A RESOURCE PACK FOR OVERVIEW AND SCRUTINY COMMITTEE MEMBERS

FINAL DRAFT

PART 1

UNDERSTANDING THE CHANGING STRUCTURES OF THE NATIONAL HEALTH SERVICE

PART 2

THE LEGACY OF COMMUNITY HEALTH COUNCILS

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APPENDICES

ASSOCIATION OF
COMMUNITY HEALTH COUNCILS
FOR ENGLAND & WALES

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FOREWORD

For over a quarter of a century Association of Community Health Councils of England and Wales (ACHCEW) has offered a training programme for CHC members. The aim of this has been to enable the members to fulfil their roles effectively. The key skills needed to be an effective CHC member include the abilities to look at healthcare services from the perspective of users and carers, listen to the views of people from all areas of the community and represent their views to those who plan and manage health services. It follows that this requires a sound knowledge of the structures of the NHS.

One of the most popular ACHCEW training days for both experienced and inexperienced members has been "Understanding the Changing Health Service". We have found that even those with a wealth of experience in the NHS have found it difficult to keep up with the changes in the way our healthcare is provided and structured.

ACHCEW was commissioned by the Department of Health to produce a training resource pack to support the implementation of local authority review and scrutiny of healthcare provision. The aim of the pack is:

- to provide an overview on the structure of the NHS for use by the members of Overview and Scrutiny Committees (OSCs) across England
- to ensure that OSCs have the benefit of Community Health Councils' years of experience of scrutinising health services

The pack needed to be easily understood by those new to this work and in a format which can be easily updated. We therefore decided to opt for this A4 format with loose leaf pages which can be simply replaced when the information needs amending.

Community Health Councils have had a long and close relationship with Local Authorities. A third of current CHC members are drawn from Local Councils. This project enabled ACHCEW to continue both its constructive relationship with Local Authorities and to ensure that its most important legacy, the skills and experience of its staff and membership, is passed on to those who can best make use of it: the new Overview and Scrutiny Committee members.

This pack was written by Christine Sheppard and Beryl Furr for ACHCEW and the Dept of Health. Part one was originally devised by Ros Levenson who is a freelance consultant and trainer.

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We are also grateful to the Department of Health for funding this project.

We hope that the users of this pack will find it a helpful resource in guiding them into their new roles as OSC members.

ACHCEW
December 2002

PART 1

UNDERSTANDING THE CHANGING STRUCTURES OF THE NATIONAL HEALTH SERVICE

SECTION 1 THE NHS PLAN AND THE MODERNISATION AGENDA

In July 2000 the Government published the NHS Plan which set out the Government's agenda for modernising and reforming the NHS. The Plan recognised that to achieve this, it required new investment in staffing; setting new national standards; and encouraging partnership working between health and local authorities. It also announced plans for changing the patient and public involvement system within the NHS and the abolition of Community Health Councils (CHCs) in England.

SHIFTING THE BALANCE

'Shifting the Balance of Power' was published at the end of July 2001 and set out further the long-term programme of change for reform and performance improvement intended to deliver the NHS Plan. The practical implications have brought about new structures within the NHS such as Primary Care Trusts and Strategic Health Authorities. The implications of 'Shifting the Balance' are outlined in Section 4 'How do Trusts, PCTs, Strategic Health Authorities inter-relate?'

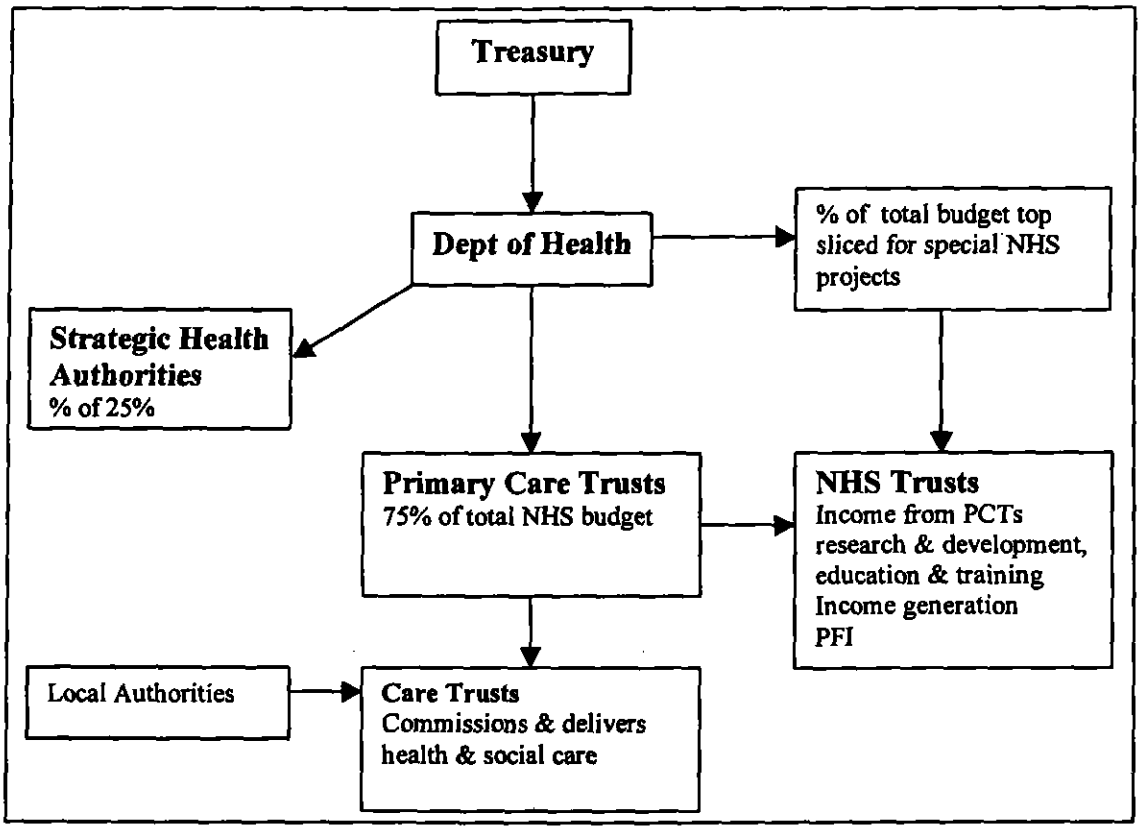
THE MODERNISATION BOARD

A Modernisation Board chaired by the Secretary of State for Health has been established with a role to ensure progress on the promises made within the NHS Plan, and take forward 'Shifting the Balance'. It has established a number of task forces to do this work.

THE MODERNISATION AGENCY

The Modernisation Agency was set up to support NHS clinicians and managers in their efforts to make the necessary changes and improvements to their services. The Agency has a Performance Fund to reward NHS Trusts that perform well, and it also supports poorly performing NHS organisations with problem-solving assistance and training.

SECTION 2 HOW MONEY FLOWS IN THE NHS



The NHS is the second largest government spending programme. The total funds made available to the NHS are determined as a result of the government's annual Public Expenditure Survey. The Chancellor announced substantial new money for the NHS in the Comprehensive Spending Review in March 2002 and £41 billion was allocated to health authorities in 2002/3. This is to continue to develop the aims of the NHS Plan which is to invest into and reform the NHS and by getting the basics right - beds, staffing, treatments, buildings and so on. It also aims to strengthen primary care, make the NHS patient-centred, and increase local rather than centrally driven decision-making.

In 2003/04 the Department of Health will make resource allocations directly to Primary Care Trusts (PCTs). Before this, the money is top sliced in order to fund:

- Special Health Authorities
- Research & development
- Education and training
- Dept of Health spending on HIV/AIDS
- NHS Direct and other special projects

Primary Care Trusts (PCTs) receive 75% of the NHS budget to commission local health care services. The other 25% is allocated directly to health authorities for family health services (GPs, dentists, pharmacists, optometrists). When this allocation transfers to Primary Care Trusts during 2002/03 the weighted capitation formula (see below) will apply.

COMMISSIONING HEALTH CARE

To put this into context: the main functions of the NHS fall broadly within two kinds of activity. On the one hand, there is the commissioning (or buying) of services, and on the other hand there is the provision (or delivery) of services.

It currently works like this. The commissioners (PCT) assess the health needs of the local population for whom they are commissioning; then specify what is required; then make an agreement with a service provider to provide the required service. The agreement as to the level and costs of services are negotiated between commissioners and providers within the Service and Financial Framework (SaFF)[1] through an increasing use of Service Level Agreements (SLAs)[2] rather than block contracts. The commissioner also monitors the delivery of that service against agreed standards.

From 1991, (when the 1990 NHS and Community Care Act came into effect) and until 1997, this division was generally known as the purchaser-provider split. 'Commissioning' was often the preferred term, rather than 'purchasing', as it implied a more pro-active way of specifying services. Also, there is now a strong emphasis on partnership and co-operation, rather than on a split between different bits of the NHS. There is still largely a separation of functions between commissioning a service (by PCTs) and the provision of NHS services, which is largely done by NHS Trusts.

From 1999/2000 resource allocations were unified to cover the previously separated three funding streams of:

[1] SaFF is an annual agreement between the health authority, PCTs and NHS Trusts regarding the funding of local services.
[2] SLA is an agreement on the level of service provision between organisations such as PCTs and NHS Trusts.

- A cash-limited sum for Hospital and community health services (HCHS)
- General medical services provided by GPs, dentists, optometrists, pharmacists (GMS)
- Prescribing

Future system of funding

The Department of Health's document: 'Improvement, Expansion and Reform: the next 3 years, Priorities and Planning Framework 2003-2006' introduces and describes the new system of funding the NHS. It envisages that from 2003 'funding will flow to the providers of patients' choices' and that hospitals and other providers will be paid for the activity that they undertake rather than through the block contract agreements that exist now. PCTs will, in consultation with other health bodies, agree a Local Delivery Plan.

Weighted capitation formula

A target is set for each Primary Care Trust (formerly for health authorities) based on what it needs as a relative share of the available resources, using a weighted capitation formula. The formula uses resident population figures weighted (adjusted) according to levels of deprivation, levels of morbidity (ill health), the age structure of the population; its health needs over and above those accounted for by age; unavoidable variations in the costs of local delivery of services.

The weighted capitation formula is under review with the new formula expected to be ready for the 2003/04 allocations.

What about family health services?

Family health services are provided by GPs, dentists, pharmacists and opticians who are independent contractors remunerated under a national contract for carrying out specified activities. Strategic Health Authorities (StHAs) were responsible for holding the contracts for family practitioners but this transferred to PCTs in 2002/3.

What about NHS Trusts?

NHS Trusts receive their funding from:

- PCTs via the commissioning process;
- Top-sliced Department of Health funds for education and training;
- Research and development;
- Income generation schemes.

Capital

Capital funding is set by the Department of Health which determines the limits on a capital spend by each Trust's External Financing Limit (EFL) and is based on the Trust's business plan. If a Trusts' income from selling its services is *more* than it's capital spend then it must pay the surplus back to the Treasury. In recent years, the level of NHS capital has diminished, and it has been assumed that Private Finance Initiative (PFI) funding would make up for the reduction in public funding. In either case, a business case must be made in order to proceed with large capital developments.

Private Public Partnerships

The government has introduced Private Finance Initiative (PFI) as a way of funding capital projects such as new hospitals and new primary care premises (LIFT- see below). The NHS Trust invites a private sector partner to submit bids for providing the building and some operating costs. The NHS provides the services based on a business plan for the new capital build and its EFL is not affected by PFI which allows it greater financial flexibility.

Local Improvement Finance Trusts (LIFT)

The NHS Plan introduced LIFT as a new initiative to develop up to 500 new one-stop care centres nationally and to refurbish many more primary care premises. In 2002 the 6 first wave pilot areas were chosen to take forward the LIFT initiative which is a public private partnership to develop primary care facilities involving a private company and NHS agency working jointly. A Joint Venture (JV) will be established between local health bodies including the local authority and the private company involved, with a LIFT Board to oversee local developments.

SECTION 3 PRIMARY CARE DEVELOPMENTS & PRIMARY CARE TRUSTS

Primary care basically means the local walk-in, self referral family health services such as:

- general medical practitioners (GPs)
- general dental practitioners (high street dentists)
- community pharmacists (chemists)
- opticians
- Walk-In Centres (nurse led, primary care drop in centres opening at flexible times and providing consultations and liaison with other family health services).

Secondly, it is a term used more widely to include the range of health services delivered in settings other than acute hospitals. Therefore, it can include preventative services, services for acute illness that can be offered in a GP surgery or health centre, and rehabilitation services. It can refer to services delivered in people's own homes or in the community. It is not easy to separate primary health care from community health care, and there is often a lack of consistency in the use of these terms.

One important development in the NHS over recent years is that primary care is becoming ever more central in the care and treatment of a wide range of conditions, some of which would have previously been hospital-based services (e.g. diabetes care, some minor surgery). The NHS Plan stressed the continuance of developing a primary care led NHS with plans for the recruitment of more GPs, nurses, midwives, therapists and other health professionals by 2004.

This was developed still further with the establishment of Primary Care Groups which became Primary Care Trusts (PCTs) in 2001/2 as the lead commissioners of health care services for the local population. GPs have also become more centrally involved in commissioning services through Primary Care Trusts.

PRIMARY CARE TRUSTS (PCTS)

Since April 2002 Primary Care Trusts are the cornerstone of the NHS and receive 75% of the NHS budget. There are currently over 300 PCTs covering England, each uniquely placed to have an overview of the organisations and bodies

providing health and social care services in the community. Each PCT is responsible for:

- Planning and securing services;
- Assessing the health needs of their local community and preparing plans for health improvement;
- Commissioning the broad mass of hospital and community health services for the local population;
- ensuring there are enough GPs to provide for their population;
- ensuring there are appropriate hospital, mental health, dental, pharmacies, opticians, Walk-In Centres, NHS Direct, patient transport (including Accident & Emergency) services as well as population screening;
- improving the health of the community. This involves working with the public, voluntary sector and other partners on public health and, from 2003, developing a Local Delivery Plan to improve health locally;
- integrating health and social care locally. Ensuring that local NHS organisations work together with local authorities - particularly social care and Care trusts where they are established.

In March 2001 the government announced a fund of £25m to establish up to 30 Teaching PCTs (TPCTs) in disadvantaged and under-doctored areas. 8 new Teaching PCTs began in April 2002 in order to attract more doctors and primary care professionals by offering the best career development and educational opportunities.

Care Trusts

The Health and Social Care Act 2002 provided the legislation for the creation of Care trusts as first envisaged in the NHS Plan. Care Trusts are NHS bodies which both commission and deliver health and social care, and involves close working relationships between Primary Care Trusts and local authorities. They are usually established where there is a joint agreement at local level that this model offers the best way to deliver better care services. At the moment there are only a small number of Care trusts in development, though more will be set up in future.

Who employs GPs?

GPs are generally self-employed and their individual contracts are now held by PCTs (formerly health authorities). In other words, they are independent contractors who are under contract to the NHS to provide general medical services

within family health services. This has been the case ever since the NHS came into existence.

The NHS (Primary Care) Act 1997 encouraged the establishment of Personal Medical Services (PMS) pilot schemes. Proposals for the pilot schemes include schemes for salaried GPs within GP partnerships or NHS Trusts. This allowed Health Authorities – but this function since devolved to Primary Care Trusts - to employ GPs on a salaried basis for the first time in order to develop a more flexible service, related to local need. For example to provide a GP led PMS specifically for refugees.

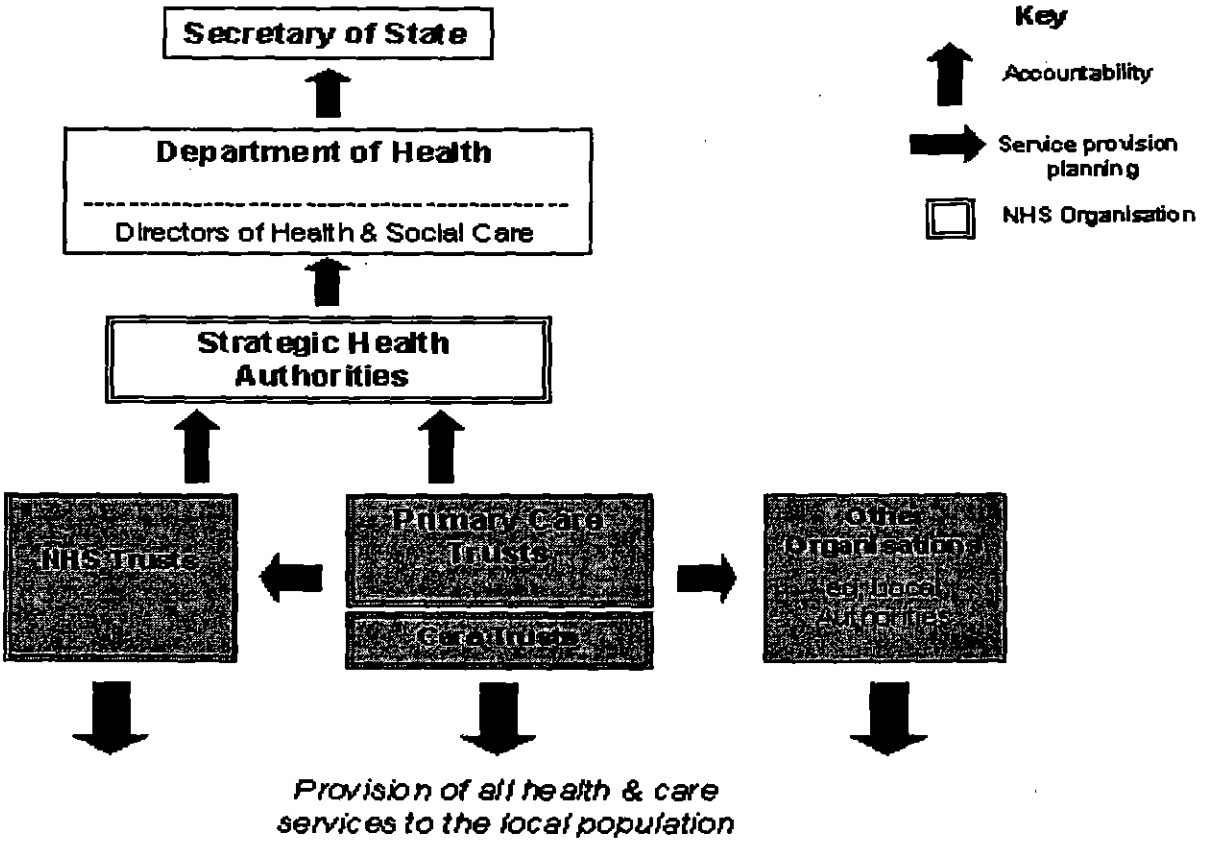
It is expected that by 2004 local PMS contracts and national arrangements will operate within one single contractual framework. This will involve negotiations to amend the current 'red book' which contains all the regulations and terms of service in the contract between GPs and PCTs.

Who employs Pharmacists and Dentists?

The majority of community pharmacists are independent. A significant number work for chains in, for example, supermarkets and a small percentage work in NHS owned premises.

In primary care, opticians provide services to those eligible for examinations as part of the general ophthalmic service (GOS) managed by PCTs. They provide private services for people who are not eligible for care under the GOS. Some may also be employed in the hospital eye service.

SECTION 4 HOW DO TRUSTS, PCTS, STRATEGIC HEALTH AUTHORITIES INTER-RELATE?



source: Department of Health website

NEW PARTNERSHIPS IN A CHANGING NHS

The changing structures within the NHS mean new ways of inter-relating at planning and operational level. All NHS organisations locally – PCTs, Care trusts and NHS trusts- are now part of a single structure in which they are held accountable to Strategic Health Authorities, which are in turn accountable to the Directors of Health and Social Care (see chart above).

Within this structure, organisations will have to work together in order to successfully achieve their functions. There may also be occasions when relationships are formed on a larger scale, for example, several PCTs in a geographical area may decide to work together to provide certain services. Also, the

provision of a highly specialised service, such as specialist cancer or spinal injury service, may be done collaboratively across a population larger even than a Strategic Health Authority. Relationships with other partners in health care such as local authorities and voluntary organisations are also vital, particularly for PCTs as they work towards improving health and integrating health and social care.

Working together more effectively - clinical networks

Clinical networks have been developing over recent years and bring health professionals from the range of NHS organisations together to work to provide the best care for the patient group with a particular disease such as cancer. The network works across institutional and local boundaries, and this involves the sharing of information and resources to smooth the patient pathway through the system. Networks are also an important part of the public health agenda in the NHS, and they should ensure that expertise and specialist skills are pooled and then shared with PCTs.

Department of Health

The Department of Health is responsible for health and personal social services in England; this includes:

- Oversight of the NHS
- Social services provided by local authorities for children, the elderly and disabled people, families in difficult circumstances and other people needing support
- environmental aspects of public health.

The Department of Health focuses on supporting the delivery of the NHS Plan which through Shifting the Balance of Power has involved the Department of Health handing over some of its operational responsibilities to Strategic Health Authorities.

The Department of Health NHS Regional Offices have been abolished and four Directors of Health and Social Care have been appointed. These Directors, supported by small teams, as well as having national responsibilities, cover geographical areas in which they work directly with the NHS. They performance manage Strategic Health Authorities, oversee the development of the NHS and provide the link between NHS organisations and the central Department.

Strategic Health Authorities (StHAs)

From April 2002 the 95 health authorities were replaced by 28 new Strategic Health Authorities (StHA). Each StHA leads the strategic development of the local health service, health and regeneration and performance manages Primary Care Trusts (PCTs) and NHS Trusts, and account nationally and locally for the performance of local health services directly to the Department of Health They also ensure that national priorities such as programmes for improving cancer services are integrated into plans for local health services.

The appointment of non-executive members to StHA, PCT and NHS Trust Boards is overseen by the NHS Appointments Commission with guidance and support from Ministers.

NHS Trusts , Primary Care Trusts (PCTS) and Care Trusts (see section 3)

NHS Trusts

NHS Trusts were formed in 1991 and are:

- Acute hospital trusts (some are also teaching hospitals)
- Mental Health Trusts

NHS Trusts provide most hospital secondary and specialist services and work closely with PCTs who commission their services. They are expected to devolve greater responsibility to clinical teams and to encourage the growth of the new clinical networks across NHS organisations. 'High performing' NHS Trusts earn greater freedoms and autonomy in recognition of their achievements, for example, a reduction in waiting lists.

They are expected to embrace all the changes outlined in the NHS Plan and Shifting the Balance of Power. The NHS plan contained a range of proposals for NHS Trusts such as extra beds by 2004, the allocation of beds for older people to impact on 'bed blocking', investment in staff, new hospitals, cleaner hospitals, performance monitoring of clinicians. NHS Trusts :

- must accept responsibility for developing and maintaining standards;
- have responsibility for clinical governance, requiring practitioners to make improvements in health and healthcare outcomes;

- are accountable to the NHS Executive for their statutory duties – if performance is not up to scratch, there will be investigation and if necessary, intervention.

Special health authorities

There are a number of special health authorities in England all of which provide a national service and they include:

- Ashworth Hospital
- Broadmoor Hospital
- Rampton Hospital
- Mental Health Act Commission
- National Blood Authority
- National Clinical Assessment Authority
- National Institute for Clinical Excellence (NICE)
- NHS Information Authority
- NHS Litigation Authority
- NHS Purchasing and Supplies Agency
- Prescription Pricing Authority
- Public Health Laboratory Service

Foundation Hospitals

Foundation Hospitals were announced by the Queen's Speech on 13 November 2002 The new hospitals will own their assets, have borrowing powers, be run by a management board a majority of which will be elected by local people and recent patients of the Trust. Further detail is awaited.

SECTION 5 HOW THE NHS INTER-RELATES WITH BROADER HEALTH ISSUES

INEQUALITIES IN HEALTH

All NHS organisations are monitored on progress towards reducing inequalities in health which is one of the key targets of the NHS Plan. This section outlines some of the agencies and mechanisms established to work specifically on this issue.

The determinants of the health and well being of the population still mainly lie outside the scope of the NHS. The broader health issues and inequalities in health are influenced by poverty, unemployment, class, ethnicity, age, housing status and environmental issues. In recognition of this there has in recent years been a significant movement to encourage the NHS to work flexibly with other agencies that influence the broader health issues that affect the population.

The NHS Plan recognised that class and ethnicity influence health outcome starting at birth resulting in the development of the Sure Start government-funded projects for under 5's, and free fruit for children aged 4-6 in nursery and school. It also brought about a new health poverty index to combine data on health status and access to health.

The development of partnership working between the NHS and local authorities, the business sector, housing, religious organisations, and the retail industry within national targets are working to reduce inequalities in health.

Public Health

Public health now covers three main areas: health protection, health promotion and clinical quality. Reducing health inequalities is an important theme throughout the public health function.

The Chief Medical Officer (CMO), Sir Liam Donaldson, is the UK government's principal medical adviser and also the professional head of all medical staff in England. He is head of what is now called the **Public Health & Clinical Quality** directorate within the Department of Health. The wide range of issues that impact on health and addressed by public health range from accident prevention, air

pollution, alcohol to tuberculosis, tobacco and yellow fever designated vaccination centres. The national targets for reducing inequalities in health are incorporated into the local plans of Strategic Health Authorities and PCTs which each have public health directors and staff who:

- Assess local health need
- Monitor the determinants of health
- Map impact of lifestyle and behaviour on health
- Provide information on the impact of inequalities in health on the local population
- monitor communicable disease outbreaks

There are now eight Regional Public Health Observatories (PHOs) established as part of the implementation of the white paper 'Saving Lives: Our Healthier Nation'. Their role is to:

- monitor health and its determinants
- highlight future health problems
- assess the health impact of potential and past policies
- work in partnership with regional and local health policymakers, practitioners and those interested in health actions.

The National Association of PHOs has useful public health information from around the country.

Planning for reducing health inequalities

In 2003 PCTs as the lead planners will be required to create local plans to progress health and service improvements in their area. Strategic Health Authorities will bring together these PCT plans including the Health Improvement Plans (Himps) into one comprehensive [3]Local Delivery Plan for their area.

Health Improvement Programmes (Himps)

The White Paper (NHS - modern, dependable) 1998 stated that Health Improvement Programmes would be the **local** strategy for tackling inequalities in health, improving health and healthcare, and the means to deliver **national** targets in each Health Authority area. A statutory duty of **partnership** was placed on local bodies to work together for the common good. PCTs are now the lead agencies in

[3] Improvement, Expansion and Reform: the next 3 years, Priorities and Planning Framework 2003- 2006.

developing the Himp in consultation with health authorities, NHS Trusts, other primary care professionals, the public and other partner organisations. Himps must:

- give a clear description of how the national aims, priorities, targets and contracts will be tackled locally
- Set out a range of locally determined priorities, with particular emphasis on addressing major health inequalities
- Specify agreed programmes of action
- Show that action proposed is based on evidence
- Show what measures of local progress will be used
- Indicate which organisations have been involved in drawing up the plans, their contribution and how they will be held to account for delivering it
- Ensure that the plan is easy to understand and accessible to the public
- Be a vehicle for setting strategies for the shaping of local health services.

It should be noted that the Himps will, in future, become part of the 'Local Delivery Plan'.

Our Healthier Nation – contract for health 1998

The Green Paper 'Our Healthier Nation- contract for health '1998 has 2 key aims:

1) To improve the health of the population as a whole by increasing the length of people's lives and the number of years people spend free form illness

2) To improve the health of the worst off in society and narrow the health gap.

There are 4 national priority areas to achieve by the year 2010:

1) Heart disease and stroke – to reduce the death rate from heart disease and stroke and related illnesses amongst people aged under 75 by at least a further third

2) Accidents - to reduce accidents by at least one fifth

3) Cancer - to reduce the death rate from cancer amongst people under 65 by at least a further fifth

4) Mental health - to reduce the death rate from suicide and undetermined injury by at least a further sixth.

Contract for health

For each priority area, there are national targets for improvements and a national contract setting out the respective roles of individuals, government and local communities. A contract for health is the idea of partnership between Government, local communities and individuals to improve health. It aims to set out a 'third way' which is 'between the old extremes of individual victim blaming on the one hand and nanny state social engineering on the other hand.'

Saving Lives: Our Healthier Nation 1999 and Reducing Health Inequalities: an action report

This required the setting of local targets for progressing the reduction of health inequalities. This builds on intentions around the 4 priorities contained in 'Our Healthier Nation 'and sets out the government's health strategy for England: the goals, the targets and how they propose to reach them.

Health Development Agency

The Health Development Agency is a special health authority established to replace the former Health Education Authority. It identifies the evidence of what works to improve people's health and reduce inequalities, advises on good practice and supports practitioners working to improve the public's health.

Health Action Zones

Health Action Zones (HAZs) were announced by the Secretary of State for Health in June 1997. They went 'live' in April 1998 and targeted the more deprived areas of the country. Their key objectives are to reduce health inequalities, improve services and secure better value from the total resources available. Partnerships between local authorities, community groups, the voluntary and private sectors, and local businesses are seen as a key means of achieving these objectives. Each HAZ usually covers the size of a city or former health authority size. The Government provided support and investment against agreed targets (but investment is not necessarily financial, it includes help with development or a

willingness to relax national requirements to fit local needs). The work of the HAZ and the planning of the Local Strategic Partnership Boards are increasingly inter-linked.

Local Strategic Partnerships (LSPs)

LSPs are designed to develop new ways of involving local people in how public services are provided in order to improve the quality of life in a local area. LSPs should bring together a wide variety of agencies including PCTs, NHS Trusts, StHAs, local authorities and the voluntary sector to work in partnership on key issues including housing, the environment, education, crime, employment, and health.

The government guidance on LSPs in April 2001 re-stated the intention that HAZ's would be integrated into the work of the LSPs - the idea being that lessons learnt from HAZ work will be mainstreamed into the work of the PCTs. LSPs are well underway with the establishment of Local Strategic Partnership Boards. Guidance gave the former health authorities the key role in ensuring that PCT plans, local authority community strategic plans, and Himps are aligned.

SECTION 6 THE QUALITY AGENDA IN THE NHS

SETTING, MONITORING, INSPECTING, REGULATING THE NHS

The NHS Plan outlined government intentions to monitor more closely the performance of the NHS, its services and staff in order to provide an NHS that is high quality. A number of scandals such as Shipman (primary care), Alder Hey (hospital) and Bristol Royal Infirmary (children's surgery) in recent years have been a huge wake-up call highlighting the need for action to ensure that ongoing poor performance by clinicians and other staff is avoided in future.

The consultation document A First Class Service 1998 set out a framework for taking forward quality improvement in the NHS, and Learning from Bristol – the Department of Health's report in January 2002 on the Bristol inquiry contained many recommendations for improving clinical governance and quality monitoring of the NHS.

Statutory duty of quality:

The new statutory duty of quality backs the system of clinical governance, and extended life-long learning. This is to help ensure that national quality standards are applied consistently within local practice.

Clinical Governance

Clinical governance can be described as 'the system of steps and procedures adopted by the NHS to ensure that patients receive the highest possible quality of care. It includes a patient centred approach, an accountability for quality, ensuring high standards and safety and improvements in patient services and care.' (Commission for Health Improvement)

Setting Quality Standards:

The National Institute for Clinical Excellence (NICE)

The National Institute for Clinical Excellence (NICE) has been operational since April 2000. Its role is to promote best practice through guidance and audit. It

assesses new drugs and treatments and advises on their use within the NHS. It will issue guidance on new standards for all aspects of NHS cancer care by 2005, has drawn up new guidelines and is ensuring that they reach all parts of the service. NHS organisations have to find funding to follow NICE decisions.

National Service Frameworks (NSFs)

The NHS Plan outlined plans for national quality standards for key conditions and diseases through National Service Frameworks (NSFs). Each NSF is a set of interlinked standards of care with target dates for implementation. A rolling programme of NSFs was launched in 1998 and took forward established frameworks on cancer and paediatric intensive care. There is usually only one new NSF published a year and each NSF is developed with the assistance of an external reference group (ERG) which brings together health professionals, service users and carers, health service managers, partner agencies, and other advocates. ERGs adopt an inclusive process to engage the full range of views. The Department of Health supports the ERGs and manages the overall process. NSFs:

- Set out what patients can expect to receive from the NHS in major care areas or disease groups;
- Set national standards and define service models for a defined service or care group;
- Put in place strategies to support implementation;
- Establish performance milestones against which progress within an agreed time-scale will be measured;
- reduce inequalities in health.

NSFs published so far are:

- Mental Health on 30 September 1999
- Coronary Heart Disease on 6 March 2000
- National Cancer Plan in September 2000
- Older People on 27 March 2001

Further NSFs will be developed on a rolling basis over the period of the NHS Plan including Diabetes (the next to be published), Renal Services, Children's Services, Long Term Conditions focusing on neurological conditions.

NSF Coronary Heart Disease (CHD):

- kills more than 110,000 people a year in England
- 1.4 million people in UK suffer from angina
- 3000,000 people have a heart attack each year.
- Accounts for about 3% of all hospital admissions in England

The NSF CHD has 12 standards which cover:

1 & 2. **Reducing heart disease in the population.** The NHS should develop, implement and monitor policies that reduce the coronary risk factors, reduce inequalities in risks, and contribute to a reduction of smoking in the population.

3 & 4. **Preventing CHD in high-risk patients in primary care.** Primary care should identify all people with established heart disease and those at risk of developing heart disease and offer advice and treatment to reduce their risks.

5, 6 & 7. **Treating heart attack and other acute coronary syndromes.** People with symptoms of a heart attack should receive help from someone trained in the use of a defibrillator within 8 minutes of calling for help. People thought to be suffering from a heart attack should be assessed professionally. NHS Trusts should put in place agreed systems of care so that people admitted to hospital receive appropriate care.

8. **Investigating and treating stable angina.** People with angina symptoms should receive appropriate investigation and treatment to relieve their pain and reduce their risk of coronary events.

9 & 10. **Revascularisation.** People with angina that is increasing should be referred to a cardiologist urgently or as an emergency. NHS Trusts should put in place hospital-wide systems of care so that patients with suspected or confirmed coronary heart disease receive timely and appropriate investigate and treatment.

11. **Managing heart failure.** Doctors should arrange for people with suspected heart failure to be offered appropriate investigations.

12. **Cardiac rehabilitation.** NHS Trusts should put in place agreed protocols of care to assist people to reduce their risk of subsequent cardiac problems.

NSF Mental Health

There are 7 main standards in the NSF:

1. **Mental health promotion.** Health and social services should promote mental health for all and combat discrimination against people with mental health problems.

2. **Primary care and access to services.** Any service user who contacts primary care team with a common mental health problem should have their mental health needs identified and assessed.

3. **Any individual with a common mental health problem** should be able to make contact round the clock with the local services necessary to meet their needs and receive adequate care; use NHS Direct.

4. **All mental health service users on the Care Programme Approach** (CPA) should receive care that prevents crisis and reduces risk; have a copy of their written care plan, be able to access services 24 hours a day, 365 days a year.

5. **Each service user who is assessed as requiring a period of care away from their home** should have timely access to an appropriate hospital bed or alternative bed or place which is as close to home as possible; and in the least restrictive environment consistent with the need to protect them and the public; receive a copy of a care plan on discharge.

6. **Caring about carers** - should also have an assessment of their caring, physical and mental health needs.

7. **Suicide prevention** - by implementing 1-6 above and other measures.

NSF Older People

There are 8 national standards:

1. **Rooting out age discrimination.** NHS services will be provided, regardless of age, on the basis of clinical need alone. Social care services will not use age in their eligibility criteria or policies, to restrict access to available services.

2. **Person-centred care.** NHS and social care services treat older people as individuals and enable them to make choices about their own care.

3. **Intermediate care.** Older people will have access to a new range of intermediate care services at home or in designed care settings.

4. **General hospital care.** Older people's care in hospitals is delivered through appropriate specialist care and by hospital staff who have the right set of skills to meet their needs.

5. **Stroke.** The NHS will take action to prevent strokes, working in partnership with other agencies where appropriate.

6. **Falls.** The NHS, working in partnership with councils, takes action to prevent falls and reduce resultant fractures or other injuries.

7. **Mental health in older people.** Older people who have mental health problems have access to integrated mental health services provided by the NHS and by councils.

8. **Promotion of health and active life in older age.** The health and well-being of older people is promoted through a co-ordinated programme of action led by the NHS with support from councils.

To progress these every NHS organisation is required to:

- Ensure older people's views are properly represented in decision-making
- Appoint an Older People's Champion
- Work with local partners to set up an interagency group to oversee implementation
- Recognise the implications for staff
- Ensure that, within finance, workforce development and information systems older people are recognised as a priority.

Delivering Quality Standards:

Life-long Learning

Life-long learning will provide NHS staff with the opportunity to continuously update their skills and knowledge to offer the most effective and high quality care to patients. 'Working Together-Learning Together - a framework for Lifelong Learning for the NHS was published in 2001. This guidance provides a framework to:

- Support changes and improvements in patient care
- Take advantage of wider career opportunities and realise staff potential

Regulatory Bodies: professional self-regulation

The government is encouraging the existing regulatory bodies to review how they work, be more open, and include more lay people on their boards. Regulatory bodies exist to enable clinicians to help set and maintain standards for their profession, and each body keeps a register of professionals which is available for public scrutiny. A professional can be removed from a register if he or she fails to provide a sufficiently high standard. These are:

- General Medical Council (doctors)
- General Dental Council
- General Optical Council
- General Osteopathic Council
- General Chiropractics Council
- Royal Pharmaceutical Society of Great Britain
- Nursing and Midwifery Council {formerly UKCC for Nursing, Midwifery & Health Visiting}

Council for the Regulation of Health Care Professionals

People need to be confident that the regulatory bodies will exercise rigorous self regulation over the standards and conduct of health professionals and that they will act promptly and openly when things go wrong. Most of the regulatory bodies are currently reviewing their constitutions to include more lay people and streamline regulations. To ensure this a new over-arching body called The Council for the Regulation of Health Care Professionals is to be established 'to promote the

interests of patients and other members of the public in relation to the performance of their functions by the bodies mentioned '.

Monitoring Quality Standards:

Standards are monitored through three mechanisms:

Commission for Health Improvement (CHI) – to be replaced by CHAI – Commission for Healthcare Audit and Inspection.

The CHI is an independent statutory body (a non-departmental public body) established under the 1999 Health Act to help secure quality improvement throughout the NHS in England and Wales. Since April 2000 CHI began a four-yearly rolling programme of visits to NHS Trusts. CHI examines organisational competence, implementation of NICE guidance and has a trouble-shooting inspection role. It is not a disciplinary body but can refer serious problems to the National Clinical Assessment Authority (NCAA), the General Medical Council (GMC), or the Nursing & Midwifery Council.

CHI looks at the human side as well as the clinical aspects of patient care and considers how well a Trust is involving patients and users in its work. CHI publishes its inspection reports and monitors progress on improvements in services. 'Poorly performing' organisations under the new Performance Assessment Framework (PAF) will have CHI inspections every 2 years. The government can send CHI into NHS organisations with serious and urgent concerns about clinical practice or patient safety.

Commission for Healthcare Audit & Inspection (CHAI)

In April 2002 Alan Milburn announced further reform of hospital inspection and the formation of a Commission for Healthcare Audit & Inspection (CHAI) in a new document 'Delivering the NHS plan'. It will bring together the inspection role of CHI, the audit function of the Audit Commission and the registration and inspection of private and voluntary hospitals carried out by the National Care Standards Commission.

National Clinical Assessment Authority (NCAA)

The NCAA is a special health authority set up to provide a support service to health authorities, hospital and Primary Care Trusts faced with concerns over the performance of individual doctors. It does this by helping the employer or health authorities to carry out objective assessments, training and support.

The National Care Standards Commission (NCSC)

The Commission became operational in 2002, and regulates residential nursing homes, children's homes, nurse agencies, domiciliary care agencies and private and voluntary hospitals and clinics.

The National Patient Safety Agency

There are an estimated 85,000 incidents and errors occurring each year in the NHS. The NPSA is an independent NHS body created to co-ordinate the efforts of all those involved in healthcare, and more importantly to learn from adverse incidents occurring in the NHS. Making sure those incidents are reported and encouraging staff to report 'near misses' is an important part of the NPSA's work. The emphasis will be on how to learn from and prevent the same mistakes happening again.

Performance Assessment Framework (PAS)

The Performance Assessment Framework was introduced in July 2000, and comprises six indicators:

- health improvement
- fair access to services
- effective delivery of appropriate care
- efficiency {indicators for this include day-case rate, length of stay, generic prescribing, missed outpatient appointments and data quality}
- patient and carer experience
- health outcomes.

Each year tables are published showing how each health authority has performed against the measures in each of the above six categories. Areas of concern are often

inpatient waiting, breast cancer waits, cancelled operations, clinical negligence, complaints resolution, and nurse vacancies.

Star Ratings

NHS Performance star ratings were developed from the PAS framework in 2002 and for 2002 placed all acute NHS Trusts in England into 4 categories:

- Trusts with the **highest levels of performance** are awarded a performance of 3 stars
- Trusts that are **performing well, but have not quite reached the same consistently** high standards are awarded a performance rating of 2 stars
- Trusts where there is **some cause for concern regarding particular key targets** are awarded a performance rating of 1 star
- Trusts that have shown the **poorest levels of performance** against key targets are awarded a performance rating of zero star

The purpose of the star ratings is to allow Trusts to assess and compare their performance locally and nationally.

NHS Performance Fund

From April 2001 a National Health Performance Fund of £500 million was established to be used until 2004 to 'reward' Trusts for progress against the PAF and other key targets such as inpatient waiting, accident and emergency wait, hospital cleanliness, nurse and consultant vacancies.

SECTION 7 COMMUNITY HEALTH COUNCILS (CHCS) AND PATIENT AND PUBLIC INVOLVEMENT - THE NEW MECHANISMS

Community Health Councils were established in 1974 and since then have been the only statutory bodies that exist within the NHS to represent the views of the public and patients to the NHS. There are 204 CHCs in England and Wales. They are statutory bodies with the right to enter and inspect NHS services; the right to information from the NHS, and the right to refer contested proposals for major service change to the Secretary of State for Health. Many CHCs have provided an independent service to assist members of the public to make a complaint to the NHS.

The Association of CHCs of England and Wales (ACHCEW) is a national statutory body that has gathered and represented CHC views to the Dept of Health.

The abolition of CHCs in England and ACHCEW was first announced in the NHS Plan in July 2000. Since then there have been many twists and turns in what CHCs and many others widely believe was an ill thought-out decision. Significant improvements were made to the proposals as a result of the debates that ensued.[4]

The NHS Reform and Health Care Professions Act 2002 provides for the abolition of ACHCEW and the CHCs and the introduction of a new system of patient and public involvement which transfer the statutory powers within CHCs to new Patients Forums and the local authority scrutiny committee. The Regulations on the detail of how the new system will work will not be issued until early in 2003. The date for the abolition of CHCs and establishment of Patients' Forums is not yet known, but is unlikely to be before September 2003.

Commission for Patient and Public Involvement in Health (CPPIH)

This new national Commission is due to be established in January 2003 based in Birmingham. It will be a non- departmental public body responsible for promoting patient and public involvement in health care. The CPPIH will:

[4] ACHCEW has produced the briefing 'The New Patient and Public Involvement System'

- Set standards for Patients' Forums and Independent Complaints Advocacy Services (ICAS);
- Submit reports to the Secretary of State on how the whole system of patient and public involvement is working and advise him on it;
- Make reports as it sees fit to other national bodies such as CHI, the National Care Standards Commission and the National Patient Safety Agency on patient and public involvement issues;
- Carry out national reviews of services from the patient's perspective and making recommendations to the Secretary of State, and to other bodies as appropriate;
- Draw on issues referred to it by Patients' Forums to do work at a national level on policy and service issues affecting patients.

Patients' Forums

Patients' Forums will be independent statutory bodies and will start in 2003 with one per NHS Trust and PCT. The membership of these is to be prescribed within the regulations and appointments will be made by the Commission for Patient and Public Involvement in Health (CPPIH) using criteria and process agreed by the Appointments Commission. Members will be volunteers.

Patients' Forums will be supported by staff deployed and accountable to the PCT Patients' Forums (but employed by the CPPIH). The regulations will prescribe matters such as funding, membership, appointments arrangements, premises, and the provision of information to or by Forums. Functions and duties are:

- Represent local views on quality and configuration of health services
- Monitor service delivery from patients' perspectives
- Inspect every aspect of NHS care (with new power to inspect services commissioned by PCTs)
- Produce an Annual Report and make its findings available to Trusts, Overview & Scrutiny Committees (OSCs), local MPs, StHAs, CPPIH, CHI
- Primary Care Trust Patients' Forums will have an enhanced role - staff deployed to them by the CPPIH to support the work of all the local Patients' Forums; promote the involvement of the wider community especially hard to reach groups. Membership of PCT Patients' Forums will also include members of each of the other Patients' Forums in the area and other relevant groups
- PCT Patients' Forums will also provide or commission an Independent Complaints Advocacy Service (ICAS). ICAS is a new service to replace the

complaints service provided by CHCs offering independent advice, support and advocacy to people wishing to make a complaint about their care or treatment by the NHS. PCT Patients' Forums may also commission ICAS from other providers such as for groups with special needs such as mental health groups or people who use English as their second language

- Patients' Forums will have the power to refer issues of concern to the local OSC and to intervene where the relevant PALS service is under - performing. It is also proposed that Patients' Forums will be able to elect one of its members to become a non-executive director of the Trust board.

Overview & Scrutiny Committee (OSCs)

There will be one OSC per local authority with social services responsibilities, and subject to outcome of consultation they are expected to start in January 2003. Membership of OSCs will comprise of local councillors and co-optees, they will:

- Scrutinise the local NHS
- Call local NHS Chief Executives and other NHS managers to account
- Have the right, but not a *duty* to refer proposed major changes to local health services to the Secretary of State for Health
- Work jointly with other local authority OSCs on cross-boundary issues

PALS (Patient Advice and Liaison Service)

By April 2002 each NHS Trust should have established a PALS. The PALS staff are employed by and responsible to the Trust, and there are no members. Patients' Forums will help monitor the quality and effectiveness of PALS and have the power to intervene if the service is unsatisfactory. PALS functions are:

- To provide information to patients, their carers and families about local health services and support groups
- To resolve problems wherever possible, or put people in touch with specialist advocacy services for formal complaints
- To act as early warning system for Trusts and Patients' Forums on complaints and issues
- To submit anonymised reports for action by Trusts and Patients' Forums

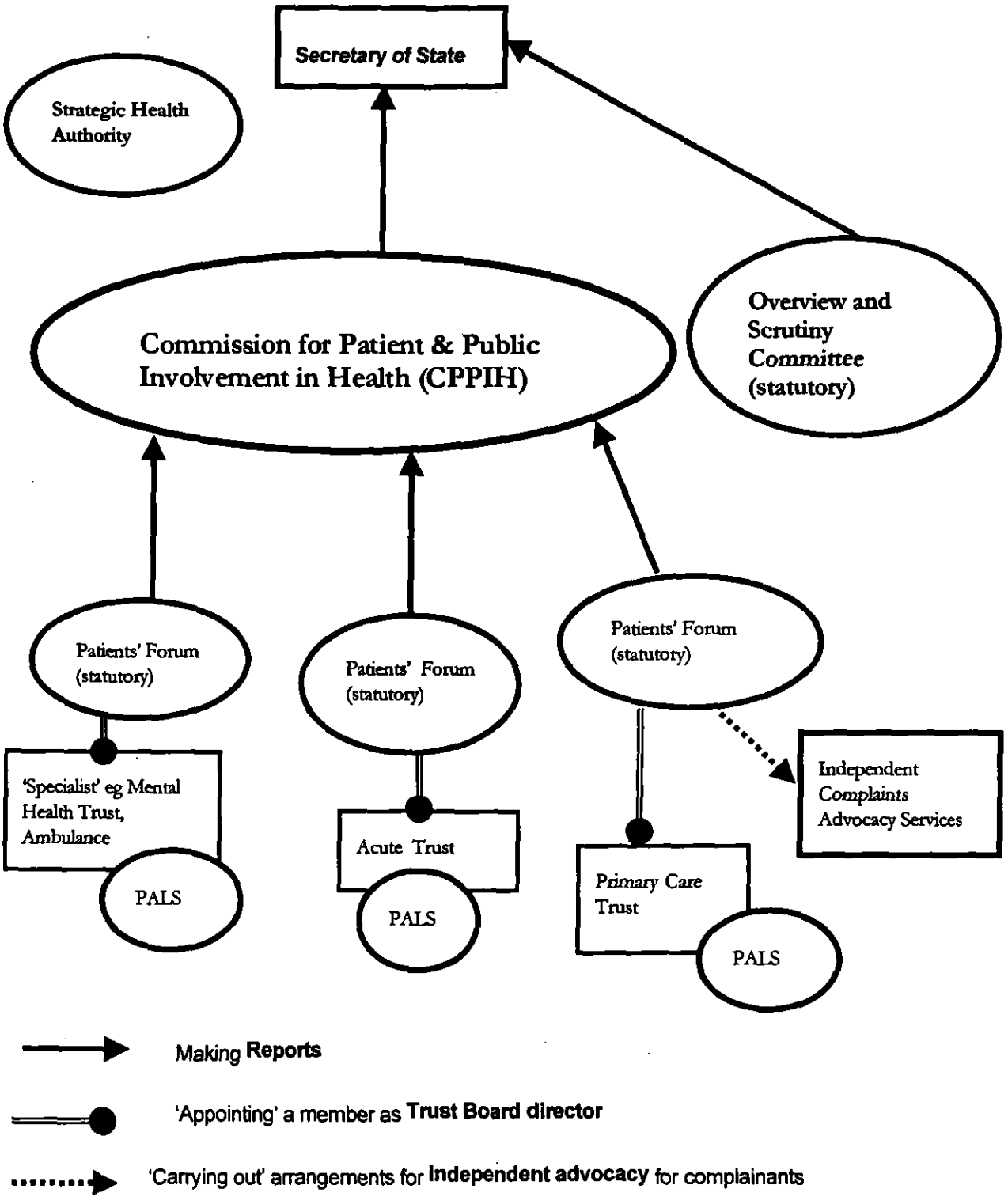
Patient Prospectus

This is an annual account of each NHS Trust's priorities which should be determined in consultation with Patients' Forums and other community representatives; with an agreed action plan to take recommendations forward. The purpose of the Patient Prospectus is to provide better information for people about their local NHS, to strengthen local accountability and place patients' views at the centre of service improvement. PCTs will take the lead role in producing the prospectuses.

Duty on all NHS Bodies to involve the Public: Section 11 of the Health & Social Care Act 2001

Section 11 of the Health & Social Care Act 2001 places a duty on all NHS bodies to involve and consult the public. This responsibility is not to be met by Patients' Forums or the CPPIH on the NHS's behalf. PCT Patients' Forums will monitor the NHS performance with respect to implementing Section 11.

Patient and Public Involvement in Health (chart amended from London Health Link)



SECTION 8 THE EQUALITIES AGENDA AND THE NHS

Listed here are some of the current equalities legislation that impact on the NHS.

Race Equality

The report of The Stephen Lawrence Inquiry by Sir William Macpherson was published in February 1999. It highlighted that institutional racism is prevalent within, not just the Metropolitan Police, but every institution in the land. To address this the government has amended The Race Relations Act 1976 and the Race Relations (Amendment) Act 2000 gives for the first time public authorities a general duty to promote race equality. This means that providers of major public services such as health, education, local government and the police are bound by this duty. The general duty as applied to NHS Trusts and PCTs is that they must aim to:

- Eliminate unlawful racial discrimination
- Promote equality of opportunity
- Promote good relations between people of different cultural groups.

Specific Duties

These cover both policy and service delivery and NHS Trusts were required to publish a Race Equality Scheme (RES) by 31st May 2002. The RES sets out how the Trust intends to meet these duties, its arrangements for monitoring progress. The Trust will also publish the results of their assessments, consult locally, and arrange training for their staff on the general duty to promote race equality.

Impact on the NHS

This Act applies to all NHS Trusts, Primary Care Trusts, Strategic Health Authorities, Mental Health Trusts and means that the NHS is subject to legal challenge for non-compliance. The NHS is now required for the first time to address institutional racism.

Patients' Forums and other mechanisms set up to replace CHCs will need to be informed about each Trust's Race Equality Scheme as well as examining their own policies and practices for unwitting institutional racism.

The Vital Connection: An equalities framework for the NHS

Published in April 2000 Vital Connection is a useful framework (not legislation) for assisting the NHS to progress the three strategic equality aims that all parts of the NHS must now work towards:

- A workforce for equality and diversity
- A better place to work
- A service using its leverage to make a difference

Sex Discrimination Acts 1975 & 1986

This Act makes it unlawful to discriminate against a person, directly and indirectly on the grounds of sex and/or marriage. The Act covers the entire area of sex discrimination in employment; including those areas relating to recruitment, advertising, selection, promotion or training.

Equal Pay Act (1970)

This Act makes it unlawful for employers to discriminate between men and women with regards to pay and other terms of employment.

The Disability Discrimination Act (1995)

The legislation applies equally to those who become disabled in the course of employment, and to job applicants. All employers of 20 or more people are legally liable for discriminating against disabled persons in recruitment, promotion training, working conditions and dismissal.

The Protection from Harassment Act (1997)

Harassment can be defined as unwanted attention which is offensive to the recipient and which may involve an element of coercion. This Act makes harassment a criminal offence, and the victim of harassment will be able to bring claims against the harasser.

PART 2

THE LEGACY OF COMMUNITY HEALTH COUNCILS

SECTION 1 INTRODUCTION

This section of the resource pack deals with the CHC experience of scrutinising the NHS. This includes the important power to 'refer' contested proposals to the Secretary of State for Health and how CHCs have used this as a lever to secure more acceptable proposals for local people. This experience should be invaluable to Overview and Scrutiny Committees (OSCs) in exercising their power of referral from January 2003.

Also covered in this section are other examples of how CHCs have monitored services, conducted research and involved local people. This pack deals with how CHCs have done things. In the future after the abolition of CHCs, many of these activities may be carried out by Patients' Forums (see Part 1, section 7 on *The Changing NHS*). It will be important for OSCs to understand different methods of gaining an overview of the local NHS and to make the most of intelligence available from CHCs in the short term and Patients' Forums in the future.

SECTION 2 THE LEGACY OF CHCS - KEY ISSUES FOR OSCS

Since 1974 CHCs have been 'critical friends' in the NHS, developing an approach to health overview and scrutiny that is continuous, consistent and comprehensive with the needs of patients and the public at its centre:

- CHCs hold a wealth of information about local, regional and national health services and provide a 'one stop' service for local people

- This service extends to providing advice and assistance to people who wish to make a complaint about the NHS. By analysing trends in the issues raised, they can establish if further action is needed to improve services

- CHCs' visits, surveys and research projects are based on the issues brought to them by local people

- The information gained from complaints, enquiries and public participation projects informs CHCs' continuous input to NHS plans

- Participation in planning gives CHC members early warning about future plans, enabling them to trigger formal consultation procedures on proposals for significant changes in service

- County-wide groups of CHCs and Regional Associations have worked in partnership on issues relating to wider and cross boundary services, including specialist services and ambulance trusts. By helping to develop communications strategies, they have ensured that all stakeholders receive timely information and have helped to avoid delays in the process

- CHCs facilitate public involvement in consultation and seek to negotiate changes or developments in the proposals so that they better meet public needs and expectations

- CHCs have had to grapple with the challenging job of representing the 'public interest' as opposed to representing popular opinion necessarily. Where a CHC is convinced that proposals are in the public interest, even though they are unpopular with local people, CHCs may not oppose a referral

- CHCs have used the *possibility of referral* to the Secretary of State as a lever: listening to all sides of the argument, seeking assurances on future developments, and negotiating outcomes that are acceptable to everybody concerned. They monitor those outcomes through their visiting and public involvement programmes. CHCs' experience is that reaching agreement about proposals through constructive but robust debate is both preferable and more common than making a referral to the Secretary of State

- Where a suitable compromise is not possible, CHCs can refer the contested proposals to the Secretary of State whose decision is final. This has helped avoid bad decisions being imposed on local communities and forced options to be re-appraised. However, CHCs' experience of the way referrals are handled is very mixed, and better processes will be needed to maximise the positive potential of OSCs making referrals.

Section 3 of this pack explores in more detail, with practical examples, how CHCs have scrutinised the NHS.

SECTION 3 CHCS AND CONSULTATION - GATHERING AND USING INFORMATION

Current statutory requirements: The right of CHCs to be consulted on proposals for substantial changes in health services

Whilst CHCs continue to exist, they retain the right to be consulted on substantial changes, and to refer contested proposals to the Secretary of State. There will be an overlapping period in 2003 during which both CHCs and OSCs have similar rights. The Department of Health is producing guidance on how both should exercise these rights and co-operate during this period. This section explains the situation pertaining to CHCs.

Strategic Health Authorities in England and health boards in Wales have a legal requirement to consult CHCs over proposals for substantial variations in health services, including primary health care services, whether these are proposed by the health authority itself, an NHS Trust or a Primary Care Trust. The term 'substantial variation' is not prescriptive since what is considered to be substantial in one area may be considered to be less significant in another. Where a CHC considers, therefore, that proposals represent a substantial variation in local services, they have the right to seek formal consultation.

- Regulation 18 of the CHC Regulations does not apply to proposals to establish or dissolve an NHS Trust or a Primary Care Trust.

- In addition to consulting CHCs, health authorities may also consult other bodies or individuals and many consultations in England already involve local authority OSCs.

- NHS Trust and PCTs may also carry out consultations with a range of bodies, including CHCs, as long as this is carried out properly.

- CHCs may agree that consultation by an NHS Trust or PCT may take place instead of the statutory consultation process. This can help to ensure that a form of consultation takes place before services are closed or varied as a matter of urgency.

- CHCs still have a right to object to inadequate consultation exercises, or decisions to change services where that decision is reached after consultation.

CHCs have the right to ask for, and receive, all the information they need from health bodies to enable them to consider proposals. This includes the right to receive any help they need to understand those proposals and consider whether all appropriate options have been considered.

Within the limits of available resources, CHCs have helped the NHS to take a balanced approach to existing services and the need to develop new services.

CONSULTATION ON PLANS TO RE-ORGANISE HEALTH SERVICE BODIES

Reorganisation of NHS Trusts

The Secretary of State has a legal requirement to consult relevant CHCs and the discretion on whether to consult with other bodies or not when considering proposals for the establishment and dissolution or merger of NHS trusts. He may issue an 'instrument in writing' instructing another NHS body, such as a strategic health authority, to carry out that consultation. Whoever conducts the consultation exercise, the Secretary of State must make the final decision about the reorganisation of NHS Trusts.

Establishment and reorganisation of Primary Care Trusts

Separate legislative provision gives CHCs the right to be consulted on proposals for the establishment or dissolution of PCTs. As with the reorganisation of NHS Trusts, the Secretary of State may delegate the consultation process to another NHS body, but is responsible for the final decision.

Reorganisation of Strategic Health Authorities and Health Boards

The Secretary of State has a legal requirement to consult before establishing or abolishing a strategic health authority in England, or changing its name or varying its area. The National Assembly for Wales has general consultation obligations before making, establishing, dissolving or varying health board regions. There are as yet no regulations detailing who must be consulted in either England or Wales.

Where proposals for the establishment or dissolution of local health bodies have implications for service delivery, consultation must be carried out under both *Section 5 of the NHS and Community Care Act 1990 and Regulation 18(1) of the CHC Regulations 1996.* A single exercise combining these requirements is normal under these circumstances.

Referrals by CHCs

Where a CHC is dissatisfied with the process of consultation, or believes that the outcome is not in the interests of patients and the public, it may refer the decision to the Secretary of State for Health. Contested changes should be put 'on hold' pending hearing of the Appeal and the issue of a report and recommendations by the Secretary of State, whose decision is final.

References:

- *Regulation 18(1) Community Health Council Regulations 1996 as amended by Community Health Council (Amendment) Regulations 2000*
- *Regulation 18(2) Community Health Council Regulations 1996*
- *'Urgent' action may be in the interests of patients or the Trust, e.g. an outbreak of infectious disease; staff shortages or financial pressures. CHCs may seek retrospective consultation which is seldom satisfactory if cuts or changes have already taken place.*
- *Section 5 NHS and Community Care Act 1990*
- *The Primary Care Trusts (Consultation on Establishment Dissolution and Transfer of Staff) Regulations 1999*
- *Section 1 National Health Service Reform and Health Care Professions Act 2002*

CHCs - A CRITICAL FRIEND IN THE NHS

The CHC role of scrutiny in the consultation process

- To be an effective partner and critical friend at all stages of the planning process by offering objective and informed advice and suggestions for improvements before formal consultation is required. Some CHCs have negotiated local 'codes of agreement' with NHS Trusts to protect the CHC's right to be consulted:

  - before cuts or changes are implemented

- the procedures to be followed if cuts or changes are implemented as an emergency measure

- To **gather and present evidence** to support the development of options

- To **promote patient choice** by actively involving local individuals and communities in the planning and provision of local health services

- To uphold the **statutory rights** of CHCS to be consulted

- To **trigger the duty to consult** where a health authority or PCT appears to have overlooked it, or is not aware of substantial proposals that are known to the CHC because of its close working relationship with local trusts.

- To use its statutory rights to **negotiate acceptable outcomes**

- If necessary and appropriate to exercise the right of CHCs to **refer proposals to the Secretary of State for Health**

- To work in **partnership** with other CHCs, representing their local communities in consultations covering cross boundary issues, e.g. Ambulance Services, Mental Health Services and Regional Specialised Commissioning, e.g. Centres of Excellence, Cleft Lip and Palate Services.

- **Promoting good practice in communications and consultation.** This is designed to ensure that all stakeholders receive sufficient early warning to enable them to plan how they will work together before, during and following the consultation process. See further reading.

Further reading:

- *South West Health Authorities: Specialist Commissioning – Communications and Consultation. A protocol for good practice.*
- *Rotherham CHC: A Consultation Framework for Rotherham's Health Services (2002)*
- *Cabinet Office: Code of Practice on Written Consultation (2000) www.cabinet-office.gov.uk/servicefirst/index/consultation.htm.*

WHERE DOES THE INFORMATION COME FROM?

There's a wealth of information – official and unofficial - that can help OSCs to develop an informed overview. CHCs have found that it's important to ask the right questions at the right time in order to get the *right* information for each specific consultation. The process of gathering information is similar in many ways to 'investigative journalism'. In the future, OSCs may be able to tap into similar data gleaned by Patients' Forums in exercising their duties.

- **CHC involvement** - CHC representatives on health authority and Trust committees and task groups get early access to issues without compromising the independence of the CHC. Members provide a two-way communication link with the NHS and can feed the views of patients and the public into the planning process
- **Strategic Service and Financial Frameworks** (SSAFF) might reveal the potential for future changes, cuts or rationalisation programmes
- **Contracts, service specifications and audit reports**
- **Reports to Board Meetings** might signal the need for 'emergency measures' to deal with emergencies or stay within budget
- **National Service Frameworks** – if local services can't meet national standards might there be proposals to change or amalgamate them?
- **NHS policies and protocols**
- **Local government information** – joint planning processes, and plans for services that impact on health
- **Results of CHC surveys into public opinion of the NHS and priorities for future health services**
- **Web-based information services** – including Department of Health, patients' organisations and consumer groups
- **Media** – especially the local press and radio
- **Meetings** - formal and informal. With officers and clinicians, patients, carers, patient participation and user groups, and the general public
- **Annual Reports** of health and local authorities and the Annual Public Health Report show what's been achieved and what remains to be done
- **Monitoring reports** - Commission for Health Improvement (CHI); Audit Commission; Health Service Ombudsman; Patient's Environmental Action Team (PEAT); NHS Performance Tables, Star Ratings, etc.
- **PFI (Private Finance Initiative) and PPP (Private Public Partnership) applications**
- **Complaints and enquiries** – what issues have been raised about the quality, quantity or location of services? Sources include CHC statistics, PALS and clinical governance leads, CABx, Local Councillors and MPs,

NHS Direct, Councils for Racial Equality, places of worship, Advocacy organisations and Community Legal Services, etc.

- **Face to face meetings** with health managers and clinicians. OSCs have the power to call NHS Managers to give evidence at meetings. Many CHCs have had relationships with their local NHS which meant that senior NHS managers attended CHC meetings to explain their organisation's perspectives. NHS managers have become very adept at handling such set pieces. It is often the less formal, smaller meetings that CHCs have found more fruitful.
- **Patient and public involvement** – 'Question Time' style meetings facilitated by the CHC with audiences including patients, carers and interested members of the public. CHCs make efforts to attract young people, refugees and travellers as well as community and advocacy groups, expert patients, patient involvement projects, MPs and members of local authorities.

PRE-CONSULTATION OR 'FACT-FINDING' IN PREPARATION FOR FORMAL CONSULTATION

How do CHCs gather and feed in the views of patients and the public into the planning process?

CHCs use a variety of imaginative and innovative methods to find out what people think about local health services and this information can provide vital evidence during a consultation process. *See Resource Pack for examples.*

Stage 1: Successful consultation

The courts have laid down that *'the essence of consultation is the communication of a genuine invitation to give advice and the receipt of that advice. In order that this might be achieved, the consultee (a health authority or PCT) must provide all necessary information and allow sufficient time for a view to be taken and advice to be formulated'.*

- Consultation must take place when proposals are at a formative stage
- The proposer must give sufficient reasons for any proposal so as to permit intelligent and informed debate and response
- Adequate time must be given for a response, ideally three months, and
- The outcome of consultation must be conscientiously taken into account in finalising the proposals

And:

- The aims and objectives of consultation should be clear and transparent
- Information should be in suitable format(s) and additional information should be provided on request
- Help should be available to understand the proposals and address any issues raised during consultation, including assistance, if necessary, to develop alternative options
- Proposals should aim to improve the quality of care and outcomes for patients.
- Any other factors, such as cost effectiveness considerations, should be identified in the consultation document
- The limitations of consultation should be recognised and made explicit, e.g. national requirements such as National Service Frameworks
- All views should be respected and taken into account, and respondents should receive constructive and informed feedback
- The consultation process should be open, genuine and explicit

Further reading:

- *Consultation: the legal requirements. Marion Chester, Legal Officer, Association of CHCs in England and Wales 1999.*
- *South West Health Authorities: Specialist Commissioning – A protocol for good practice*

Stage 2: the power to refer proposals to the Secretary of State for Health - a tool for negotiation and compromise

If the consultation process is in jeopardy because one or more of the above criteria are not met, CHCs have the power to refer matters further. However, the threat of referral can often provide the necessary stimulus for negotiation and compromise, and can achieve greater benefits for patients and the public than the formal referral process. The threat of referral by OSCs can achieve similar results.

Key points:

- Where matters cannot be resolved locally the CHC may refer matters to the Secretary of State
- In practice, many disagreements can be resolved through discussion and negotiation
- However, if local discussions reach stalemate the threat of referral to the next stage can act as a catalyst, giving all parties time and space to take a

fresh look at the issues. This can be more effective than an appeal to the Secretary of State.

- The threat of referral may prompt the health authority or PCT to review their proposals and accept alternative views
- Or it can create a 'stand off' – giving consultees time to listen to all sides of the argument, seek compromises, and if necessary, develop fresh options

Case study: protecting community mental health services

Croydon CHC participated in the development of the Mental Health Strategy, a key component of which was the closure of an old psychiatric hospital. This was to be replaced by a greatly reduced number of inpatient facilities and a range of innovative community based services, including 24 hour crisis intervention and Safe Houses. The CHC recognised that these were crucial elements of the reprovision programme, and during the consultation process negotiated for them to be included in the Strategy. However, by the time the Strategy reached the implementation stage the health authority was in financial difficulties, and attempted to drop several community initiatives from the Business Case, including the 24-hour crisis intervention and Safe Houses.

The CHC took up the issue, in partnership with users of the mental health services and their representatives. It pointed out that it would be left with no option but to refer the matter to the Secretary of State for Health.

The threat of referral helped persuade the health authority to restore the proposals.

The outcome was a range of more appropriate mental health services than those previously provided.

For more information:

Croydon CHC
90 London Road
Croydon CRO 2TB
Tel: 020 8401 3919
Email: info@croydonchc.plus.com

Stage 3: The referral to the Secretary of State for Health

Where proposals remain in dispute following consultation, CHCs have the right to refer matters to the Secretary of State for Health, whose decision will be taken in line with Government policy. Patient and public groups do not have this right of appeal, but they work in partnership with CHCs to provide evidence for appeals. In the future, OSCs will be the only bodies with the right to make a referral. Whilst CHCs continue to exist, both the relevant CHC and OSC will have similar powers. The following represents CHCs' experience.

Key points:

- Notice of Appeal must be given to both the health authority or PCT and to the Secretary of State
- The referral letter must contain sufficient information and evidence to allow the Secretary of State to assess and evaluate the possible options and reach an informed decision
- The experience of CHCs is that pro-active appeals can be the most successful: active and vigorous local support for action by the CHC is crucial

Reasons for referral to the Secretary of State:

- **Proposals are not in the public interest** – after due consideration, the CHC considers that the proposed changes are detrimental
- **Inadequate consultation** - insufficient time to consult; or where the health authority appears to have reached a decision before they have considered the views of those being consulted
- **Inadequate consultation document** – misrepresentation of the facts
- **Access to information** - refusal to disclose necessary information
- **Failure to consult** – because the health body does not consider that changes are substantial in nature; or because the health authority or PCT is not aware of changes being made by a health provider

And:

- Disputes over implementation of an agreed strategy
- Disputes about commissioning and 'rationing' health services
- Sales of NHS land and buildings
- Private Finance Initiative / Private Public Partnership Plans

The Secretary of State may:

- Require a health authority or PCT to restart the consultation process, complying more fully with guidelines on consultation, timescales, information or access
- Consider the case on the written evidence alone
- Conduct an enquiry

The problems with referrals to the Secretary of State

Whilst some referrals have resulted in the prevention of bad decisions and improved consultation and proposals, the experience of CHCs is that referrals to the Secretary of State for Health are seldom satisfactory. 75% of CHCs in England and Wales (157 CHCs) responded to a survey by the Association of Community Health Councils for England and Wales (ACHCEW) of whom 75% found that the process was not open and accountable. (*The Problem with Referrals* :1999).

Key concerns reported included:

1. Lack of transparency and lack of respect for the public interest

- Once a referral has been made, health authorities and PCTs may comment on responses made by the CHC
- There is no reciprocal arrangement and CHCs – and local people – may be 'frozen' out of the process
- Many CHCs have received no acknowledgement of their referral
- CHCs frequently find out the results of their referral from a health authority or trust
- The referral process may therefore demonstrate a lack of respect for people who represent the public interest in the NHS, and undermines the legitimacy of the process

2. Delay

- Delay, together with a lack of acknowledgement and failure to respond can undermine the purpose and benefit of referral and undermine public confidence in the process
- Proposals should be put 'on hold' pending appeal, but delays of over a year are common, and the report and recommendations of the Secretary of State may be rendered useless if disputed proposals are put into place during this time.
- Delays may also lead to financial problems or the demoralisation of staff, for which the CHC is unfairly held responsible.

3. Bias/unfairness

- Civil servants who may have been responsible for developing plans are also responsible for briefing Ministers on disputed issues. These briefings are not available to the CHC.
- It is not clear how or who takes decisions on disputed issues.
- Where a regional office supports the proposals, but is expected to act as an 'independent arbiter' in the process, CHCs have had to rely on MPs to provide Ministers with unbiased briefings on local views.

Other findings of the ACHCEW survey

- ❖ 37% of issues were not resolved by the Secretary of State
- ❖ Only 36% deemed the outcome 'acceptable'
- ❖ 62% of issues had also been considered by Regional Offices of the NHSE
- ❖ But 59% found that the Regional Office was 'not impartial'
- ❖ Only 39% received copies of submissions by health authorities
- ❖ 51% reported that proposals were implemented during the referral
- ❖ 21% received no reasons for the final decision
- ❖ Only 25% found the process 'open and accountable'

CHALLENGING THE FAILURES OF REFERRAL

Judicial Review

The decisions and procedures of health authorities, PCTs and NHS trusts are open to legal challenge and review. There are strict criteria for judicial review, and an application for leave for judicial review must be made within three months of the decision to be challenged.

Parliamentary Ombudsman

The Ombudsman may investigate alleged mal-administration that has resulted in injustice. These might include the delays or bias characterised by referrals to the Secretary of State. The matter must have occurred within the previous twelve months and must be channelled through an MP: usually the local constituency MP.

Changes needed in the referral process

As a result of the survey of CHCs, ACHCEW recommended a series of steps to improve transparency. Decisions (even adverse decisions) reached as a result of a

transparent process are more likely to be accepted by the public. Regulations are yet to be agreed for how referrals by OSCs will be handled are yet to be finalised, but may address some of the concerns from CHCs' experience.

Key points:

- The decision-making body should conduct consultation on substantial variations in services
- There should be consultation on proposals to dispose of or acquire land or buildings
- Submissions to the Secretary of State made by health authorities or other health service bodies involved in the disputed proposals should be made publicly available
- All referral letters should be acknowledged
- There should be a clear timetable for consideration of referrals: not more than three months for all referrals, except for urgent matters which require to be fast-tracked
- Any delays should be reported to all parties
- The Secretary of State should supply reasons for the decisions reached

Further reading:

The Problem with Referrals: Marion Chester, Legal Officer, Association of CHCs in England and Wales 1999.

SECTION 4 MONITORING VISITS TO HEALTH SERVICES

One of the key tasks of CHCs is to 'keep under review the operation of health services in the district and to make recommendations for improvements in that service'. This is supported by CHCs' right to visit and inspect hospital and community health service premises in their 'home' district. The right to visit 'out of district' and private hospitals and clinics that are providing services to local residents is also specified in NHS contracts. They cannot enter and inspect premises owned by general practitioners. However, this right will be extended to PCT Patients' Forums.

Reference: *Community Health Council Regulations 1996 as amended by Community Health Council (Amendment) Regulations 2000*

Patients' Forums

Patients' Forums will have the right to 'follow the patient's journey' through all aspects of care provided by, or commissioned by their PCT or NHS Trust. Their reports and recommendations will provide valuable evidence for OSCs on patients' perceptions of the quality and quantity of local health services.

Patients' Forums will be free to plan an independent programme of visits and publish recommendations that are in the interests of patients and the public, and to refer matters of concern to an OSC for them to consider. However, more will be achieved if Patients' Forums and OSCs work closely together so that their respective programmes complement each other. There need to be clear understandings between OSCs and Patients' Forums about their respective roles. The Patients' Forums covering PCTs will be particularly useful partners for OSCs.

Guidance on how Patients' Forums exercise their right to monitor and inspect NHS services will come from the Commission for Patient and Public Involvement in Health. In this section we set out some good practice based on the experience of CHCs. They are all set out in the *Directory of CHCs and Public Involvement, Octber 2002, Southend District Community Health Council, 6 Nelson Street, Southend on Sea, SS1 1EF*

Good practice No.1
Announced or unannounced visits?

There is no statutory guidance for conducting visits, or recommendations on how frequently visits should be carried out. Each CHC sets its own priorities for announced and unannounced visits.
CHC members participate in their CHC's annual review and business planning process which aims to balance the concerns and interests of patients with the CHC's statutory responsibilities for consultation, monitoring and representing the views of patients and the public to the NHS. This process allows CHCs to agree a broad framework for longer term monitoring projects.
Many CHCs have arrangements with their local Trusts for making unannounced visits. This allows the CHC to get a picture of how the service operates on an 'ordinary' day, without the Trust being able to make special arrangements. Announced visits are agreed in advance, and health organisations know when to expect CHC visitors. The CHC will usually request a range of information in preparation for these visits, including staffing ratios, the age groups and conditions of patients treated, untoward incidents, etc.
Most CHCs notify hospitals and clinics of the date, but not the time they will arrive.

Announced visits are appropriate for:

- 'Educational visits' for new members
- 'Gathering evidence' in preparation for responses to consultation on proposals to close or change services
- Monitoring developments – when services have recently undergone changes
- Visits that are part of a longer term CHC project, e.g. Casualty Watch, monitoring standards of food or cleanliness in hospitals, reviewing services for older people, etc.

Unannounced visits:

Unannounced visits allow the CHC to see how services work in reality – avoiding the 'set dressing' that might take place before a planned visit. Because they are unannounced, members may need to undertake more detailed work to find out about the way the service works, and uncover any potential problems.

- Enable the CHC to speedily monitor services that are the subject of complaints or concerns by patients or the public
- Facilitate the development of recommendations to improve services and protect future patients

Good practice No.2 – Codes of understanding

Health Circular (81) 15 (Paragraph 5 Appendix 1) states that visits must be agreed with the health authority or PCT, and must take account of the pressures on medical and nursing staff. They must not interfere with the running of the service concerned. However, because of the particular value of unannounced visits, some CHCs have developed Codes of Understanding with their local Trusts.

Case study – A Code of Understanding

Patients' Forums need free access to services, but must also respect the privacy and dignity of patients.

Mid Downs CHC wrote to the chief executives of all NHS Trusts to request permission to carry out both announced and unannounced visits to wards and departments in their hospitals and units. Acute trusts gave their unreserved permission, and CHC members carrying out unannounced visits carry both identification and 'letters of authority' from the CHC.

The mental health trust was concerned that members may arrive during a crisis on the ward. It was therefore agreed that they should contact the Director responsible for the unit on the morning of a proposed unannounced visit, and that they would leave if it should become necessary to do so. In the event, the new Mental Health Trust accepts that CHC members are capable of deciding whether a visit should continue and is happy for the CHC to visit on an announced or unannounced basis.

For more information:

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Email: middowns@hotmail.com

Good practice No.3 – Visits as a tool in the monitoring armoury

Monitoring means 'continuous or regularly repeated observations of important parts of the service structure, process, output or outcome' Morgan and Everitt 1991.

Monitoring is wider than just visiting, but effective visiting is an important part of monitoring.

Monitoring includes:

- **Monitoring the monitors** – scrutinising the way others monitor health services, e.g. the Commission for Health Improvement (CHI), the NHS Ombudsman, health authorities and PCTs, NHS Performance Tables, Clinical Governance Committees, PALS, the GMC, Independent Review Panels, Patients' Environmental Action Team (PEAT), Professional Colleges and Trades Unions, etc.
- **Avoiding duplication and adding value to the scrutiny process** - by working in partnership, and helping to develop the scrutiny programme for those bodies
- **Listening to and involving local people** – and prioritising their complaints and concerns about local services when developing its annual monitoring programme.
- **Focusing on quality** – from the patient's perspective: gathering local opinions and representing the public to the NHS. Are services accessible, acceptable, appropriate, effective, equitable, efficient and equal?
- **Issuing reports** – that are independent, factual and constructive

Visits are an important part of the monitoring process and CHCs have developed tools to help them ascertain the quality of care and service in clinical settings, including wards and specialist departments. The aims of visits are to:

- See and be seen by patients, visitors and staff
- Identify issues that require further investigation
- Raise concerns about shortfalls in service provision or resources
- Indicate poor quality
- Indicate good quality

Visits need to have clear objectives - and mechanisms for follow up monitoring to ensure that recommendations made by the CHC are put into place, and stay in place over time. Visits may be:

- **General** i.e. related to the overall objectives of the CHC to represent the health interests of local people by learning about the operation of services, and establishing users' views

- **Specific** i.e. related to a specific issue such as cleanliness, food services, waiting times in clinics, standards in A&E departments, or a particular specialty such as diabetes, maternity, cancer care, mental health or learning disabilities.

CHC visitors receive training in visiting techniques and codes of conduct prior to visits. This ensures that they can make the most of the visit, and not be diverted into carefully managed 'guided tours'. This training enables them to evaluate the quality of care from the patients' perspective.

Visits may last from two hours to 24, and always include opportunities to elicit the views of patients and visitors, either through one-to-one interviews, or through a questionnaire. The advice of nursing staff is always sought before individuals are approached, since some people may be in pain or distress, coping with bad news or disability, or simply be too frail or ill to participate. However, visitors must also be alert to the fact that nursing staff may not want them to speak to 'difficult' patients or realise the importance of enabling people to express a view, especially if their first language is not English, or if they have other communication difficulties.

During a visit, CHCs may consider any or all aspects of the patients' experience. See case studies Appendix A.

- **The physical environment** - including cleanliness, personal hygiene, warmth, food and nutrition, access to services

- **Medical care and treatment** – including admission procedures, clinical attitudes, procedures, ward routines, the reliability of equipment

- **Therapy and rehabilitation** – including discharge arrangements and aftercare

- **The emotional environment** – including information systems, counselling and bereavement support

- The intellectual environment – including informed consent to treatment, decision making, stimulation, e.g. Occupational Therapy, entertainment and conversation

- The social environment – including privacy and dignity, visiting arrangements, provision for carers who need overnight accommodation or assistance with travelling

  - References:
  - *East Dorset CHC. Making the most of monitoring – a guide for members visiting NHS premises (2001). This guide provides useful checklists for visits, based on Maslow's 'Hierarchy of Need'.*
  - *Rotherham CHC – Protocol for CHC Members' Visits*

Good practice No. 4 – sharing experiences of visiting and monitoring services

CHCs share good practices: pooling reports, experiences and recommendations via the Association of CHCs in England and Wales. This helps to make an individual monitoring programme greater than the sum of its parts, because it can draw on the experience of others - developing and adapting their work as necessary to suit local needs.

Further reading:

'Case Studies' pack

Directory of CHCs and Public Involvement 2002

APPENDIX A: SOME EXAMPLES OF PREPARING FOR, AND RESPONDING TO PROPOSALS FOR CONSULTATION ON SIGNIFICANT CHANGES IN SERVICES

PRE-CONSULTATION AND FACT FINDING:

Case study 1: Patient and public priorities for health services in Dorset

CHCs in Dorset conducted an extensive survey of local views on NHS Services in 2001/2002. 1% of the local population was involved, and almost one third of household completed and returned the questionnaire. The age group of respondents ranged from 18 to over 85, with younger people relatively under-represented and older people relatively over-represented. Two thirds were female and more than 15% of respondents indicated that they or someone in their household was a carer. Only a quarter knew who to approach if they had a complaint or query about the NHS, and people's preferred method of dealing with such issues would be to 'talk to someone who might be able to resolve the issue'.

Key issues

A large number of people expressed interest in, and concern about health and health related issues, and indicated that they were willing to continue to share their views in future. The key concern was waiting times in A&E Departments. Other issues included:

- Availability and cost of dental care
- Services for children and young people
- Care of the elderly/age discrimination
- Mental health/addiction services
- Cancer services
- Cardiac services
- Preventative care
- Pharmacy services
- Access to information
- Staffing
- Finance

Health related issues

- Pollution, air and noise

- Alternative therapies
- Nutrition

People's preferred methods of consultation and participation - key areas in which people would like to be involved:

- The development and management of local health care when changes are being made to existing NHS services
- Developing new NHS services
- Giving views on patients' experiences in hospital and GP surgeries
- Only 29% of people wanted to be consulted on the development of health care priorities (health rationing).

The CHC recommended greater use of postal questionnaire surveys to elicit patient and public views – the method most strongly favoured by respondents. Other recommendations included action on patient held records; weekend and evening outpatient clinics, and better information about local services for local people.

- The CHCs' very detailed and comprehensive report includes respondents' views on:
- Family doctor services
- Waiting times for GP appointments
- Patients' preferred times for visiting their doctor
- Alternative first points of contact for primary care services, e.g. NHS Direct
- Complaining about family doctor services
- Community based care
- Outpatient appointments
- Waiting times for outpatient appointments
- Satisfaction with outpatient care
- Inpatient treatment
- Satisfaction with inpatient treatment
- Day surgery and satisfaction with day surgery
- Other hospital services
- A&E
- Hospital administration
- Hospital cleanliness
- Access to therapy services

Patients and public priorities for future health services in Dorset

- Heart disease and stroke
- Mental health and suicides

- Drug misuse
- Cancers
- Reduction of accidents
- Teenage pregnancy
- Air pollution, food poisoning and crime
- Promoting independence in older people
- Reducing health inequalities
- Reducing homelessness
- HIV/Aids

People's priorities for health were:

- Dental care
- Mental health and addiction services
- Care of the elderly
- Waiting times

For more information contact:
East Dorset CHC
28 Poole Hill
Bournemouth BH2 5PS
Tel: 01202 292961
Denise.holden@eastdorset-chc.nhs.uk

Case study 2: Putting patients in the centre of the process: finding out health priorities in Northallerton

A qualitative postal survey carried out by sending 5000 response forms out through service providers (social services, GPs, housing offices, etc.) to find out people's priorities for current and future health services in the rural area.

The CHC addressed these priorities during simultaneous consultations on changes to form a PCT and to merge Acute Trusts.

For more information:

Northallerton District CHC
32 High Street
Northallerton

DL7 8EE
Tel: 01609 770627
Email:chief-officer@ms.northallerton-chc.northy.nhs.uk

Case study 3: Two way communications with the public - Health Action Links (HALs)

A number of CHCs have developed Health Action Links and similar projects – sometimes in partnership with local PCTs. The projects aim to improve patient and public involvement and empowerment, provide multiple access channels for local views and provide information that will help to improve access and outcomes. Information from HALs helps to inform the process for setting CHC priorities, and provides valuable evidence for consultation exercises. Membership of HALs is made up of volunteer members of the public who give their views in a variety of ways, including surveys, informal meetings and serving on NHS user involvement groups. The South Tees HALs provides information via 'Links' - a regular newsletter and it has closed the 'feedback loop' by informing members about the impact their views have had. NHS Trusts and PCTs also respond to members' Self-Reporting Forms showing how their views are improving local services.

For more information:

South Tees CHC
Cleveland Business Centre
1 Watson Street Middlesborough TS1 2RQ
Tel: 01642 254555
Email: chief-officer@ms.stees-chc.northy.nhs.uk

Case study 4: Health Link News

Maidstone and Malling CHC's quarterly 'Health Link News' has 253 local 'reporters' and was commended by a local Non-Executive Director as 'a clear and understandable way of getting a bird's eye view of what is going on locally'.

For more information:

Maidstone & Malling CHC
Ascot House, 22-24 Albion Place

Maidstone, Kent ME 14 5DZ
Tel: 01622 674146
Email: office@mchc.demon.co.uk

Case study 5: Upholding the rights of service users to contribute to the planning process by challenging a rushed consultation process

In October 1998 the local health authority began discussing proposals to change the management of community and mental health services throughout East London. The thrust was to establish two separate 'mega-trusts' – one each for community and mental health services, to replace the three existing community trusts in April 2002. It was said that the impetus for change came from central government.

The CHC contributed to stakeholder workshops in November 1998 and discussed the consequences of the proposals for service users at its public meetings during 1999. It received clear messages from a range of different commentators that the three existing community trusts should remain intact until their functions were taken over by the three PCTs to be established in April 2001. The three CHCs in East London expressed these views to both the health authority and the Regional Office of the NHS Executive, despite which, formal consultation on the original proposals began in September 1999. In October, the health authority included a new option - which was subsequently approved – to retain the community trusts until the PCTs were established. However, no change was made to the proposal for a single mental health trust.

There were no fundamental objections to the establishment of a single trust, but the three CHCs and local mental health organisations were concerned that users should be able to contribute to the decisions about future services. Their fears were confirmed when, only 44 hours after the announcement by the Regional Office that a single trust would be established immediately, the health authority asked the CHCs to comment on which services should go where – effectively excluding users from the process.

On 17th February Newham CHC referred the decision to the Secretary of State for Health, arguing that the views of local service users should be taken into account in planning the range and location of services. However, the process of setting up the new trust was not put 'on hold' pending outcome of the Appeal, and the Department of Health advised the CHC in writing within a month that there

would be no change. The concerns and issues it had raised on behalf of local people were not addressed.

The CHC decided that a continued fight would not benefit users of local mental health services. It therefore worked in partnership with the new trust towards much needed improvements in mental health services in East London.

For more information:

Newham CHC
128 The Grove
Stratford, London E15 1NS
Tel: 020 8534 4217/8
Email: newham-chc@clara.co.uk

Case study 6: Challenging the temporary move of a Special Care Baby Unit (SCBU) and Maternity Service

North West Herts CHC challenged the temporary move of the SCBU and Maternity Service from Hemel Hempstead Hospital to Watford Hospital which it had learned about through the local media. It was concerned about both the process of decision making and about the way in which those decisions were reported to patients and staff. The result was uncertainty and loss of choice for women and their GPs, and demoralisation and confusion for staff who were faced with unsubstantiated rumours about the quality of services.

While the CHC accepted the need for, and welcomed a review of maternity services, it challenged the decision not to publish terms of reference in advance. It had not itself been involved in the decision-making process and pointed out that involving patient representatives would have enhanced that process, and also helped to assure the public that alternatives were considered. It called for a freeze on the move for six months pending review of the decision, and a 'joined up' approach taking account of the wider issues of safety and the impact on other services. It particularly criticised:

Lack of information:

- No background papers detailing the issues to be addressed
- No development or discussion of options

- No rationale for the chosen option
- Slow, incomplete and questionable accuracy of information
- Discrepancies between birth figures provided by the Trust and the local Registrar of Births
- Examples of selective, partial information, e.g. data for SCBU staffing
- Inadequate information for the public about the rationale for proposed closure and how future standards and safety would be maintained
- Absence of risk assessment
- No rationale behind decision to close SCBU
- The lack of a risk assessment before other decisions were taken, especially the impact and risk to mothers and babies, and the effect on other services including the ambulance trust, community midwifery and the capacity of other hospitals to cope
- No evaluation of the quality of services by alternative providers
- No consideration of the impact on the viability of other services provided at the hospital

Referral to the Secretary of State for Health

The CHC referred the closure to the Eastern Regional Office of the NHS Executive, who asked Lord Hunt, Parliamentary Under Secretary of State for Health to convene a Taskforce to restore appropriate maternity services at Hemel Hempstead Hospital as rapidly as possible. The SCBU was moved to Watford Hospital, but two PCTs were commissioned to develop a feasibility study into the provision of Low Risk Maternity Services in North West Hertfordshire. This service was subsequently put into place.

The Strategic Health Authority established complementary Taskforce and Overview Reference Groups on Maternity, with members drawn from the CHC, the National Childbirth Trust, MPs, Local Councillors and professional maternity staff.

Notwithstanding these developments, the CHC agreed that they must act in the public interest by referring both the absence of any meaningful information and the failure of the health authority to consult on this issue. In doing so they secured the involvement of the CHC and the public on the future of maternity services in North West Hertfordshire:

- The timescale for consultation and the medium and longer term plans for SCBU

- Any other 'temporary' decisions about maternity and/or gynaecology services in North West Herts
- The contribution of the CHC, patients and the public in plans to improve services and in debating any 'urgent' proposals for change
- Information to mothers-to-be as to why any decisions would improve the quality of their care and choice(s) when giving birth
- Developing options for the future of this service

For more information:
North West Hertfordshire CHC
1 Canberra House, 17 London Road
St Albans, Herts AL1 1LE
Tel: 01727 855338
Email: nwhertschc@internet.com

Case study 7: Contesting proposals to reconfigure acute services and downgrade a general hospital to 'community hospital' status

The stated aim of the consultation was to meet the standards of the Royal Colleges for the training of junior doctors. Without College approval for training posts the Trust would be unable to recruit doctors, and thus would be unable to provide hospital services for patients.

The key elements of the proposals affected residents in Crawley, Horsham and surrounding areas, including:

- Transfer of all emergency inpatients and complex surgery
- Changing the status of an A&E Unit to 24 hour urgent treatment centre
- Transfer of inpatient Paediatrics and inpatient Maternity; and
- Retention of outpatient, therapy and less complex inpatient work at Crawley Hospital
- Development of Day Surgery Unit and the addition of a renal dialysis unit, Stroke Unit and Foetal Monitoring Unit at Crawley
- Development of services at Horsham – especially additional day surgery
- Retention of the remaining Community hospitals
- The consultation process
- The health authority issued a consultation document and a summary leaflet to most households. It held seven public meetings and information events which were independently chaired by the CHC, and conducted a newspaper campaign.

- The CHC distributed 9000 questionnaires, of which 2013 were returned in time for the CHC's preliminary response to the proposals.
- Key public concerns focused on the proposals to 'downgrade' Crawley Hospital; and:
- Transport, especially for maternity emergencies; distance and inconvenience of public transport
- A&E journey times by private car and ambulance
- Reduced choice, especially for midwifery services
- The impact on East Surrey Hospital which was already overstretched
- The possible impact of a major emergency at Gatwick Airport on East Surrey Hospital
- Whether the changes would prejudice a longer term solution
- Public demand for a new hospital – this would take at least ten years to achieve
- Pressure on the social infrastructure with plans for new housing in West Sussex

Referral to the Secretary of State for Health

Before referring the proposal to the Secretary of State for Health, the CHC sought amendments and guarantees on maternity services, ambulance services, transport, future developments and investment in local health services. These could not be met and it referred the proposals to the Secretary of State for Health. Its reasons included:

- Crawley is a main centre of population with 96,000 residents. This figure is significantly greater during the working week since it is also a major employment centre. In addition it draws people from outside the immediate area to its shopping and entertainment facilities.
- As a new town in the 1960s, Crawley has a high percentage of people reaching 75 years or older within the next decade – set to rise by 50% over the next decade. This age group places greater demands on health services and needs accessible acute services for both patients and visitors. Patient recovery can be aided by regular visits from relatives and friends.
- A significant section of the population has no access to a car, and Crawley has the highest levels of social deprivation in West Sussex. There are poor public transport services, and journeys to alternative hospitals are costly, time consuming and difficult – possibly involving bus or taxi journey from railway stations. It was not clear how often a proposed shuttle bus would run.

- Potential difficulties in getting patients who have had a heart attack to a hospital within the 'Golden Hour' and concern about obstetric emergencies, especially since the journey to Brighton Hospital is hindered by traffic and parking problems.

Outcome

The Secretary of State ordered a moratorium on the transfer of services from Crawley Hospital to east Surrey while a review was carried out. The review involved representatives of local voluntary organisations, local council members, members of the public and medical professions, and CHC representatives. The review group made its recommendations early in 2002 and a decision is awaited from the PCTs and SHAs.

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APPENDIX B: SOME EXAMPLES OF CHC VISITS AND MONITORING PROJECTS

Case study 8: Monitoring the physical environment

Scrutinising infection control policies and practice in hospitals and residential facilities

Hospital acquired infections cause distress to patients and carers, and can have severe implications on a Trust's resources and its ability to admit or discharge patients. East Dorset CHC set out to review the central guidance for the control of infection in hospitals and to establish the extent to which these policies were being followed in hospitals and residential facilities in East Dorset. Central guidance requires Trusts to have:

- An Infection Control Committee
- A deputy for the Chief Executive appointed to liase closely with the Infection Control Team (ICT)
- An infection Control Team comprising Infection Control Doctor(s) (Consultant Medical Microbiologist) and Infection Control Nurse(s)

Key Responsibilities of the Infection Control Committee:

- Identification and control of outbreaks
- Education of all hospital staff in infection control procedures
- Preparation of policy documents
- Annual Programme of work including surveillance of infection
- Implementation of the Annual Programme and regular progress reports to the Chief Executive covering all-important incidents, lessons learned and surveillance and audit results. The reports to be discussed at each Hospital Infection Committee before being sent to the Chief Executive
- An Annual Report
- Liaison with Occupational Health Services and clinical teams on the development of standards, audit and research
- Infection control programme – key points:
- Production and review of policies
- Audit and other mechanisms to evaluate effectiveness and extent of implementation of policies and procedures
- Staff education
- Surveillance – outbreaks, information on trends, sporadic infections etc.
- Monitoring hospital hygiene

- Procedures for transfer and discharge of patients with infection; setting and auditing standards for ICT and other clinical and support services; sitting on relevant committees, etc.

What information did the CHC consider, and where did it come from?

The CHC studied a range of documentation from the Department of Health, the Trust and professional organisations, including:

- Hospital Infection Control: DoH March 1995
- Guidance on Infection Control in Hospitals: RCN 1995
- Guidelines for the control of infection in nursing and residential homes: Dorset HA 1999
- Hospital Acquired Infections: Principles and prevention. Public Health Laboratory Service 1997
- The Economics of Hospital Acquired Infection: E Currie and A Maynard 1989
- Hospital Accreditation Programme, Standards: Kings Fund 1994/5

Other resources:

Briefing session with the Health Authority Consultant in Communicable Disease covering policy issues, hand hygiene/use of protective clothing, disposal of linen and waste, decontamination of equipment and the environment and practice

Methodology:

The CHC wanted to establish whether staff were aware of infection control policies and how to implement them, and to discuss with Hospital Managers and Infection Control staff how data was collected and reports, and how training and education was addressed:

- That best practice in hand-washing was understood and followed and whether basic facilities were appropriate
- Use of disposable gloves and aprons in high risk situations - and the appropriate disposal of those items
- Disposal of soiled linen and waste and the appropriate 'fill level' to avoid spillage and cross contamination.
- Determine the suitability of bins, e.g. pedal operated and fitted with lids to avoid hand-contact.
- Decontamination of equipment and the environment
- Ensuring good practices in disposal of sharps and needles
- Retaining tubing and masks in sterile packaging until needed
- Keeping contaminated items, e.g. soiled linen bags, catheter bags and bottles clear of floors and tables

- Use of heat disinfected and disposable receptacles
- Assessment of different degrees of risk in different procedures, e.g. invasive procedures including insertion of lines and drips represent a high risk, while rehabilitation and assessment is generally low risk

Outcome:

The CHC visited and reported on Acute Hospitals, Community Hospitals and 'Other Facilities'. The great majority of its recommendations were accepted and Chief Executives in Dorset set up a multi-professional Dorset wide team to review the control and management of hospital infections.

For more information:
East Dorset CHC
28 Poole Hill
Bournemouth BH2 5PS
Tel: 01202 292961
Denise.holden@eastdorset-chc.nhs.uk

Case study 9 – Monitoring Medical Care and Treatment

Survey of women's experience of colposcopy

- This survey looked at colposcopy services against a NHS measurement tool:
- Information
- Choice
- Environment
- Facilities
- Counselling
- General satisfaction levels

For more information:
Wigan and Leigh CHC
Suite 7, 2nd Floor, Buckingham Row
Brick Kiln Lane
Wigan WN1 1XB
Tel: 01942 239631
Email: 106030.1067@compuserve.com

Case study 10 - Monitoring Therapy and rehabilitation

The discharge of older people from hospital

Mid Downs CHC adopted a targeted programme of visiting tailored to specific areas of current concern. One such concern, which was clearly a key issue for the community, was that of delayed discharge from hospital. The problem was generally recognised as in need of a range of solutions, and needs to be urgently addressed if plans to modernise the NHS are to make progress.

Patients assessed as being ready for hospital discharge are often unable to leave hospital straight away. There may be a variety of reasons, including:

- Delays in obtaining Social Services funding
- Shortage of continuing care places available locally
- Wait for tertiary referral to a specialist unit
- Wait for home support services to be put into place
- Wait for adaptations or specialist equipment to be put in place at home

The problem in a nutshell:

- There may be resistance from patients who don't feel ready for discharge
- Or resistance from relatives or carers who would prefer them to remain in hospital for a longer period – or until a care home of their choice becomes available
- There may be worries about the cost of a nursing or residential home
- People may be reluctant to give up their independence and resist making a decision to move into long-term care, even when they are assessed as needing it
- There may be a shortage of residential or nursing home places – many homes are closing and some patients are offered places out of district
- Patients waiting for transfer are at risk of hospital acquired infections such as MRSA – or they may lose confidence during their wait for discharge
- Trolley waits in A&E become longer when there is no spare capacity on wards
- People wait longer on waiting lists for operations – some may then have to be admitted as emergencies
- There are a growing number of older people, many of whom are frail and vulnerable
- There are a growing number of people with dementia or Alzheimer's Disease, placing additional pressures on community based places

Mid Downs CHC visited hospital wards specifically to talk to patients on a one-to-one basis about their discharge arrangements, using a questionnaire to aid the process. The aim was to find out:

- When the subject of discharge was first raised and by whom
- If patients were happy with the information they received and the arrangements being made for them
- Whether they felt that appropriate information had been given to relatives or carers
- Where patients had been living prior to admission, i.e. at home or in residential care
- Whether the admission was planned or was an emergency or a readmission
- How long people had been in hospital

The CHC felt that much could be learned by talking direct to patients and listening to their experiences. It concluded that this is a shared problem, and its report and conclusions were disseminated widely throughout the community in order to stimulate discussion and action by all stakeholders, including hospitals, PCTs and strategic health authorities, housing agencies, social services and the voluntary sector.

- Carers must have their own assessment and the opportunity for respite care
- Identify and assess patients who are 'at risk' and support them in independent living for as long as possible. If continuing care becomes essential, make sure that patients have all the information they need to enable them to make a suitable choice
- A single assessment process
- Rapid development of intermediate care:
    - More step down/step home beds
    - Enlarged Medical Assessment Units
    - More intensive home nursing and additional community nurses
    - More therapy treatment in the home
- Helping patients and families to avoid accidents
- Improved communications between agencies
- Improved communications with the wider public

For more information:
Mid Downs CHC
Maxwelton House, Boltro Road
Haywards Heath
West Sussex RH16 1BJ

Tel: 01444 450025
Email: middowns@hotmail.com

Case study 11 – Monitoring the emotional environment

Young Persons' Sexual Health Information Conference

A report of the Sexual Health Information Conference organised by the 'Shadow' CHC made up of local young people.

For more information:
Basildon, Brentwood and Thurrock CHC
67 Southernhay
Basildon
Essex SS14 1EU
Tel: 01268 284602
Email: basbt@essexchcs.freeserve.co.uk

Case study 12 – Monitoring the intellectual environment

Cardiac Rehabilitation – views of patients and carers

Patients and carers took part in a consultation on cardiac rehabilitation services. The project was commissioned by South Gloucestershire PCT and organised by North Bristol Trust and the Local Voices Project at the CHC. A high percentage of patients responded through discussion groups and detailed telephone conversations. A full report is available of patient's views, comments and ideas for improving different stages of the inpatient, rehabilitation and primary care service. A clear message that came across was that if the structured discharge care plan, rehabilitation programme and a clear link to primary care worked, it was invaluable.

For more information:
Bristol and District CHC
3rd Floor, Riverside House
Welsh Back, Bristol BS1 4RR
Tel: 0117 975 3800
Email: office@bristolchc.org.uk

Case study 13 - Monitoring the social environment

Privacy and dignity audit

The principal aim of the audit was to look at the availability of washing and toilet facilities and management of mixed sex wards to ensure that guidelines are being followed. In the course of the audit, however, it became obvious that other privacy and dignity issues needed to be addressed.

For more information:
Salisbury and District CHC
95 Crane Street
Salisbury, Wiltshire SP1 2PU
Tel: 01722 342736
Email: sbealy@salisburychc.demon.co.uk

Further reading:

Directory of CHCs and public involvement 2002 (resource pack), Southend District CHC

APPENDIX C USEFUL WEBSITES REFERRED IN THIS PACK

Enter the website and then simply click on the topic you require from the long list:

ACHCEW website – **www.achcew.org.uk**

CHI – www.chi.nhs.uk

Department of Health website - **www.doh.gov.uk**

The NHS website **www.nhs.uk/thenhsexplained/default.asp**

Examples are given here:

Financial and planning	**www.doh.gov.uk/nhsfinancialreforms.htm**
Improvement, Expansion Reform: the next 3 years, Priorities & Planning Framework 2003-2006	**www.doh.gov.uk/financialreforms.htm**
Life Long Learning	www.doh.gov.uk/lifelonglearning
Modernisation Board	**www.doh.gov.uk/about/modboard/htm**
Modernisation Agency	**www.doh.gov.uk/about/modagency/htm**
National Service Frameworks	**www.doh.gov.uk/nsf/about.htm**

Other useful websites are:

Health Development Agency	**www.had-online.org.uk**
Local Strategic Partnership	**www.lsp.eastriding.gov.uk**
National Association of Public Health Observatories	**www.pho.org.uk**
National Patient Safety Agency	**www.npsa.org.uk**

APPENDIX D GLOSSARY

ACHCEW	Association of Community Health Councils for England and Wales
CHC	Community Health Council
CHD	Coronary Heart Disease
CHI	Commission for Health Improvement
CHAI	Commission for Healthcare Audit and Inspection
CPA	Care Programme Approach
CPPIH	Commission for Patient and Public Involvement in Health
DoH	Dept of Health
DHSC	Directors of Health and Social Care
EFL	External Financing Limit
ERG	External Reference Group
GMC	General Medical Council
GMSL	General Medical Services Council
GOS	General Ophthalmic Service
HCHS	Hospital and Community Health Services
HAD	Health Development Agency
HAZ	Health Action Zone

HIMP	Health Improvement Programme
ICAS	Independent Complaints Advocacy Services
LIFT	Local Improvement Finance Trusts
LSPs	Local Strategic Partnerships
NCAA	National Clinical Assessment Authority
NICE	National Institute for Clinical Excellence
NCSC	National Care Standards Commission
NPSA	National Patient Safety Agency
NSF	National Service Frameworks
OSC	Overview and Scrutiny Committee
PALS	Patient Advisory Liaison Service
PAS	Performance Assessment Framework
PCT	Primary Care Trust
PES	Public Expenditure Survey
PF	Patients' Forum
PFI	Public Finance Initiative
PMS	Personal Medical Services
PPP	Private Public Partnership
RES	Race Equality Scheme

SAFF	Service and Financial Framework
StHA	Strategic Health Authority
SoS	Secretary of State
SLA	Service Level Agreement
TPCT	Teaching Primary Care Trust

ACHCEW, Earlsmead House, 30 Drayton Park, London, N5 1PB, 0207 609 8405