keen to avoid disasters in the NHS, as they are aware that the media and the electorate may criticise Government for not preventing the problem (Alaszewski and Brown, 2012: 139). Since 1983, different performance indicators and assessment frameworks have been used to encourage NHS personnel to develop services that met particular targets (Ham, 2009: 235-236). The performance management mechanisms include regulators. Walshe suggests that the distinctive feature of regulators is that they are a 'third party', rather than being directly involved in any transaction within a service (2003a: 10). The third party model of regulation only received marked attention as a mechanism for the NHS after 1997, when the Labour government moved away from depending upon market forces to maintain the quality of health services (Ham, 2009: 243; Walshe, 2003a: 113). The professional regulators (or police patrols) have been subject to a series of reforms within a similar timeframe to the reforms to

statutory public involvement institutions. As discussed in Chapter Three, oversight can take the form of an alarm raised by interest groups (the watchdog model in this study). This watchdog model of oversight can be used by politicians in place of the regulatory police patrol or as a complement to it.

The second sub-question in this study considers whether statutory public involvement institutions act as watchdogs, alerting national politicians to problems before they become disasters. Political oversight of expert agents may be most effective when it is least apparent (Ogul and Rockman, 1990: 6). On this basis, McCubbins and Schwartz proposed that a less-formal alert system (which they refer to as fire-alarm oversight, but is described here as a watchdog role) may be a rational preference over the high costs of a professional regulatory mechanism (police-patrol oversight), or that politicians may choose to combine the mechanisms (1984: 167).

As statutory public involvement institutions sometimes describe themselves as watchdogs, this analogy is used in exploring whether statutory public involvement institutions barked or sounded an alarm to notify Ministers of problems before they became disasters. Since more formalised processes may be the preferred oversight mechanism or combined with this watchdog role, this chapter discusses police-patrol oversight alongside the less formal watchdog oversight. This opening section considers the powers that would enable institutions to act as oversight mechanisms. It considers the professional police patrol institutions first and then the statutory public involvement institutions as watchdogs. In each case, there have been several top-down changes introduced during the period of this study, 1974 to 2010.

Police-patrol oversight in the NHS

Police patrols are described by McCubbins and Schwartz as having a surveillance role, authority to discourage violations and access to information, including rights to commission studies, conduct fieldwork and call hearings. Figure 6.1 outlines the most likely candidates to be police-patrol oversight mechanisms in the English NHS. As McCubbins and Schwartz describe a centralised process, this figure presents national organisations with a responsibility for monitoring health services, rather than local organisations such as the Overview and Scrutiny Committees within local authorities. It focuses on the third-party regulators, rather than mechanisms applied within NHS organisations, such as performance indicators. The national bodies described in this section reviewed the quality of services, rather than individual professionals' competence,

which has been predominantly the domain of the professional associations, or Royal Colleges, for clinical specialists.

Figure 6.1: Overview of NHS monitoring bodies against police-patrol oversight

	Hospital [later Health] Advisory Service (1969-1997)	Commission for Health Improvement (2001-2004) Healthcare Commission (2004-2009)	Monitor (2004 onwards)	Care Quality Commission (2009 onwards)
Police patrol characteristics				
Surveillance role	Rejected an inspection model in favour of working with NHS organisations to improve the quality of services	Mandated to undertake clinical governance review of every NHS trust every four years	Determine whether NHS trusts fulfil Foundation Trust (FT) status; Surveillance proportionate to perceived risk	Process of registering all NHS and social care organisations (including NHS Foundation Trusts) and monitoring activity
Discourage violations	Reports were not published until the mid 1980s; Approach of compliance not blame	Reviews (presented as star ratings) could result in strong public criticisms and change of leadership; Referrals to Secretary of State	De-authorisation of FT registration; Referrals of problems to Care Quality Commission	Publishing results and enforcement of regulation, including cancelling registration
Access to information	Limited statutory role	Data collection	Data collection	Data collection, including real-time
Commission studies	No statutory powers	Commission surveys	No statutory powers	Commission surveys and studies
Field work	Visits to NHS organisations, averaging once every ten years	Systematic cycle of visits, timings based on random sample	Visits to FTs proportionate to risk	Regular review of services, including unannounced visits
Hearings	No statutory powers	Consultation with stakeholders to inform reviews	No statutory powers	Consultation with stakeholders to inform reviews

The Hospital Advisory Service, later known as the Health Advisory Service, is the first organisation presented in Figure 6.1. Walshe describes the Hospital Advisory Service as the first regulator in the NHS (2003a: 112). It was established by Richard Crossman as Secretary of State in response to the Ely Hospital Inquiry in 1969. Crossman's diary entries suggest that he intended the Hospital Advisory Service to be an independent inspectorate (Crossman, 1977: 418). Once established, however, the institution rejected an inspection approach and modelled its activity on the basis of peer review by health

professionals of fellow professionals' activities (Walshe, 2003a: 115). The Hospital Advisory Service formed a weak police patrol, as its sole access to information was through visits to hospitals once every ten years approximately on a rotation basis. The focus of the Hospital Advisory Service was also predominantly on one aspect of NHS services: long-stay hospitals (Webster, 2002: 119). It took the approach of encouraging compliance with recommendations and only started to publish reports from its visits in the 1980s.

For the purposes of Figure 6.1, the Commission for Health Improvement and its successor, the Healthcare Commission (or, more formally, the Commission for Healthcare Audit and Inspection), have been entered in one column. The two organisations undertook broadly similar roles. The Commission for Health Improvement introduced a star-rating system, which was continued by the Healthcare Commission during its first two years of operation (Ham, 2009: 238). The organisations were mandated to undertake a clinical governance review of each NHS trust every four years. Unlike the Hospital Advisory Service, the Healthcare Commission published its reports from the outset, although the evidence remained confidential. The stipulated activities of both the Commission for Health Improvement and the Healthcare Commission seem to reflect police-patrol oversight: data collection; commissioning of surveys; a systematic cycle of visits; and consultation with stakeholders to inform reviews.

The introduction of Foundation Trusts into the English National Health Service from 2004 complicated consistent national surveillance. An independent regulator, Monitor, was set up to authorise and regulate Foundation Trusts. In return for demonstrating their ability to meet Government targets, hospitals could apply for Foundation Trust status. In keeping with the greater autonomy of Foundation Trusts, Monitor's approach to regulation was proportionate to risk: if a Foundation Trust demonstrated that it was well governed and that its likelihood of breaching Monitor's compliance framework was low, then Monitor would require limited information from the trust (Ham, 2009: 242).

In 2009, the Healthcare Commission was replaced by the Care Quality Commission. The Care Quality Commission's remit covered social care as well as health services. Unlike its predecessors, the Care Quality Commission undertook a process of registering all health service providers and adult social care services; organisations that were not registered with the Care Quality Commission as meeting essential quality standards were not permitted to operate (Care Quality Commission, 2009a: 6). The registration process provided the Care Quality Commission with baseline data on all health and social care services against which to record future progress. As with the Commission

for Health Improvement and the Healthcare Commission, the Care Quality Commission seems to fulfil a police-patrol role when presented in Figure 6.1: data collection, including real-time data; commissioning of surveys; a systematic programme of visits, including unannounced visits; and consultation with stakeholders to inform reviews.

The trend indicated in this overview of regulatory bodies suggests a progressive strengthening of police-patrol oversight since 2001.

Watchdog oversight in the NHS

As discussed in Chapter Three, a watchdog in the context of this study is a mechanism through which interest groups or members of the public alert politicians to problems before they become disasters. A watchdog can be attractive to Ministers as it alerts them to issues that are of concern to the electorate and enables politicians to gain credit from being seen to respond. The watchdog is also likely to focus on matters that might cause harm to service users, rather than procedural matters, and the main costs of intensive monitoring are borne by volunteers.

Successive statutory public involvement institutions in England are framed in Figure 6.2 against a watchdog role (based on the McCubbins and Schwartz fire-alarm model). The overview implies a good match between the model and the rights and responsibilities of Community Health Councils. From the point when Community Health Councils first appeared in legislation, the *National Health Services Reorganisation Act 1973*, they had rights ‘to enter and inspect’ NHS premises, suggesting that from the outset they had a role in scrutinising health services. They had rights to access information, enshrined in guidance to the NHS and later in the *Community Health Councils (Access to Information) Act 1988*. NHS organisations had an explicit statutory duty to consult Community Health Councils, covered by a series of statutes, the last of which was *The Community Health Council Regulations (1996): Statutory Instrument 1996 No. 640*. The same statutory instruments gave Community Health Councils the right to refer unresolved consultations and problems to the Secretary of State. The recruitment processes for Community Health Councils also ensured that they represented all interests, not just well-organised groups, and could filter issues.

Patient and Public Involvement Forums (PPI Forums) linked to hospital trusts had a duty ‘to monitor and review’ the services in the hospital to which they were connected (*Patients’ Forums (Functions) Regulations 2003*). The PPI Forums linked to Primary Care Trusts (PCTs) retained the broader right ‘to enter and inspect’ NHS premises throughout

their PCT area. The PPI Forums had less access to decision making than Community Health Councils had done, as the duty of NHS organisations to consult that was introduced in the *Health and Social Care Act 2001* referred to consulting the public more broadly. Also, PPI Forums did not coordinate the involvement of interest groups in the way that Community Health Councils had done or Local Involvement Networks were granted the opportunity to do (*Patients' Forums (Membership and Procedure) Regulations 2003*).

Figure 6.2: Overview of NHS statutory public involvement institutions in England against watchdog oversight

Watchdog characteristics	Community Health Councils (CHCs) (1974-2003)	Patient and Public Involvement Forums (PPI Forums) (2003-2008)	Local Involvement Networks (LINKs) (2008 -2013 ⁴²)
Gather intelligence about local services	Rights 'to enter and inspect' NHS premises; Rights to access meetings and associated papers; Right to appeal to Secretary of State if 'reasonably required' information is declined; Ability to support complainants	Duty 'to monitor and review' NHS trust in which based; Rights of PCT-based PPI Forums to 'enter and inspect' NHS premises	Rights to receive information in response to requests within set timeframe; Duty of service provider to allow 'to enter and view', except where this compromises 'effective care' or 'privacy and dignity'
Influence decisions about local services	Rights to consultation; Duty of NHS organisations to consult the CHC	Duty of NHS organisations to consult the public	Duty of NHS organisations to consult the public
Challenge local decisions and refer problems	Right of CHC to refer unresolved issues to Secretary of State	Rights to refer locally to Overview and Scrutiny Committee or nationally through Commission for Patient and Public Involvement in Health	Right to make recommendations to service providers and to receive a response; Rights to refer issues to and receive a response from the Overview and Scrutiny Committee
Filter significant issues from problems raised by interest groups	Interest groups represented by appointees to the CHC	Broader representation of the community, with at least one representative of the voluntary sector	Interest groups can become members of a LINK

The *NHS and Health Care Professions Act 2002* granted very broad referral rights to PPI Forums, as they could refer issues: to the Overview and Scrutiny Committee of the relevant local authority; or to the Commission for Patient and Public Involvement in Health

⁴² Local Involvement Networks are to be transferred into local Healthwatch groups in April 2013 (under the terms of the *Health and Social Care Act 2012*)

(the national statutory coordinating body for PPI Forums). The Overview and Scrutiny Committee or the Commission would then refer issues on to Ministers. This may be a revised watchdog role, modified to ensure that only major issues were raised through the Commission for Patient and Public Involvement in Health with the Secretary of State.

The third type of organisation outlined in Figure 6.2 is the Local Involvement Networks (LINKs). Rather than having a right of entry to NHS premises, service providers were given a duty to allow LINKs members 'to enter and view' services (*Local Involvement Networks (Duty of Service-Providers to Allow Entry) Regulations 2008*). The Local Involvement Networks, unlike their predecessors, were set up to cover both health and social care. Local Involvement Networks were granted the right to receive a response if they made a recommendation to an NHS or social care provider. Under the *Local Government and Public Involvement in Health Act 2007*, rights of referral were to local councillors through the Overview and Scrutiny Committee, although the LINKs were also given a right to receive a response from the committee and problems could be referred on to the Secretary of State by the committee. Like Community Health Councils, LINKs were set up to cover a geographical area and they had the right to include voluntary organisation as members and so could work with local groups to identify significant issues. Referrals to the Overview and Scrutiny Committee provided a watchdog opportunity, but one that was filtered locally.

This overview of institutions suggests that both police-patrol and watchdog oversight mechanisms are found in the NHS. The trend for the watchdog oversight seems on the assessment of institutional characteristics to have varied whilst police-patrol oversight has increased. For expectations of how each form of oversight would operate in times of crisis in the NHS, we turn to NHS inquiries.

6.2 NHS inquiries: the failure of oversight?

An NHS inquiry is a Committee of Inquiry established to conduct a retrospective investigation of an event or of circumstances that cannot be evaluated using the standard quality control mechanisms available within the National Health Service (Kewell and Beck, 2008: 376). NHS inquiries take place when there has been a failure of oversight, in that effective oversight mechanisms should resolve issues before they become major problems. Inquiries, particularly public inquiries, are essentially examinations of disasters.

Comments from Ministers and evidence provided by witnesses include reflections on what should have happened to prevent the disaster. This provides insights into

expectations of oversight at the time of a particular inquiry. Ministers have choices over the oversight mechanisms to use, so the nature of expectations may change over time. When Ministers prefer professional police-patrol oversight, statutory public involvement institutions may be ignored as a watchdog. If Ministers regard watchdog oversight as the primary mechanism, statutory public involvement institutions may be blamed directly for not raising the alarm. In a mixed model of oversight, the response will vary according to the precise expectations of the watchdog within the model. If watchdog oversight is a significant mechanism, watchdog institutions may be blamed for not acting sooner. If the watchdog provides an additional source, more along the lines of a back-up support, it may be praised or blamed for particular actions, but not blamed to the same degree for failing to prevent the disaster.

Selection of NHS inquiries for this study

Changes to both the potential police-patrol and watchdog oversight mechanisms, outlined in Section 6.1, indicate when there may have been shifts in Ministerial preference for oversight mechanisms. Specific public inquiries of themselves have sometimes acted as turning points: where there has been a major disaster, politicians may wish to be seen to be acting decisively. Changing oversight mechanisms is within the powers of the Secretary of State, whereas managing experts within the NHS is more complex. A Secretary of State may therefore change oversight mechanisms in order to be seen by the electorate to be taking action that may prevent future disasters.

The first inquiry, into events at the Ely Hospital, Cardiff, in 1969 has been credited with inspiring both the Hospital Advisory Service and Community Health Councils (Webster, 2002: 119; Hogg, 2009: 16). The report and responses to it should therefore cast light on the rationale for the creation of the new institutions and how they might prevent disasters in the future. Criticisms within the report of previous structures may also indicate what Ministers hoped to avoid through the creation of new structures.

Following the establishment of both the Hospital Advisory Service and the Community Health Councils, the first major NHS inquiry examined events at Normansfield Hospital in Teddington, Surrey. Normansfield Hospital, like Ely, was a long-stay psychiatric hospital supporting both children and adults. The Normansfield Hospital Inquiry was selected to explore expectations of the oversight mechanisms in the late 1970s.

The Bristol Royal Infirmary Inquiry acted as a turning point both for regulatory mechanisms and for the nature of public involvement in the NHS. Early findings from the Bristol Inquiry were cited by the Secretary of State as part of the rationale for replacing Community Health Councils with PPI Forums (Department of Health, 2003b: vii-viii; Gerrard, 2006: 270-271). Recommendations from the Bristol Inquiry also shaped the Commission for Health Improvement. The Bristol Inquiry has therefore been selected both for its reflections on the failure of oversight and for its role as a turning point in political oversight mechanisms.

Finally, the multiple inquiries into the Mid Staffordshire NHS Foundation Trust, in 2009, 2010 and 2010-12, have been selected as the initial inquiry led to a review of early warning systems and regulatory monitoring and to the closure and reform of the Staffordshire Local Involvement Network. The events at the Stafford Hospital are discussed as a potential turning-point in political preferences, as reforms proposed following the inquiry could be interpreted as strengthening the role of statutory public involvement institutions in watchdog oversight.

Ely Hospital, Cardiff, 1969

The Ely Hospital in Cardiff was a long-stay psychiatric hospital for adults and children, many of whom had physical as well as mental disabilities. Conditions at the Ely Hospital were brought to the attention of the public and politicians by a former nursing assistant, who wrote to a national newspaper, *The News of the World*. Independent inquiries had previously been set up into allegations of ill-treatment of patients in long-stay hospitals for people with mental illness or mental disability; unlike previous inquiries, the inquiry led by Geoffrey Howe into the conditions at the Ely Hospital found that the allegations were largely true (Ham, 2009: 259).

In the late 1960s, the oversight of hospitals was the responsibility of Hospital Management Committees. These committees consisted of both lay and professional members. The Hospital Management Committee members were appointed by the Regional Health Boards and could be understood to be indirect agents of the Minister (Klein, 2006: 57). Hospital Management Committees, however, tended to work closely with the management teams in hospitals they oversaw. Members of staff in current employment at the Ely Hospital did not feel able to complain or to raise concerns with the Hospital Management Committee (Secretary of State for Social Services, 1969: §70). Whistleblowers could not, therefore, be depended upon to raise issues.

The Hospital Management Committee overseeing the Ely Hospital was heavily criticised by the Committee of Inquiry for failing to use its rights to access information in the interests of patients. The rights of Hospital Management Committee members included the ability visit premises in order to inspect hospital services (1969: §433). The former nursing assistant who wrote to *The News of the World* (referred to in the inquiry report as XY) was critical of the way in which members of the Hospital Management Committee made use of their visiting rights:

'XY was candid in his view of this: "I saw some of the members of the Committee coming every three or four months here. I am not making an accusation, of course. I am just saying how I came to the conclusion to say these things. They were coming in, seeing one or two of the senior staff, walking from one ward to the other, not asking the junior staff how they liked their job, or creating an atmosphere of co-operation or respect ... I have no doubt that the Management Committee are very good at their jobs outside, but here they are ineffective. ... There is no point in them coming around. Because they do not interest themselves in anything. They see [the Chief Male Nurse] or if they go into the wards, the Chief Nurse. They come round, pass through the door, and finish. What they are interested in is: "You have got a very nice shining floor"." XY was not the only member of the staff to have formed this impression.' (Secretary of State for Social Services, 1969: §434)

The description by XY of the visiting process demonstrates that the Hospital Management Committee members saw senior members of staff as their point of contact, rather than attempting to speak to junior personnel or to interact either with patients or with the patients' families. The brief reference to the members as being 'very good at their jobs outside' is an allusion to the social profile of the members, who tended to hold positions of respectability or authority in the local community. The Committee of Inquiry visited Ely Hospital and indicated that many of the problems were visible to a lay inspector (1969: §88). The inquiry team proposed that visiting premises should be the main means to identify problems (1969: §564). They criticised the rota set up by the Hospital Management Committee overseeing Ely, as the rota meant that individual members of the Hospital Management Committee visited Ely just once every 20 months (1969: §435).

Watchdog oversight mechanisms need to be able to access local decision-making processes and to challenge decisions. In the case of the Hospital Management Committees, members formed part of the decision-making processes in hospitals, which made it complicated for them to undertake the consumer representation part of their role (Klein and Lewis, 1976: 7).

One of the strongest concerns expressed in the Ely Hospital Inquiry is the lack of representation for vulnerable patients. Although the Committee of Inquiry endeavoured to interview patients, 'because of the severe disabilities of most of them, little assistance was

derived from this source' (1969: §76). The Hospital Management Committee covering the Ely Hospital was responsible for seven hospitals, of which two hospitals (including the Ely Hospital) were psychiatric hospitals. Despite having two psychiatric hospitals in their care, none of the committee members had been recruited from groups with an interest in mental health or mental disability (1969: §447). The Committee of Inquiry also found that none of the members of the Hospital Management Committee were 'battling for' patients at the Ely Hospital (1969: §417a).

In effect, the Hospital Management Committee combined police patrol and watchdog functions. The Committee of Inquiry alluded to broader questions about the nature of the Hospital Management Committees and 'watchdog' roles, but refrained from commenting on whether new mechanisms were needed (1969: §451). The interpretation, nonetheless, that the Secretary of State, Richard Crossman, gave of the report on presenting it to the House of Commons was that 'the main recommendation of the Report is that a new system of regular visiting and inspection is needed. I agree' (HC Deb (1968-69) 780 col. 1809).

Richard Crossman was forced to act quickly on the Ely Hospital Inquiry: the report had been the subject of dispute between Howe and civil servants for three months before Crossman saw the document, so his first sight of the report was on 10 March 1969, just days before responsibility for the NHS in Wales was transferred to the Secretary of State for Wales on 1 April 1969. The parliamentary constituency of the Secretary of State for Wales, George Thomas, included the Ely Hospital, so the report needed to be published before responsibility was transferred. Howe wanted the report to be published in full and civil servants were reluctant to take this unusual step. As Crossman indicated in his diary entry for 11 March 1969, he took the view that he could only survive politically if a full publication was followed by the creation of oversight mechanisms in the NHS:

'So tonight I went to bed and read and read and read and it seemed clearer than ever that the whole thing had to be published. The report completely substantiated the *News of the World* story and I might as well make the best of it by outright publication. But I was also clear in my own mind that I could only publish and survive politically if in the course of my statement I announced necessary changes in policy including the adoption by the Ministry and the RHBs [Regional Hospital Boards] of a system of inspectorates, central and regional, such as there are in almost every other Ministry and such as the Health Service has never yet permitted itself.' (Crossman, 1977: 409)

Crossman oversaw the creation of the Hospital Advisory Service personally. Rather than reporting to civil servants or within the internal hierarchy of the NHS, Crossman ensured that the reporting line went directly to the Secretary of State (Crossman, 1977: 418). The

origins of the Hospital Advisory Service therefore lie in a Secretary of State's need for police-patrol oversight so that he could be informed about any difficulties in hospitals before a disaster arose on a similar scale to that at the Ely Hospital. He was also concerned about the membership of the Hospital Management Committees and told the House of Commons that he wanted 'young vigorous people who really will do a job' (HC Deb (1968-69) 780 col. 1816). This concern about representation can be seen as a contributory factor in the development of the Community Health Council concept by Crossman's successor, Keith Joseph.

Normansfield Hospital, Teddington, 1978

The first major inquiry to take place following the introduction of Community Health Councils and the Hospital Advisory Service was the Normansfield Hospital Inquiry. The inquiry was chaired by Michael Sherrard and was, at the time, the longest inquiry in British legal history (Merriman, 2007: 199). Normansfield, like the Ely Hospital, was a long-stay hospital. The hospital was originally founded by Dr Langdon Down, the physician who first identified 'Mongolism', later known as Down's Syndrome (Ward, n.d.: 106). The hospital had been a private establishment for disabled members of well-to-do families, but it had been falling into disrepair since being incorporated into the NHS and was badly managed by the consultant in charge (Earl, 2010: 16; Merriman, 2007: 129, 187). The Kingston, Richmond and Esher Community Health Council started to raise concerns about quality of care and conditions at the Normansfield Hospital soon after the CHC was established. The initial trigger for the CHC's concerns was a letter of complaint from a former member of staff (Secretary of State for Social Services, 1978: 39). The Community Health Council raised its concerns initially with the Area Health Authority and later at a more strategic level with the Regional Health Authority, with correspondence copied to the Secretary of State and a press release issued to the local papers (1978: 40). The Committee of Inquiry into Normansfield was established following the first strike by medical personnel in the history of the NHS, rather than as a result of the concerns raised by the Community Health Council. Klein recognised the role played by the CHC in alerting the Area Health Authority to problems at Normansfield, but later suggested that the lack of attention paid by the authority to the warnings demonstrated 'the limits to CHC influence' (1984: 28; 2006: 94).

The report of the Committee of Inquiry into the Normansfield Hospital is structured into twenty two chapters, one of which is devoted to the activity of the Community Health Council. By contrast, there are very few references to the Hospital Advisory Service. The

Hospital Advisory Service visited Normansfield in 1972 and is quoted in the report as describing itself as 'not an inspectorate, but propagating good ideas' (Secretary of State for Social Services, 1978: 32). The Hospital Advisory Service had reported that the north and south wings of the hospital constituted a serious fire risk and were not suitable for patient accommodation, but the imminent NHS reorganisation meant that the health authorities did not act on the recommendation (Merriman, 2007: 188). In effect, the Hospital Advisory Service's recommendation was overlooked without any ramifications. The Committee of Inquiry did not express any expectation that the Hospital Advisory Service would conduct surveillance, discourage violations, access information, commission studies or carry out field work. Thus there is no expectation within the Normansfield report that the Hospital Advisory Service would or could have acted as a police patrol.

The Area Health Authority was aware of the problems, but the inquiry report indicates that it had not taken action (Secretary of State for Social Services, 1978: 9). The Community Health Council had repeatedly provided information to the Area Health Authority, but still no action had been taken. The Committee of Inquiry heard the Chair of the CHC read out a statement of how the Community Health Council had decided to refer matters to the Secretary of State:

'During a private⁴³ session of the Community Health Council on Wednesday, 5th February 1975, great concern was expressed at conditions found at Normansfield Hospital during a visit by Members, under its programme of familiarising the Council with hospitals in the area. After careful consideration, it was felt that the Area Health Authority could offer little hope of immediate improvements being made to bring the standards up to those of other subnormality hospitals. It was decided therefore, that a letter should go to the Regional Health Authority, and a copy be sent to the Rt Hon Barbara Castle, Secretary of State. This letter would contain details of observations made of the conditions found at the hospital during Members' visits.' (Kingston, Richmond and Esher CHC, 1977: 4-5)

The Community Health Council's referral of the issues to Barbara Castle is cited within the inquiry report (1978: 40). In giving evidence, however, the Community Health Council indicated that no direct response was received from the Secretary of State (Kingston, Richmond and Esher CHC, 1977: 6). The Community Health Council therefore took the opportunity to raise an alarm, but it was not heard by the then Secretary of State.

At the conclusion of the inquiry, the Community Health Council was praised by the Secretary of State in post, David Ennals, in his introduction to the Normansfield report for

⁴³ Community Health Councils held their full meetings in public, but with some committee meetings on sensitive matters in private.

'its persistent efforts to improve conditions at Normansfield' (Secretary of State for Social Services, 1978: iv). Similarly, the Committee of Inquiry spoke highly of the CHC: 'The Kingston, Richmond and Esher Community Health Council is to be congratulated on its tenacity in exposing and reporting on the situation it found at the hospital' (1978: 11). This praise suggests that the newly-created CHCs were seen to have similar preferences to those of the Secretary of State, in exposing poor NHS services.

In the course of the inquiry report, the CHC is described as demonstrating each of the main attributes of a watchdog role. The CHC accessed information largely through visits to the hospital, including regular monitoring visits (1978: 42). Members of the Community Health Council also made comparative visits to similar hospitals and encouraged neighbouring CHCs to visit Normansfield, so that they could draw on comparative experiences to comment on Normansfield (Kingston, Richmond and Esher CHC, 1977: 9). Sections from some of the reports made by CHC members following their visits are quoted by the Committee of Inquiry 'to show that the CHC members were readily able to detect deficiencies which those more closely concerned, and with a statutory duty to do so, apparently failed to do' (Secretary of State for Social Services, 1978: 39). Demonstrating the ability of the CHC to make a valuable contribution to planning, the Committee reported a visit made by CHC members to a 69-bed unit in another hospital that was similar to a unit proposed for Normansfield. The CHC members indicated that the unit was not suitable and did not meet national guidelines, on which the Committee of Inquiry comment that 'this was indeed so, as the Authorities should have known' (1978: 41).

Ministers and health authorities also expected the Community Health Council to filter issues raised by local interest groups. The main local charity with an interest in Normansfield was the Richmond upon Thames Society for Mentally Handicapped Children, which was advised both by the Area Health Authority and by David Owen, Minister of State, to raise any concerns about Normansfield through the Community Health Council (Secretary of State for Social Services, 1978: 41). This reference in the inquiry report to exclusive representation through the Community Health Council is confirmed in an article by Morris Malin, Vice Chair of the Wandsworth Society for the Mentally Handicapped:

'On 9 June 1975 Dr David Owen, then Minister of State for the DHSS [Department of Health and Social Security], informed an MP that the suggestions of the Richmond upon Thames Society for Mentally Handicapped Children, and the view of other interested bodies, should get to health authorities through the medium of the CHC. This neat arrangement, making the CHC the recognised spokesman for

the entire community, would work if the CHC made proper use of the expertise the voluntary organisations have gathered over many years. But if the CHC, for one reason or another, chooses to disregard the voluntary society, then one might well ask whether the CHC has become a mini-authority instead of the grass-roots organisation it was intended to be.' (Malin, 1978: 4)

Malin's response to local interest groups being referred to the Community Health Council reflects the role of statutory public involvement institutions in filtering issues raised by local groups. As part of the role in alerting a Secretary of State to problems, this filtering process ensured that only issues that were of concern to a wide group of interests would be raised.

Whilst the Community Health Council did not trigger the Normansfield Hospital Inquiry, it did use its powers to act as a watchdog. The Association of Community Health Councils for England and Wales cited the activity at Normansfield as exemplifying the 'determination' with which CHCs 'pursued the interests of the public', in contrast to the approach of Area Health Authorities (Working Group on the Role and Development of CHCs, 1980: 2). The praise expressed both by David Ennals as the Secretary of State and by the Committee of Inquiry suggests that, at this early stage in their career, the Community Health Councils were seen by Ministers as providing watchdog oversight.

Bristol Royal Infirmary, 2001

The Bristol Inquiry investigated the high death rate amongst babies during open-heart surgery, or in the 30 days after surgery, at the Bristol Royal Infirmary. During the period 1984-1995, more children aged less than 12 months died than would have been expected statistically from comparisons with other paediatric surgery units (Secretary of State for Health, 2001: 2). The public inquiry, chaired by Ian Kennedy, was triggered by the concerns of an anaesthetist at the hospital, Dr Bolsin, who had collated his own statistics and compared them with those for other services (2001: 9).

A problem that could only be identified through statistical comparison is more likely to be identified by police patrols than by fire alarms. Bristol Royal Infirmary was 'awash with data', but 'little if any of this information was available to the parents or to the public' (2001: 3). The rights of Community Health Councils to enter and inspect hospital premises would not enable the members to identify higher than average death rates amongst a small number of patients.

During the period investigated by the Bristol Inquiry, the Health Advisory Service (formerly the Hospital Advisory Service) was in place. This was not considered by the

Committee of Inquiry to provide a police patrol function. The report is introduced as ‘an account of a time when there was no agreed means of assessing the quality of care’ (2001: 2). The Committee of Inquiry allude to political assumptions that the quality of health care should be ‘a matter for individual healthcare professionals’ and conclude that Bristol ‘has taught us that this is not enough’ (2001: 303, 305). The Committee of Inquiry recommends that the new Commission for Health Improvement should undertake a stronger monitoring role, with access to data in order to identify trends (2001: 386), commissioned studies (2001: 407) and field work to include unannounced visits (2001: 390). These powers exemplify stronger police-patrol oversight. In evidence provided to the inquiry, the Department of Health emphasised the importance of ‘modern information systems’ that would ‘provide timely audit data to help clinical teams to identify issues before they become real problems’ (Department of Health, 2000b: §29). This response from the Department of Health underlines the assumption that quantifiable and comparable data are needed in order to identify problems.

The ability of Community Health Councils and other public interests to challenge health service managers is presented as problematic in the Bristol Inquiry. When an interest group makes an issue public, then someone has ‘to be singled out for blame’ (Secretary of State for Health, 2001: 271). The Committee of Inquiry suggested that public involvement ‘should be “on the inside”, rather than represented by some organisation “on the outside” ’ (2001:18). Alan Milburn, as Secretary of State for Health, later cited this finding as his rationale for replacing Community Health Councils outside NHS institutions with PPI Forums aligned with NHS trusts (Gerrard, 2006: 270-271). Involvement inside the NHS is presented as more empowering for patients as it enables them to ‘feel truly in partnership with the professionals who run and provide our healthcare service’ (2001: 401). Such partnership does not sit comfortably with a watchdog role. The Committee of Inquiry proposed that Community Health Councils ‘were tolerated mechanisms for venting public concern, because ultimately they could do nothing’ (2001: 407). This suggests a weak oversight mechanism, as it is not one that would be heard.

The Committee of Inquiry explicitly considered whether there was a need for a watchdog to represent the interest of patients in the NHS. In this case, the committee considered the watchdog as a national body:

‘On a separate matter, there is an argument as to whether there is a need for Government to establish some body at a national level to represent the public’s interest but which stands outside the organisational structure of the NHS. There is some force in the idea of some form of permanent watchdog: a national, publicly funded body to represent and promote the patient’s perspective. There are,

however, counterarguments. First, by being outside the system, the scene may be set for the development of confrontational attitudes between the patients' watchdog and the NHS which serve the interests of neither. Secondly, without formal powers to challenge or change, the body may soon lose credibility and be seen as 'toothless', a gesture towards public engagement rather than a reality. If, on the other hand, the body were given formal powers, it would, perhaps, endanger the creation of that partnership between professional and public which we regard as the essential building block for the future, by appearing to endorse the sovereignty of patient power. This would be to go too far. A patient-centred service is not a patient dominated service.' (Secretary of State for Health, 2001: 411)

The emphasis in the Bristol Inquiry is on reducing blame so that professionals feel able to raise concerns; in this context, a formal watchdog is problematic. In order to be effective, a watchdog needs to be able to challenge current practice, so the confrontation that is presented as posing a problem by the Committee of Inquiry is part of the role. As the report states, without the powers to confront poor practice in the NHS a watchdog would be seen as lacking credibility. The closing statement that 'a patient-centred service is not a patient dominated service' is indicative of an approach that emphasises patients working with professionals rather than the involvement of members of the public as citizens commenting on acceptable standards for services.

In terms of the characteristics of a watchdog, Community Health Councils are presented in the Bristol Inquiry as having a very limited role. Rather than problems being visible for volunteers to view, the problems at Bristol could only be identified by gathering performance data and making statistical comparisons. The CHCs were not seen as influencing decisions, but as 'tolerated mechanisms' that could do nothing (2001: 401). Their ability to challenge professional practice was rejected as leading to confrontation and a culture of blame. The dimension of filtering issues raised by different interests did not arise with a weaker watchdog, as the emphasis of the report was on partnership between individual patients and professionals, rather than the involvement of interest groups.

Changes attributed to the Bristol Inquiry led to weaker scrutiny powers initially for PPI Forums and then for Local Involvement Networks than had been held by Community Health Councils. The inquiry seems to mark a shift in the preferences of political principals from utilising watchdog oversight to focusing on police-patrol oversight. More recent findings at the Stafford Hospital demonstrate that in the complexity of health services police-patrol oversight alone may not be sufficient.

Mid Staffordshire NHS Foundation Trust, 2009, 2010 and 2010-12

The poor quality of care at the Stafford Hospital came to light through a combination of mortality rates data and concerns raised, initially with the Healthcare Commission, by a group of local patients and family members known as Cure the NHS. This local group did not have the official standing of the statutory public involvement institutions, which during this period were the PPI Forum for the hospital and then the Staffordshire Local Involvement Network (LINK). Despite lacking formal status, Cure the NHS could be interpreted as having acted as a watchdog, as its members compiled information on patient experiences, arranged to meet with the NHS trust Board to express their concerns and challenged local decisions about service quality (Francis, 2010a: 8, 20). The founder of Cure the NHS, Julie Bailey, was advised by a solicitor that her only means to alert authorities outside Stafford to the problems was to contact the Healthcare Commission. Cure the NHS was asked by the Healthcare Commission to collect more evidence to determine whether an investigation was needed (Francis, 2010b: 284).

The Healthcare Commission conducted an investigation, but Cure the NHS continued to call for a public inquiry following the Healthcare Commission's report (Healthcare Commission, 2009; Francis, 2010a: 30). Andy Burnham, as Secretary of State, declined to establish a public inquiry, but agreed to set up an independent inquiry chaired by Robert Francis. This independent inquiry was followed by a public inquiry, also chaired by Robert Francis, which was commissioned by Andrew Lansley, the Secretary of State within the Conservative-Liberal Democrat Coalition government of 2010. When Andy Burnham was asked to give evidence to the public inquiry, he indicated that he would have expected a greater outcry if a Minister were to understand that problems were on the scale of those found at the Stafford Hospital:

'I would particularly have expected any concerns or issues in relation to Mid Staffordshire to have been highlighted by the local public involvement structure – the PPIF [PPI Forum] at that time – but to my knowledge, nothing came through this channel either.' (Burnham, 2011: §45)

This comment was included in the written evidence submitted by Andy Burnham, suggesting that he was keen to report that he would have expected the PPI Forum to alert him to any significant problems at the Stafford Hospital. Continuing his comments on the lack of information received through public involvement mechanisms, Andy Burnham volunteered the view that 'the abolition of the Community Health Councils (CHCs) was not one of the Government's finest moments' (2011: §47). In context, the implication is that as

Secretary of State he would have expected that if a Community Health Council had still been in place the problems at the hospital would have been drawn to his attention sooner.

The statutory public involvement institutions that were in place during the period of the Mid Staffordshire inquiries were the PPI Forum (2005-2008) and the Staffordshire LINK (2008-2009). The PPI Forum was closely embedded within Stafford Hospital (Counsel to the Inquiry, 2011: 215). This working relationship is exemplified in the Healthcare Commission report by an incident in which a member of the PPI Forum was expelled by the Chair for releasing information to a newspaper on the *Clostridium difficile* (*C. difficile*) infection rates at the hospital (Healthcare Commission, 2009: 89). Following this incident, 'confidential' information was screened by the PPI Forum Chair before being passed on to other members (Healthcare Commission, 2009: 89). Owing to this screening of information, the members of the Forum did not discuss the death rates at Stafford Hospital (Francis, 2010a: 388). The PPI Forum was not seen to be coordinating interest representation and the rules established for PPI Forums were regarded by respondents to the independent inquiry as restricting the Forum's ability to engage with interest groups (Francis, 2010a: 397). Former members of the PPI Forum were called as witnesses to the full public inquiry and questioned about their awareness of their powers. The member who had been expelled for disclosing *C. difficile* infection rates was asked whether he was aware that the PPI Forum had the right to be able to refer issues to the Secretary of State:

'Q: Were you, and other members of the PPIF [PPI Forum], aware of the power to go to the Minister of Health or a Minister?

A: No, I – I would think most members of the PPI would have sort of held up their hands in amazement if that had been made available to us. So I don't recall that ever coming up on the agenda at all.' (Bastin, 2010: 121)

The lack of awareness of the power to refer issues to Ministers meant that individual members of the PPI Forum were not in a position to propose use of those powers.

The Staffordshire Local Involvement Network was subject to a separate review in the wake of the Healthcare Commission's investigation, commissioned by the Department of Health (Wood and Cunnett, 2009a and 2009b). After receiving the report, Staffordshire County Council decided to close the existing LINK and to recruit a new support organisation and new LINK members (Francis, 2010a: 389). The Staffordshire LINK was criticised for not having fulfilled its watchdog role. During the period 2008 to 2010 it failed to use its powers to enter and inspect the Stafford Hospital (Counsel to the Inquiry, 2011: 109). The reason given by the Staffordshire LINK for not visiting was that, despite Department of Health advice to the contrary, the LINK decided that its members would

need to be insured before any inspections were carried out (Counsel to the Inquiry, 2011: 227). The LINK did not use its scrutiny rights to access information effectively, it was not seen as a credible participant in decision-making processes and it had not created a network for interest representation, including struggling to build effective relationships with Cure the NHS (Wood and Cunnett, 2009a: 5, 3, 2). In summing up at the end of the public inquiry, the Counsel to the Inquiry commented on the impact of politics within the Staffordshire LINK at a point when the events at the Stafford Hospital were having a significant impact across the NHS:

‘At a time when the shockwaves from the publication of the HCC [Healthcare Commission]’s report into the trust were still being felt throughout the NHS, the external organisation supposed to ensure public involvement with the trust’s affairs was completely consumed with an internal, factional struggle.’ (Counsel to the Inquiry, 2011: 191)

Respondents to the public inquiry expressed the expectation that a LINK should act as a watchdog. Malcolm Alexander, formerly Director of the Association of CHCs for England and Wales, informed the inquiry that the division of the complaints function from public involvement had made it harder for statutory public involvement institutions to raise an alarm, as they did not hear about problems (Counsel to the Inquiry, 2011: 246).

Staffordshire County Council expressed the expectation that the LINK should act as a watchdog, as it wanted to ensure that concerns were raised by the LINK with the Overview and Scrutiny Committee at the local authority – which, in the Council’s view, would result in prompter action than referring problems to the national regulator (Francis, 2010a: 389).

The role of LINKs was also considered more broadly as part of an examination of early warning mechanisms commissioned following the Healthcare Commission’s report into the Stafford Hospital (National Quality Board, 2010). The National Quality Board expressed the expectation that Local Involvement Networks would act as early warning systems. Two of the seven recommendations by the National Quality Board to improve early warning mechanisms relate to strengthening the feedback routes for Local Involvement Networks (2010: 50-51).

A review of the role played by regulatory bodies fell outside the scope of the initial independent inquiry led by Robert Francis, but the terms of reference for the public inquiry cover ‘the operation of the commissioning, supervising and regulatory organisations’ including ‘local scrutiny and public engagement bodies’. The full public inquiry therefore considers both police-patrol and watchdog oversight. As a police patrol accessing information, the Healthcare Commission expressed concern about the lack of narrative to explain data received from Stafford Hospital (Healthcare Commission, 2009: 3). Whilst the

data indicated that there might be a problem, it was the narrative provided by Cure the NHS that illuminated the nature and scale of the issue. In terms of discouraging violations, the Healthcare Commission referred the Mid Staffordshire NHS Foundation Trust to Monitor with a view to de-authorising the trust's Foundation status (2009: 12). The Healthcare Commission's report did not stop the problems at the hospital, however, so there were limits to the extent to which the Commission could discourage violations (Francis, 2010b: 285). The events at Stafford Hospital seem to demonstrate the limits to police-patrol oversight and, as discussed below, a potential shift in Ministerial preference to strengthen the watchdog role.

6.3 Demonstrating watchdog characteristics

The four NHS inquiries were selected to cast light on understandings of the potential oversight roles that could be played by statutory public involvement institutions. The Ely Hospital Inquiry was very critical of the Hospital Management Committee arrangements and informed the development of NHS oversight mechanisms. The elements that were lacking at the Ely Hospital and were integrated into the powers of Community Health Councils seem to reflect a watchdog role. At the Normansfield Hospital, the Community Health Council was expected and encouraged to act as an early warning mechanism. With the Bristol Royal Infirmary Inquiry, there was a shift to greater reliance on data collection to identify problems, which implied stronger police-patrol oversight. The events at the Mid Staffordshire NHS Foundation Trust, however, have called into question the effectiveness of police-patrol oversight, cast doubt on the value of a close relationship between a PPI Forum and the organisation to which it was connected, and encouraged Local Involvement Networks and their successors, the local Healthwatch, to take on a greater role as watchdogs.

Statutory public involvement institutions were not in place at the time of the Ely Hospital Inquiry. The inquiry was included in this chapter for the light the report and Crossman's response to it casts on the development of oversight mechanisms. In each of the following inquiries, however, the reports provide examples of whether the institutions acted as watchdogs in practice or were expected to do so. The extent to which the institutions demonstrated or were expected to have each of the watchdog characteristics is summarised in Figure 6.3 and discussed below.

Figure 6.3: Demonstration of watchdog characteristics in public inquiries				
Watchdog characteristics	Normansfield (CHC)	Bristol (CHC)	Mid Staffs (PPI Forum)	Mid Staffs (LINK)
Gather intelligence about local services	Regular visits, including comparative visits to similar services; Access to information from complaints	Lay visits replaced by professional statistics	Lay visits and limited access to performance data	Limited information and criticised for not prioritising Stafford Hospital
Influence decisions about local services	Gathered information on policy and other hospital units to change planned unit	CHCs seen as 'tolerated mechanisms' as could do nothing	Close to Trust Board and seen to be part of decisions	Criticised for not being credible participant in decision making
Challenge decisions and refer problems	Referred issue to Regional Health Authority and Secretary of State	Challenge rejected by inquiry team as generates blame	Too close to the Trust to challenge; Members not aware of right to refer to Minister	Not a credible challenge to local decisions
Filter significant issues from problems raised by interest groups	Issue-specific groups referred to CHC by Minister	Emphasis of inquiry on partnership with individual patients, not groups	Criticised for failure to work with Cure the NHS	Criticised for failure to develop network or work with Cure the NHS

Statutory public involvement institutions' ability to gather intelligence, the first characteristic, has predominantly been through visiting services and observing problems. Whilst the Bristol Inquiry called this practice into question, as some problems are only apparent through statistical comparison, this has continued to be a major activity for statutory public involvement institutions. At Normansfield, the Community Health Council undertook regular visits to the hospital, but it also asked other CHCs to view the problems at Normansfield and visited similar services in other districts. The CHC's concerns about Normansfield were first triggered by a letter of complaint from a former member of staff (Secretary of State for Social Services, 1978: 39). Complaints, usually from patients or family members, provided Community Health Councils with valuable insights into possible problems. As discussed above, Malcolm Alexander advised the Mid Staffordshire public inquiry about the impact of the loss of a complainants support role on the successors of CHCs (Counsel to the Inquiry, 2011: 246). The combination of intelligence sources and comparative visiting activity gave the Kingston, Richmond and Esher Community Health Council a perspective on the extent to which the standards at Normansfield were either acceptable or fell short of what was being delivered in other long-stay hospitals. The

Community Health Council at Bristol was able to see complaints and to visit, but the role of lay visiting was disregarded in favour of statistical analysis of data in the Bristol Inquiry report. The reports into the Mid Staffordshire NHS Foundation Trust include extracts from visits made by the lay PPI Forum to the Stafford Hospital, but only the Chair of the PPI Forum saw other performance data and so the intelligence from the visits could not be put into context. The Staffordshire LINK was criticised for not prioritising visits to the Stafford Hospital (Wood and Cunnett, 2009a: 5). The inquiries demonstrate examples of the successive statutory public involvement institutions gathering intelligence, predominantly through visits to hospitals; as discussed in Section 6.4 below, however, the value placed by Ministers on such information has varied over time.

In order to be watchdogs for the local community, statutory public involvement institutions need to be able to influence local decisions in the interests of patients and the wider population. The Normansfield Inquiry report included the example of the CHC checking national guidelines and visiting a 69-bed unit to inform its advice that a proposed unit would not be suitable, on the basis of which the decision about the unit was overturned (Secretary of State for Social Services, 1978: 41). At Bristol, by contrast, the Community Health Council was described as a ‘tolerated mechanism’ that could not influence decisions (Secretary of State for Health, 2001: 407). The PPI Forum at the Stafford Hospital was too close to the hospital Board to influence decisions, whilst the Staffordshire LINK was criticised for not being a credible participant in local decisions (Healthcare Commission, 2009: 89; Wood and Cunnett, 2009a: 3). If issues are to be resolved before they become serious problems, statutory public involvement institutions need to be able to influence local decisions.

The right to challenge decisions and, if necessary, refer matters to Health Ministers is a fundamental element in the watchdog role. At Normansfield, David Ennals praised the CHC in the published report for raising the issue of problems at the hospital (Secretary of State for Social Services, 1978: iv). Examination of the evidence presented to the Normansfield committee of inquiry, however, shows that his predecessor, Barbara Castle, did not respond when the Community Health Council tried to alert her to problems at Normansfield (Kingston, Richmond and Esher CHC, 1977: 6). The balance of sources therefore suggests that David Ennals was happy to be seen to be responding to a concern raised through the watchdog, but that Barbara Castle had ignored an earlier opportunity to respond. Alan Milburn used the response to the Bristol inquiry as part of the rationale for changes to statutory public involvement institutions, but the local Community Health Council would not have had access to the data that would enable them to raise an alarm.

Evidence presented to the Mid Staffordshire inquiry suggests that PPI Forum members were not aware of the broad right of PPI Forums to refer issues either through the local Overview and Scrutiny Committee or through the Commission for Patient and Public Involvement in Health, but that Andy Burnham as Secretary of State would have expected to hear of the PPI Forum's concerns (Bastin, 2010: 121; Burnham, 2011: §45). The short-lived initial Staffordshire LINK did not have sufficient time to develop a role in challenging decisions either locally or nationally.

The last of the dimensions to the role is the filtering of issues raised by interest groups, ensuring that issues of broad interest, rather than those of the best-resourced groups, were raised. At Normansfield, this chapter has outlined evidence both through the inquiry and other articles that local voluntary organisations were referred by David Owen, as Minister, to the Community Health Council (Secretary of State for Social Services, 1978: 41; Malin, 1978: 4). There is less evidence of this filtering role in the later public inquiries. Part of the shift between the Community Health Councils and PPI Forums was to individual members rather than representation of interest groups and the Stafford Hospital PPI Forum interpreted its role as not working with interest groups. Local Involvement Networks were expected to include interest groups as members, however, and the Staffordshire LINK was criticised for its failure to create a network of groups and for not working effectively with Cure the NHS (Wood and Cunnett, 2009a: 2).

The characteristics outlined in Figure 6.3 and discussed above suggest that there have been shifts in political preference for the use of a watchdog. This examination of the watchdog role considered statutory public involvement institutions as presented in public inquiries at specific points in time. The next section draws on information from the statutory public involvement institutions' archives to place the inquiries into a historical narrative and considers the trends in the value placed on statutory public involvement institutions as watchdogs in political management of the NHS.

6.4 Changing political value placed on watchdog role

To establish whether the patterns identified at the specific points of the public inquiries formed part of trends over time, this section considers the watchdog role through the examination of archival sources from the statutory public involvement institutions and in policy documentation. It then reviews the trends in the value placed on statutory public involvement institutions as watchdogs. The response to the Normansfield Inquiry suggested that the watchdog role was welcomed in the late 1970s. The *Patients first*

consultation questioned in sheepdog terms whether there was a need for Community Health Councils if smaller health authorities were able to consult directly with health authorities (Department of Health and Social Security and Welsh Office, 1979: 14). The watchdog role of CHCs was not included as a matter for debate in the *Patients first* consultation; and, once support for CHCs had been confirmed, the *Community Health Councils in England* consultation paper stated that the role of CHCs in inspecting NHS services should continue (Department of Health and Social Security, 1981a: 3). This suggests that it was the value of the sheepdog role rather than the watchdog role that was being questioned in the early 1980s consultations.

None of the public inquiries discussed in this chapter reported their findings in the 1980s, although the cases covered in the Birmingham Royal Infirmary Inquiry started in 1984. During the 1980s, however, Community Health Councils were commended where they played a role in identifying or reporting on problems. In the case of nineteen deaths from food poisoning at the Stanley Royd Hospital in 1984, the 'considerable assistance' of the CHC was put on record even though reports from the CHC and others about risks from open drainage channels in the kitchens had not been acted upon (Hogg, 1986: 20). The assumption leading up to the Bristol Royal Infirmary Inquiry seems to have been that problems in hospitals and other NHS services would have been visible to Community Health Council members undertaking visits to monitor services.

The discussion of the Bristol Royal Infirmary Inquiry showed that a lower value was placed on the watchdog role played by CHCs by the late 1990s. Community Health Councils continued to have a value for Ministers in the 1990s, however, in commenting on issues and responses to problems in the NHS from a public perspective. When Virginia Bottomley was challenged in the House of Commons on the rationale for an independent rather than a public inquiry into the deaths of children under the care of Nurse Beverly Allitt, she justified it on the grounds that the Community Health Council covering the Grantham and Kesteven general hospital had agreed that an independent inquiry would be more appropriate for the NHS personnel and the parents involved (HC Deb (1993-94) 237 col. 590).

Leading up to the abolition of Community Health Councils, the Association of CHCs for England and Wales facilitated a national form of the watchdog role. This was Casualty Watch, a coordinated monitoring of casualty services, noting numbers, such as the number of people on trolleys, which could be combined quickly and brought to the attention of national politicians (as an example, ACHCEW, 2000a). In this approach, CHCs were using the data-generating techniques associated with police-patrol oversight.

Casualty Watch created confrontation at a national level. In the Bristol Royal Infirmary Inquiry, there was an assumption that local confrontation was detrimental to identifying problems. As discussed above, the inquiry at Bristol shifted the emphasis away from what was visible to the collation of data in order to identify problems through statistical comparison. Whilst individual Community Health Councils could not develop comparative data alone, ACHCEW had the capability to support consistent data collection and compare the findings. This watchdog role utilised the mechanisms of police-patrol oversight and does not seem to have been welcomed. It is possible that this national watchdog role contributed to the decision to abolish Community Health Councils.

Whilst Patient and Public Involvement Forums retained the rights of Community Health Councils to enter and inspect NHS services, their activity was steered towards monitoring hospital cleanliness. The political value placed on inspection at this point in time seems to have been influenced by the contemporary issue of *methicillin-resistant staphylococcus aureus* (MRSA), a bacterium that causes infections in different parts of the body and cannot be treated with common antibiotics. The spread of MRSA is associated with poor hospital hygiene and the application pack for PPI Forum members advised them that they would be 'inspecting wards for MRSA and cleanliness' (CPPIH, n.d. [2003b]: unpaginated [2]). This specific role in a politically-resonant issue suggests that the watchdog role had a value, but that it was a symbolic link with current issues rather than a powerful watchdog to alert the Secretary of State to major problems.

The inquiries into the Mid Staffordshire NHS Foundation Trust covered the activity of both the PPI Forum and the Local Involvement Network. The transition from Local Involvement Networks to local Healthwatch seems to have been triggered by the political need to be seen to strengthen the watchdog role in response to the problems at the Stafford Hospital. Local Healthwatch groups will be supported by Healthwatch England, a statutory committee within the Care Quality Commission. Guidance notes on local Healthwatch indicate that they will receive advice from Healthwatch England and that Healthwatch England will have access to the data and analytical support found in its host organisation:

'CQC [Care Quality Commission] will also be able to offer Healthwatch England valuable expertise in data management, gathering and use of intelligence, analysis and evidence base of information about services across the country. Whatever arrangements are made for sharing policy knowledge or pooling intelligence, Healthwatch England will have operational and editorial independence from CQC; it will reach its own conclusions and publish its own findings and advice.'
(Department of Health, 2012b: 11)

Despite changes in statutory powers, the watchdog-related activities of the statutory public involvement institutions have remained fairly consistent in their visiting of services to gather intelligence, although the reporting of this and the value placed upon it has varied over time. The changes in the political value do not just relate to the activities of the statutory public involvement institutions in isolation, but broader changes to the options for police-patrol oversight, particularly with the increasing ease of data collection and analysis with the development of computer systems in the NHS.

Examining NHS inquiries illuminates the role played by the evolution of computerisation and statistical analysis in shaping political preferences between watchdogs and police patrols. The Ely and Normansfield inquiries in the 1960s and 1970s both concluded that problems in hospitals should be visible to lay people. By the period covered by the Bristol Inquiry, in the 1980s and 1990s, computerisation meant that data on small samples of patients could be gathered over time and compared to outcomes for patients in similar services. This led to greater dependence on the data collection and analysis abilities of police patrols. Events at the Stafford Hospital then showed that dependence upon data and statistical comparison was not sufficient. Although data were supplied to the Healthcare Commission, the hospital did not provide a clear narrative to explain the information supplied. Matters had reached an extreme point by the time that the NHS had formed itself into an issue-specific group to call for health services at Stafford Hospital to be investigated. The shifting preferences elucidate the impact of information management systems on quality management in the NHS, but also show the limitations of depending upon standardised data collection to identify problems. This has ramifications for the nature of police-patrol oversight and its combination with watchdog oversight. On the basis of experience in the NHS, a police-patrol could be predominantly a mechanism to collect and analyse data, combined with a watchdog visiting role.

Access to information for the PPI Forums and Local Involvement Networks was predominantly through visiting services. Community Health Councils also had rights to enter and inspect services, but these were complemented by a role in supporting complainants. The CHCs never had a statutory role in complaints management, but supporting people who had complaints about NHS services provided the CHCs with insights into potential problems in local services that they could examine. The role of supporting complainants was transferred on the abolition of the Community Health Councils to organisations within the NHS trusts, the Patient Advice and Liaison Services (PALS). Considered from a Hirschmanian perspective, it is valuable to managers to learn directly from the voice of complaining consumers in order to rectify individual problems and

improve services (Hirschman, 1970: 42). In the wake of the Bristol Royal Infirmary, management of complaints through PALS was probably also seen as less confrontational, supporting a culture of greater openness between patients and professionals so that professionals could learn from their mistakes without feeling as though they were being blamed. As the evidence to the Mid Staffordshire NHS Foundation Trust Public Inquiry suggested, however, the lack of information about complaints may have weakened the watchdog abilities of statutory public involvement institutions (Counsel of Inquiry, 2011: 246).

One of the shifts in the relationship between Ministers and statutory public involvement institutions over time has been the ease with which the local organisations could refer problems directly to the Secretary of State, or whether referrals were made through another institution. The Community Health Councils could refer unresolved issues directly to the Secretary of State. PPI Forums could refer issues either through the Commission for Patient and Public Involvement in Health or through the Overview and Scrutiny Committees within local authorities. The referral rights for Local Involvement Networks covered local referrals to the Overview and Scrutiny Committees, so LINKs were dependent on the willingness of their local Overview and Scrutiny Committee to refer an issue on their behalf. Taken alongside the shifts in watchdog and police-patrol preferences indicated in the NHS inquiries, the direct referrals to the Secretary of State occur when greater prominence was given to a watchdog role. The transition to local Healthwatch develops a body that still has close connections with its Overview and Scrutiny Committee, but also has opportunities to raise national issues through Healthwatch England.

The empirical example of statutory public involvement institutions in the NHS adds to the legislative oversight model developed by McCubbins and Schwartz. McCubbins and Schwartz suggest that fire alarms are created through the development of 'rules, procedures and informal practices' that enable citizens and interest groups to act as fire alarms (1984: 166). The example of statutory public involvement institutions in the NHS demonstrates that organisations can also be created specifically to provide a watchdog or fire-alarm oversight. Where there are multiple local interests, creating an institution to filter issues may avoid the problem of alarms only being raised by well-organised interests (Hopenhayn and Lohmann, 1996: 209). The analysis in this chapter indicates that statutory public involvement institutions have been intended to raise alarms in the general public interest, but that they may be seen as too antagonistic (as in the Bristol Inquiry report) or as captured by compromised individuals (as with the PPI Forum at

the Stafford Hospital), leaving professionals or non-statutory organisations to take on the watchdog role.

Lupia and McCubbins indicated that politicians may prefer to work with a combination of oversight mechanisms, rather than relying solely on one form of oversight (1994: 97-98). The expectations of statutory public involvement institutions expressed in the NHS inquiries suggest that political preferences for the desired balance of watchdog and police-patrol oversight have varied over time. The Bristol Inquiry was a high point for police patrols; subsequently events at the Stafford Hospital have tilted the balance back towards watchdogs (National Quality Board, 2010: 8). Following the independent inquiry into Mid Staffordshire it was proposed that Local Involvement Networks would be transferred into a new statutory public involvement institution, local Healthwatch. Local Healthwatch have greater scrutiny powers than LINKs and clearer rights to refer issues (Department of Health & Communities and Local Government, 2010). The changes include the creation of a national body, Healthwatch England, as part of the Care Quality Commission (*Health and Social Care Act 2012*). Healthwatch England will work with local Healthwatch groups to alert the Secretary of State to problems. Placing Healthwatch England within the Care Quality Commission locates the central body for local watchdogs within the national police patrol. This positioning may have ramifications for modelling of oversight mechanisms. The changes also suggest an acknowledgement of the need for greater powers, including access to data analysis, to support a watchdog role.

Chapter summary

This chapter reviewed the potential role of statutory public involvement institutions as watchdogs, alerting politicians to problems before they become disasters. The first section considered the statutory powers of both professional monitoring bodies and statutory public involvement institutions to establish the extent to which different institutions over time may be understood to provide either police-patrol oversight or watchdog oversight. This section applied models taken from the legislative oversight literature, drawing on work by McCubbins and Schwartz. The second part of the chapter reviewed four NHS inquiries to examine over time whether statutory public involvement institutions alerted politicians to problems or were expected to do so. The statutory public involvement institutions in each of the NHS inquiries were then discussed in terms of watchdog characteristics. The chapter concluded with a summary of shifts over time, such

as the move towards performance data as a means to identify problems in the Bristol Inquiry and a shift following the problems at the Stafford Hospital back towards the need for intelligence gathered through visiting services.

The closing chapter brings together themes from the discussion of both the watchdog role and the sheepdog role presented in the two preceding chapters and returns to the research question of the role(s) statutory public involvement institutions played in political management of the English NHS between 1974 and 2010.

Chapter Seven: Sheepdog or watchdog? Conclusions

In this study, I considered roles that statutory public involvement institutions may have played in political management of the English NHS during the period from 1974 to 2010. The statutory public involvement institutions are local volunteer-led organisations, which are established and granted statutory powers by Ministers. The period for this study covered a succession of statutory public involvement institutions: Community Health Councils, 1974-2003; Patient and Public Involvement Forums, 2003-2008; and Local Involvement Networks from 2008. Research into these institutions is timely, as Local Involvement Networks are due to be replaced by local Healthwatch in April 2013. I identified two potential political management roles for these institutions from within the political science literature and explored these using documentary sources: a sheepdog, rounding up participants and managing potential opposition; and a watchdog, providing fire-alarm-style oversight and alerting politicians to problems before they become disasters. Each of these roles draws on the statutory powers of statutory public involvement institutions. The sheepdog reflects the consultation rights, whilst the watchdog utilises the rights to inspect services and to refer unresolved issues.

This closing chapter opens with a summary of the findings on a chapter-by-chapter basis. The next four sections consider each of the main conclusions in turn. Firstly, there was strong evidence of the sheepdog role in the 1970s, but the political value placed on the sheepdog role has declined. Secondly, the watchdog role is being reappraised; having fallen from favour with increasing data capacity through computerisation and the growth of regulatory police patrols, the watchdog role seems to have been revived following problems at the Mid Staffordshire NHS Foundation Trust. Thirdly, the extent to which sheepdog and watchdog roles have been combined has varied over time. The last of the conclusions discussed in this chapter is that changes to statutory public involvement institutions tend to take place as part of wider NHS reforms. This may suggest that transitions between statutory public involvement institutions moderate the ability of their committed voluntary members to oppose wider reforms.

Drawing on these conclusions, I propose that statutory public involvement institutions play roles in political management of the NHS, but that the institutions themselves are also subject to management by Ministers. These conclusions expand upon themes in the existing literature of managing local representation and monitoring service quality. They also contribute to the public involvement literature by providing new

perspectives on the value to Ministers of statutory public involvement institutions in political management of public services.

7.1 Summary: review of the findings in preceding chapters

To contextualise the main conclusions, this section revisits the findings presented in the previous chapters. The first three chapters of this dissertation introduced the empirical puzzle, the existing literature and the research framework for this study. The next three chapters discussed the empirical material drawn from policy documents and archives to assess whether statutory public involvement institutions could be considered as playing either sheepdog or watchdog roles in political management of the NHS.

Chapter One introduced the challenges faced by Ministers undertaking political management of the NHS. It also described the history of the statutory public involvement institutions in the wider context of changes to the NHS. The description of the statutory public involvement institutions touched briefly on the different forms in each of the UK nations, but established that the focus of this study is on the successive statutory public involvement institutions in England. The opening chapter proposed that the ongoing state investment in statutory public involvement institutions could be seen as something of a puzzle in the context of the growth of two alternative forms of public involvement, self-generating interest groups and NHS-led forms of public involvement.

The literature review in Chapter Two examined approaches to public involvement in the existing literature. The review took a chronological approach, demonstrating that academic interests in public involvement in the NHS have shifted over time. In the 1970s and 1980s, statutory public involvement institutions were studied in terms of their membership and working relationships. In the 1990s, there was considerable academic interest in innovative NHS-led forms of public involvement, such as citizens' juries. Since 2000, there has been a growth in the literature on interest groups and the successive changes to statutory public involvement institutions have also received academic attention. Broad themes of democratic and consumerist approaches to involvement run through the literature. In reviewing the literature, I also identified the themes of managing interest representation and monitoring service quality.

Chapter Three discussed the research question and the theoretical approaches underlying the sheepdog and watchdog models for roles in political management of the NHS. The sheepdog analogy builds on the theme of managing interest representation in the existing literature. Like an actual sheepdog, it both rounds up potential participants

and pens them into management processes. The term 'watchdog' in this study refers to the fire-alarm style oversight provided by interest groups. I propose that in their watchdog role the statutory public involvement institutions monitor service quality and alert politicians to problems before they become disasters. In the third chapter, I also outlined the selection of methods used, including the rationale for a documentary approach and the selection of archival sources.

Chapter Four was the first of three empirical chapters. It considered Community Health Councils during the period between their introduction in 1974 and the election in 1997 of the Labour government that would abolish Community Health Councils. The chapter applied a sheepdog model to review changes and stability over time. The combination of guidance on appointments and the cross-section of appointing bodies ensured that local interest groups were members of Community Health Councils throughout this period, particularly representatives of vulnerable groups, such as people with mental health problems (Section 4.1). Considered from a sheepdog perspective, the appointment mechanisms structured membership in a way that could support local interest intermediation.

The findings in Chapter Four suggested that intermediation was very much at a local level, rather than a national level. The mediation of local interest group participation was not consistent over time, however, as from 1984 onwards local interest groups participated directly in joint consultative committees operating between health services and local authorities (Section 4.2). During the 1990s, there was a shift in policy from relying on consultation with interest groups to encouraging NHS-led selection of participants to mirror the demographic profile of a community. With the closure of Regional Health Authorities in 1995, regional offices of the NHS Executive took on the role of establishing Community Health Councils and the offices were encouraged to seek a balance of representation in terms of race, age, sex and geographical localities within the membership (Section 4.3). This incorporated a more demographic sense of representativeness of the community into the selection of members, rather than focusing on the interest groups that members represented.

The sheepdog role provides an opportunity for Ministers to avoid blame for contentious local decisions by 'passing the buck' to statutory public involvement institutions (Weaver, 1986: 379). Chapter Four presented the right of Community Health Councils to agree local hospital closures as a blame-avoidance strategy by Ministers. This was the most apparent example of blame avoidance during the period studied,

demonstrating that state-funded groups of volunteers can take the blame locally for unpopular initiatives.

Chapter Five reviewed the period from 1997 to 2010. This covered a series of transitions between statutory public involvement institutions: Community Health Councils; Patient and Public Involvement Forums; Local Involvement Networks; and plans to replace Local Involvement Networks with local Healthwatch. The chapter considered the changes in terms of a sheepdog role.

The local intermediation role has varied between the successive statutory public involvement institutions. Chapter Five opened with the final years of the Community Health Councils. The initial model for their successors, referred to as ‘patients’ forums’ in *The NHS plan*, continued to have half of the members as representatives of local interest groups and half ‘randomly drawn from respondents to the trust’s annual patient survey’ (Secretary of State for Health, 2000: 94). In practice, however, all members of the PPI Forums were recruited as individuals rather than as representatives of interest groups (Section 5.2). This meant that PPI Forums were not in a position to act as interest intermediaries, although they took steps, such as working with sign-language translators, to enable people who were members of vulnerable communities to take part in the PPI Forums directly. The relationship between interest groups and statutory public involvement institutions changed again with the creation of Local Involvement Networks. The ethos underlying LINKs was one of multiple forms of engagement, not necessarily membership. LINKs included interest groups within their networks, but, like PPI Forums, LINKs lacked statutory rights to be consulted. Without statutory rights, some LINKs chose not to participate in formal consultation exercises and some mobilised opposition to local plans (Section 5.3). Whilst LINKs incorporated more activity with local interest groups than PPI Forums, they did not mediate local interests to the same degree as Community Health Councils had done.

Chapter Five also considered the national intermediary role in the period 1997 to 2010. National roles changed with the transitions between different forms of local statutory public involvement institution. The Association of CHCs for England and Wales had rejected a national intermediary role. The PPI Forums were modeled on the basis of being supported by a national organisation, the Commission for Patient and Public Involvement in Health (CPPIH), which would recruit members for the local forums and coordinate activity between them. The CPPIH also had the potential to become a national intermediary for patient and public involvement more widely, as it was granted a role in representing national patient groups, although it was not given time to develop this role.

The Local Involvement Networks, by contrast, were set up without a national body that could take on an intermediation role.

The period 1997 to 2010 saw a shift from rights of the statutory public involvement institutions to be consulted, to a wider duty placed on the NHS to consult the public. The account in Chapter Five describes a transition from the right of Community Health Councils to be consulted, to a duty under the *Health and Social Care Act 2001* Section 11 (reiterated in the *National Health Services Act 2006* Section 242) that health services make arrangements ‘that persons to whom those services are being or may be provided are, directly or through representatives, involved in and consulted’ on plans for or changes to services. The suggestion in Chapter Five was that this did not give a specific role for statutory public involvement institutions in the process. If they did not have an allocated consultation role, the institutions were not a strong enough position to enable Ministers to avoid blame for unpopular decisions.

Whereas Chapters Four and Five reviewed the sheepdog role using the archives of the statutory public involvement institutions themselves, Chapter Six examined the watchdog role using material from public inquiries into problems in NHS hospitals. The rationale for using public inquiries data is that the evidence received by the inquiries, with Ministerial responses, provides insight at specific points in time into whether statutory public involvement institutions were expected to alert Ministers to resolvable problems before they became disasters. I selected four public inquiries to cast light on expectations at different points in time. The first inquiry, into the Ely Hospital in Cardiff, criticised the lack of systematic visiting by the Hospital Management Committee; this critique influenced the visiting rights granted to statutory public involvement institutions. The second inquiry, into the Normansfield Hospital in Teddington, was the first major inquiry following the establishment of Community Health Councils. Thirdly, the Bristol Royal Infirmary Inquiry influenced the transition from Community Health Councils to PPI Forums. The most recent inquiry selected, into the Mid Staffordshire NHS Foundation Trust, included criticisms of the former PPI Forum and Staffordshire LINK and is likely to have contributed to the replacement of LINKs with local Healthwatch.

Chapter Six opened with a review of the organisations that may have provided professional police-patrol oversight, followed by an assessment of whether the successive statutory public involvement institutions had the powers to act as watchdogs by identifying and alerting Ministers to problems. The findings in the chapter suggest that Ministers have expected the institutions to act as watchdogs, but that this expectation has not been consistent. The local Community Health Council in the Normansfield Inquiry was praised

by David Ennals for its tenacity in identifying and reporting on problems. Volunteers from the PPI Forum and Local Involvement Network in the Stafford Hospital case were asked whether they were aware that they could refer problems to the Secretary of State and Andy Burnham indicated that he would have expected the PPI Forum to inform him of any major problems when he was Secretary of State. In the Bristol Royal Infirmary Inquiry, by contrast, the watchdog role is seen as problematic because it is confrontational and so deters professionals from admitting to difficulties. No expectation is expressed in the Bristol Inquiry report that the local Community Health Council could have raised concerns about a problem that was apparent only through statistical comparison with similar services. The narrative in Chapter Six suggests that following the Bristol Inquiry Ministers focused on police-patrol oversight, including capturing data on services, and that the problems at Stafford Hospital demonstrated that a stronger watchdog role was needed alongside the professional regulatory mechanisms.

The chapter summary above suggests that, at different points in time, both the sheepdog and watchdog roles have formed part of Ministers' political management of the NHS. The value placed on the sheepdog and watchdog roles has changed over time, however, with a decline in Ministerial preference for the sheepdog role and a reappraisal of the value of the watchdog role following problems at the Mid Staffordshire NHS Foundation Trust. These trends are considered within the conclusions below.

7.2 Sheepdog decline

Ministers have placed varying value on the sheepdog aspects of statutory public involvement institutions, but the general trend has been a decline in the sheepdog role. As presented in Figure 3.1 in Chapter Three, I propose that the sheepdog role has four characteristics: mediation between local interest groups, including ensuring representation of vulnerable groups; structuring consultation on local services; focusing attention on a state-determined range of issues; and taking responsibility for unpopular local decisions. My 'sheepdog' analogy describes public involvement in terms of corporatist-style rounding up of interest groups, such as patient organisations and Leagues of Friends of particular NHS institutions, and managing involvement in ways that enable Ministers to avoid blame for unpopular decisions. Ministerial interest in the full range of sheepdog characteristics was most apparent during the 1970s and least apparent with the Patient and Public Involvement Forums. Whilst there has been increased involvement of interest groups through Local Involvement Networks and local Healthwatch, this has not been as explicitly

an intermediation role as it was for the Community Health Councils. This section considers each of the sheepdog characteristics and the overarching decline.

Interest group intermediation seemed to be valued most during the 1970s, at a time of small governmental majorities and considerable unrest following the oil crisis. The appointment structures for Community Health Councils ensured that the voluntary members would be representatives of local interest groups. In case representatives of vulnerable groups were not selected as members by local authorities and local voluntary organisations, Regional Health Authorities were expected to use their sixth of appointments 'to honour the Secretary of State's obligations to allocate places on CHCs to certain organisations in order to ensure continued representation of special interests' (Department of Health and Social Security, 1974a: §15). The appointment mechanisms created a degree of local ownership of the appointments process: with half of the members appointed by local authorities; a third by local voluntary sector organisations; and a sixth by the Regional Health Authority. This local involvement, particularly the requirement that voluntary organisations should 'agree amongst themselves how the places to be filled by them should be allocated', ensured a corporatist-style intermediation in the creation of CHCs that could form the basis of further mediation (Department of Health and Social Security, 1974a: §14).

During the 1970s, Ministers referred local interest groups that had concerns about health services to their Community Health Council and discouraged them from approaching NHS organisations directly (Malin, 1978). At this early stage, Ministers' actions suggest that they valued statutory public involvement institutions as local intermediaries. Over time, however, the Community Health Councils applied their sheepdog skills to coordinating opposition. The rogue sheepdog behaviour of Community Health Councils meant that they could not be depended upon to intermediate. In addition, the value placed on the intermediation role lessened over time, with greater direct involvement from the 1980s onwards of the voluntary sector in decisions about health services and the increase, particularly from the 1990s, in the number of health or social care services that voluntary organisations were contracted to provide on the behalf of the state. Where interest groups were providers of services for the state, this could be argued to influence their perspective on local service provision, leading to greater emphasis on participation by ordinary members of the public rather than interest groups.

The second characteristic of sheepdogs is that they structure the local consultation process. At points when interest groups are seen by Ministers as needing to have their involvement moderated, this structuring is valuable. Seen from the perspective of

collective voice input into decision-making in the NHS, the structured consultation aspects of a sheepdog role ensure that the input is received in a form that can be processed by NHS personnel. In effect, the intermediation aspects of structured consultation mean that differences of opinion between interest groups are worked through by the interest groups themselves under the auspices of the statutory public involvement institution. This is of less value to Ministers if they prioritise learning from individual consumers over the input of collective voices. The Griffiths report in 1983 marked a turning point, with a new focus on the need to learn from consumer feedback (Department of Health and Social Security, 1983). From this point onwards, statutory public involvement institutions became mechanisms to gather the views of consumers, alongside NHS-led engagement and market research. Seen in these terms, the input of statutory public involvement institutions was layered with other forms of feedback to inform managers about the quality of services. This meant that their input contributed to consumer feedback, but may not have been valued as a means to filter or coordinate comments from interest groups.

Throughout the period studied, statutory public involvement institutions have retained a state-determined remit, the third of the sheepdog characteristics. Whilst Local Involvement Networks were given more freedom in terms of organisational structure than their predecessors, the breadth of their remit was still determined by the state. The breadth of the successive remits seems to have changed in line with wider Ministerial concerns: after the cultural issues identified at Bristol Royal Infirmary, PPI Forums were established to develop relationships with specific NHS trusts; and Local Involvement Networks were granted remits across both health and social care when the trend was towards creating more integrated patient experience that covered both health and social care services. The remits were all local, whether health services for Community Health Councils, specific NHS trusts for PPI Forums or the combination of health and social care services for Local Involvement Networks. In practice, however, Community Health Councils extended beyond their local remit as the activity of the Association of CHCs for England and Wales enabled them to identify national trends. This national facilitative role was rejected and replaced by a more formal management through the Commission for Patient and Public Involvement in Health, followed by a framework in which the Local Involvement Networks had no national body. Keeping the remit as essentially local has been a consistent part of the Ministerial steer given to statutory public involvement institutions.

In developing the sheepdog model for this study, I incorporated blame-avoidance characteristics as the fourth dimension to the role. Like the herding dog of the analogy, a

sheepdog keeps participants penned so that they can be managed. A managed local group can be used to keep problems at a distance from the Minister. Whereas other aspects of the role drew on Schmitter's model of state corporatism, this fourth characteristic was taken from the blame-avoidance literature (Schmitter, 1974; Weaver, 1986). In common with the intermediation aspects of statutory public involvement institutions, the blame-avoidance role seems to have been utilised and valued by Ministers most during the 1970s. If a Minister is to 'pass the buck', they either have to trust the institution to which the decision has been delegated or to be willing to take the risk of an outcome with which they might not agree (Weaver, 1986: 385). In instances where costly decisions are delegated to intermediaries, Ministers need to be able to trust that the institutions will undertake effective intermediation to reduce the risk of criticisms being raised by individual interest groups. Costly decisions are only likely to be delegated to an intermediary body, therefore, if it is a strong intermediary. In Chapters Four and Five, the most likely evidence for statutory public involvement institutions as blame-avoidance mechanisms was found in the case of their rights to agree local hospital closures. This took a responsibility from the Secretary of State and placed it directly with the Community Health Councils. Whilst the statutory public involvement institutions were not authorised to agree hospital closures after 1985, the strength of this blame-avoidance example suggests that the creation or re-shaping of state-funded voluntary bodies provides an option for Ministers that adds to the models in the literature on blame avoidance.

Considered overall, the sheepdog role seems to have been valued most by Ministers at points when there has been a small parliamentary majority. As the NHS is revered by the public, issues raised by interest groups at a local level could have a significant impact in marginal parliamentary constituencies. With a Coalition government, with no overall majority in Parliament, overseeing the transition from Local Involvement Networks to local Healthwatch, it is possible that a stronger intermediary could be integrated into the next generation of institutions. Trends in consumerism and interest group activity outlined below, however, suggest that there is unlikely to be a marked return to the sheepdog role and that it is the watchdog role that is likely to be of interest to Ministers in the development of local Healthwatch.

The decline in the sheepdog role seems to be connected to greater emphasis on the service user as a consumer. As a consumer, an individual provides feedback on their personal experience of service quality. This is a very different role from that of a citizen involved in decisions about the future of health services. Part of the consumer role is to choose their preferred service or service provider. Trends from these choices are

analysed to inform service development, rather than engaging service users either individually or collectively in voicing their preferences (Williamson, 2010: 122-125; Coulter, 2011: 22-26). This is a different form of involvement from that provided by the statutory public involvement institutions, as it emphasises learning from the exit or choice dimensions of Hirschman's model (Hirschman, 1970). Ministers who value individual patient choice as a mechanism may not value the collective voice facilitated by statutory public involvement institutions in sheepdog mode.

The politics of interest group engagement have also changed. At the national level, patient organisations have become more influential and Ministers have sought direct engagement with them. At the local level, some interest groups are contracted to provide state services, which complicates the nature of their involvement in decisions about the future of local services. The experience of the Local Involvement Networks suggests that where voluntary sector organisations are contracted to provide services, the statutory public involvement institutions facilitate their involvement in care provision rather than taking a pure intermediation role in representing their interests as part of consultation on service developments.

The case of statutory public involvement institutions demonstrates that state-funded voluntary groups may take on a sheepdog role, but that creating a framework for intermediation is risky for Ministers as the sheepdog may use its powers to round up opposition rather than to control it. The discussions in Chapters Four and Five include examples of each of the successive statutory public involvement institutions facilitating opposition to proposed reforms. With the transition to local Healthwatch, I suggest that the watchdog role is the main focus of Ministerial interest in statutory public involvement institutions.

7.3 Watchdog reappraisal

I drew upon the legislative oversight literature for the characteristics of the watchdog role, taking the 'watchdog' terminology from documents produced by statutory public involvement institutions and applying this to the fire-alarm analogy developed by McCubbins and Schwartz. This watchdog is not a formalised regulator, but a means by which issues can be identified and referred by volunteers committed to assuring the quality of their local services. As I outlined in Figure 3.2 in Chapter Three, the watchdog has four characteristics: gathering intelligence so that it can identify problems in services; influencing decisions about local services; challenging local decisions, including referring

unresolved issues; and filtering significant issues from the concerns raised by interest groups and others. The trend in the value placed by Ministers on a watchdog role seemed to be in decline, outweighed by the emphasis on police-patrol regulation and the improvement in data collection and statistical comparison following computerisation. I suggested in Chapter Six, however, that the watchdog role is being reappraised following the failure of data-based mechanisms to alert Ministers to problems at the Mid Staffordshire NHS Foundation Trust.

The ability to gather intelligence and identify problems is essential to the watchdog role. Throughout the period from 1974 to 2010, statutory public involvement institutions had rights to enter and inspect NHS premises. These rights were extended with the creation of Local Involvement Networks to include premises in which social care took place, with the exception of individuals' homes. On the premise that any problems would be visible, these rights provide statutory public involvement institutions with the means to act as watchdogs. Following the inquiry into the deaths of babies at the Bristol Royal Infirmary, the emphasis on data collection increased, as the higher than expected number of deaths was only apparent through statistical comparison. Collation of data and statistical comparison shifted Ministerial preference towards a police-patrol model for oversight of NHS services. Much of the quality of care depends upon the quality of interactions between NHS personnel and patients. The quality of interactions is generally observable and may not be apparent through completed responses to patient experience surveys. The experience at the Mid Staffordshire NHS Foundation Trust demonstrated that services need to be observed by people with local knowledge and local relationships who can compile the narrative to explain any trends in data and establish whether local concerns amount to significant problems. The Ministerial preference therefore seems to have shifted back towards a watchdog role with the new local Healthwatch. As discussed below, however, the new watchdog model places the central body for Healthwatch, Healthwatch England, within the police patrol for the NHS and social care.

Complaints provide a specific form of intelligence on problems in services. Statutory public involvement institutions were not granted statutory powers over complaints management at any point in the period between 1974 and 2010. In practice, however, Community Health Councils acted as a 'patient's friend' and provided support to complainants who were experiencing problems in the NHS. Supporting complainants provided Community Health Councils with a valuable insight into problems in local NHS organisations. Complaints could be monitored to identify trends. As the NHS started to take a more consumerist approach to public involvement during the 1990s, however, the

complaints management processes within the NHS were improved so that managers could refine services on the basis of customer feedback. When CHCs were abolished, their informal complainant support activity was transferred to Patient Advice and Liaison Services (PALS). As services within the NHS, PALS were able to ensure that problems were addressed swiftly and that NHS managers received information from the complaints to enable them to improve services. With the advent of PALS, the PPI Forums and Local Involvement Networks had limited access to information from complaints. As part of the reappraisal of the watchdog role, local Healthwatch will have access to data through the Care Quality Commission. On the basis of the data used by Community Health Councils, it is possible that this may include information about complaints.

The second characteristic of the watchdog is that it needs to be able to influence local decisions about health services, in order to prevent or resolve problems. The ability of statutory public involvement institutions to influence local decisions has not been consistent. A criticism of the institutions on an ongoing basis seems to have been their variability; the House of Commons Health Committee found that both Community Health Councils and PPI Forums had been accused by Ministers of variability (House of Commons Health Committee, 2007a: 31). If perceptions of statutory public involvement institutions vary locally, their ability to influence local services is also likely to vary. To counter this perceived variability, statutory public involvement institutions seem to have been layered with other means of public involvement in quality mechanisms. This has included involvement in the development of NICE guidelines at the national level and the inclusion of patients in teams of peer reviewers assessing whether services meet standards for particular medical conditions at the local level. Election to the boards of Foundation Trusts could also be interpreted as a means of involving members of the public in decisions about the quality of local services. With the transition to local Healthwatch, representatives of the statutory public involvement institutions are included in the Health and Wellbeing Boards. Inclusion in the Health and Wellbeing Boards will integrate local Healthwatch into processes for reviewing local service issues and the needs of the local community. This change may again reflect a strengthening of the watchdog role.

Watchdogs need to be able to challenge and to refer unresolved problems if they are to be able to prevent avoidable disasters. Community Health Councils retained the right to refer issues to the Secretary of State throughout their history. The Patient and Public Involvement Forums had the right in legislation to refer issues either nationally or locally, through the Commission for Patient and Public Involvement in Health and the Overview and Scrutiny Committees of local authorities. The Local Involvement Networks

referred issues through the Overview and Scrutiny Committees. If Ministers are to benefit from a watchdog, they need either to be confident that local mechanisms will resolve any issues raised by the watchdog or to have a means to hear from the watchdog promptly. Community Health Councils had the clearest rights of referral direct to Ministers, but they may have over-used this right from a Ministerial perspective. The rights of PPI Forums included referral to Ministers through the Commission for Patient and Public Involvement in Health, although they could also escalate local issues through the Overview and Scrutiny Committee of their local authority. Taken with the referral process for LINKs through Overview and Scrutiny Committees, the trend has distanced the referrals from the Minister. Even the transition to Healthwatch, discussed below, has continued to distance the referral from the Minister, as issues are raised through Healthwatch England based within the police-patrol organisation, the Care Quality Commission. This strengthens the ability of statutory public involvement institutions to raise concerns at a national level, but in a manner that retains a distance from the Secretary of State.

The fourth characteristic of a watchdog is its ability to filter significant issues from the range of concerns raised about local services. This filtering role is closely linked to the watchdog intelligence-gathering function and to the sheepdog intermediation role, as the sheepdog learns of concerns raised by local interest groups. McCubbins and Schwartz refer in their modelling of fire-alarm oversight to the ability to facilitate 'collective action by comparatively disorganised groups' (1984: 166). Hopenhayn and Lohnmann raise the concern that better-resourced groups may be in a better position to ensure that their views are heard (1996: 209). Whilst McCubbins and Schwartz were not explicit about the nature of collective action in their fire-alarm model, I interpreted it within the watchdog as a process whereby the watchdog collates views from a range of sources, including 'comparatively disorganised groups', and filters the significant issues to be raised as concerns. The membership structure for Community Health Councils ensured that the organisations themselves reflected a range of interests, but the CHCs also sought information from the public and additional interest groups. Patient and Public Involvement Forums did not formally include members of interest groups and could only seek feedback on the NHS trusts to which they were attached. The Local Involvement Networks were developed in a way that encouraged a filtering-style intermediation, as interest groups could be members of LINKs and could increase or reduce their involvement depending on the issues that were of concern to them. Individuals and groups who are part of LINKs are being encouraged to transfer into local Healthwatch, maintaining a pool of people to provide feedback on local health and social care services. The successive statutory public

involvement institutions have had differing structural relationships with interest groups, but they have all had the ability to gather and filter information from them.

Voluntary members of the former Stafford Hospital PPI Forum and the Staffordshire LINK were called to give evidence to the Mid Staffordshire NHS Foundation Trust public inquiry. The questions they were asked and the comments of the former Secretary of State, Andy Burnham, suggest that a more active watchdog role was expected. The transition to local Healthwatch seems to demonstrate that a greater Ministerial value is being placed on the watchdog role. It is a watchdog on a slightly different model, however. In the legislative oversight literature, a voluntary watchdog (or fire alarm) is presented as separate from and complementary to a professional police patrol (McCubbins and Schwartz, 1984). In the case of local Healthwatch, the local groups are connected nationally to Healthwatch England, which is a statutory committee within the Care Quality Commission (Department of Health, 2012b: 5). Any major issues will be referred by local Healthwatch through Healthwatch England and thus integrated into the police patrol function of the Care Quality Commission. The referral processes for major problems are thus transferred through the police patrol in the first instance, rather than going immediately to the Secretary of State. The local Healthwatch groups will gain from access to the data and analysis skills of the police patrol (Department of Health, 2012b: 7). They will not, therefore, be as dependent on observation to identify issues, but may be able to identify or contextualise potential problems for the police patrol. This is a model that adds to the existing understanding of oversight options in the legislative oversight literature.

7.4 Combining sheepdog and watchdog roles

The extent to which statutory public involvement institutions have combined the sheepdog and watchdog roles has varied over time. In this section, I consider the issues around combined roles, including the activity of volunteers, intermediation and feedback mechanisms.

Community Health Councils combined the sheepdog and watchdog roles, as they both acted as interest group intermediaries and also alerted Ministers to unresolved problems in NHS services. Both of these roles were weakened over time: CHCs were rejected as sheepdogs by Ministers when they coordinated opposition; and police patrols were preferred to watchdogs as an indicator of problems in services. Patient and Public Involvement Forums fulfilled a weaker watchdog role, they also did not have the interest

group membership or connections to act as sheepdogs. There was an element of a combined role in the Local Involvement Networks, as LINKs included interest groups as members as well as providing feedback on services. The evolution of voluntary sector organisations as providers of services for the state, however, complicated the extent to which LINKs could fulfil either a sheepdog or a watchdog role.

Taken from the perspective of the elements that are common to both the sheepdog and watchdog roles, both involve activity undertaken by committed volunteers. The watchdog benefits from the passion of the volunteers in identifying potential problems in services, taking time to get to know the services and to gather feedback. The sheepdog role may benefit from volunteers in different ways: if the members are representatives of interest groups, they can support intermediation; and if the core activity is seen by other voluntary groups to be undertaken by volunteers, the sheepdog may be taken more seriously as an intermediary. The commonality of volunteer roles may make it apparent that a sheepdog and a watchdog can be combined. Just because both roles involve volunteers, however, does not necessarily mean that they are most effective in combination. The development of volunteer-led institutions means that Ministers need to be able to trust that interest intermediation and service review can be delegated to unpaid workers. As discussed in the triggers for reform (Section 7.5 below), this creation of volunteer-led institutions also makes them difficult to abolish in a true sense.

The sheepdog and watchdog models both include intermediation elements: in the sheepdog, it is a formal intermediation between interest groups; in the watchdog, the concerns of different interests are filtered so that significant issues are raised. The fact that they both mediate interest groups involvement may make a combined role seem appropriate. They are, however, different forms of intermediation. The sheepdog rounds up the activity of interest groups in order to ensure representation of vulnerable groups and to manage opposition to changes. This is an active form of intermediation in which the sheepdog interacts and negotiates with the interest groups. The intermediation aspect of the watchdog model treats intermediation as a means to filter issues from different sources in order to establish issues that are significant problems across the population, rather than just concerns for a specific interest group. As discussed below, the watchdog may be stronger for having the interest group relationships of a sheepdog, but the filtering role played by a watchdog may create difficulties for the negotiations undertaken by a sheepdog. Conversely, if a watchdog identifies significant problems, the coordination capability of a sheepdog may lead to a confrontational situation, with the sheepdog acting on the behalf of concerned interest groups, rather than intermediating between the groups

and relevant authorities. The two forms of intermediation may therefore not operate together in ways that support Ministerial preferences for sheepdog and watchdog roles.

A watchdog may potentially be stronger for being part of a sheepdog, as interest groups provide information and can support monitoring of specialist services. The sheepdog also ensures that the concerns of vulnerable or minority groups are represented (Klein, 1984: 30). If Ministers see public involvement as a democratic mechanism, collective feedback from interest groups may be viewed as part of a means to hear collective concerns from groups of citizens. If public involvement is interpreted as being part of consumerism, however, it is individual patient feedback rather than collective interest group feedback that is sought. Consumer comments that are gathered by NHS personnel can be integrated into internal quality improvement options (Hirschman, 1970). As discussed under the reappraisal of the watchdog role in Section 7.3, complaints provide a valuable form of intelligence to watchdogs. A watchdog will use the complaint as a source of information to identify problems and to assess whether there are issues over time that are not being addressed locally. Where the watchdog is combined with a sheepdog, the sheepdog may use this information about poor services to coordinate campaigns. Perceptions that a sheepdog might coordinate opposition, rather than intermediate, could therefore put the watchdog at risk if it is part of a combined model. There is a fine balance in the combined model between the benefits to a watchdog of the sheepdog's links within interest groups and the risk that the sheepdog aspects of a combined role may generate opposition and reduce the overall value to Ministers of the statutory public involvement institution.

Each of the successive statutory public involvement institutions has included differing degrees of combination between the sheepdog and watchdog roles. Whilst both roles involve working with volunteers and include mediating between interest groups, the combination of a watchdog's ability to identify problems with a sheepdog's powers to coordinate activity may lead to confrontation and make the combined role unattractive to Ministers.

7.5 Triggers for reform

This study opened with the puzzle of ongoing investment in funding and reforming statutory public involvement institutions. Analysis of documentary sources shows that the institutions have been valued by Ministers as sheepdogs and as watchdogs, although the sheepdog role has declined over time and the watchdog role seemed before the problems

at the Stafford Hospital to be being replaced by a stronger preference for police-patrol regulation. There are examples of Ministers valuing the roles, such as referring hospital closure issues to the Community Health Councils, but there have also been periods when the statutory public involvement institutions have ceased to be politically useful and have been the subject of reform themselves.

Considered throughout the period from 1974 to 2010, there have been three points at which the institutions have been reformed and replaced and one point, with the *Patients first* consultation in the early 1980s, when abolition was overtly considered. The active support for Community Health Councils in response to the 1980s consultation made it difficult to abolish the institutions. As volunteer-led organisations, they have remained hard to abolish in a true sense, since the institutions enable volunteers to develop skills that they may take on to the next statutory public involvement institution or into other groups in the voluntary sector. The nature of the volunteer engagement may have meant that Ministers felt that they had to replace the institutions in a formal sense, rather than risk finding that volunteers had set up alternative public involvement institutions over which they had no control.

If the statutory public involvement institutions cease to be politically useful, they can either be ignored or replaced. Both of these options are costly. In the early 1980s, Conservative party Ministers considered abolishing Community Health Councils. When the popularity of the CHCs made them difficult to abolish, the Conservative governments of the 1980s and 1990s largely ignored the Community Health Councils, layering their influence with alternative forms of public involvement. When organisations with sheepdog skills sense that they are being ignored, however, there is a risk that they will mobilise opposition. This opposition has included campaigns that are embarrassing to Ministers, such as coordinating the Casualty Watch activity to raise awareness of the length of time that patients had to wait on trolleys in hospitals as there were no beds available. Where the statutory public involvement institutions felt that they were themselves under threat, the likelihood was that they would use their sheepdog skills to mount campaigns to retain their roles.

Abolition was first considered publicly in the *Patients first* consultation. This took place when the Conservatives had a majority of 43 seats, which gave them a greater majority than the preceding Labour government (which had had a majority of just four seats), but still a modest majority. As discussed in Section 4.2, responses to the *Patients first* consultation from both professionals and the public were supportive of Community Health Councils. As part of a Government with a small majority, Ministers may have felt

that they could not counter the wishes expressed in a public consultation. They were able, however, to reduce the coordination capabilities of the Association of CHCs for England and Wales by cutting the funding for *CHC News* and the associated information service. The potential abolition was considered as part of a reform to reduce the layers of bureaucracy in the NHS. Abolition at this point would have muzzled opposition to radical options that the Conservative government was considering for funding the NHS.

The first abolition of a statutory public involvement institution took place when Labour had a majority of 179 seats; the strength of this majority may have given Ministers the confidence to abolish Community Health Councils, although the CHCs' activities were replaced. It is possible that as part of a strong Government, Labour Ministers were less concerned about the electoral dimensions of local interest group management; and following the Bristol Royal Infirmary Inquiry they placed less value on the watchdog role. At a national level, patient organisations and other interest groups also had more influence and were included in the teams overseeing the modernisation of the NHS. The abolition formed part of the major reforms of *The NHS plan* and the energy that Community Health Councils put into fighting abolition deflected their activity from opposing other aspects of the reforms.

The abolition of Patient and Public Involvement Forums also took place under a Labour government, but one with a more modest majority of 66 seats. Between the point of their establishment in December 2003 and the announcement in July 2006 that they were to be abolished, the PPI Forums did not have a great deal of time to establish a network of influential supporters. Interest groups had been represented on and responded to the expert panel that advised on the transition to Local Involvement Networks, whereas they had had no direct involvement in the PPI Forums; so interest groups were likely to be supportive of the transition. The abolition of PPI Forums coincided with changes that included new commissioning arrangements. Long-term contracts were being put in place with significant ramifications for local services. As Sharon Grant advised the House of Commons Health Committee, the timing of the PPI Forum abolition meant that the public were largely excluded from long-term contracting decisions (House of Commons Health Committee, 2007a: 49).

The announcement in 2010 that Local Involvement Networks would be transferred into local Healthwatch was slightly different: as there was no overall majority following the 2010 General Election, the announcement was made by a Conservative-Liberal Democrat Coalition government. Unlike previous changes, this was explicitly announced as a transition, rather than abolition followed by replacement. The softer transition may be due

to the combination of a less secure Government and the weaker position of the statutory public involvement institutions following successive changes. My analysis of the watchdog role also suggests that the emphasis of this most recent reform is on improving the watchdog function, whereas the emphasis in earlier changes may, as discussed below, have been on reducing the risk that a sheepdog would mobilise opposition to wider reforms. Like the earlier transitions, the shift from LINKs to local Healthwatch takes place as part of a major reform to the NHS, with the introduction of the *Health and Social Care Act 2012*. As with the earlier changes to public involvement, revising the statutory public involvement institutions moderated potential opposition at a point of major change.

With the exception of the transition to local Healthwatch, the changes have occurred when governments have been sufficiently secure to risk alienating interest groups and voluntary members of the statutory public involvement institutions. They have also taken place at times of major change to the NHS. The contemplated change on which the *Patients first* consultation took place was the reform of the NHS to create smaller administrative units through District Health Authorities. The abolition of Community Health Councils was included in *The NHS plan*, which announced increased investment in the NHS on the condition that extensive modernisation took place. The PPI Forums were abolished at the point when commissioners were establishing contracts for services on a new model, in which the Primary Care Trusts held budgets for services in hospitals. The abolition of Local Involvement Networks forms part of the *Health and Social Care Act 2012*, which changes the commissioning and accountability structures across the NHS. If volunteers in the statutory public involvement institutions were likely to coordinate opposition to the wider reforms, Ministers may have judged that reshaping the statutory public involvement institutions at the same time as the other reforms would weaken the ability of volunteers to oppose these wider reforms.

The timings of the changes suggest that they were triggered by Ministers' desire to minimise opposition to wider reforms. The powers granted to a sheepdog enable it to mobilise opposition if it objects to Ministers' proposals. Considered from the perspective of the welfare state retrenchment literature, Ministers contemplating NHS reforms would make changes to statutory public involvement institutions to distract them or limit their ability to mobilise opposition to the wider reforms (Pierson, 1994: 19). The abolitions of Community Health Councils and PPI Forums can be understood in these terms, making the statutory public involvement institutions subject to political management as well as playing roles in political management of the NHS. The transition from Local Involvement Networks to local Healthwatch also coincides with a major reform to the NHS. In the case

of the move towards local Healthwatch, however, I suggest that the successive changes had weakened the ability of LINKs to act as rogue sheepdogs and that the focus of the most recent reform is on reshaping the watchdog role.

7.6 Close: roles in political management of the NHS

In this study, I questioned whether statutory public involvement institutions had played roles in political management of the English NHS during the period from 1974 to 2010. I identified two potential roles from the political science literature, which I described using the analogies of a ‘sheepdog’ and a ‘watchdog’. I examined the archives of statutory public involvement institutions to assess whether the institutions had acted as sheepdogs, rounding up participants and managing potential opposition; and I explored whether they had been expected to act as watchdogs to prevent disasters, drawing on the accounts in NHS inquiries.

On the basis of the findings presented in the study, I propose that there is evidence that statutory public involvement institutions have been valued by Ministers as tools to support them in political management of the NHS. The roles have not been valued consistently over time: developing volunteer-led organisations is risky, as the volunteers cannot be managed in the same way as paid personnel and, similarly, their activity cannot be stopped. Nonetheless, the creation of corporatist-style intermediation through sheepdogs and observation-based oversight by watchdogs provides Ministers with tools that can coordinate local participation by the public and enable Ministers to manage expert health professionals, by alerting the Ministers to problems.

As discussed in this chapter, there are four main conclusions arising from this study. Firstly, the Ministerial value placed on the sheepdog role has declined over time. Secondly, the preference for oversight mechanisms also seemed to have transferred from the voluntary watchdogs to a professional police patrol, but I suggest that the problems at the Mid Staffordshire NHS Foundation Trust have renewed interest in the watchdog role. Thirdly, whilst the sheepdog and watchdog roles are both volunteer-led and involve working with local interest groups, combining the two roles has proved problematic for Ministers, as the knowledge of a watchdog may be a threat when combined with the potential of a sheepdog to mobilise opposition. Finally, the sheepdog powers granted to statutory public involvement institutions mean that they may be seen as a potential threat at times of major reforms to the wider NHS, as a rogue sheepdog could round up

opponents to the reforms, so changes to the institutions have been timed to limit the ability of the statutory public involvement institutions to mobilise opposition to wider reforms.

The scope of this study was confined to the NHS in England. It is therefore possible that statutory public involvement institutions for the NHS in other parts of the UK or for other public services may not fulfil the same roles in political management of services. The findings here, however, indicate that statutory public involvement institutions have been valued by Ministers at different points in time for their sheepdog and watchdog roles. This may suggest that either the sheepdog or the watchdog role is played by state-sponsored and volunteer-led institutions in other public services. The study adds to the corporatist and blame-avoidance literatures by providing an example, in the sheepdog role, of a volunteer-led intermediary with statutory powers that can be sufficiently authoritative to take the blame for local decisions. I also propose that a watchdog (or interest group involved in fire-alarm oversight) may be a state-funded body rather than an independent interest group as presented in the legislative oversight literature, which provides opportunities for politicians to determine the information to which the institutions have access and to grant institutions powers to filter concerns raised by different issue-specific interest groups.

The findings provide a complementary perspective to existing studies of statutory public involvement institutions in the NHS. The sheepdog role builds upon the issue of managing local representation, particularly of vulnerable groups, in the literature on public involvement in health (Klein and Lewis, 1976: 38; Klein, 1984: 30; Bates, 1982: 97; Hogg, 2007: 132). Similarly, the watchdog role extends an aspect of the existing literature on monitoring service quality (Klein and Lewis, 1976: 122; Hogg, 1999: 91). In both cases, the roles outlined in this study relate to the statutory powers granted to the institutions, treating statutory public involvement institutions as a distinctive form of public involvement.

The conclusions to this study demonstrate that the statutory powers granted to the institutions gave them the capability to contribute to political management of the NHS, but Ministerial utilisation of this has varied. In their early days, Community Health Councils were clearly valued by David Owen as Minister for Health:

‘The doctors themselves were highly sceptical of any consumer “watch-dog”. Councillors were anxious in case a “consumer voice” might be an attempt to undermine the role of the democratically elected local representative and their ability to represent the views of the electorate. My own view is that the decision to establish Community Health Councils will probably be looked back on by social historians as the most significant aspect of the whole of the *National Health Service Reorganisation Act* of 1973. For the first time there exists a strong consumer voice to both criticise and champion the NHS.’ (Owen, 1976: 17-18)

The quotation from Owen's *In sickness and in health* distinguishes between a watchdog role, reporting on the activity of health professionals, and a collective consumer voice, or sheepdog role. Owen's prediction that founding Community Health Councils 'will probably be looked back on by social historians as the most significant aspect of the whole of the *National Health Service Reorganisation Act*' has proved over optimistic. As Hogg reports, 'CHCs now barely receive a mention in books on health policy' (2009: 58). I mentioned in the opening to Chapter One that statutory public involvement institutions represent a substantial financial commitment, with £4 million invested annually in 1974 and £24.4 million in 2010 (Department of Health and Social Security and Welsh Office, 1979; Commissioning, Analysis and Intelligence Team, 2010). Taken in terms of public involvement, this ongoing investment is a puzzle in the context of the growth of NHS-led and self-generating alternatives. Considered as sheepdog and watchdog tools, however, their statutory powers and state-funded status mean that statutory public involvement institutions can contribute to Ministers' political management of the NHS. Conversely, the control Ministers hold over the institutions' funding and powers means that they can reshape the institutions to suit their agenda. Statutory public involvement institutions are therefore both part of and subject to political management.

Appendix: Archive sources

All items used in this study are fully referenced within the bibliography. This appendix provides an overview of relevant archives.

A. Archives for statutory public involvement institutions

Community Health Councils

CHC News (journal)

Hard copies held in the library at the Wellcome Trust

ACHCEW archive

Archive of document images on CD-ROM at the Wellcome Trust library, *The golden age of patient and public involvement, 1974-2003*, referenced as computer media 55

Some hard copy publications held in King's Fund library

Patients' Association archive

The archives held by the Patients' Association on Community Health Councils, 1974-1983, and NHS Reorganisation, 1972-1984, include correspondence relating to the establishment of CHCs and ACHCEW that are not covered within the ACHCEW CD-ROM archive. The Patients' Association records also include copies of guidance issued to NHS personnel and to the voluntary sector on the establishment of Community Health Councils. The Patients' Association archives are held at the Wellcome Trust. Principal files relating to Community Health Councils are:

SA/PAT/C/10 – Community Health Councils, 1974-1983

SA/PAT/D/37 – NHS reorganisation, 1972-1984

SA/PAT/C/3 [4 boxes/files] – ACHCEW, 1979-1986

Papers from individual Community Health Councils

Local authority archives – searchable through <http://www.nationalarchives.gov.uk/a2a>

King's Fund Library

Wellcome Trust library

Royal London Hospital archives

Patient and Public Involvement Forums

***Forum Focus* (journal)**

Copies available on archived copy of Commission for Patient and Public Involvement in Health website through the National Archives,

<http://webarchive.nationalarchives.gov.uk/20080313140813/http://www.cppih.org>

PPI Forum archive

Online to January 2011 at <http://www.lx.nhs.uk> but no longer available

Reports, particularly annual reports, for some PPI Forums held on hospital websites and local authority websites

Some documents held by the King's Fund library

Commission for Patient and Public Involvement in Health archive

Website with minutes of meetings and published reports archived through the National Archives (the fullest version of the website is dated 13 March 2008)

<http://webarchive.nationalarchives.gov.uk/20080313140813/http://www.cppih.org>

Local Involvement Networks

LINKs archive

Archive of reports and e-communications at <http://www.lx.nhs.uk>

NHS Centre for Involvement

Resources online until July 2011 at <http://www.nhscentreforinvolvement.nhs.uk> but no longer available

Guidance notes produced by the NHS Centre for Involvement are included on the websites for some individual Local Involvement Networks

B. Archives for NHS inquiries

Ely Hospital Inquiry – unusual for a report of its date in being published in full. Access to the original aided by the Socialist Health Association digitisation of the resource, held at <http://www.sochealth.co.uk/history/Ely.htm>

Archive of sources for the inquiry is held at the National Archives in Kew, but with closed access until January 2025. National Archives piece reference BD 18/2527

Normansfield Hospital Inquiry – report published in full and accessed through King's Fund library (Item held in offsite storage: HOOU:QYA).

Archive of transcripts and evidence from the inquiry held (hard copy only) at the London Metropolitan Archives and released for public access in January 2009. Key files relating to the involvement of the Community Health Council in the Normansfield Hospital Inquiry are H29/NF/F/06/008, H29/NF/F/07/007 and H29/NF/F/07/008

Bristol Royal Infirmary Inquiry – archive of evidence and transcripts with the full report online. The search facility does not search text within the evidence supplied. The inquiry included a series of seminars; one of these, seminar 7, was on 'empowering the public in the healthcare process' and the archive includes a range of position papers generated to inform the seminar.

<http://www.bristol-inquiry.org.uk/index.htm>

Mid Staffordshire NHS Foundation Trust

Evidence to the Healthcare Commission inquiry was presented in confidence and weekly summaries of oral evidence were given for the independent inquiry, but full text of the transcripts and evidence for the full public inquiry are available online, with links to earlier reports. The search facility on the public inquiry site does not search text within the PDFs of evidence supplied, but the itinerary for the hearings indicates which participants belonged to the PPI Forum or the Staffordshire LINK.

Independent inquiry: <http://www.midstaffsinquiry.com>

Public inquiry: <http://www.midstaffspublicinquiry.com>

Documents for the separate inquiry into the Staffordshire Local Involvement Network are included on the websites for Patient and Public Involvement Solutions (which undertook the review) and Staffordshire County Council.

<http://patientpublicinvolvement.com> and <http://www.staffordshire.gov.uk>

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