ASSOCIATION OF
COMMUNITY HEALTH COUNCILS
FOR ENGLAND & WALES

UNDERSTANDING THE NHS AND THE ROLE OF THE CHC

TRAINING RESOURCE PACK

JULY 1998

TRAINER'S PACK

Earlsmead House, 30 Drayton Park, London N5 1PB. Tel: 0171 609 8405 Fax: 0171 700 1152
CHAIR: JENNIFER ELLIOTT, DIRECTOR: TOBY HARRIS

The pack contains all the material you need to run the course, including:

- handout-notes for participants (white)
- tutor's notes for sessions -annotated versions of participants' notes (green)
- tutor's notes on how to run the sessions (green)
- overhead projection transparencies
- evaluation forms (green)

Please note the contents numbers for the participants pack are given in brackets.

The pack consists of:

Contents	Item	Required by tutor	Required by participants
1.	Tutor's introductory notes	✓	×
2. (1)	Outline of course content	✓	✓
3. (2)	Course programme	✓	✓
4.	Tutor's notes on using quiz	✓	×
5. (3)	Quiz on the new NHS	✓	✓
6. (4)	Answers to quiz	✓	✓ (after completion of quiz)
7.	Tutor's notes for afternoon session	✓	×
8. (5)	CHC rights and duties - notes for course participants	✓	✓ (after completion of session)
9.	CHC rights and duties - discussion points for tutors	✓	×
10. (6)	How CHCs work	✓	✓ (after completion of session)
11.	How CHCs work - notes for tutors	✓	×
12. (7)	OHP transparencies	✓	✓ (paper copies only)
13. (8)	Evaluation Form	✓	✓
14.	Evaluation of pack	✓	×

4. Tutor's notes on using quiz

Why use a quiz?

A quiz offers one way to:

- provide a high volume of information in an interesting way
- update knowledge in a period of rapid change
- reinforce participants' existing knowledge
- share knowledge in the group
- make participants aware of issues where they need explanation and clarification
- reassure participants that no-one has all the answers
- have a bit of fun

What you need

- a room large enough for people to sit comfortably in plenary session, and move into small groups of 3-5 people
- Enough quiz sheets for everyone to have one
- Quiz answer sheets to give out at end of session
- Overhead projector (OHP) and transparencies to explain specific points
- Flip charts and pens

Setting up the quiz

- Begin by explaining the purposes of using a quiz - i.e. to increase knowledge and understanding of participants on the topics in the quiz, while sharing the knowledge that exists in the group.
- Explain that it is a quiz, not a test, and that no individual will have to demonstrate how much or how little they know, as it is a group activity.
- Reassure that no-one knows everything, as the NHS is in a state of perpetual change, but everyone will know part of what they need to know.
- Reassure that many new members may know little about the NHS - that's OK too.
- Request that participants should, as a group, record the key points of their answers, with particular reference to issues where they require further knowledge or explanation.
- Inform participants that they will be given an answer sheet at the end of the morning as a take-home resource.
- Request that they do not attempt to look up answers in any material that they might have with them, as this is too lengthy a procedure.
- Then, ask participants to get into small groups (3-5 people is ideal). Generally, participants can divide themselves into groups, but you can assist the process, as required. You may wish to suggest that people do not work exclusively with people whom they know.
- Explain the time limits and allow participants to begin.

- You may wish to circulate among groups to ensure that progress is being made and that participants are not getting stuck on one question.

Time required

This exercise can be long or short, as required. In this course, 30 minutes is allowed for small group work in going through the quiz, followed by a break, then 90 minutes to go through the answers.

Going through the answers

- Ask participants to adjust their seating arrangements so that they are still sitting with their small group, but can also see and hear you, the flip chart and the overhead projector.
- Explain that you will ask each group in turn to give their answer to one question (in numerical order), and that you will then invite the whole group to add information or questions.

Using the prepared answer sheet as your guide, you should use the answers that have been offered by participants to:

- reinforce accurate information
- correct inaccurate information
- impart additional information

Use OHPs and flip charts occasionally, as required.

Time management

Be careful - going through the answers can take a very long time. Do make sure that you can get through all the answers.

What can go wrong?

Quizzes are tried and tested ways of helping adults learn. If you are confident of their value, and well briefed on the answers, little can go wrong. Time management is the biggest challenge (see above). Other possible issues to consider are:

- Resisters - people who do not like quizzes, or who press you to deliver a lecture instead. You should reassure them that completing the quiz takes only a short while, and that there will be plenty of factual input from you and others, and that it will be reinforced with written information.
- Know-alls - Sometimes one person knows everything, or claims to, and wishes to answer every question personally. You need to tactfully prevent this, as it disempowers others.
- Not knowing the answers to questions that arise - Minimise this possibility by being well briefed, but if you do not know something, someone else in

the group may have information to help. Or you can suggest ways to find out the answer.

- Errors in the answers - with the best will in the world, these can creep in. It's not a big problem. Concede with grace, and use it as an opportunity to reassure that no-one can know everything.

Special needs

- People with sensory problems - If you have notice of a blind person attending, you may be able to supply material in advance for their reader, or on tape or on large print.
- It is possible for a deaf person to join in the quiz using a signer, though more time is needed. People who use hearing aids or who lip-read may find small group discussions difficult and you should ask them how you can make things easier for them.

5. Quiz on the new NHS

1. In the context of the NHS, what do you understand by "commissioning"?

2. What is primary health care (primary care)?

3. Who employs GPs?

4. In December 1997, the Government published a White Paper on the NHS in England *The new NHS - Modern, Dependable*. What do you know about the implications of the White Paper for:

a) Health Authorities?
b) Primary Care Groups?
c) NHS Trusts?

5. The White Paper introduced Health Improvement Programmes. What are they?

6. The White Paper refers to a proposed new Commission for Health Improvement. What is it?

7. The White Paper refers to a proposed new National Institute for Clinical Excellence. What is it?

8. How does/will the money flow?

9. In January 1998 the Government published a Green Paper *Our Healthier Nation - a contract for health*.
a) What are its aims and the 4 priority areas?
b) In the context of *Our Healthier Nation*, what is "a contract for health?"

10. What are Health Action Zones?

11. In January 1998, the NHS Executive published a consultation document on A National Framework for Assessing Performance, which sets out six areas of the proposed new framework. What are they?

12. Can you name the Secretary of State for Health and the Ministerial Team for Health?

6. Quiz on the new NHS: Answers

These questions have been formulated in March 1998 - answers reflect the situation at that date, and will need to be up-dated as the situation develops.

1. In the context of the NHS, what do you understand by "commissioning"?

Commissioning is a process by which the commissioners assess the health needs of the population for whom they are commissioning, then specifies what is required, then makes an agreement with a service provider to provide the required service. The commissioner also monitors the delivery of that service against agreed standards.

To put this into context: the main functions of the NHS fall broadly within 2 kinds of activity. On the one hand, there is the commissioning of services, and on the other hand there is the provision (or delivery) of services.

From 1991, (when the 1990 NHS and Community Care Act came into effect) until recently, this division was generally known as the purchaser-provider split, although "commissioning" was often the preferred term, rather than "purchasing", as it implied a more pro-active way of specifying services. With the Labour government's commitment to abolish the internal market, the concept of "commissioning" has largely replaced "purchasing". Also, there is a new emphasis on partnership and co-operation, rather than on a split between different bits of the NHS. However, there is still largely a separation of functions between commissioning a service (which is done at present by Health Authorities and some GPs, but will in future increasingly be done by Primary Care Groups (PCGs) - see below) and the provision of NHS services, which is largely done by NHS Trusts.

All GPs are providers of family health services, but up to now, GPs have had variable levels of involvement in commissioning. In some areas, GPs have been involved in commissioning groups, advising Health Authorities on what to commission/purchase for the population covered by the Health Authority. Many GPs have also been GP Fundholders, directly responsible for purchasing services for their practice population. In future, all GPs will be involved, at some level, in commissioning.

See diagrams of the old and new NHS structures.

2. What is primary health care (primary care)?

Surprisingly, there is no "official" definition of primary care, but it is used in several common ways. Firstly, it is the term used to include the walk-in (self-referral) family health services, e.g. General Medical Practitioners, General Dental Practitioners, community pharmacists and opticians. 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, rehabilitation services etc. 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 the last 15 years or more 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). GPs have also become more centrally involved in commissioning services, and this trend looks set to continue through Primary Care Groups.

3. Who employs GPs?

GPs are generally self employed. In other words, they are independent contractors who are under contract to the NHS to provide General Medical Services. This has been the case ever since the NHS came into existence. However, recent legislation *The NHS (Primary Care) Act 1997* allows for pilot schemes for new ways of organising primary care and more flexibility in the kinds of contracts that that Health Authorities can make with GPs. Proposals for the pilot schemes under the *NHS (Primary Care) Act* include schemes for salaried GPs within partnerships or within NHS Trusts. While salaried GPs are likely to remain in a small minority, the *NHS (Primary Care) Act* may allow for a more flexible service, related to local need.

4. In December 1997, the Government published a White Paper on the NHS in England *The new NHS - Modern, Dependable.* What do you know about the implications of the White Paper for:

a) Health Authorities?
b) Primary Care Groups?
c) NHS Trusts?

a) Health Authorities

- Will give strategic leadership
- Will lead the development of Health Improvement Programmes (local strategy for improving health and healthcare, drawn up in consultation with NHS Trusts, Primary Care Groups, primary care professionals and other partner organisations.)
- Will decide on the range and location of health services, which should flow from the HIP
- Will support Primary Care Groups, allocate resources to them, and hold them to account for their decisions and performance.

b) Primary Care Groups

Main functions:

- to contribute to the Health Authority's Health Improvement Programme (see below)
- to work in partnership with others to promote the health of local people
- to commission health services for their local population
- to monitor performance against targets by NHS Trusts
- to develop primary care by working across practices
- to achieve better integration of primary and community health services, and to work more closely with social services on planning and delivery of care.

There are 4 options for Primary Care Groups, who may be involved in commissioning in the following ways:

1. advising the Health Authority on commissioning
2. devolved responsibility for managing the budget
3. free standing bodies accountable to the Health Authority for commissioning care
4. as above, but also responsible for provision of community health services to their population

Primary Care Groups will begin at whatever point on the spectrum is appropriate for them, and it is assumed that all Primary Care Groups will assume fuller responsibilities. the Government will bring in legislation to establish Primary Care Trusts for Primary Care Groups who wish to be free-standing (options 3 and 4 above).

PCGs replace GP Fundholders, and develop from a range of recent commissioning models, including locality commissioning, GP fundholding, multifunds, Total Purchasing Projects and GP Commissioning Group pilots.

c) NHS Trusts

The White Paper seeks to free Trusts from market-style incentives, and to free them to use their managerial and clinical expertise to provide improved services for patients.

- Will be required to work in partnership with other NHS organisations
- Will participate by right in strategy and planning and by helping shape the HIP
- Will have responsibilities for clinical governance, requiring practitioners to accept responsibility for developing and maintaining standards
- Will meet in pubic and be more representative of local community
- Will have to publish and benchmark the costs of the treatments they offer
- Will be assessed against wider goals than previously, including improvements in health and healthcare outcomes

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

5. The White Paper introduced Health Improvement Programmes. What are they?

The White Paper stated that Health Improvement Programmes will be the local strategy for improving health and healthcare, and will be the means to deliver national targets in each Health Authority area. The Health Authority will have lead responsibility for drawing up the HIP in consultation with NHS Trusts, Primary Care Groups, other primary care professionals, the public and other partner organisations.

A new statutory duty of partnership is to be placed on local bodies to work together for the common good.

The initial HIP will cover a three year period and will be updated progressively, with a part of it reviewed each year. Health Improvement Programmes will be in place by April 1999.

The Green Paper, *Our Healthier Nation* gives a fuller account of what Health Improvement Programmes will do.

Health Improvement Programmes (HIPs) will:

- 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.

6. The White Paper refers to a proposed new Commission for Health Improvement. What is it?

The proposed Commission for Health Improvement is already beginning to be known colloquially as CHIMP! The Commission for Health Improvement will be established to oversee clinical governance and if there are concerns, it could be called in to investigate and report on a problem.

7. The White Paper refers to a proposed new National Institute for Clinical Excellence. What is it?

The proposed National Institute for Clinical Excellence (NICE) will give a lead on clinical and cost effectiveness. It will draw up new guidelines and ensure that they reach all parts of the service.

8. How does/will the money flow?

At present

The total funds made available to the NHS are determined as a result of the government's annual Public Expenditure Survey. Expenditure falls into two headings:

1. Hospital and Community Health Services (HCHS) - which are cash-limited (i.e. have to be delivered within a given budget) HCHS is divided between revenue and capital.
2. General Medical Services (GMS) - this is not currently not cash limited (i.e. neither Health Authorities nor the GPs are bound by predetermined cash limits, though at a national level, pressures have to be managed within overall NHS resources.)

Revenue - Health Authorities are responsible for ensuring that their resident populations have access to a comprehensive range of services. They have a statutory duty under the NHS Act 1997 not to exceed their approved cash limited allocations. At present, general allocations are provided to health authorities for them to commission health care services for their resident population. Health Authority allocations for any given year use the previous year's allocations as the starting point. This is called the baseline. In addition, a target is set for each Health Authority 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) for:

- 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.

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. Health Authorities are responsible for holding the contracts for family practitioners.

Capital - Capital funding may either come from the NHS or from private capital under the Private Finance Initiative (PFI). In recent years, the level of NHS capital has diminished, and it has been assumed that 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.

In future

When the provisions of the White Paper come into effect, money will be distributed through Health Authorities to Primary Care Groups, which will have unified budgets covering hospital and community services. There will be a new Advisory Committee on Resource Allocation to improve the arrangements for distributing resources for primary and secondary care. The healthcare needs of populations, including the impact of deprivation, will be "the driving force" in where money goes.

Long term agreements will replace annual contracts.

The extra contractual referral (ECR) system will be abolished and replaced by simplified arrangements. A new system that reflects actual referrals will be based on adjustments to PCG and Health Authority Allocations (rather than invoicing, as was the case for ECRs). Details of how this will work are not yet known.

There will be a Capital Prioritisation Advisory Group to assess which major capital development projects should proceed.

9. In January 1998 the Government published a Green Paper *Our Healthier Nation - a contract for health.*

a) What are its aims and the 4 priority areas?

Our Healthier Nation has 2 key aims:

- 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 from illness
- To improve the health of the worst off in society and narrow the health gap.

There are 4 priority areas:

By year 2010

- Heart disease and stroke - to reduce the death rate from heart disease and stroke and related illnesses amongst people aged under 65 by at least a further third
- Accidents - to reduce accidents by at least one fifth
- Cancer - to reduce the death rate from cancer amongst people under 65 by at least a further fifth
- Mental health - to reduce the death rate from suicide and undetermined injury by at least a further sixth.

For each priority area, there will be a national target for improvements and a national contract setting out the respective roles of individuals, government and local communities.

The framework outlined in *Our Healthier Nation* is designed to replace the previous government's policy which was called *The Health of the Nation.*

b) In the context of *Our Healthier Nation*, what is "a contract for health?"

This 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".

10. What are Health Action Zones?

Health Action Zones (HAZs) were announced by the Secretary of State for Health in June 1997. They are due to "go live" from April 1998. There will be up to 10 HAZs. Their key objective is to reduce health inequalities, improve services and secure better value from the total resources available. Partnerships will be a key means of achieving these objectives. HAZs will involve local authorities, community groups, the voluntary sector and local businesses in their work. Government will deliver support and investment against agreed targets (but investment might not be financial, it might be help with development or a willingness to relax national requirements to fit local needs).

There are no upper or lower size limits for HAZs, but it is expected that they will need to be of at least health authority size, or a large city within a health authority.

HAZs will have these opportunities

- better working between local authorities and NHS
- synergy with other initiatives within HAZ, such as Single Regeneration Budget Schemes, Education Action Zones
- a positive status in bidding for Lottery Healthy Living Centre funds
- earmarked joint finance
- piloting new arrangements to find ways of reducing administrative burden on local NHS organisations.

11. In January 1998, the NHS Executive published a consultation document on A National Framework for Assessing Performance, which sets out six areas of the proposed new framework. What are they?

Areas	Aspects of performance
1. Health improvement	The overall health of populations, reflecting social and environmental factors and individual behaviour as well as care provided by the NHS and other agencies.
2. Fair access	The fairness of the provision of services in relation to need on various dimensions: - geographical - socio-economic - demographic (age, ethnicity, sex) - care groups (e.g. people with learning difficulties)
3. Effective delivery of appropriate healthcare	The extent to which services are: - clinically effective (interventions or care packages are evidence-based) - appropriate to need - timely - in line with agreed standards - provided according to best practice service organisation - delivered by appropriately trained and educated staff
4. Efficiency	The extent to which the NHS provides efficient services, including: - cost per unit of care/outcome - productivity of capital estate - labour productivity
5. Patient/carer experience	The patient/carer perceptions on the delivery of services, including: - responsiveness to individual needs and preferences - the skill, care and continuity of service provision - patient involvement, good information and choice - waiting times and accessibility

	- the physical environment, the organisation and courtesy of administrative arrangements
6. Health outcomes of NHS care	NHS success in using its resources to: - reduce levels of risk factors - reduce levels of disease, impairment and complications of treatment - improve quality of life for patients and carer - reduce premature deaths

(The above table is reproduced from *The new NHS - Modern and Dependable: A National Framework for Assessing Performance. Consultation Document*. January 1998)

12. Can you name the Secretary of State for Health and the Ministerial Team for Health?

Secretary of State: Frank Dobson
Ministers: Tessa Jowell, Alan Milburn, Baroness Jay
Parliamentary Under Secretary: Paul Boateng

quizan.doc

7. Tutor's notes for afternoon session

To begin the afternoon session

It is always sensible after a lunch break to check if catering etc. was satisfactory, so that people do not begin the afternoon with any unstated grumbles on their mind. It is also useful to offer a strictly limited opportunity - say 5 minutes - for people to flag up any issues from the morning about which they remain unclear. You may be able to:

- deal with the question swiftly
- refer them to written information
- assure them that you will cover the point during the afternoon

Then, introduce the afternoon session by reminding people of the aims (below)

The aims of the afternoon

to impart and share information on how CHCs work, including:

- **powers and duties of CHCs**
- **membership of CHCs**
- **how CHCs work**
- **being an effective CHC member**

It is important to:

- recognise that participants may have differential levels of knowledge and experience about CHCs
- recognise that CHCs vary in many aspects of their organisation and practice
- facilitate learning and sharing between CHCs
- empower new members to feel that they can become involved in the work and development of their own CHC
- build on information from the morning session so that knowledge about the CHC relates to the wider context of NHS organisation and development

The suggested structure of the afternoon is basically a plenary session, with some opportunities to work in pairs or small groups. The afternoon programme is set out in the following pages, and can be summarised as follows:

Part 1 - Rights and duties of CHCs - Brainstorm and plenary discussion. (30 - 40 minutes)
Part 2 - How CHCs work - Plenary session (40 minutes)
Part 3 - Being an effective member - Exercise in pairs or threes and plenary feedback (25 minutes)
Part 4 - Final exercise - Plenary session (10 minutes)

Afternoon session

What you need

- A room large enough for people to sit comfortably in plenary session, and turn to each other for some discussion in pairs or small groups
- Overhead projector and transparencies to explain specific points
- Flip charts and pens the first page of the flip chart should be prepared as in the illustration below:

Part 1 - Rights and duties of CHCs (30 - 40 minutes)

Rights and duties of CHCs	
Rights	Duties

Brainstorm

The purposes of a brainstorm are:

- to start the session off in a participative manner
- to bring out a number of "headline" points very quickly
- to get a feel for what participants already know

Ask the plenary group to list the rights and duties of a CHC. List them if they are correct, and explain if they are incorrect. You will probably be able to come up with a list that resembles the headings in the tutor's notes. Use the flip chart, backed up by the tutor's notes, to discuss the rights and duties, using illustrations from the experience of participants.

For example, if someone suggests visits as a right, you can tease out knowledge on what rights a CHC has in this respect, and fill in gaps. Then ask: What kinds of visits does your CHC make?

To round off the discussion (if time permits) you could invite participants to work in pairs to discuss any rights they think the CHC should have, but does not have. Feedback on this is optional.

What can go wrong?

The commonest problem at this stage is for one or more members to conclude that CHCs are completely useless as they do not have sufficient powers. It is valuable to discuss the adequacy or otherwise of CHC powers and to identify areas where more powers would be helpful. However, it is also important to avoid terminal gloom and to try to empower people to make best use of the powers that CHCs do have, while trying to work for appropriate extensions of those powers.

It is also important to emphasise the value and past successes of CHC activities by drawing on specific examples. These can be generated from your own experience and from the group.

Afternoon session
Part 2 - How CHCs work (40 minutes)

This session is best conducted as a plenary session, with discussion led by the tutor. A useful approach is a structured discussion around the following questions:

1. How many members does a CHC have?
2. Who nominates and appoints CHC members?
3. When and how do CHC meetings take place?
4. What working groups or sub-committees does your CHC have?
5. How does your CHC review its progress, objectives and priorities?

There is little point in recording the discussion on a flip chart, but you should inform participants that the essential facts are in a handout, but they may want to make a personal note of local practices and names of people to contact, if applicable.

Part 3 - Being an effective member - Exercise in pairs or threes, followed by plenary feedback. (25 minutes including feedback.)

The pairs/threes should discuss for 10 minutes :
What are the qualities of an effective CHC member?

These should be recorded on flip chart. The tutor should then ask people to think about what kind of information, support and training they require to become more personally effective.

The tutor should draw attention to information that is available for reference and guidance, e.g.

- local training material
- ACHCEW courses
- Regional Associations of CHCs
- Code of Conduct for CHC members (this is essential)
- Briefings from NAHAT, ACHCEW, etc.
- Publications such as the Health Service Journal

8. CHC rights and duties - notes for course participants

What rights does a CHC have?

Consultation

Generally, Health Authorities must consult the relevant CHCs on any proposals for substantial development of the Health Service in the CHC's district and on any proposals to make any substantial variation in the provision of such service. This applies equally if the changes are being considered as a result of changes elsewhere. It is for the Health Authority to define whether the changes it proposes constitute a "substantial" development or variation. Their decisions have occasionally been challenged in Court when their "reasonableness" has been called into question.

If the Health Authority decides that in the interests of the Health Service, an urgent decision has to be taken without allowing time for consultation, it must immediately notify the CHC of the decision and why consultation was not possible.

The Health Authority must allow "sufficient" time for a view to be taken and advice to be formulated, but the decision on what is "sufficient" is the Health Authority's. Their decision could be challenged in Court, if it were unreasonable.

The Lynton Judgement

In August 1997, an interesting judgement was given in a consultation case by Mr Justice Moses in the High Court. The case was brought by a number of patients of two North Devon community hospitals threatened with closure. Their application for judicial review of the Health Authority's decision to close these hospitals without prior consultation was supported by a community group. The application was successful and the Health Authority's decision to close the hospitals was quashed by the Court. North Devon Health Authority was directed to carry out consultation with the CHC and the local community before reaching any final decision on the future of the hospitals. The Court took into account the Health Authority's argument that the closures were in order to save money, so as to allow it to meet its statutory obligation to balance its budget.

Information

A Health Authority must provide the relevant CHC with such information about the planning and operation of health services in the district of that Authority as the CHC may reasonably require in order to carry out its duties. The Health Authority may refuse to disclose information which it regards as confidential, and it is not required to disclose confidential information about individual patients or any personnel matters relating to its individual officers. If the Health Authority does not disclose information that is requested, the CHC may appeal to its establishing authority (i.e. The Regional Officer of the NHS Executive). The Regional Office's decision on this is final.

Visits

CHCs have statutory rights to enter and inspect any health services premises controlled by a Health Authority or NHS Trust providing health care within their own district. CHCs do not have a right to visit staff accommodation within NHS premises. The CHC's rights to visit extends to private and voluntary providers' premises, where health care is provided in the district, if the provider holds a contract that allows visits with the Health Authority. For out-of-district health services, the local CHC has a statutory right to visit in its district, and other CHCs may have a contractual right to do so (i.e. if specified in the contract). CHCs do not have a right to visit the premises of GPs, dentists, pharmacists or opticians, except where these are part of NHS premises, such as a community dentistry service which is part of an NHS Trust.

Health Authority meetings

Health Authorities must hold their Board meetings in public, though there is provision for certain issues to be taken in a private part of the meeting. CHCs are generally invited to attend the public part of the meeting and to contribute to it. Some may be invited to remain for part of the private section of the meeting, though not all CHCs would wish to do so.

Annual meeting with Health Authority

CHCs have a right to meet formally at least annually with the members of the Health Authority to which they relate.

Trust meetings

NHS Trusts have now been instructed by the Secretary of State to meet in public. In many cases, the CHC has been invited to attend meetings and to speak in the open part of the meeting. Some may be invited to remain for part of the private section of the meeting, though not all CHCs would wish to do so.

Annual meeting of NHS Trusts

Trusts must have an annual general meeting in public. This is also an opportunity for the Trust to engage in discussion with the local community and the CHC, though the CHC would wish to have other ways of maintaining a regular dialogue with a Trust.

What duties does a CHC have?

CHCs were set up to "...keep under review the operation of the health service in their district and make recommendations for improvement of such service..." and to "...represent the interests in the health service of the public in its district."

This can be interpreted very widely, but the CHC has few rigorously defined functions and duties. However, there are some things which it is obliged to do:

- CHCs must produce an annual report
- CHC must meet the Health Authority in its district at least once a year
- CHCs must meet in public at least every 3 months, giving proper notice of meetings to its members and the public. There are rules about when the public may be excluded from parts of a meeting.
- CHCs must make their meeting agendas open to inspection at the CHC's office.

In practice most CHCs undertake a huge range of responsibilities, including advice and information to the public, involvement in commissioning, visits to monitor services, collaboration with voluntary sector etc.

The role of CHCs in complaints was formally recognised explicitly for the first time in guidance issued in 1994, though most CHCs do help complainants, and have always helped complainants, albeit to varying degrees. Members do not get involved in advising individual complainants.

chc1.doc

9. CHC rights and duties - with discussion points for tutors

Please note: questions and discussion points for tutors are in boxes.

These notes are not, and do not attempt to be, a definitive statement of law or regulations. They are notes to guide new members. You should refer members to their Chief Officers or Chairs for further information. You may also wish to recommend any locally produced material for new members, and other reference sources such as ACHCEW's Health Briefing *Bibliography on CHCs,* by J. S. MacKeith. March 1996.

What rights does a CHC have?

Consultation

Generally, Health Authorities must consult the relevant CHCs on any proposals for substantial development of the Health Service in the CHC's district and on any proposals to make any substantial variation in the provision of such service. This applies equally if the changes are being considered as a result of changes elsewhere. It is for the Health Authority to define whether the changes it proposes constitute a "substantial" development or variation. Their decisions have occasionally been challenged in Court when their "reasonableness" has been called into question.

If the Health Authority decides that in the interests of the Health Service, an urgent decision has to be taken without allowing time for consultation, it must immediately notify the CHC of the decision and why consultation was not possible.

The Health Authority must allow "sufficient" time for a view to be taken and advice to be formulated, but the decision on what is "sufficient" is the Health Authority's. Their decision could be challenged in Court, if it were unreasonable.

The Lynton Judgement

In August 1997, an interesting judgement was given in a consultation case by Mr Justice Moses in the High Court. The case was brought by a number of patients of two North Devon community hospitals threatened with closure. Their application for judicial review of the Health Authority's decision to close these hospitals without prior consultation was supported by a community group. The application was successful and the Health Authority's decision to close the hospitals was quashed by the Court. North Devon Health Authority was directed to carry out consultation with the CHC and the local community before reaching any final decision on the future of the hospitals. The Court took into account the Health Authority's argument that the closures were in order to save money, so as to allow it to meet its statutory obligation to balance its budget.

- There is more to consultation than formal "set piece" consultations on major changes. CHCs need to get involved at early stages in the process of change.
- When would early involvement in a change process possibly compromise the CHC's independent role?

Information

A Health Authority must provide the relevant CHC with such information about the planning and operation of health services in the district of that Authority as the CHC may reasonably require in order to carry out its duties. The Health Authority may refuse to disclose information which it regards as confidential, and it is not required to disclose confidential information about individual patients or any personnel matters relating to its individual officers. If the Health Authority does not disclose information that is requested, the CHC may appeal to its establishing authority (i.e. The Regional Officer of the NHS Executive). The Regional Office's decision on this is final.

- What sorts of information does a CHC require in order to do its job?
- In what circumstances should the CHC agree to receive information from a Health Authority or Trust on a confidential basis?
- Do all members need to see everything that comes in to the CHC?
- As a first impression, do members feel that they personally get enough information/too much information or the right amount of information?

Visits

CHCs have statutory rights to enter and inspect any health services premises controlled by a Health Authority or NHS Trust providing health care within their own district. CHCs do not have a right to visit staff accommodation within NHS premises. The CHC's rights to visit extends to private and voluntary providers' premises, where health care is provided in the district, if the provider holds a contract that allows visits with the Health Authority. For out-of-district health services, the local CHC has a statutory right to visit in its district, and other CHCs may have a contractual right to do so (i.e. if specified in the contract). CHCs do not have a right to visit the premises of GPs, dentists, pharmacists or opticians, except where these are part of NHS premises, such as a community dentistry service which is part of an NHS Trust.

- What are the purposes of CHC visits?
- In what other ways can services be monitored?
- In particular, how can primary care be monitored, and how can CHCs relate to GPs and other members of the primary health care team?
- Would members like to have visiting rights to GPs' premises? If yes, what would they hope to get out of them?

Health Authority meetings

Health Authorities must hold their Board meetings in public, though there is provision for certain issues to be taken in a private part of the meeting. CHCs

are generally invited to attend the public part of the meeting and to contribute to it. Some may be invited to remain for part of the private section of the meeting, though not all CHCs would wish to do so.

- Have members ever attended a Health Authority board meeting? If so, what were their impressions?
- Should the CHC attend the private part of a Health Authority Board meeting?

Annual meeting with Health Authority

CHCs have a right to meet formally at least annually with the members of the Health Authority to which they relate.

Trust meetings

NHS Trusts have now been instructed by the Secretary of State to meet in public. In many cases, the CHC has been invited to attend meetings and to speak in the open part of the meeting. Some may be invited to remain for part of the private section of the meeting, though not all CHCs would wish to do so.

- Have members ever attended a Trust Board meeting? If so, what were their impressions?
- Should the CHC attend the private part of a Trust Board meeting?

Annual meeting of NHS Trusts

Trusts must have an annual general meeting in public. This is also an opportunity for the Trust to engage in discussion with the local community and the CHC, though the CHC would wish to have other ways of maintaining a regular dialogue with a Trust.

What duties does a CHC have?

CHCs were set up to "...keep under review the operation of the health service in their district and make recommendations for improvement of such service..." and to "...represent the interests in the health service of the public in its district."

This can be interpreted very widely, but the CHC has few rigorously defined functions and duties. However, there are some things which it is obliged to do:

- CHCs must produce an annual report
- CHC must meet the Health Authority in its district at least once a year
- CHCs must meet in public at least every 3 months, giving proper notice of meetings to its members and the public. There are rules about when the public may be excluded from parts of a meeting
- CHCs must make their meeting agendas open to inspection at the CHC's office.

In practice most CHCs undertake a huge range of responsibilities, including advice and information to the public, involvement in commissioning, visits to monitor services, collaboration with voluntary sector etc.

The role of CHCs in complaints was formally recognised explicitly for the first time in guidance issued in 1994, though most CHCs do help complainants, and have always helped complainants, albeit to varying degrees. Members do not get involved in advising individual complainants.

General discussion points

- Do CHCs have enough rights?
- What other rights should they have?
- The powers and duties of CHCs do not extend to local authority services.
- CHCs can extend their influence far beyond their actual rights - Encourage members to think creatively about how the CHC can make relationships with statutory and voluntary agencies and with primary care practices.
- How might the White Paper impact on CHCs?

You might point out that CHCs only get one mention in the whole of the White Paper:

" The Government wants a strong public voice in health and healthcare decision making, recognising the important part played by CHCs in providing information and advice and in representing the patients' interests."

It is not yet clear how the Primary Care Groups will have to involve the community, or whether CHCs will be involved in a formal way. The implications for CHCs are potentially huge. They could be marginalised, or they could be asked to get involved far beyond the level at which they are resourced to function.

10. How CHCs work

Membership

CHCs in England usually have 18-24 members. Half are nominated by the local council(s), one third are nominated by local voluntary organisations though elections held for the purpose and the remaining one sixth are chosen by the Regional Office. In some instances where several CHCs have merged to cover a wider areas, there may, exceptionally, be more members.

Co-options

CHCs may co-opt members to the CHC or to its working groups or sub-committees, up to one third of the membership of the group in question.

The NHS Executive's *Guidance on the changes in the establishing arrangements for CHCs*, issued with EL(95)142 states that CHCs "should develop a protocol ideally incorporated into their Standing Orders, which details the eligibility criteria, selection procedure, and length of appointment, of co-options to its committees".

A standard protocol has been drafted by ACHCEW which is available for CHCs to adopt or amend as they think fit.

Full CHC meetings and working group meetings

CHCs must meet in public at least every 3 months. In practice, most meet more often. CHCs have standing orders to govern the conduct of meetings.

CHCs usually have a number of sub-committees or working groups, and all members are usually expected to serve on at least one sub-committee. CHCs vary a great deal in how they configure their sub-committees. Some examples are:

- By type of patient, e.g. women and children, acute, older people
- By type of service, e.g. primary, acute, mental health
- On an ad hoc basis, e.g. to oversee a current local issue or a CHC project

Reviews

It is increasingly accepted as good practice that CHCs have some means of reviewing their work and discussing the objectives to inform their next year's work programme. CHCs in some Regions have developed protocols for peer review, while others vary their approach from year to year, often using an external facilitator to help them.

There is usually also a general purposes or liaison/co-ordinating committee to bring together chairs of all sub-committees and the chair and vice-chair of the CHC.

11. How CHCs work - notes for tutors

Discussion points for tutors are in boxes

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- Ask participants how many members are in their CHCs - you may wish to discuss how many of those are active members.
- Discuss what kinds of co-options may be useful. It is possible that some participants may have been co-optees and will have an interesting perspective to add.
- You may be able to discuss the need to liaise with neighbouring CHCs as there is often more than 1 CHC per Health Authority.

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- Do members of the public attend CHC meetings (as they have a right to do)? If so, how and when are they allowed to speak?
- Discuss where CHCs meet - in the office, in other NHS premises, in community halls, same place each time or different venue - how does the decision on where to meet influence the "feel" of the meeting.
- Discuss seating arrangements - how formal or informal - how this can affect the conduct of meetings.
- Discuss the merits of different kinds of working groups and sub-committees - How are they configured? Do they vary from year to year?

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