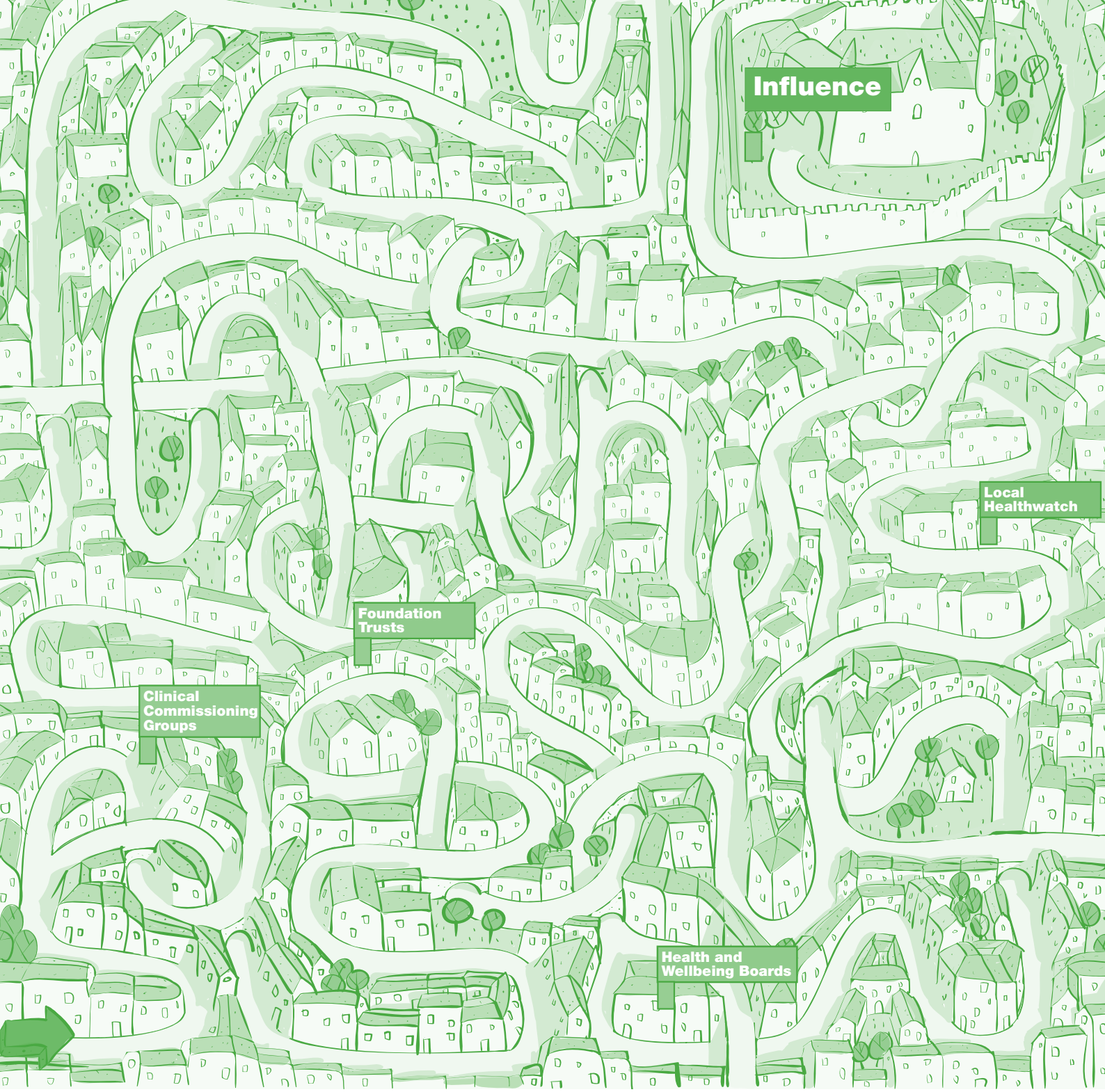

Stronger together

A UNISON guide to influencing the new NHS

2012

a million voices for public services

Our NHS Our Future

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UNISON
the public service union

Foreword

From the very beginning, UNISON fought a hard battle against the government's Health and Social Care Bill.

We fought so hard because we believe that the moves towards wholesale marketisation are completely inappropriate for our NHS – a system that has always thrived on co-operation and solidarity.

We know the NHS is important because it binds patients and staff together in a shared endeavour to improve the nation's health – with need taking precedence over the ability to pay.

And contrary to the government's scaremongering, the international comparisons continue to show the NHS outperforming other health systems in terms of both equity and efficiency.

The Bill is now an Act; but the fight to protect our NHS goes on.

UNISON will continue campaigning at all levels to defend everything that the NHS stands for.

Part of this strategy includes working within the new structures to exert an influence over the future direction of our health services.

The new NHS envisaged by the government is one of increasing complexity that includes many new structures.

But, as this guide shows, there are opportunities for all of us that value the NHS to get involved and do our bit to put a stop to damaging cuts and privatisation.

Aneurin Bevan said that the NHS would last as long as there were people with the faith to fight for it.

UNISON has that faith and we will not let this government destroy our NHS.

Dave Prentis,
UNISON general secretary

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Introduction – getting involved

You do not have to work in the NHS to care about its future; it is there for all of us. The changes being forced on our NHS are far reaching and dangerous and we all need to find ways to get involved to try and prevent the worst from happening. If we do nothing else we should at least try and observe what is happening to the NHS in our locality and to make sure detrimental changes and unacceptable practices are made known.

Alongside more traditional campaigning, there are openings for involvement for those that want to join local groups or even stand for election to one of the many NHS bodies. Even though we disagree with the new structures, UNISON's 2012 Healthcare Service Group and National Delegate Conferences both passed motions calling upon the union to expand involvement in NHS structures[1]. At the very least, we need to know what is happening.

Almost everyone will live in an area covered by a foundation trust and will be entitled to become a member. We are all patients or potential patients and there any many groups around that represent patients and their interests – join one. Going to meetings to find out what is happening to your local NHS is increasingly important as organisations try and hide behind commercial confidentiality. Even a letter to the local paper raises the issue – and we can help with model letters that strike the right tone.

If you want to help then you are not alone. UNISON is able to provide you with support and connect you with others of a like mind. We are setting up an expert panel of those who have experience within the NHS structures who can mentor, help and advise those who wish to be involved or who already have taken up posts and appointments.

Trade unionists are used to involvement in terms of local workplace negotiations, health and safety or training. We have an honourable tradition of raising issues and arguing our case. Getting involved need not compromise our principles; it gives us a chance to support our values.

Support our NHS

The Act does offer many opportunities for those who care about our NHS to become involved. One of the key themes of the government was about patients being more involved in their own treatment options – something we all agree is valuable. But beyond that is the right to be involved in the wider decisions which affect whole communities or whole groups of patients – about priority setting and about rationing and restrictions on services, closures and takeovers.

In theory there are opportunities for patients and members of the public to get involved in the decision-making bodies but just how much power and influence will be given to those who become involved has yet to be seen.

There are many decision-making bodies, far more than in the old NHS, and there remain many patient groups and organisations which represent patients with particular conditions.

Getting involved is easy

You can join one of the many groups set up to represent patients – the key one at the moment being local involvement networks (LINks). Being a member often allows you a say in how LINks represent patients' interests in the local area.

HealthWatch, which is to replace LINks as the patient representative body locally, will be commissioned by local authorities and so will come in all sorts of shapes and sizes, but the most likely form will allow people to join as members and so to have a say. Many will also have leadership groups (boards) which will be made up of a mix of appointed and elected members.

You can become a member of a foundation trust (FT) which ensures you get information and allows you a vote on who becomes an elected governor of the trust. You can be a member of several FTs. Most NHS trusts, hoping to become FTs, also have membership structures and may have “shadow” governors.

You can become a governor of a FT by being elected as a public member, elected as a staff governor or, in some cases, appointed. You can even become a non executive director (NED) of a trust if you are appointed and this gives major influence and insight. If you are unable to become a director or governor, you can still attend the board meetings which will have to be in public and also get the relevant papers.

The new commissioning bodies, the clinical commissioning groups (CCGs), will be made up mostly of GPs with only a few additional appointees. Many of the more enlightened CCGs will co-opt patient representatives onto their boards and will create patient groups as many primary care trusts have done.

Health and wellbeing boards are made up mostly of councillors and council officers and there are limited opportunities for lay people to get directly involved but many will set up sub groups which may offer opportunities.

It is also important that all of us who are involved have ways to share our experience and to gain advice when we need it to support what we do. UNISON is here to help.

Finding out

Local and national media cover NHS issues but only rarely will they provide information about how to become active. Almost all communications are nowadays through the internet so the best way to find out what is going on is through web searches. There are sites like NHS Choices[2] which will tell you what NHS organisations serve your local area. Once you identify the organisation then their website will carry information about how you can get involved, when meetings will take place and about any consultations that are taking place. This is not always easy but in the end most information is available somewhere.

You can also learn a lot just from speaking to those who already have positions in the system. If you work in the NHS there may be staff representatives at your workplace; if you are within an active Branch there may be members who have knowledge or experience to share. If help is not there locally then contact us and we can put you in touch with someone to help and advise.

About this document

This document gives a quick outline of the new NHS, followed by a series of briefings on how to get involved in different parts of the new structure.

As of autumn 2012, much of the exact implementation of the legislation is still to be determined. This should therefore be considered an evolving document with updates to follow as required. Feedback is welcome too – please send comments to OurNHS@unison.co.uk.

The influencing strategy outlined in this document is part of a wider activist approach to defending the NHS. For more on the union’s campaigning, visit unison.org.uk/ournhs.

The new NHS

The Health and Social Care Act 2012 made its way onto the statute book after many months of fierce resistance and against a barrage of criticism.

UNISON was at the forefront of this and produced an alternative vision for the NHS[3] in the process – unison.org.uk/acrobat/19874.pdf.

The Act fundamentally changes our NHS. UNISON's summary of the new Act is at unison.org.uk/ournhs/news_view.asp?did=14432[4] and other organisations have produced similar attempts to explain the new system[5].

Under the Act the new NHS will become a regulated market system. The public accountabilities are weak and competition will drive out cooperation and integration. A short UNISON factsheet describing the problems is available at unison.org.uk/acrobat/18878.pdf[6].

The new NHS will now be made up of a large number of quangos which have varying degrees of accountability. Two major organisations are the NHS Commissioning Board[7] (NHS CB) and Monitor the economic regulator.[8]

The NHS CB (commissioningboard.nhs.uk) performance manages commissioning across the NHS and is also directly responsible for some primary care and some specialised commissioning. It has huge powers but is, like Monitor, almost totally unaccountable.

Monitor (monitor-nhsft.gov.uk) currently authorises then oversees foundation trusts (FTs) and will take on a powerful new role as economic regulator[9] – fixing prices, "levelling the playing field" (so more private providers can enter) and also acting to "prevent anti-competitive behaviour". It is expected that Monitor will use its powers to drive our healthcare towards fuller marketisation.

NHS trusts were set up first in the 1990s and were the core NHS providers managed within the NHS but with some local accountability. They must now become FTs which have greater autonomy and a different governance structure. Some will fail and be broken up or merged, or even run by a private organisation, as with Circle Health taking on Hinchingbrooke Hospital.

FTs have been in the NHS since 2004 and will eventually number around 300. They will eventually include acute (hospital), mental health, primary and community care, and ambulance trusts. FTs are increasingly treated as separate businesses which provide services to the NHS at prices which are determined either nationally by the tariff or locally in negotiation with commissioners. An explanation of FTs is available at monitor-nhsft.gov.uk[10].

Clinical commissioning groups are being brought in by the Act and currently there are just over 200. They will have the responsibility for commissioning a total of around £60bn of NHS services. An explanation of CCGs is provided at commissioningboard.nhs.uk[11].

Health and wellbeing boards are also new and are an attempt to bring health and social care closer together. There will be one board in the area of each tier one local authority (those with social care responsibilities). Sadly they have only very limited powers and lack genuine democratic legitimacy. An explanation of health and wellbeing boards is provided at healthandcare.dh.gov.uk[12]. Some helpful material explaining key aspects in more detail is available at nhsconfed.org/publications[13]. HealthWatch is the latest overhaul of patient and public involvement, taking over from LINks. There will be a national HealthWatch based within the Care Quality Commission and a local Healthwatch in each local authority area – further information is on www.cqc.org.uk/public/about-us/partnerships-other-organisations/healthwatch[14].

Foundation trusts, clinical commissioning groups, health and wellbeing boards and HealthWatch are the organisations where there has to be some involvement for lay people and some rights to participation. An analysis of each of these forms the rest of this document.

Influence 1 – foundation trust membership

The main features of FTs can be found at monitor-nhsft.gov.uk/home/about-nhs-foundation-trusts/what-are-nhs-foundation-trusts[15]. They have a membership base and are corporate bodies and they each have to have their own constitution – the model for this can be found at monitor-nhsft.gov.uk/[16]. Some have compared them to mutuals or co-operatives, but the similarity is limited. A very general guide[17] to involvement in foundation trusts (FTs) is provided by the regulator Monitor.

WHY GET INVOLVED?

All NHS providers will become FTs and the fear is that will then lead to them becoming far more like businesses and far less part of an integrated care system. The idea of NHS organisations having a more local governance structure and some autonomy is one thing, but FTs should be NHS bodies acting in the public interest not behaving like profit seeking private companies. FTs are membership bodies. By being involved in an FT, activists can make the arguments and there are always avenues to make complaints to the regulator if views of members and governors are being ignored.

Anyone who lives in the defined areas of the FT (which for some can actually be the whole country or a region) can be a member and many FTs open memberships to anyone who is a patient regardless of where they live.

Membership is free, joining is very easy and as a member you should get regular information through some kind of magazine; you get invited to meetings to learn more, and you get a vote to elect governor(s) to represent the members on the council of governors.

Everyone who is concerned about the NHS can become a member of their local FT. The national membership of some FTs means you can be a member of more than one. It is easy to do and costs nothing.

Those who are members and have some time to spare can do more, by engaging with the governor who represents them and asking questions. Many FTs also hold meetings for members where they can raise issues and contribute towards the development of policies – these are all opportunities to support the kind of NHS we wish to defend.

TAKE ACTION

A directory of all current foundation trusts can be found on the Monitor website at www.monitor-nhsft.gov.uk/about-nhs-foundation-trusts.

The Socialist Health Association has a list of FTs with national memberships on their website at www.sochealth.co.uk/national-health-service/foundation-hospitals/foundation-trust-membership.

Influence 2 – Foundation Trust Governors

All FTs have a council of governors made up of three types of governor: those appointed by local stakeholders such as the council; those elected based on geographical area, such as a group of council wards, a whole county or even the whole country; and elected staff governors from various groups such as doctors, nurses, allied health professionals and others. The chair of the governing body is also the chair of the trust. Chairs of FTs are very influential within the NHS.

FTs are regulated by Monitor which sets out a strict code of governance[18] which all must apply. They also have codes of conduct which require governors not to do anything which might bring the trust into disrepute and limit the ability to engage with the media. Nothing can prevent a governor from expressing an opinion in a meeting though, and this can be reported. Monitor provides some important materials about the role of governors under the new Act[19].

Governors are not paid, although they can get reimbursed for expenses. The time commitment varies a great deal from some appointed governors who do little more than attend four or five meetings a year to very active elected governors who may put in many days a month.

FTs come in many different shapes and sizes and you need to find out the character of any FT you are thinking of getting involved with, by visiting their website or speaking to an existing governor.

Powers and duties

Governors have a number of key roles:

- appointing the chair and non-executive directors (NEDs), and determining their terms and conditions and appraisal
- approving the annual plan of the trust
- approving any major change in the proportion of private patient income

WHY GET INVOLVED?

As a result of the campaigning of UNISON and others, a change made by the government to the Health and Social Care Act means that FTs can only increase the amount of income they make from private patients by more than 5% if they have the approval of a majority of their governors. This gives governors a chance to stand up for the NHS if they are concerned that extra private patient income will push NHS patients further back in the queue for treatment.

The main power that governors can exercise is around holding non-executives to account. To do so governors should be entitled to have access to all relevant meetings and papers where non-executives are involved. They are bound by the code of conduct around preserving confidentiality.

If access is denied then governors are able to take that into account when carrying out the review of the chair and NED's performance, and setting their remuneration. In difficult cases the governors can remove the chair or NEDs, or they can complain to the regulator that they are inhibited from carrying out their proper governance role.

There is a divergence within FTs about how involved governors become. In some the governors are reduced to cheerleaders for the board and have very limited impact. In others governors have a close relationship with the board and are valued as part of the overall decision structures, given regular briefings and updates, as well as being involved early on in any proposed developments.

There is also a growing disparity between the approaches to the NHS adopted by particular FTs. On the one hand, there are those FTs which have a business model remote from the wider NHS and are looking to diversify to generate additional non-NHS income. The other model

is preferable with the FT more grounded in the community, with closer relationships with local stakeholders such as councils. The latter are also more likely to give their governors more support and to value their contribution, seeing themselves more as a part of the NHS than as a separate business.

Sadly the Act gave very strong signals that the community ownership type of FT was to be overshadowed by the aggressive expansionist business model, with these freed up to focus increasingly on services for private patients, with much greater leeway permitted for private patient activities.

One key role for governors is to try and prevent this trend to a business model and to support greater cooperation and integration within our NHS.

How governors are elected or appointed

There are different structures depending on the type of governor and different trusts have different arrangements – they have a fair amount of freedom as long as they are within the Monitor code. Most trusts will respond positively to any enquiries about becoming a governor and the best have taster sessions and make genuine attempts to get a representative cross section of elected governors. Once appointed or elected governors will have to sign a code of conduct which sets out clearly their roles and responsibilities and which should cover things like relationships with the media, conflicts of interest and confidentiality.

Staff governors

Staff governors will usually make up a third of the governing body. They are elected from their various staff groups. Most trusts will give paid time off for governor duties. Staff governors should make sure they meet together from time to time and in some trusts they also meet collectively with the chair.

Public governors

Some union members may feel that getting involved as staff governors at the FT where they work has the potential for conflicts of interest. In which case others can get involved instead, who need not be employed by the FT or even working in the NHS.

Public governors are elected usually for three year terms of office. They represent the members in a defined area. This could be a group of electoral wards, a whole borough, a county or in some cases for a specialist trusts for the whole region or even the whole country. How someone effectively represents the members in a very wide area is problematic, but for those who have a smaller local patch governors can, individually or with others, have local meetings.

Some FTs may also make a distinction between public governors and patient governors, who represent the patients who use the services of the hospitals.

Appointed governors

Each council of governors will have around a third of members from “stakeholders” such as the local authority, university, PCT, voluntary sector, and voluntary groups. It is up to the stakeholder organisation to decide who represents them. These appointed governors tend to have the worst attendance record and may take a more narrow viewpoint.

General points about governors

Governors are not directors; in the main they do not make the decisions in the way a board does. But they have major influence and should direct the strategy and key plans. They must also be the first line of defence and ensure good standards are maintained.

Governors have been disciplined and also asked to resign because they have broken the code of conduct, usually by putting a letter or a quote into the local media. For some the

threat of action is enough to deter effective communication, but governors should be able to resist being gagged or subject to unreasonable restrictions.

Governors may find the FT excluding them from meetings or making it difficult for them to get information by walking about. Again this should be resisted.

The key leverage governors have is that they both appoint, appraise and manage the performance of the NEDs and the chair. Governors oversee these appointments and can remove them from office.

The NHS needs supportive people to join FTs as members and to elect governors who will genuinely represent patients and local communities, as well as challenging bad practices.

TAKE ACTION

Anyone wishing to consider becoming a staff governor can contact UNISON for support and advice – see the "UNISON – Here to Help" section at the end of this document.

FTs should also include information on their websites about the process for electing both staff and public governors – see the link for lists of FTs in the "Foundation Trust Membership" section above.

For appointed governors, the website of the FT should set out the make-up of the council so you can identify what organisations are entitled to have appointed governors – this may offer an opportunity.

Influence 3 – Foundation Trust Non-Executive Directors and Chairs

WHY GET INVOLVED?

Getting appointed is not easy and the roles are significant commitments, but chairs and other non-executive directors are the most powerful roles at foundation trusts.

Non-executive directors (NEDs) have opportunities to direct and shape how the trust operates and performs. The NEDs also have a role in appointing the senior management team of the trust.

The responsibilities of an NHS non-executive are:

- helping to plan for the future to improve healthcare services
- making sure that the management team meets its performance targets
- making sure that the finances of the organisation are managed properly with accurate information
- helping the board work in the public interest and keeping its patients and the public properly informed
- serving on important board committees.

There are still some hospitals that have not reached foundation trust status and these tusts have separate arrangements. Chairs of trusts will spend two or three days a week at the least and some have converted the role into a full-time occupation. Other NEDs are expected to work around five or six days a month although many spend far more. They are paid under a national scale which reflects the type of trust. You are not an employee and have no employment rights.

Those appointed should be able to take time off for public duties but sadly it is difficult for anyone in full time employment to be a chair or even a NED.

As board members these NEDs play a key role in all major decisions of the trust. They will have access to all the key information and reports within the trust. Many NEDs also have additional roles beyond just the board as they become involved in major projects or proposals for change. As a NED they have the absolute right to take part in decision making and are able to put forward views and have them recorded. NHS trust boards have to meet in public, are subject to Freedom of Information legislation, and will publish agendas, minutes and reports.

FTs are able to use their own procedures to appoint the chair and other NEDs. The appointments are made by the FT governors. They are required to follow the usual practices of equal opportunities and non-discrimination and will almost always have some independent element involved in the process. The appointment process is very thorough and an example of this is provided at www.rdehospital.nhs.uk/docs/trust/ft/CGPGv1.pdf[20].

The chair of a FT is an exacting appointment. Many work long hours, with the role effectively a full time commitment.

The board of a FT is made up of the chair and NEDs (who must be in the majority) and the chief officers, which will include the chief executive, medical director, finance director and director of nursing. The board acts collectively although it can, and does, delegate most of its powers and functions to the executives and to committees.

Since they are to a large degree autonomous, being a NED of a FT is a position that has great responsibilities since they are the highest level of governance apart from any regulator. Not even the Secretary of State has powers to direct or instruct a FT and the board is responsible for the performance management of the organisation not the strategic health authority.

TAKE ACTION

You should think carefully before applying to become a NED, but people who can represent NHS values are needed on the boards of FTs, which are going to be the major NHS employing bodies into the future. See the website of your local FT for details.

Influence 4 – Clinical Commissioning Groups

WHY GET INVOLVED?

CCGs are the point where tough decisions about priorities and restrictions have to be decided, which could include closures of services or changes of use of buildings, such as clinics or even hospitals.

One of the major concerns is that CCGs will effectively contract out their functions to others, such as the major private sector players. The involvement of local activists can help identify at the earliest stage when there are moves to bring in private providers so that this can be challenged.

In the rhetoric accompanying the Health and Social Care Act, clinical commissioning groups (CCGs) are intended to be the new powerhouses of the NHS, making the important decisions about what services are provided by which organisations to what standards. Already some GPs who are supposed to be involved in CCGs are realising they will be getting the blame for cuts, service restrictions and long waits.

How CCGs operate and their governance is not yet entirely clear and much of the guidance and secondary legislation is still not available.

CCGs are based on a defined geographical area and on a membership model made up of all the GP practices in the defined area. They have a governing body which is made up of GPs, elected from member practices and others as set out in regulations.

The final rules around governance structures have yet to be published, but it is known that there will have to be two lay members of the governing body – appointed by the CCG itself – one to oversee key audit, remuneration and other governance issues, and another to head up patient and public involvement. Finally there has to be a nurse and a secondary care clinician, although they cannot be anyone currently employed in any of the service providing organisations in the area.

Beneath the CCG governing body there will be committees and consultative groups, and each CCG will make its own arrangements for this. These sub-structures will offer opportunities to get involved and UNISON will monitor how the various models for governance develop and look for further opportunities for members and reps to have an input.

Each GP practice will have to belong to a CCG, so one route in may be through the patient participation group (PPG) of your local GP surgery. Some PPGs will just be focused on the surgery itself, but others may look further into decisions made in the wider NHS that directly affect their community.

CCGs are “authorised” by the NHS Commissioning Board after they go through a rigorous evaluation and part of the criteria for authorisation is that they involve public and patients – this is the opportunity for activists to become engaged.

TAKE ACTION

As of autumn 2012, there are 212 CCGs moving from shadow form to full authorisation by April 2013. The NHS Commissioning Board holds information on the make-up of CCGs, with the initial list available from commissioningboard.nhs.uk/2012/05/31/ccg-configs-agreed

When they are fully operational, CCGs will have to meet in public and publish their agendas. This offers an opportunity to find out what they are doing, and some may offer to take questions or contributions at their meetings.

Influence 5 – HealthWatch

HealthWatch are the latest bodies set up to represent patient interests. They will have a duty to monitor health and social care services, engage with the public to find their views on the effectiveness of services, and influence commissioners (Clinical Commissioning Groups) and service providers, to bring about improvements to services that local people want and need. In some cases, by local agreement, they will help patients with NHS complaints and provide advocacy. They will cover both health and social care.

WHY GET INVOLVED?

One of the major concerns in the new NHS is that competition and financial pressures will force an acceleration of service closures and treatment restrictions, as well as longer waiting times.

The involvement of local activists in patient and public involvement can help identify at the earliest stage when there are proposals for reconfigurations and other changes in services locally.

HealthWatch will replace the current bodies, Local Involvement Networks (LINks), and in some cases where LINks are well developed these may morph into local HealthWatch.

The job of "commissioning" Healthwatch is given to local authorities and they have a very wide remit about what exactly they commission. They can only commission the service from a "social enterprise" (which have yet to be defined and could be in the voluntary or private sectors), but the functions can then be sub-contracted by the social enterprise to other bodies. This procurement process means that as long as the requirements of the service are met there can be many different shapes, sizes and structures for local HealthWatch bodies. This will become clearer over the coming months as the new bodies must all be in place by April 2013.

HealthWatch will not be required to have members (unlike LINks) so participation is subject to the decision of the social enterprise management. The best guess we have is that most HealthWatch bodies will have some kind of executive or board made up of appointed members; in some cases there will be a membership, which will elect an executive or board to lead local HealthWatch.

HealthWatch can get information about any changes that are damaging to the NHS so that they can be challenged, offering real opportunities to find out about services, plans and proposals. HealthWatch will be able to raise issues in a way that will be difficult to ignore. A representative of the local HealthWatch will also have a voting seat on the local Health and Wellbeing Board (see "Local Authorities" section below).

TAKE ACTION

Your local authority will be able to provide information on what is proposed and your existing LINk should also be able to help.

The website for the National Association of LINks Members (nalm2010.org.uk) is a helpful resource. NALM offers valuable support and guidance over current LINks and also the emerging HealthWatch bodies. See also healthwatchdevelopment.net to find out what is happening in your area.

Influence 6 – Local Authorities

There are major concerns that the new system will lead to greater inequalities and fragmentation. There is also a need to ensure that the public health functions being transferred to local authorities are properly funded and well organised. Local authorities can use their powers to produce strategies which make reducing inequality a priority.

WHY GET INVOLVED?

Local activists can get involved in the formation of local health and wellbeing strategies, and in the plans to deliver care services.

Councillors have clear rights to obtain information and access to meetings where care issues are discussed and decisions are made. Some councillors can also become part of the scrutiny arrangements which oversee changes to care services.

Health and Wellbeing Boards

The Act requires all local authorities which have social care responsibilities to have a Health and Wellbeing Board in place by April 2013. The Act says little about the structures to be used, leaving this to each local authority; almost all already have some form of Board running in "shadow" form. The progress being made in establishing Health and Wellbeing Boards is set out by the Department of Health on its website (healthandcare.dh.gov.uk)[21].

Health and Wellbeing Boards will have strategic influence over commissioning decisions across health, public health and social care. They will involve democratically elected representatives and patient representatives in commissioning decisions alongside commissioners across health and social care. The boards will also provide a forum for challenge, discussion, and the involvement of local people.

Boards will bring together clinical commissioning groups and councils to develop a shared understanding of the health and wellbeing needs of the community. They will undertake the Joint Strategic Needs Assessment (JSNA) and develop a joint strategy for how these needs can be best addressed. This will include recommendations for joint commissioning and integrating services across health and care.

Through undertaking the JSNA, the idea is that the Board will drive local commissioning of health care, social care and public health to create a more effective and responsive local health and care system. Other services that impact on health and wellbeing such as housing and education provision will also be addressed.

Boards must have at least one elected member (and most will have more than one) plus some key council officers, representatives from the relevant CCGs and one representative from the local HealthWatch. There can be others at the discretion of the authority and some are, for example, making arrangements to include tier two councils such as boroughs and districts where these exist.

While councillors may get a place on the Boards as of right there is only one "lay" person and they will be appointed to the post through HealthWatch.

Health Overview and Scrutiny Committees

Thanks to the campaigning of UNISON and others, the role of health overview and scrutiny committees (OSCs) has been protected.[22] These committees of councillors have considerable power to scrutinise "substantial" changes to services and to ensure change is preceded by proper consultations.

The Act gives some greater flexibility about how the local authority sets up its OSC and also makes the full council responsible for

any reference to the Secretary of State, which previously came from the OSC itself.

OSCs meet in public and they can be a valuable forum to find out what major changes are being proposed and what consultations may be planned about changes.

TAKE ACTION

***For councillors**, it is important to attend Health and Wellbeing Board meetings and to get the papers. Opposition councillors who want to support the NHS should argue for a seat at the table.*

Labour councils should sign up to the NHS Pledge to protect the NHS from cuts and privatisation at labour.org.uk/nhs-pledge.

UNISON can also assist with model questions to ask any local commissioners.

***For members of the public** there is the right to attend Heath and Wellbeing Board meetings so you can raise issues and ask questions whenever the opportunities arise.*

In addition OSCs meet in public, so you can attend for information on important changes to the NHS. Your local authority should have information about these meetings on its website.

In between council meetings you can also lobby your councillors to take up NHS issues – either in person at local surgeries, or via email from the council website.

UNISON – here to help

If you are currently involved within the NHS or if you are considering taking on a role then you can contact us for more information, advice and assistance by emailing:
OurNHS@unison.co.uk

UNISON is setting up an expert panel made up of those who have worked in the NHS and who have been involved as senior managers, chairs and non executive directors, governors, and councillors who will be able to offer the benefit of their knowledge and experience to help others.

This report was funded by UNISON's General Political Fund.

References

[1] UNISON Health Conference 2012 composite F called on the union to "encourage UNISON members to become active in the staff membership constituencies of foundation trusts, as a means of influencing plans that could harm staff and patients" and UNISON National Delegate Conference 2012 composite N called on the union to "encourage members to use new and existing structures to mitigate the most damaging effects of government plans".

[2] nhs.uk/Pages/homepage.aspx?WT.srch=1

[3] UNISON.org.uk/acrobat/19874.pdf

[4] UNISON.org.uk/file/Understanding%20Health%20Act%20-%20MV%20-%20June%202012.pdf

[5] See for example, NHS Confederation (£):nhsconfed.org/Publications/nhs-handbook/Pages/The-NHS-Handbook.aspx

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