ASSOCIATION · OF
COMMUNITY HEALTH COUNCILS
FOR · ENGLAND · & · WALES
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14th December 1989

PARLIAMENTARY BRIEFING
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NATIONAL HEALTH SERVICE AND COMMUNITY CARE BILL

CLAUSE 1, CLAUSE 2 AND SCHEDULE 1

Streamlining the NHS

Clauses 1 and 2 of the Bill provide for the establishment of the new "streamlined" Health Authorities and Family Practitioner Service Authorities. The NHS White Paper, "Working for Patients", boasted that "The overall effect of these changes will be to introduce for the first time a clear and effective chain of management command running from Districts through Regions to the Chief Executive and from there to the Secretary of State." This intention has, in fact, been evident for some time and has led to the increasing marginalisation of health authority members, as general managers have appeared to respond to directives from on high.

The users' voice

It is important that in establishing such a chain of command, increased emphasis is given to a stronger voice for the user of service. This point was well recognised by the Institute of Health Services Management in the report of their Working Party on Alternative Delivery and Funding of Health Services. This saw it as essential for there to be "truly powerful local bodies... in the community to affect the health service as it operates in their locality."

Health Authority and FPSA members

The size of RHAs, DHAs and FPCs (now FPSAs) is to be cut significantly. Local authority nominees are to disappear. The removal of local council representatives removes the last health

authority members who could have been seen in any way as directly and personally accountable to the local population. All members of RHAs, DHAs and FPSAs will now be appointed by the Secretary of State or his/her nominees, (Schedule 1, paragraphs 1(1), 2(1), 3(1), 4(1), and 5(1)). When this is coupled with the overall reduction in size of health authorities and the greater role of professional managers, it is apparent that the degree of lay influence over the organisation and planning of the service will have been sharply diminished. The Association of CHCs deeply regrets this. Arrangements need to be made for lay people representative of the local Community to be appointed to DHAs and FPSAs.

The role of CHC observers

While the CHC observers at health authority meetings have often been better informed about what has been going on in the local services than the DHA members themselves, there is no doubt that the presence of a range of lay DHA members did at least provide some occasional check on rampant managerialism.

The role of CHC observers on DHAs and FPSAs will become even more important. Indeed, CHCs should also now be given the right to observer status on DHA and FPSA committees and sub-committees. The Secretary of State is taking powers to make regulations on the constitution of DHA and FPSA committees and sub-committees (schedule 1, clause 9). It would therefore be possible in principle for CHC observer status to be required by these means. It is not clear that this is the Government's intention.

There are at present no arrangements for CHCs to have observer status at meetings of Regional Health Authorities.

Remuneration of health authority members

According to the Financial and Explanatory Memorandum to the Bill, the power to offer remuneration to non-Executive members of health authorities and FPSAs (schedule 1, paragraph 7) will lead to an estimated increase in costs of up to £ 10.5 million. This compares with the total cost of CHCs in England and Wales which amounts to some £ 7 million. There is no remuneration offered to the 4000 or more CHC members who give their time and energies voluntarily.

Boundary alterations and mergers of DHAs and of FPSAs

Clause 1(1)(c) and clause 2(3)(b) abolish the requirement to consult before changing the boundaries of DHAs and FPSAs. The White Paper envisaged that, particularly as hospitals become self-governing, DHAs would merge with their neighbours and possibly even with FPSAs. Those clauses are clearly designed to make this easier. It follows on from a process of ad hoc mergers that have taken place in a number of regions.

Larger health districts are likely to be remote from patients. Moreover, recent DHA mergers have been followed by the merger of

the respective CHCs which has made it more difficult for individual patients to be represented and for the specific concerns of local communities to be articulated.

In any event, it is of concern that there would in future be no consultation on such proposals.

This briefing is prepared by the Association of Community Health Councils for England and Wales (ACHCEW). ACHCEW was set up in 1977 to represent the consumer of health services at national level and to provide a forum for member CHCs. 194 CHCs in England and Wales are members of the Association. ACHCEW is mainly funded by subscriptions from individual CHCs, but also receives grants from the Department of Health and a number of bodies.

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Clause 1, Page 2, Line 17 at end add -
'(6) There shall continue to be a Community Health Council on each District Health Authority and such Community Health Councils shall be administered by an independent agency.'

This amendment provides an opportunity to confirm again that Community Health Councils will continue to have a role as the local patients' watchdogs. It also enables them to be administered independently of the health authority structure.

At present CHCs are 'established' by the Regional Health Authority (or the Welsh Office in Wales). RHAs allocate CHC budgets and also formally employ CHC staff. This in theory at least cuts across the CHC role as the independent advocate of patients' interests. Whilst in most cases CHCs do not have an unsatisfactory relationship with their establishing authority, there are some circumstances where CHCs and RHAs will have conflicts of interest. In any event, there is a potential for an RHA to undermine the work of CHCs as effective organs of user representation independent of the NHS. Yet if patients are to have confidence that CHCs will represent their interests either collectively or individually, it is important that CHCs are and are seen to be independent of the health authority structure.

An independent agency could also be responsible for quality control of CHCs. Members of the public should be confident that their local CHC will offer a high standard of service to them either individually or to the community as a whole. The establishing authority for CHCs therefore needs to ensure that each CHC is acting effectively and efficiently, in terms of the overall objectives set for CHCs. However, if CHCs are to be independent, the body that carries out this quality control must