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A. BACKGROUND

2.01 Introduction

The National Health Service, of which the mental health services are an integral part was originally established by the National Health Service Act 1946, and came into operation on 5th July 1948. Since that date there have been a number of legislative changes¹, culminating in the National Health Service Act 1977. This Act is still the principal statute concerned with the Health Service.

2.01.1 *The Royal Commission on the National Health Service*

A Royal Commission on the National Health Service was appointed in May 1976 with terms of reference to consider "in the interests both of patients and of those who work in the National Health Service the best use and management of the financial and manpower resources of the National Health Service".² This Royal Commission published its report in 1979 providing the first comprehensive review of the National Health Service since the Guillebaud Committee reported in 1956.³ The main criticisms made by the Royal Commission of the Health Service organisation were that it had too many tiers of management; too many administrators in all disciplines; failure to take speedy decisions; and was wasteful of resources.

2.01.2 "*Patients First*"

Following publication of the Report of the Royal Commission, a consultative paper on the structure and management of the National Health Service in England and Wales entitled "*Patients First*" was published by the Government in December 1979.⁴ The criticisms of the Health Service organisation made by the Royal Commission were accepted, although most of its numerous proposals for reform were not to be implemented.⁵ *Patients First* proposed a pattern of operational authorities throughout the Health Service based upon single districts.

¹ For the background to the 1974 reorganisation see DHSS (1972) *National Health Reorganisation: England*, Cmnd. 5055, HMSO, London; Welsh Office (1972) *National Health Service Reorganisation: Wales*, Cmnd. 5057, HMSO, Cardiff.

² *Report of the Royal Commission on the National Health Service* (1979; Chairman: Sir Alec Merrison) Cmnd. 7615, HMSO, London.

³ *Report of the Committee of Enquiry into the Cost of the National Health Service* (1956) Cmnd. 9663, HMSO, London.

⁴ DHSS (1979) *Patients First: Consultative Paper on the Structure and Management of the National Health Service in England and Wales*, HMSO, London.

⁵ *Ibid.*, paras. 1-6.

2.01.3 "Working for Patients"

The government published its White Paper on the NHS, "Working for Patients," in January, 1989.¹ The White Paper had two objectives: to give patients better health care and greater choice of the services available to provide greater satisfaction and rewards for persons working in the NHS.

The seven key changes introduced in "Working for Patients" are designed to do the following:

- (i) Make the Health Service more responsive to the needs of patients by delegating power and responsibility to the local level – e.g., from regions to districts, and from districts to hospitals.
- (ii) Stimulate better patient service by allowing hospitals to apply for a new self-governing status called "NHS Hospital Trusts." NHS Hospital Trusts would remain in the NHS, but would take fuller responsibility for their own affairs including earning revenue from the services they provide.
- (iii) Enable hospitals to best meet patients' needs, by allowing resources to cross administrative boundaries. All NHS hospitals would be free to offer their services to different health authorities and to the private sector.
- (iv) Reduce waiting times and improve the quality of service by creating 100 new consulting posts over the next three years.
- (v) Help family doctors improve services by allowing large GP practices to apply for their own budgets to obtain a defined range of services direct from the hospitals.
- (vi) Improve the effectiveness of NHS management by reducing the size of regional, district and family practitioners management bodies and reforming them on business lines with both executive and non-executive directors.
- (vii) Ensure that health care providers make the best use of resources by rigorously auditing the resources allocated. This includes a "medical audit" which would be extended throughout the Health Service to provide peer review of the quality of care. The Audit Commission would also assume responsibility for auditing accounts of health authorities and other NHS bodies to ensure they are providing value for money.

¹ *Working for Patients: The Health Service – Caring for the 1990s*, CM 555, January 1989.

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The government also published eleven working papers explaining how major aspects of the White Paper would be implemented.¹

2.02 Current Legislation

Following the consultative document, "*Patients First*", the Health Services Act 1980 was passed.² Section 1 of this Act gave the Secretary of State for Social Services power to make changes in the local administration of the Health Service in England and Wales. This power has been exercised by regulations³ which have replaced the former area health authorities with district health authorities, with effect from 1st April 1982.⁴

Regulations made under the 1980 Act replaced the former Area Health Authorities with District Health Authorities. The White Paper proposals in *Working for Patients* were enacted in the National Health Service and Community Care Act 1990. In 1995 the system was further reorganised with the National Health Service (Amendment) Act 1995 and the Health Authorities Act 1995. The latter Act provided for one type of health authority (HA) to preside over the provision of local hospital and family practitioner services, replacing the former District Health Authorities and Family Health Services Authorities. Regional Health Authorities were abolished and their functions devolved either to regional offices of the National Health Service Executive, or to the newly created Health Authorities (HAs).

The White Paper proposals in "*Working for Patients*" were enacted in the National Health Service and Community Care Act of 1990.⁵

¹ Working papers 1-10 were published in 1989 and working paper 11 in 1990. The titles, in order, are: *Self Governing Hospitals*; *Funding and Contracts for Hospital Services*; *Practice Budgets for General Medical Practitioners*; *Prescribing Budgets for GPs*; *Capital Charges*; *Medical Audit*; *NHS Consultants*; *Family Practitioner Committees*; *Capital Charges*; *Funding Issues*; *Education and Training*; *Information Systems*.

² DHSS Circular HC(80)8 announced the basic structure of the reorganised health service.

³ *National Health Service (Determination of Districts) Order 1981*, S.I. 1981 No. 1837 (as amended); *National Health Service (Constitution of District Health Authorities) Order 1981*, S.I. 1981 No. 1838 (as amended). See HC(82)2/HC(FP)(82)1/LAC(82)8.

⁴ For a more detailed account of health services law see J. Jacob, ed. (1978; 6th ed.) *Speller's Law Relating to Hospitals and Kindred Institutions*, H. K. Lewis & Co., London; N. W. Chaplin, ed. (1982) *Health Care in the United Kingdom: Its Organisation and Management*, Kluwer Medical for the Institute of Health Service Administrators, London; J. D. Finch, (1981) *Health Services Law*, Sweet & Maxwell, London; *Halsbury's Laws of England* (1982; 4th ed.) National Health and Social Security, vol. 33, Butterworths, London.

⁵ Part I of the 1990 Act was implemented in stages from July 1990 to 1st April 1991: The NHS and Community Care Act 1990 (Commentment No. 1) Order 1990. S.I. 1990 No. 1329.

B. THE SECRETARY OF STATE FOR HEALTH AND THE SECRETARY OF STATE FOR WALES

2.03 Introduction

The central authority for the administration of the health service is the Secretary of State—in England, the Secretary of State for Health and in Wales, the Secretary of State for Wales. The Secretary of State for Health presides over the Department of Health¹ and the Secretary of State for Wales presides over the Welsh Office.

Although the secretarial duties are divided among the persons presiding over their particular departments of government, the office of the Secretary of State is one. In law each Secretary of State is capable of performing the duties of all or any of the departments.² In this chapter, and throughout the text, an attempt will be made to identify the Secretary who in practice exercises the particular function of the Secretary of State; this should not obscure the fact that in law there is no differentiation among Secretaries of State.

2.04 Services

2.04.1 *Duties as to Services*

It is the duty of the Secretary of State to continue the promotion of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and Wales, and the prevention, diagnosis and treatment of illness.³ It is the Secretary of State's duty, in particular, to provide, to such extent as he considers necessary to meet all reasonable requirements:⁴

- (a) hospital accommodation;
- (b) other accommodation for the purpose of any service provided under the National Health Service Act 1977;
- (c) medical, dental, nursing and ambulance services;
- (d) such other facilities for the care of expectant and nursing mothers and young children as he considers are appropriate as part of the health service;
- (e) such facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have

¹ The role of the DHSS is described and assessed in the *Regional Chairmen's Enquiry into the Working of the DHSS in Relation to Regional Health Authorities* (1976; the "three Chairmen's" report).

² *Harrison v. Bush* (1855) 5 E & B 344, at 352.

³ National Health Service Act 1977, s. 1(1). "Illness" under s. 128(1) of the 1977 Act includes mental disorder within the meaning of the Mental Health Act 1983, s. 1(2). See paras. 9.01–9.06 *post*.

⁴ National Health Service Act 1977, s. 3(1). See further para. 18.14A.2 *post*.

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suffered illness as he considers are appropriate as part of the health service;

- (f) such other services as are required for the diagnosis and treatment of illness.

The duties imposed upon the Secretary of State under the National Health Service Act 1977 include the duty to provide special hospitals.¹

The Secretary of State may also make directions to local authorities for the carrying out of social services functions. See paras **4.02–4.03A post.**

2.04.2 Powers as to Services

Without prejudice to any of his powers the Secretary of State may provide any services which he considers appropriate for the purpose of discharging any of his statutory duties and to do any other thing calculated to facilitate, or conducive or incidental to, the discharge of such duties.²

2.04.3 Charges as to Services

The services are to be free of charge except if the making and recovery is expressly provided by statute.³ The National Health Service (Charges to Overseas Visitors) (No. 2) Regulations 1982, S.I. 1982, No. 863 (as amended) provide for the making and recovery of charges for health services provided in respect of persons not ordinarily resident in Great Britain. Regulation 3(e), (f) provides that no charges can be made for an overseas visitor who is compulsorily detained in hospital or received into guardianship; or with a view to the improvement of his medical condition where treatment is, under section 3(1) of the Powers of the Criminal Courts Act 1973, included by the court in a probation order under section 2 of that Act. (As to psychiatric probation order, see para. **15.25 post.**)

2.05 Miscellaneous Functions Relating to Mental Health

The Secretary of State has a number of specific functions under the National Health Service Act 1977, the Mental Health Act 1983 and the National Health Service and Community Care Act 1990 which are dealt with in greater detail elsewhere in this text:

- general protection of detained patients, including the preparation of a code of practice, approval of medical practitioners and other per-

¹ National Health Service Act 1977, s. 4; see further paras. **3.04–3.13 post.**

² *Ibid.*, s. 2.

³ *Ibid.*, ss. 1(2), 121.

- sons to give second opinions under Part IV of the Act, and visiting detained patients and investigating complaints;¹
- provision of pocket money for patients in hospital;²
 - duty of supervising and the power to direct local social services authorities in the arrangements which they make for the prevention of mental disorder, the care or after-care of persons suffering from mental disorder;³ and for carrying out their functions in relation to patients received into guardianship under Part II or III of the 1983 Act.
 - after inquiry, the power to make an order declaring a health or social services authority to be in default in carrying out its statutory functions;⁴
 - by reason of emergency in order to ensure that a statutory service under the 1977 Act or Part I of the National Health Service and Community Care Act 1990 is performed, the power to direct a function conferred on any body or person under that Act to be performed exclusively or concurrently by another body or person;⁵
 - to direct the removal and return of patients within the United Kingdom etc.⁶

The Secretary of State is the authority with power to make regulations for most purposes relating to mental health.⁷

¹ Mental Health Act 1983, ss. 118–121. Many of these functions are undertaken on behalf of the Secretary of State by the Mental Health Act Commission. See further paras. 22.02–22.14 *post*.

² *Ibid.*, s. 122. See further para. 23.21 *post*.

³ National Health Service Act 1977, s. 21(1), Sch. 8, para. 2(1) as amended by the National Health Service and Community Care Act 1990, s. 66(1) and Sch. 9, para. 18.14, and the Mental Health Act 1983, s. 148 and Sch. 4, para. 47. See further paras. 4.07 *post*.

⁴ The Secretary of State has (i) default powers in relation to local authority social services functions under s. 7D of the Local Authority Social Services Act 1970 (ii) default powers in relation to health authorities, NHS trusts and Family Health Services Authorities under the National Health Service Act 1977 s. 85 (as amended by the National Health Service and Community Care Act 1990, Sch. 9, para. 18.7) and (iii) the power to cause an enquiry to be held under the 1977 Act, s. 84, the 1983 Act, s. 125 or into any matter connected with the discharge of a local authority social service function under s. 7C of the Local Authority Social Services Act 1970. Both ss. 7C and 7D of the 1970 Act were inserted by s. 50 of the National Health Service and Community Care Act 1990. See further paras 22.19–22.20 *post*.

⁵ National Health Service Act 1977, s. 86, as amended by the National Health Service and Community Care Act 1990, Sch. 9, para. 18.8.

⁶ Mental Health Act 1983, Part VI (ss. 80–92). See further Chapter 19.

⁷ See, *e.g.*, the Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, S.I. 1983 No. 893; Mental Health Act Commission Regulations 1983, S.I. 1983 No. 894 (both reproduced in Appendix B).

C. HEALTH AUTHORITIES

2.06 Introduction

In order to carry out their duties in relation to the National Health Service, the Secretaries of State for Health and for Wales are obliged to establish Health Authorities (HAs).¹ The Health Authorities Act 1995 has abolished regional health authorities (RHAs) and district health authorities (DHAs) as well as family health services authorities (FHSAs). Section 1 of the 1995 Act replaces sections 8 and 10 of the National Health Service Act 1977 and the Secretary of State, is now required by order under section 126 of the 1977 Act, to establish one type of health authority (HA), merging the responsibilities of DHAs and FHSAs. The composition of HAs is governed by the Health Authorities (Membership and Procedure) Regulations 1996.² The bodies which succeed authorities abolished on 1 April 1995 with the coming into force of the 1995 Act are identified in the Health Authorities Act 1995 (Transitional Provisions) Order 1996.³ Prior to the entry in force of the Health Authorities Act 1995, the number of RHAs had already been reduced to eight. Following their abolition by the 1995 Act, responsibility for providing a regional level of management has been taken over by regional offices of the NHS Executive. Many of the statutory functions previously exercised by RHAs have been conferred on HAs under the 1995 Act. The Secretary of State's power to establish special health authorities under s. 11 of the 1977 Act remains. References to District Health Authorities, Family Health Services Authorities and Family Practitioner Committees in any document or instrument having effect before 31 March 1996 are to be construed as references to Health Authorities. References to Regional Health Authorities are to be construed as referring to the Secretary of State where functions have been transferred to him, and to Health Authorities where functions have been transferred to them.⁴

2.07 Membership

Part 1 of Schedule 5 to the 1977 Act as inserted by Sched 1 Para. 59 to the 1995 Act provides that HAs shall consist of a chairman, seven non-officer members, and five officer members. The chairman and non-officer members are appointed by the Secretary of State.⁵ The officer

¹ National Health Service Act 1977, s. 8, as amended by the National Health Service and Community Care Act 1990, Sch. 1, Part 1 and by the Health Authorities Act 1995.

² S.I. 1996, No. 707.

³ S.I. 1996, No. 971.

⁴ Health Authorities Act 1995 (Amendment of Transitional Provisions and Modification of References) Order 1996, S.I. 1996, No. 971, Art. 3.

⁵ Health Authorities (Membership and Procedure) Regulations 1996, S.I. 1996, No. 707.

members must include the chief executive, the director of finance, and the director of public health.¹

2.08 Conduct of Meetings

Meetings and proceedings of Health Authorities must be conducted in accordance with the Health Authorities (Membership and Procedure) Regulations 1996.² Health Authorities are required to make Standing Orders for the regulation of their proceedings and business, and in so doing must act in accordance with any directions given by the Secretary of State.³

All health authorities (including special health authorities and community health councils) are public bodies governed by the Public Bodies (Admission to Meetings) Act 1960.⁴ Under that Act (s. 1(1), (6)), any meeting of an authority will be open to the public and if during a meeting the authority resolves itself into committee, the proceedings in committee will be treated as if they were proceedings of the authority.

Meetings of Disciplinary Committees hearing complaints that a general practitioner has breached the terms of service in the general practitioner contract are held in private.⁵

The authority may by resolution exclude the public from the whole or part of a meeting "whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted, or for other special reasons . . ." (s. 1(2), (3)).

Where a meeting is required by the Act to be open to the public in whole or in part, the authority has a duty under section 1(4) to give public notice of the time and place of the meeting; to supply, on request, a copy of the agenda for the benefit of the media; and to afford so far as is practicable to accredited representatives of the media reasonable facilities for making their report.

The Secretary of State has advised health authorities to exercise their power to exclude the public from their meetings sparingly.⁶ In *R. v Liverpool City Council ex parte Liverpool Taxi Fleet Operators Associations*⁷ it was held that there must be reasonable but not unlimited accommodation for members of the public.

¹ *Ibid.*, reg. 2(1) and (5).

² *Ibid.*, reg. 15 and Sch. 3.

³ *Ibid.*, reg. 15(2).

⁴ Public Bodies (Admission to Meetings) Act 1960, as amended by the Health Authorities Act 1995, Sch. 1, para. 91.

⁵ Schedule to the Public Bodies (Admission to Meetings) Act 1960, para. 1(f), as amended by the Health Authorities Act 1995, Sch. 1, para. 91.

⁶ *Ibid.*, para. 8.

⁷ [1975] 1 W.L.R. 701; 1 All E.R. 379.

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2.09 Functions

The Health Authorities Act 1995 provides for the abolition of Regional Health Authorities (RHAs) and the merger of District Health Authorities (DHAs) and Family Health Services Authorities (FHSAs) into Health Authorities (HAs). The HAs have taken over the functions of DHAs of purchasing hospital and community health services on behalf of the local population, and those of the FHSAs of providing primary medical care by general practitioners, dental care, and pharmaceutical and ophthalmic services. HAs enter into contracts with general practitioners, who are independent contractors, but who must comply with their terms of service.¹ HAs have also assumed some of the duties formerly imposed on RHAs. The National Health Service (Functions of Health Authorities and Administration Arrangements) Regulations 1996 make provision for the Secretary of State's "specified health service functions" to be exercised by HAs.² "Specified health service functions" are defined in Schedule 1 to the regulations. The Secretary of State is empowered to direct a HA or a special health authority to exercise on his behalf such of his functions in relation to the health service as are specified in the directions.³

2.10 Functions of Regional Health Authorities assumed by Health Authorities

A Health Authority which maintains under a contract a patient who is liable to be detained following admission for assessment or for treatment has the power to order his discharge. The authority may authorise a doctor to visit and examine the patient detained in a mental nursing home, and may authorise any other person to inspect the home.⁴ The duty which was previously imposed on Regional Health Authorities to provide information to courts minded to make hospital orders is now placed on Health Authorities.⁵ Health Authorities have taken over the function of Regional Health Authorities of notifying local social services authorities of arrangements for admission, in cases of special urgency, of persons suffering from mental disorder.⁶ Mental Health Review Tribunals continue to be organised on a regional basis.⁷

¹ As defined in the Schedule to the National Health Service (General Medical Services) Regulations 1992, S.I. 1992, No. 635, as amended by S.I. 1992, No. 2412, S.I. 1993, No. 540, S.I. 1994, No. 633, S.I. 1995, No. 80, and S.I. 1996, No. 702.

² S.I. 1996, No. 708, regs 3 and 4.

³ National Health Service Act 1977, s. 17 as amended by the Health Authorities Act 1995, Sch. 1, para. 8.

⁴ Mental Health Act 1983, ss 23-4 as amended by the Health Authorities Act 1995, Sch. 1, para. 107(2) and (3).

⁵ Mental Health Act 1983, s. 39 as amended by the Health Authorities Act 1995, Sch. 1, para. 107(5).

⁶ Mental Health Act 1983, s. 140 as amended by the Health Authorities Act 1995, Sch. 1, para. 107(12).

⁷ Mental Health Act 1983, s. 65 as amended by the Health Authorities Act 1995, Sch. 1, para. 107(6).

Consultants are no longer appointed by RHAs. The appointment of consultants by Health Authorities and Special Health Authorities is now governed by the National Health Service (Appointment of Consultants) Regulations 1996.¹ Approval of medical practitioners as having special experience in the diagnosis or treatment of mental disorder under Section 12(2) of the Mental Health Act 1983 is now given by HAs (As to approved medical practitioners see para. 6.17.5 *post*).²

D. SPECIAL HEALTH AUTHORITIES

2.11 Special Health Authorities

If the Secretary of State considers that a special body should be established for the purpose of performing any functions which he may direct the body to perform on his behalf or on behalf of a HA, he may by order establish that body.³ Unless the body is allocated a particular name, it is to be called a Special Health Authority.⁴ The Secretary of State has established under these provisions, *inter alia*, the Mental Health Act Commission (see para. 22.03 *post*), Special Health Authorities to run each of the Special Hospitals (see para. 3.05.2–3.05.2a *post*),⁵ and the National Health Service Litigation Authority.⁶ Special Health Authorities are bodies corporate with perpetual succession and a common seal.⁷

E. NATIONAL HEALTH SERVICE TRUSTS

2.12 National Health Services Trusts

One of the key proposals in “*Working for Patients*” was the establishment of self-governing hospitals, known as NHS Hospital Trusts.⁸ The Government encouraged major acute hospitals to consider running their own affairs, while remaining in the NHS, in order to encourage a stronger sense of local ownership, pride, and efficiency. The powers

¹ S.I. 1996, No. 701.

² National Health Service (Functions of Health Authorities and Administration Arrangements) Regulations 1996, S.I. 1996, No. 708, Sch. 1.

³ National Health Service Act 1977, s. 11, as amended by the Health Authorities Act 1995, Sch. 1, para. 2.

⁴ *Ibid.*

⁵ The Authorities for the Ashworth, Broadmoor and Rampton Hospitals (Establishment and Constitution) Order 1996, S.I. 1996, No. 488.

⁶ National Health Service Litigation Authority (Establishment and Constitution) Order 1995, S.I. 1995, No. 2800.

⁷ National Health Service Act 1977, s. 12, Sch. 5, Part III.

⁸ CM 555, Jan. 1990, paras. 3.1–3.22.

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and responsibilities of each self-governing hospital must be formally vested in a separate legal body, an NHS Trust.

Section 5 of the National Health Service and Community Care Act 1990 authorizes the Secretary of State by Order to establish bodies known as National Health Service Trusts. NHS Trusts assume responsibility for the ownership and management of hospitals or other facilities which were previously managed by Regional, District, or Special Health Authorities. Prior to establishing a trust, the Community Health Council and other appropriate bodies must be consulted (s. 5(2)).

An NHS Trust is a body corporate having a Board of Directors consisting of a chairman appointed by the Secretary of State, executive and non-executive members. The duties, powers, and status of NHS Trusts are set out in Schedule 2 of the 1990 Act.

2.13 Delegation of Functions

The NHS Policy Board, chaired and appointed by the Secretary of State, has responsibility for developing Health Service strategy. The NHS Policy Board determines the strategy, objectives, and finances of the NHS in light of Government policy. The Policy Board sets the objectives and monitors the NHS Management Executive. The Management Executive, chaired by the Chief Executive, is responsible for all operational matters within the strategy and objectives set by the Policy Board. The Management Executive also has responsibility for the management of family practitioner services.

The Secretary of State for Health may direct a HA or Special Health Authority (SHA) to exercise on his behalf such of his functions as are specified in the directions, and it is the duty of the HA or SHA to comply with the directions.¹ Any directions given by the Secretary of State are to be given by regulations or by an instrument in writing, and directions in relation to his functions regarding Special Hospitals have to be given by regulation.² The National Health Service (Functions of Health Authorities and Administration Arrangements) Regulations 1996 give details of the functions which HAs are to exercise on the Secretary of State's behalf, and allow HAs and SHAs to make arrangements for their functions to be exercised jointly with other bodies, or on their behalf by their committees, sub-committees or officers, or by the committees, sub-committees or officers of other bodies.³

¹ National Health Service Act 1977, s. 13, as amended by the Health Authorities Act 1995, Sch. 1, Part I, para. 6.

² National Health Service Act 1977, s. 18, as amended by the Health Authorities Act 1995, Sch. 1, Part I, para. 9.

³ S.I. 1996, No. 708.

F. PROFESSIONAL ADVISORY MACHINERY

2.14 Professional Advisory Machinery

The Secretary of State may by order constitute standing advisory committees for the purpose of advising him on such of the services provided under the National Health Service Act 1977 as may be specified in the order.¹ Each committee is under a duty to advise the Secretary of State on such matters relating to the services with which they are concerned as they think fit and upon any question referred to them by the Secretary of State in relation to those services.²

Section 12 of the National Health Service Act 1977 requires every Health Authority to make arrangements for securing that they receive from (a) medical practitioners, registered nurses and registered midwives; and (b) other persons with professional expertise in and experience of health care, advice appropriate for enabling the Health Authority effectively to exercise the functions conferred or imposed on them under or by virtue of the 1977 Act or any other Act. This replaces section 19 of the 1977 Act which required the Secretary of State to recognise committees formed by different health authorities, and differs from it in placing the responsibility on Health Authorities to secure advice, leaving them considerable discretion as to how it is obtained.³ In Wales the recognition of professional advisory committees under section 19 remains in force.⁴ Section 44 of the 1977 Act continues the recognition of local committees representing providers of general medical, dental, ophthalmic and pharmaceutical services.⁵

¹ National Health Service Act 1977, s. 6(3); Health Services Act 1980, s. 25(4), Sch. 7. The committees currently established are set out in the National Health Service (Standing Advisory Committees) Order 1981, S.I. 1981, No. 597; the terms of appointment are set out in S.I. 1981, No. 101.

² National Health Service Act 1977, s. 6(5).

³ Guidance has been issued to Health Authorities on how they will be expected to secure professional advice HSG(95)11 'Ensuring the Effective Involvement of Professionals in Health Authority Work.'

⁴ National Health Service Act 1977, s. 19, as amended by the Health Authorities Act 1995, Sch. 1, para. 10.

⁵ National Health Service Act 1977, s. 44, as amended by the Health Authorities Act 1995, Sch. 1, para. 32.

G. COOPERATION BETWEEN HEALTH AUTHORITIES AND LOCAL AUTHORITIES

2.15 Introduction

Since 1974 it has been the policy of central government to encourage joint planning by health and local authorities in which each authority contributes to all stages of the other's planning, from the development of common policies and strategies to the production of operational plans.¹ The client groups which most require joint planning are the mentally ill, mentally handicapped, disabled and elderly infirm. Collaborative planning in partnership between health and local authorities can help devise and implement effective complementary patterns of services.² The Royal Commission on the National Health Service (see para. 2.01.1 above) identified four formal arrangements for facilitating effective cooperation:³ coterminosity, common membership of local government and health authorities,⁴ joint consultation, and exchange of goods and services. In 1981 a major consultative process was initiated relating to the transfer of resources from health authorities to the personal social services to enable long-stay patients to move out of hospital.⁵

The remaining paragraphs of this section will examine the various forms of collaboration between health authorities and local authorities.

2.16 Coterminosity

In the 1974 reorganisation, health authority boundaries were drawn so as to conform with those of the reorganised local authorities responsible for providing education and personal social services (see para. 2.14 above). The principle of coterminosity was abandoned in the 1982 reorganisation; only a minority of district health authorities have boundaries which match those of a local authority. Where one-to-one coterminosity of boundaries between health and local authorities does not exist, authorities are instructed to determine the most effective formal consultative machinery and how best to foster less formal arrangements.

¹ The collaborative process introduced in the 1974 reorganisation was influenced by the *Report of the Working Party on Collaboration between the NHS and Local Government* (in three parts: 1973, 1974) HMSO, London.

² See HC(77)17/LAC(77)10.

³ Para. 16.5.

⁴ For local authority selection of members of district health authorities see para. 2.12 above.

⁵ See DHSS (1981) *Care in the Community: A Consultative Document on Moving Resources for Care in England*.

2.17 Joint Consultation and Planning

In exercising their respective functions Health Authorities and Special Health Authorities on the one hand and local authorities on the other must cooperate with each other in order to secure and advance the health and welfare of the people of England and Wales.¹ To further cooperation among these bodies, Joint Consultative Committees are to be established by Health Authorities.² These committees must advise the bodies represented on them on their duty to cooperate and on the planning and operation of services of common concern to those authorities.³

The Secretary of State has a power by order to provide for any matter relating to the functioning of Joint Consultative Committees.⁴ He has a duty to ensure that each Joint Consultative Committee contains representatives of the constituent Health Authorities and local authorities, and that they include members appointed by voluntary organisations.⁵ He is also under a duty, before making any order, to consult with such associations of local authorities as appear to him to be concerned and with any local authority with whom consultation appears to be desirable.⁶

In order to develop joint planning, each body, with advice from the Joint Consultative Committee, is to establish a joint care planning team to work under the general guidance of the consultative committee or a sub-committee. The team comprises officers of the bodies. Teams may set up specialist sub-groups, relating to services for mentally ill people, people with learning disabilities or elderly mentally infirm. The role of the teams is advisory, not executive. Their function is to advise the bodies on the development of strategic plans and guidelines covering priority services identified by consultative committees as requiring a joint approach to planning.⁷

The Health Service (Joint Consultative Committees) Access to Information Act 1986 provides that meetings of Joint Consultative Committees, their sub-committees and joint sub-committees should generally be open to the public, including the press. The 1986 Act also provides for public and press access to certain papers relating to those committees. The Act makes certain "confidential" information exempt from its provisions.

¹ National Health Service Act 1977, s. 22, as amended by the Health Authorities Act 1995, s. 2(1), Sch. 1, para. 12.

² *Ibid.*, s. 22(2).

³ The Joint Consultative Committees Order 1985, S.I. 1985, No. 305.

⁴ National Health Service Act 1977, s. 22(4).

⁵ *Ibid.*, s. 22(3A).

⁶ *Ibid.*, s. 22(5).

⁷ HC(77)17/LAC(77)10, para. 3.

2.18 Joint Financing of Community Services

Section 28A of the National Health Service Act 1977 empowers Health Authorities and Special Health Authorities to make payments to local social services authorities, local housing authorities, local education authorities, housing associations and certain other bodies as well as voluntary organisations, towards expenditure on community services. Payments made under section 28A must accord with the advice given by a Joint Consultative Committee and must conform to conditions set out in directions issued by the Secretary of State.¹ The directions are to be found in Annex A to LAC(92)17 "Health Authority Payments in Respect of Social Services Functions." The power under section 28A may be used where locally it has been decided that a service, or a major part of it could be more appropriately provided by a local authority.² The categories of payment are: (1) joint finance; (2) dowry payments; and (3) other arrangements.

1. Joint Finance

Health Authorities may enter into joint finance arrangements with local authorities only on the basis that the local authority assumes financial responsibility as soon as possible, "to help get activities started or to prevent their premature abandonment."³ The directions give details of the permitted periods of Health Authority funding. The maximum period of joint financing for schemes aimed at enabling people to move out of hospital into the community or to provide services for drug misusers may be for up to ten years at 100% financing and 13 years in all. With other projects full revenue costs may be met for up to three years and part costs for up to seven years.

2. Dowry Payments

These are used to facilitate the transfer of patients from long-stay hospitals into the community, and may be made by way of a lump sum or annual payments to the authority taking over the patient's care. The amount, method and duration of payments are negotiated by the relevant authorities.

3. Other Payments

In preparing community care plans under the National Health Service and Community Care Act 1990 Health Authorities and local authorities are to consider whose resources can be jointly used to provide care.

¹ National Health Service Act 1977, s. 28A(5) and (8)(a)-(b), Health Authorities Act 1995, s. 2(1), Sch. 1, para. 17.

² LAC(92)17 "Health Authority Payments in Respect of Social Services Functions." Annex A, para. 3.

³ *Ibid.*, Annex B, para. 7.

This may entail Health Authorities supporting social services in ways other than joint finance or dowry payments using the general powers in section 28A. The Guidance states that this may mean shifting responsibility for a particular client group from health to social services. If this is done there should be a specific financing agreement between the relevant authorities.¹

4. Payments to Voluntary Organisations

Where the expenditure recommended by a Joint Consultative Committee is in connection with services to be provided by a voluntary organisation, then the Health Authority, Special Health Authority, or the local authority (out of monies paid to it under section 28A) may make payments to the voluntary organisation in connection with the provision of those services.

5. Power of the Secretary of State for Wales

The Secretary of State for Wales may, if he thinks fit, make similar payments to authorities and voluntary organisations in Wales of the kind described above, and under similar conditions.²

2.19 Exchange of Goods and Services

There are provisions in the 1977 Act for authorising the exchange of goods and services among Health Authorities, local authorities and voluntary organisations.³

H COMMUNITY HEALTH COUNCILS

2.20 Community Health Councils

Under section 20(1) of the National Health Service Act 1977 it is the Secretary of State's duty to establish, in the case of each Health Authority, a Community Health Council for the area or separate councils for such separate parts of the area as he thinks fit. This function is exercised by the Regional offices of the National Health Service Executive. There need not be one Community Health Council for each Health Authority's district, and the Secretary of State may, if he thinks fit discharge his duty by establishing a Community Health Council which includes the areas or parts of the areas of two or more Health Authori-

¹ *Ibid.*, Annex A, para. 12.

² National Health Service Act 1977, s. 28B.

³ National Health Service Act 1977, ss 23, 26 and 28, Health Services Act 1980, s. 1(7), Sch. 1, para. 40, Health Authorities Act 1995, s. 2(1), Sch. 1, paras 13-16.

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ties. However, he will be treated as not having discharged his duty unless he secures that there is no part of the area of a Health Authority which is not included in some Community Health Council's district.¹ In Wales the duty to appoint falls on the Secretary of State for Wales.

2.21 Membership

At least one half of the membership must be appointed by local authorities, and at least one must be appointed by each of the local authorities whose area, or part of whose area is included in the district covered by the Council. At least one third of the members must be appointed by voluntary organisations. The remaining members must be appointed by the Secretary of State, after appropriate consultation.² The Chairman, members or employees of Health Authorities or Special Health Authorities providing services within the Council's district are ineligible to be members. Similarly providers of services under contracts with Health Authorities or Trusts in the district of the Council are ineligible to serve on the Council.³ Councils must elect a chairman and a vice-chairman from among their members.⁴

2.22 Staffing

The Secretary of State is required to appoint a person acceptable to each Council to act as its Chief Officer, and also to appoint other officers after consultation with the Council and subject to its acceptance. Officers are employed by a Health Authority within the district of the regional office of the NHS Executive, determined for the purpose by the Secretary of State.⁵

2.23 Functions

1. Representation of local interests

It is the duty of a community health council to represent the interests in the health service of the public in its district and to perform functions conferred on it by regulations.⁶ The Secretary of State has stated that councils should act as local bodies, representing the interests of their local populations.

¹ National Health Service Act 1977, s. 20(2).

² The Community Health Council Regulations 1996, S.I. 1996, No. 640, reg. 2. See also NHS Executive Letter EL(95)142.

³ *Ibid.*, reg. 7.

⁴ *Ibid.*, reg. 10.

⁵ *Ibid.*, reg. 13.

⁶ National Health Service Act 1977, s. 20(3), Sch. 7, para. 1.

2. Advising on the operation of the Health Service

Councils have an advisory role, without formal executive powers. A council has a specific duty "to keep under review the operation of the health service in its district and to make recommendations for the improvement of that service."¹

3. Consultation

Each Health Authority must consult a council on any proposals which the Authority may have under consideration for "any substantial development of the health service in the council's district and on any such proposals to make any substantial variation in the provision of such service." A Health Authority may specify the date by which comments on any proposals are to be submitted by the council. If the council is not satisfied that sufficient time has been allowed, or that consultation has not been adequate, it must notify the Secretary of State in writing, and he may require the Health Authority to carry out such further consultation as he considers appropriate. The duty to consult, however, does not apply to any proposal to establish or dissolve a NHS Trust. Nor does it apply if the authority is satisfied that, in the interests of the health service, a decision has to be taken without allowing time for consultation; but in such cases the authority must notify the council immediately of the decision and any consultation that has taken place.²

4. Information to be furnished by Health Authorities

Each relevant Health Authority must provide the council with information about planning and operation of health services within its district as the council may reasonably require in order to discharge its functions. However, the authority may refuse to disclose certain confidential information. In the event that the Authority refuses to disclose information, the council may appeal to the Secretary of State whose decision as to whether information is reasonably required shall be final.³

5. Visits to Health Service premises

Councils have the right (subject to certain safeguards) to enter and inspect any premises controlled by a relevant Health Authority or NHS Trust at such times and subject to such conditions as may be agreed between the Council and the Authority or Trust.⁴ Councils do not have a right of access to private hospitals or registered nursing homes. However, in the case of such premises where National health Service patients receive services under contractual arrangements, representa-

¹ The Community Health Council Regulations 1996, S.I. 1996, No. 640, reg. 17.

² *Ibid.*, reg. 18.

³ *Ibid.*, reg. 19.

⁴ *Ibid.*, reg. 20.

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tives of the private health sector have agreed that Councils should have access to the appropriate parts of the premises concerned.

6. *Complaints*

Most Councils advise members of the public on how to make a complaint about the health service. However, some Council members and officers provide an individual service to complainants, for example by writing to Health Authorities on their behalf, or acting as a "patient's friend" at hearings or enquiries. The Secretary of State does not consider such representation to be a formal role of Councils, but has been prepared to allow the service to be provided on an informal basis.¹

7. *Meetings between Councils and Health Authorities and attendance of Council Members at Health Authority meetings*

Each relevant Health Authority must arrange, not less than once a year, a meeting between at least one third of its members and the members of the Council to discuss an agenda of matters raised by the Council or the Authority.² The Secretary of State has advised that each Community Health Council is expected to send one of its members to each meeting of the Health Authority; Council members have observer status and can speak, but cannot vote. They will not automatically be excluded from meetings where the authority excludes the public and the press. However, the Authority may exclude Council members occasionally where confidential matters are to be discussed.

2.24 Conduct of Meetings

Regulation 12 of the National Health Service (Community Health Councils) Regulations 1996 governs all arrangements for setting up and conducting Council meetings. The provisions of the Public Bodies (Admission to Meetings) Act 1960 apply to Councils (see para. 2.08 above). The Community Health Councils (Access to Information) Act 1988 provides for public access to meetings of, and certain documents relating to Community Health Councils and their committees.

¹ NHS Executive Letter EL(95)142.

² *Ibid.*, reg. 21.