

ASSOCIATION · OF
COMMUNITY HEALTH COUNCILS

FOR · ENGLAND · & · WALES

30 DRAYTON PARK · LONDON N5 1PB · TEL: 01-609 8405 · FAX: 01 700 1152

PARLIAMENTARY BRIEFING

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TOBY HARRIS

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(DIRECTOR)

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01-609 8405

NATIONAL HEALTH SERVICE AND COMMUNITY CARE BILL

Clause 5, page 5, line 50, at the end insert:-

"(1A) Three months prior to making an order under Section 5(1) above the Secretary of State shall publish a document setting out the reasons for the proposed order and shall seek the views of such Community Health Councils and such other persons as seem to him to have an interest in the matter.

(1B) The Secretary of State shall not make an order under Section 5(1) above unless he has taken account of any views expressed in respect of a document published under section 5(1A) above."

The Department of Health's Working Paper on self-governing hospitals suggested that Regional Health Authorities would be expected to give local publicity to all proposals to seek self-governing status and would:

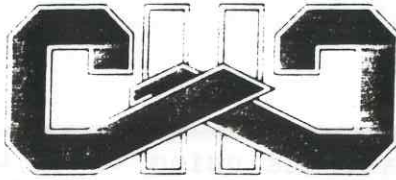
"... seek the views of those with an interest, particularly the health authorities concerned, staff at the hospital, general practitioners, Community Health Councils and the local community."

Any responses would then be submitted to the Secretary of State so that he could consider them prior to making a decision on the application for self-governing status.

However, nothing is said in the Bill about any process of consultation prior to an NHS Trust being established by the Secretary of State. This amendment would write arrangements for consultation into the Bill.

It is important that there is some form of consultation on the principle of establishing individual NHS Trusts, as it is likely that NHS Trusts will have major effects on the development of local health services. The comments of relevant organisations on the impact of establishing an NHS Trust should be sought and considered. Community Health Councils, as the statutory representatives of patients, together with voluntary organisations such as Age Concern, MIND, MENCAP etc., should all be able to express views on behalf of the users of the services affected. Given that the establishment of an NHS Trust may have an impact on the range of services provided and their location, on the availability of staff for other NHS facilities, and for future plans for health facilities, these views should be taken into account.

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 out of the 215 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 other bodies.



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NATIONAL HEALTH SERVICE AND COMMUNITY CARE BILL

Amendment 21

Clause 5, page 6, line 7, at end insert:-

'(h) shall grant observer status to a number of the local Community Health Council.'

There has been much concern that NHS Trusts will not be accountable to the public, even though they will still in theory be part of the NHS. This amendment would ensure that a CHC observer was able to participate in their proceedings as an observer.

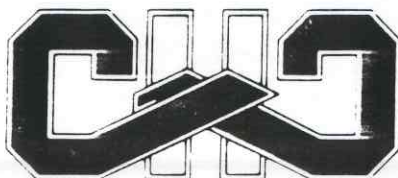
At present, CHCs are able to send an observer to meetings of District Health Authorities and Family Practitioner Committees. These observers are able to participate fully in discussions, but not to vote. This amendment would apply a similar arrangement to meetings of NHS Trusts.

Paragraph 7(2) of Schedule 2 says that Trusts will only be required to hold a meeting in public to present their accounts and annual reports. It is not clear why other meetings need to be held in secrecy and it would seem appropriate that Trusts, like other public bodies, should be required to make their decisions openly and subject to public scrutiny. Allowing a CHC observer to participate in Trust meetings would at least be one step in this direction.

The decisions made by NHS Trusts will potentially have a very significant impact both directly and indirectly on the interests of patients. Not only will decisions about the organisation of

services affect the patients using them, but decisions about the facilities to be offered and the pay scales to be followed in a self-governing hospital will all impact on the services provided by other local health care providers. Given this, it is important that the CHC as the statutory representative of patients' interests should have the opportunity to feed into their decisions, by having an observer at NHS Trust meetings.

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NATIONAL HEALTH SERVICE AND COMMUNITY CARE BILL

REPORT STAGE

Amendment 138

Page 6, line 6, [Clause 5], after "directors", insert "including two representatives of the local Community Health Council."

This amendment would have the effect of requiring that two representatives of the local Community Health Council be appointed as non-executive directors of each NHS Trust.

NHS Trusts will be separate from much of the rest of the NHS and will be able to decide what services they will provide on the basis of decisions made by the Trust's Directors. NHS Trusts will apparently play virtually no part in the NHS planning system. The only obligation placed on them, according to the White Paper, would have been to submit an operational plan on an annual basis to the Regional Health Authority (not even to the District or Districts to whom, they provide the bulk of their services). In fact, paragraph 8 of Schedule 2 only requires NHS Trusts to provide information on forward planning to the Secretary of State.

The implication of this is that NHS Trusts will make decisions on their operational arrangements purely on the basis of commercial considerations and will then merely provide information on their intentions. No consultation is proposed on such matters and they will not be reviewed as part of an overall planning system. Indeed, it is difficult to see how any coherent planning will be

possible. District Health Authorities will be left to administer and plan the "rump" services that are not part of the self-governing unit, and will merely respond to decisions made by the NHS Trust without any real ability to influence those decisions.

This has particularly serious implications for the input of lay user representatives into the planning process. Over the last fifteen years, CHCs have taken an increasingly prominent role in many parts of the country in NHS planning. Managers have recognised the value of having this input at an early stage in the planning process. As the planning process is itself marginalised by the arrival of self-governing units on the scene, so too will be the input from the patients.

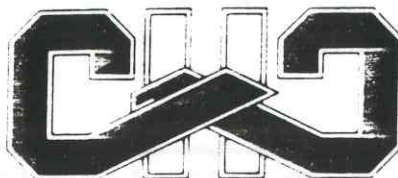
The autonomy given to self-governing hospitals will have other major effects on local services. They will be free to set their own rates of pay for staff. Many may therefore start to pay more than NHS agreed scales and will drain staff from non-self governing local hospitals.

Most Department of Health Directives will not apply to self-governing hospitals. As these directives are frequently to do with the quality and range of services to be provided, it is not clear what safeguards there will be to prevent a decline in the standards and a drift away from the overall objectives set for the health service.

Given the enormous direct and indirect impact of the decisions made by NHS Trusts and given that the Government continues to stress that the Trusts will continue to be part of the NHS, it is unfortunate that so limited a system of public accountability is proposed for them. According to Paragraph 7(2) of Schedule 2, the Trusts will only be required to hold a meeting in public to present their accounts and annual reports. It is not clear why other meetings need to be held in secrecy and it would seem appropriate that Trusts, like other public bodies, should be required to make their decisions openly and subject to public scrutiny.

This amendment would enable CHC representatives to have a direct influence on the decisions of NHS Trusts. This influence will work both to promote high standards of patient care in NHS Trust facilities, to ensure that the operations of NHS Trusts are not to the detriment of other NHS facilities, and to encourage the accountability of NHS Trusts.

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Amendment 147

Clause 5, Page 6, Line 7, at end add:-

'(2A) such services provided at the time of the establishment of the Hospital Trust shall not be reduced without the agreement of:

- (i) the district health authority and,**
- (ii) the Community Health Council**

One of the major concerns that has been expressed by a wide variety of organisations about the introduction of NHS Trusts is that after a few years NHS Trusts will give notice of their intention no longer to supply core services to their local District Health Authority. This amendment would build two key safeguards into this - first the local DHA (as presumably the major purchaser of services) would have to agree, and second so would the local Community Health Council (as the statutory representative of patients).

Initially at least, it is likely that contracts between an NHS Trust and its local DHA will specify a range of services to be provided to local residents. However, NHS Trusts will after a while on giving due notice to the DHA be able to cease to provide such services. This leaves the fear that some self-governing hospitals may over time choose to specialise in those services that are more glamorous and will attract more revenue. This could well be to the detriment of local residents whose core services may then have to be provided further afield. This

amendment by providing safeguards will offer some reassurances on this point.

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