"COMMUNITY HEALTH COUNCILS AT THE MILLENNIUM"

'The views of CHC members'

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November 1995

'CHCs at the millennium'

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INVESTING IN CHCs

The 'CHCs at the millennium' project was started in an attempt to raise the level of debate about the future of CHCs, at a time when the only discussion taking place concerned the form that establishing arrangements might take for CHCs. In this respect the project has contributed to the wider debate about the nature of CHCs and the possibilities which present themselves in an era of the contract culture in the NHS.

The project was also a first attempt at seeking the views of all CHC members and co-opted members across England & Wales. Over 4,000 reports were sent to CHCs and the response rate was just over 1,000. This report is based on an analysis of the first 864 questionnaires. It has proved to be the single biggest survey of CHC members ever undertaken in the 21 year history of CHCs and offers a valuable litmus test of opinion with further opportunity for such opinion gathering in the future.

Finally, the project did not seek answers to current problems, but sought to raise awareness of issues which deserved further detailed consideration by CHCs , their membership, staff, and bodies representing their opinions,- such as ACHCEW.

Many telling remarks have been made by CHC members in response to an open ended question contained in the pull out questionnaire in the report, with members frequently referring to the "increasing complexities of CHC work" in the context of a voluntary membership, sometimes of "being led too closely by officers", but, more often than not, of the pleasure at being "invited to offer their views directly on the likely futures for CHCs". Addressing the question of *investment in CHC membership* will be the main focus of this report.

CHC MEMBERSHIP PROFILE

The first part of the pull out members questionnaire contained in the 'CHCs at the millennium' report was devoted to obtaining information about the background of existing CHC members and the time spent on CHC duties. It is worth remembering that CHC membership is not, however, recognised as a public duty - unlike, for instance, Non - Executive Directors of Health Authorities or school governors. CHC membership may seem an anachronism in a service now dominated by the contract culture, with CHC members being expected to act as volunteers.

The findings of the questionnaire may not startle many people, but they do offer some very clear information about issues which need to be addressed when finding a balance in the hours expected of CHC members and in the continuing problem of finding new members.

On the question of the age range of respondents, the overwhelming majority (56%) were aged between 55 to-69 years. 26% were slightly younger - 40 to-54 years - and 12.5% were of 70 years and over. Only 0.23 % were aged between 16 to 24 years of age. These figures offer an interesting insight into CHC membership - an apparent lack of attraction to CHC activity for younger aged people; and the need to reflect upon training needs and scope of CHC work which can more readily be undertaken by members within the known age profile.

Nearly half of the respondents (47%) were in their 1st term of membership, 34% in their 2nd term , and 12% indicated that they were now serving for a 3rd term of office. These figures clearly indicate that there is a healthy turnover of CHC membership and that a reasonable level of new members were being attracted to CHCs. When constructing training opportunities for members these statistics may prove useful in targeting audiences.

CHC MEMBERSHIP PROFILE (continued)

It may come as no surprise to learn that 57% of respondents were currently retired from full time work. 30% were employed (6%) were self employed. The remaining 12% were either in unpaid employment or unemployed.

56% of respondents were female and 44% male and from all the replies nearly 14% stated that they suffered from a known disability.

5% of respondents self identified as being non white. Within the detailed breakdown of that 5%, as this amounted to small absolute numbers of people, the proportions may not prove adequate enough to extract any further meaningful information.

On joining a CHC too many members appear not to have been advised of the level of time commitment for CHC duties, or were informed that it would only amount to a few hours a month. In contrast, just under 50% of members state that CHC work was taking an average of around 4-6 hours a week. A significant proportion, 21%, claim that CHC work takes between 8-12 hours of their personal time / week. Most interestingly, 14 members indicated that they were dedicating 20 hours and over / week on CHC duties.

The sheer amount of time devoted to CHC work, on a voluntary basis, is outstanding and indicates a need for greater recognition than mere thanks. In total, the figures indicate a workforce of volunteers averaging nearly 3,000 hours a week on CHC duties -or 100,000 hours a year working for the NHS without pay.

This level of commitment would amount to three W.T.E. staff for each CHC.

CHC MEMBERSHIP PROFILE (continued)

Lessons to be learnt from the membership profiles suggests that action is required in the following areas:

- **establish an active campaign to recruit younger members;**
- **training for current members should take account of age profiling;**
- **Schemes need to be developed to attract more non retired people into CHCs;**
- **further detailed research work is needed to identify / monitor levels of CHC members from black and other ethnic communities;**
- **CHCs need to be more honest and explicit about the amount of time required of CHC members;**
- **A more detailed audit of time spent on CHC duties needs to be undertaken for the benefit of members, an upper limit being placed on the amount of time spent on CHC duties.**

DEVELOPMENT OF CHC MEMBERS' NEEDS

The needs of CHC members should not be viewed in isolation. Lay monitoring by Non Executive Directors (NEDs) within the NHS is undergoing rapid change. As from 1st April 1996 Regional Authorities and Family Health Authorities will disappear and, consequently, the actual numbers of NEDs will significantly diminish. Additionally, Trusts are merging and the number of fund holding GPs is increasing. The accumulated impact of these changes will result in a further increase in the burden placed on the already modest level of member representation in CHCs. By the same token, the introduction of Total Purchasing Pilots (TPPs) will further shift CHC interests and, in the medium / longer term, increase CHC workload.

At this time, the challenge facing CHC members could not appear greater in the defence of lay interests in the NHS. And in order to achieve even more than at present, CHCs require an active programme of investment in the training and development potential of their members.

Throughout the millennium questionnaire, members identified overwhelming support for such needs to be addressed. 90% of respondents clearly expressed the need to develop existing methods of working and to find new ways of undertaking their public duties. 78% recognised that they could not do this alone and welcomed greater partnership arrangements with Trusts and Authorities. 81% wanted to see improvements to existing information sharing and the integration of current information sources. 85% sought improvements in the role of CHCs in respect of the CHC empowerment role and 97% believed CHCs should actively encourage the development of advocacy services.

Most notably, 90% agree that new tools are required. 94% of respondents were in support of the statement that "it is important to address the development needs of CHC members" and 89% wanted "more developmental training opportunities" to assist in the process of change that is taking place. Obvious conclusions could be drawn from the members replies made, and some initiatives are currently being worked on to address the more basic needs.

DEVELOPMENT OF CHC MEMBERS' NEEDS (continued)

However, the development of CHC members as validators of NHS decision taking and initiators of public interest in the NHS would now appear more essential than ever. A lack of investment in the abilities of CHC members at this stage would merely undermine the basic fabric of public confidence in the NHS.

To improve the efficiency and effectiveness of CHC membership will require:

- ***expansion of existing skill training programmes for CHC members;***
- **further in depth identification of training needs for CHC members;**
- **immediate consideration being given to a programme of developmental training;**
- **ACHCEW to consider the value of establishing a CHC membership database and sponsorship of regular surveys of CHC membership opinion**
- **the Department of Health to reflect on the need to improve levels of investment in CHC members needs and support.**

CHCs AS A VALUABLE RESOURCE

Consistent challenges have been made over the years to abolish CHCs and each time this has occurred, for one reason or another, CHCs have emerged unscathed. This could be due to the strength of argument in favour of CHCs, or they could merely have been seen as a convenient window dressing to address the question of public accountability. What CHCs *cannot be accused of is being* an expensive form of local representation. Compared to the accountability of Local Authorities - where local people elect Parish, District, County and Borough Councillors to represent their interests - levels of CHC membership are, by comparison, very modest . But what is the intrinsic value of CHCs?

A watchdog without teeth? A sop to democracy? A valuable local resource...

CHCS - A UNIQUE CHALLENGE

By the turn of the century the landscape of the NHS will have altered *dramatically. The NHS 'reforms' will* have become part of history and, most probably, there will be greater devolution of responsibility from the centre to local areas - whether they be Health Authorities or GPs deciding upon the nature of the services needed by the patients and general public. So where might be the contribution of CHCs?

The single most important attribute, which CHC members jealously guard is their autonomy and independent status. 97% of respondents consider this to be of critical importance to the current and future value of CHCs. 79% of respondents are of the opinion that their local Health Authorities value the CHC independent status, as it offers Authorities the opportunity of having their decisions ***validated*** by an independent public body - as well as being invited by CHCs to be accountable to the public on proposals for change.

Another explanation for the strength of CHC members opinion about independence and autonomy could be that members do not receive any reward for their efforts.

CHCS - A UNIQUE CHALLENGE (continued)

Members often perceive themselves as being 'informed' lay people, as they more clearly understand the jargon and language of the NHS, and also some of the fairly sophisticated arguments about rethinking existing patterns of service delivery. In itself this can lead to conflict as to whether CHCs should merely reflect local peoples views, or act to represent their best interests.

The dichotomy for CHCs is balancing the two positions - continually seeking an assessment of how valuable the CHC has been in its representative role. What has the CHC achieved on behalf of its constituency of interest?

85% of respondents accept that their CHC reflects the grassroots concerns of the wider community. So, if the internal belief in the CHC's ability to listen and reflect is high, how do we show this is the case to the outside world? When asked a question about the need of CHCs to improve existing skills of empowerment, 85% stated they were convinced that this was necessary. Perhaps then, the internal belief is high because it is CHC members themselves that are the main witnesses of their own actions. This is not to say that members want this state of affairs to remain - 82% are of the opinion that CHCs should be more accountable for their actions to local people. This may also refer to the role which some CHCs perceive they have in informing and educating the public about local health services. And, in addition, 98% of those responding considered it was particularly important for CHCs to ensure that advocacy services are developed - which may be an extension of the view that CHCs recognise local need and use their position to ensure that it happens, as CHCs do not have the immediate resources to sponsor such change.

All of these findings fit well with previous research into CHCs, where differing models have been identified - along a scale which includes consumer advocate, patient's friend, independent arbiter, DHA partner and independent challenger.

CHCS - A UNIQUE CHALLENGE (continued)

The most significant change amongst CHCs at this stage is the desire of members to introduce more public accountability into the process by which CHCs perform, and a recognition that CHCs could offer more to the NHS in terms of community development - so long as adequate investment is made in terms of CHC member development as the same time.

A significant challenge exists for CHCs, and the funders of CHCs, to meet an agenda for change that needs to accommodate:

- **maintenance of the ability of CHCs to act in the capacity as validators of both purchasers and providers decisions;**
- ***acknowledge the need for members time on CHC duties to be recognised as a public duty, in much the same way as school governors;***
- ***review the need to offer honorariums to CHC members elected to public positions as CHC Chair and Vice Chair;***
- **as part of a developmental package, review the current techniques of accountability to local people and forge new *methodologies;***
- **sponsor proposals for the establishment of an independent development agency for pursuit of public interests in the NHS , to include the needs of CHC members and staff.**

ASSESSING THE VALUE OF CHCs

A further aspect of the contract culture which CHCs are being asked to address in respect of CHC accountability is the need to agree explicit standards to measure performance - which can then be subjected to regular revision in negotiations between the 'buyer' and 'supplier'.

In the past, CHCs have pressed for the identification of such measures within the NHS and have proposed, for instance, an original charter for patients. The process of top down standard setting in the Patients' Charter and resultant NHS 'League Tables', however, finds little resonance amongst many CHCs, whose main focus of interest is centred on local needs. CHCs know, from the local perspective, that, unless projected standards are agreed and 'owned' by those who are expected to meet them , the achievement of set standards may simply degenerate into a statistical exercise which will not meet the desired improvement.

The target of public accountability for CHCs is not in question, but the means of achieving such accountability is open to debate. Over recent years, ACHCEW has continued to actively promote the interest of member Councils in the development of CHC performance standards; CHC objective setting and review process; and resource allocations to CHCs. CHC members views on these questions have produced a most interesting insight into the desire of voluntary members to address issues of public accountability.

CHC STANDARDS - GROWTH OR RESTRAINT?

The debate about standards for CHCs is now less about whether they are necessary and more about how they might best be implemented and monitored. CHC members overwhelmingly recognise and accept the need to set explicit standards for the service which they provide to the public and other users, yet it is known that the process of implementation is proceeding at a slow pace. ACHCEW's publication of 'Performance standards for CHCs' in 1994 assisted the debate, but developments have been rather ad hoc. An unmistakable view is expressed by over 80% of respondents to the millennium questionnaire, in that CHCs should be subject to explicit service standards in the work they undertake.

CHC STANDARDS - GROWTH OR RESTRAINT? (continued)

An inherent paradox exists, however, in members responses on the question of standards. Over two thirds believe that standards should be linked to the allocation of resources to CHCs, but fewer than 5% want the NHS Executive to have a prominent role in either setting or monitoring standards. But it cannot be denied that, so long as the NHS Executive plays a role in the distribution in resources, they will have a legitimate interest in how those resources are being used. In this respect, CHCs need to recognise and accommodate the role of the NHS Executive, at Regional and National levels.

77% of respondents are of the opinion that the procedure needs external validation, although there is little consensus as to who should undertake this role. Use could be made, in this instance, of the contracting process to introduce third party monitoring of standards.

Debate on standards has centred on local variability between CHCs and the need to ensure that organisations that promote accountability are themselves accountable in a meaningful way. CHC members do, however, recognise that there is an important role for CHCs in the determination of local standards. 41% consider that CHCs alone should be responsible for the development of standards. This would immediately raise the question of how to address the issue of variability - with the outside world having a legitimate complaint that 'in house' standards were being set at the lowest common denominator.

Discussion about CHC standards cannot be considered in isolation from other stakeholders views - members, local organisations, complainants, the general public, NHS bodies, and the wider community which CHCs represent. Gathering and accommodating such views will be critical to the success and continuing development of standards.

Only 28% of respondents expressed the view that ACHCEW should play a main role in setting standards and a similar number (25%) consider the Association should be responsible for monitoring the implementation. It would appear that members would resist ACHCEW having a direct or leading role in the standard setting process. Acting in an 'enabling' capacity could, of course, alter this position.

CHC STANDARDS- GROWTH OR RESTRAINT? (continued)

ACHCEW might, for instance, ensure that a set of core standards were made available for use in a local context -upon which local consultation might then take place with stakeholders. Such baseline standards might then be linked to a core allocation by the NHS Executive, which would then be in a position to satisfy itself, year on year, that progress was being made.

As mentioned above, independent monitoring of this process is critical to its success.

Within such a model, CHCs would retain their ability to allocate resources towards the development of identified standards, at the same time as ensuring that other standards were maintained at the required minimum. Development plans could then be agreed with the local CHC and the NHS Executive, to include a dual responsibility for the achievement of the plan. Elements of development plans could also be subject to 'performance related' allocations. Obviously, in this context, criteria for such development needs to be related to quality improvements, not quantity.

Accountability to local people features as a high priority amongst CHC members, including the need to be held accountable for actions, views and policies. 95% of respondents consider this to be important or very important. But traditional methods may need to be reviewed - Annual reports, public meetings and publications of CHC papers are all actively undertaken by CHCs. Relatively few members recognised a need to extend the formal methods to include the Annual Plan (14% support), or surveys of local opinion (17%).

CHCs would be the first to criticise Health Authorities or NHS Trusts if they viewed their responsibility to be accountable through the relatively narrow channel of an Annual Report or Annual General Meeting. CHCs may not, of course, yet be ready to accept the challenge of demonstrating their accountability to local communities. In the era when GPs and their status in the process of purchasing services could not be greater (Total Funding Pilots), the ability of CHCs to seek further confidence from the public in carrying out public duties can only enhance their position as autonomous validators.

CHC STANDARDS- GROWTH OR RESTRAINT? (continued)

95% of respondents stated that their CHC undertook an Annual review of its own priorities. On further analysis, however, it became clear that, in one or two CHCs, there was confusion as to what was meant by a CHC Review.

There remain many unanswered questions in respect of how standards can be maintained and developed and to demonstrate to the public, to whom the CHC is ultimately responsible, how it is intended to improve the values of the CHC. Consideration of the following needs to be addressed:

- **how to introduce an arrangement for independent validation and assessment of CHCs performances;**
- ***refine the role of ACHCEW in the process of setting core standards for CHCs;***
- **extend existing lines of CHC accountability to accommodate the direct views of other stakeholders.**
- ***refine the process of objective setting by 'CHC self review'.***

APPENDICES

CHCs at the millennium questionnaire

Table 1	Membership profile
Table 2	Hours spent on CHC duties
Table 3	Preliminary advice on time spent on CHC duties
Table 4	Analysis of responses to questionnaires

Your Views

CHC

PLEASE TICK WHERE APPROPRIATE

NOMINATING BODY

- Local Authority ☐
- Voluntary Group ☐
- RHA ☐
- Co-opted member ☐

LENGTH OF CHC MEMBERSHIP

- 1st term ☐
- 2nd term ☐
- over 2 terms ☐
- Other periods ☐

AGE RANGE

- 16-24 ☐
- 25-39 ☐
- 40-54 ☐
- 55-69 ☐
- 70+ ☐

SEX

- Male ☐
- Female ☐

DO YOU HAVE A DISABILITY?

- Yes ☐
- No ☐

ECONOMIC STATUS

- Are you currently in paid employment? ☐
- Self employed? ☐
- Are you currently in unpaid employment? ☐
- Unemployed? ☐
- Retired? ☐

WHICH OF THE FOLLOWING BEST DESCRIBES YOUR ETHNIC BACKGROUND?

- White ☐
- Black - British ☐
- Black - Caribbean ☐
- Black - African ☐
- Indian ☐
- Pakistani ☐
- Bangladeshi ☐
- Chinese ☐
- Other ☐

WHEN YOU JOINED THE CHC, WHAT ADVICE WERE YOU GIVEN ABOUT THE TIME IT MIGHT TAKE?

- No advice ☐
- a few hours a month ☐
- a few hours a week ☐
- more than a few hours a week ☐
- Other ☐

HOW MUCH TIME DO YOU SPEND ON AVERAGE ON CHC DUTIES?

- per week ____ hours
- per month ____ hours

Cont....

Community Health Councils at the millennium

The views of CHC members

May 1995

All CHC members and co-optees are invited to complete and return this questionnaire. There is space on page four for any supplementary comments you may have.

Responses will be analysed, and the results will help inform the debate about future thinking for CHCs.

The questionnaire does not address the issue of resource constraints currently imposed on CHCs.

On completion of the questionnaire, please remove the centre pages of the document for return to:

CHCDA
FREEPOST 1534
PRESTON
PR3 0BR

using the FREEPOST envelope provided by 31 May 1995.

YOUR VIEWS

This, to our knowledge, is the first time all CHC members have been asked for their views on the future direction and development of CHCs.

This questionnaire has been devised to highlight the key issues facing CHCs as we come into the millennium. The current changes in the NHS give us an opportunity to determine our CHC agenda. It is important that you contribute to this debate.

Below are a series of statements, please indicate your response by ticking the appropriate box:

1 = Wholly agree	2 = Partly agree	3 = Neither agree or disagree	4 = Partly disagree	5 = Wholly disagree

1 It is important for CHCs to remain as autonomous and independent bodies within the NHS.

1	2	3	4	5

2 Do you consider the local Health Authority values the independent nature of CHC contributions to health debates?

Yes ☐ No ☐

3 *It is important for CHCs to be held accountable for its actions to local people.*

1	2	3	4	5

4 *It is important for CHCs to be held accountable for its views and policies to local people.*

1	2	3	4	5

5 CHCs are the best agents, in consultation with local interests, to devise the most appropriate boundaries locally, for the purpose of CHC representation.

1	2	3	4	5

6 CHCs are, by law, subject to the Access to Public Information Act; are obliged to publish Annual Reports; meet once every three months and meet Health Authority(s) at least once a year. How else does your CHC make itself accountable to local people?

Surveys of local opinion	☐	Surveys of users of CHC services	☐
Focus Groups	☐	Annual Reviews of CHC activity	☐
Publication of Annual Plan	☐	Radio 'Phone-Ins'	☐
Computer Information Services	☐	CHC Newsletter contact	☐
Others			

7 *As from next April it is intended that CHCs will be established by the Regional Office of the NHS Executive. It has been suggested that this would diminish current levels of accountability for CHCs and would detract from their known role as an independent voice.*

1	2	3	4	5

8 Sould CHCs be subject to explicit standards in the provision of services they provide to the public?

Yes ☐ No ☐

9 If local standards were to be set for CHCs, who should be held responsible for developing them?

Local CHC	☐	ACHCEW	☐
NHS Executive	☐	Audit Commission	☐
Independent Agency	☐	Other	

(You may tick more than one box)

10 And, who should be responsible for policing the implementation of standards?

Local CHC	☐	ACHCEW	☐
NHS Executive	☐	Audit Commission	☐
Independent Agency	☐	Other	

(You may tick more than one box)

11 The current policies of this CHC reflects grassroots concerns of the wider community.

1	2	3	4	5

12 Does your own CHC undertake an Annual Review of its own priorities?

Yes ☐ No ☐

13 The allocation of resources to CHCs should be linked to the setting of standards.

1	2	3	4	5

14 *External evaluation of CHC activities offer added benefits to their performance.*

1	2	3	4	5

15 It is important to link the development and implementation of CHC standards to a formal review of regulations governing the relationship between CHCs and other NHS agencies - Authorities/ Commissions/Trusts/GP Fundholders.

1	2	3	4	5

16 In the shift towards a 'primary care led' NHS, CHCs need new tools to meet the changes.

1	2	3	4	5

17 It is important for CHCs to continue in the role of facilitating, consultation, networking and building alliances with other agencies.

1	2	3	4	5

18 CHCs should promote/facilitate the development of advocacy services.

1	2	3	4	5

19 *CHCs should become more closely involved, as partners, with health commissioners/providers, in purchasing and quality monitoring.*

1	2	3	4	5

20 CHCs should actively recognise the constraints placed on Authorities and promote understanding of their strategic/wider picture.

1	2	3	4	5

21 *CHCs should move away from being seen as the voice of the people towards the role of facilitating consultation, networking and actively encourage collaboration with a range of agencies.*

1	2	3	4	5

22 CHCs should take less account of Authorities' plans/constraints and focus more directly on the representation of local people's expressed interests.

1	2	3	4	5

23 CHCs existing skills of empowerment and facilitation need to be improved.

1	2	3	4	5

24 CHCs should engage in the discussion about rationing healthcare.

1	2	3	4	5

25 There is a need to review the integration of information obtained from other sources (eg. Local Authorities) into CHC activity.

1	2	3	4	5

26 *There is a need to review how CHCs currently share information/good practices.*

1	2	3	4	5

27 It is important to address the development needs of CHC members.

1	2	3	4	5

28 CHC members need more developmental training opportunities (eg. Leadership, advocacy, facilitation) to assist in relating to the changed NHS.

1	2	3	4	5

CHCs at the millennium Table 1

Nominating Body	no reply	Local Authority	Voluntary Group	RHA	Co-opted member		
	6	305	306	157	90	864	
%	*0.69%*	*35.30%*	*35.42%*	*18.17%*	*10.42%*	*100%*	
Period of CHC membership	***no reply***	***1st term***	***2nd term***	***3rd term***	***other***	**Total**	
	24	406	291	102	41	864	
%	*2.78%*	*46.99%*	*33.68%*	*11.81%*	*4.75%*	*100%*	
Age	**no reply**	**16 - 24 yrs.**	**25 - 39 yrs.**	**Totals**			
	2	2	46	50			
%	*0.23%*	*0.23%*	*5.32%*				
	40 - 54 yrs.	55 -69 yrs.	70 + yrs.		864		
	226	480	108	814			
	26.16%	*55.56%*	*12.50%*				
Sex	no reply	Male	Female	Total			
	4	379	481	864			
%	*0.46%*	*43.87%*	*55.67%*				
Disability	No reply	Yes	No	Total			
	33	123	708	864			
%	*3.82%*	*14.24%*	*81.94%*				
Economic Status	No reply	Paid employment	Self employed	Unpaid employment	Unemployed	Retired	Total
	7	206	52	59	50	490	864
%	*0.81%*	*23.84%*	*6.02%*	*6.83%*	*5.79%*	*56.71%*	
Ethnic Background	no reply	white	black - british	black - caribbean	black - african		Total
	2	821	6	5	1	835	
%	*0.23%*	*95.02%*	*0.69%*	*0.58%*	*0.12%*		864
	indian	pakistani	bangladeshi	chinese	other		
	11	7	1	0	10	29	
%	*1.27%*	*0.81%*	*0.12%*	*0.00%*	*1.16%*		

Membership profile

CHCs at the millennium Table 2

Hours	No of responses	Total hours/ week	%	No of responses	Total hours/ month	%
0.00	403		14.70%	310		3.69%
0>				1		
1.00	16	16	0.58%	3	3	0.04%
1.50	1	1.5	0.05%			
2.00	67	134	4.89%	12	24	0.29%
2.50	3	7.5	0.27%	1	2.5	0.03%
3.00	61	183	6.67%	1	3	0.04%
3.50	1	3.5	0.13%			
4.00	68	272	9.92%	41	164	1.95%
4>6				1	5	0.06%
4.50	1	4.5	0.16%			
5.00	49	245	8.93%	20	100	1.19%
5>7	1	6	0.22%			
6.00	63	378	13.78%	48	288	3.43%
7.00	8	56	2.04%	10	70	0.83%
7.50				1	7.5	0.09%
8.00	30	240	8.75%	54	432	5.14%
9.00	3	27	0.98%	9	81	0.96%
10.00	39	390	14.22%	68	680	8.10%
12.00	17	204	7.44%	58	696	8.29%
13.00	1	13	0.47%	1	13	0.15%
14.00	1	14	0.51%	8	112	1.33%
15.00	7	105	3.83%	20	300	3.57%
16.00	2	32	1.17%	20	320	3.81%
17.00				2	34	0.40%
18.00	2	36	1.31%	5	90	1.07%
19.25	1	19.25	0.70%			
20.00	8	160	5.83%	46	920	10.96%
20>	1	20	0.73%			
21.00				1	21	0.25%
22.00				3	66	0.79%
24.00	1	24	0.88%	21	504	6.00%
25.00	1	25	0.91%	7	175	2.08%
26.00				3	78	0.93%
28.00				9	252	3.00%
30.00	3	90	3.28%	15	450	5.36%
32.00				5	160	1.91%
35.00				1	35	0.42%
36.00	1	36	1.31%	1	36	0.43%
40.00				13	520	6.19%
42.00				3	126	1.61%
45.00				3	135	1.61%
48.00				2	96	1.14%
50.00				7	350	4.17%
52.00				1	52	0.62%
56.00				1	56	0.67%
60.00				4	240	2.86%
64.00				2	128	1.52%
72.00				1	72	0.86%
80.00				1	80	0.95%
100.00				3	300	3.57%
120.00				1	120	1.43%
		2742.25			8397	

Hours spent on CHC duties