HEALTH NEWS BRIEFING

CHCs, Health Authorities and Social Services Departments:

Accountability and Joint Working

April 1996

Contents

1. Summary

One of the key objectives of the *NHS and Community Care Act 1990* was to clarify the responsibilities of health and local authorities so that it would be easier to hold them to account for their performance. The Act and subsequent guidance also encourage authorities to work together to provide 'seamless' packages of care for those in need. In many areas poor co-operation and co-ordination between authorities mean that care is far from seamless and that many vulnerable people suffer as a result. In addition, although the NHS is accountable in some respects, many feel that it is not accountable to the public.

This paper looks at accountability in the NHS and considers whether accountability and service provision could be improved by placing responsibility for commissioning health and social services with a single agency - a unified commissioner. It also considers how the remit of CHCs might be extended to cover care in the community and suggests how they might develop links with social services departments.

It is intended that this paper be used to inform discussion at a local level when considering future developments in health care provision.

2. Introduction

At the 1995 AGM of the Association of Community Health Councils for England and Wales a resolution was passed calling upon the Standing Committee to establish a working party to:

a) advise local CHCs on best practice in working relationships between CHCs, DHAs and Social Services departments;

b) consider the benefits of introducing a unified purchaser organisation fully accountable to the public;

c) examine how the statutory remit of CHCs can be extended to enable CHCs to monitor care in the community services provided by local authorities; and

d) bring back a policy for discussion and adoption, and as a result call upon the Government to implement the recommendations.

In proposing the motion Aylesbury Vale CHC highlighted that the different cultures of health and local authorities hamper effective co-ordination and prevent them from providing the seamless services envisaged in the *Care in the Community Act 1990*. The casualties of poor co-ordination and co-operation are the most vulnerable people - people who are mentally infirm and the elderly. It is felt that people are made more vulnerable because they are outside the remit of CHCs.

In line with this resolution this paper considers the present arrangements for commissioning health care, looking in particular at whether the NHS is accountable and whether unified commissioning organisations would protect vulnerable people and improve the accountability of the NHS. It also looks at how the remit of CHCs can be extended to enable them to monitor care in the community services provided by local authorities and offers suggestions to CHCs about best practice when working with DHAs and social services departments. Many of the suggestions for best practice have been taken from the information provided by CHCs responding to a survey[1] which looked at CHC relationships with local authorities and social services departments.

3. Accountability

In basic terms accountability means giving account of or explaining actions and decisions. There is growing concern that any accountability in the NHS is only upwards and does not include accountability to the public at local level. Some argue that the NHS is ultimately accountable to the public at national level - managers are accountable to health authorities; health authorities are accountable to the Secretary of State; NHS trusts are accountable to the Secretary of State through the NHS Executive; and the Secretary of State is accountable to Parliament. However, others argue that this is not satisfactory and that there should be accountability at local level.

Prior to the implementation of the NHS reforms in 1991 there was a degree of local accountability, albeit minimal, in that health authorities were linked to local democratic processes through local authority nominated members and trade union representation on health authority boards. The reforms brought about changes to the membership of health authorities which no longer have elected members but now consist of members appointed by the Secretary of State and executive directors who are managers in the health authority.

Is the NHS accountable?

This section examines some of the mechanisms by which the NHS is said to be accountable.

Accountability to Parliament.

The Secretary of State for Health is accountable to Parliament - democratically elected MPs are able to question the Secretary of State and enter into debate about issues in the NHS . This is the case in theory but in practice as Cooper et al[2] point out "...there is little point in challenging the Secretary of State who can always evade responsibility on the grounds that there is a distinction between policy (which is made at the national level) and its execution (inevitably local)". It is also possible for the Secretary of State to avoid debate on issues by giving information or introducing changes in written answers to MPs' questions. For example, it has become common practice to announce increases in prescription charges in written answers.

The introduction of TV cameras to the House of Commons is considered to be another mechanism by which accountability is enhanced by increasing publicity.

But how many members of the general public take an interest in parliamentary procedures and actually watch televised debates?

Cross party select committees were established as a means of strengthening the accountability of Ministers to Parliament. The Health Committee is able to examine issues of concern, but like the other select committees it has only an advisory role and does not have the power to insist that its recommendations are implemented. The committees cannot even insist that their reports are debated in the House. The ability of select committees to strengthen the accountability of Ministers has to be questioned especially since a survey of MPs in 1990[3] revealed that almost half of the respondents felt that the committees were not scrutinising government as effectively as they should be.

Health Authorities and Trusts

Reports and public meetings: The publication of health authority annual reports and their public meetings are also cited as ways of improving accountability. Again, since the real issue here is not just accountability but accountability to local people, the question of accessibility must be raised. Does the public know about the meetings and where they are held? do the public have any input to the meetings? Even if members of the public attend health authority meetings they do not have an automatic right to speak and many items can be held over for discussion in the closed sessions of the meetings or outside of the meetings altogether. Some of these problems may be overcome if CHCs can persuade health authorities to improve access to their meetings. Finally, how many members of the public know about and would be interested in reading health authority annual reports?

Accountability of chief executives of trusts and health authorities for the way they spend resources: In 1994 the Department of Health issued the *Code of Conduct and Code of Accountability for NHS Boards*. The letter, from the Secretary of State, that accompanied the Codes stated the "all boards will need to comply with the spirit as well as the letter of the Codes"[4]. According to the Code of conduct one of the key public service values which must underpin the health service is accountability. It states "...everything done by those who work in the NHS must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct". The Code of Accountability goes on to say that "NHS boards must continue to co-operate fully with the NHS Executive and the Audit Commission when required to account for the use they have made of public funds, the delivery of patient care and others services, and compliance with statutes, directions, guidance and policies of the Secretary of State".

Non-executive directors of health authorities: Non-executive directors are selected to broaden the perspective of the authorities by providing expertise and independence. Although they should be responsive to the needs of the local community they are not appointed as representatives of the public. They are ultimately accountable to the Secretary of State who appoints them and decides whether or not to renew their appointment. Accountability should not just be in an upwards direction to the Secretary of State it should also be to the public.

The procedure for appointing non-executive members has been criticised for, amongst other reasons, appointments based on friendships and political persuasions rather than merit, the low proportion of appointments made from women and ethnic minority groups, and the increasing proportion of members from private sector backgrounds rather than from the public and voluntary sectors. In 1995 the criticisms led to changes in the appointments procedure. In order to attract a wider range of candidates for the positions of non-executive directors greater use must be made of advertising. And following open advertisements candidates should be assessed, by local sifting panels, against clear criteria.

Patient's Charter

Another way in which the NHS is said to be accountable is through the Patient's Charter. Accountability in this context relies heavily upon making information available:

- hospitals should openly display information on their Charter performance in public places

- health authorities should produce an annual report on local hospitals' Patient's Charter performance. The report should include the name of a contact to write to with any comments

- NHS Comparative Performance Tables, often referred to as 'league' tables, show how local hospitals and ambulance services are performing against the national charter standards.

In a discussion paper[5] looking at the Patient's Charter from the patient's perspective ACHCEW questioned whether the wealth of information available to patients is useful to them. In particular the paper asked whether patients are, as a result of the Charter, more likely to receive accurate and informed answers to their questions. It would seem that there is very little action open to individual patients who find that Charter standards are not being met.

Community Health Councils

Community Health Councils were established in 1974 to monitor the health service on behalf of local people. The statutory rights of CHCs as 'watchdogs' for the community include the right to be consulted by health authorities on proposals for substantial changes in use and development of NHS services locally; the right to enter and inspect NHS premises; and the right to meet with their health authorities at least annually. Since CHCs were established the NHS has changed. Howland and Harris[6] point out that "...other arrangements for public scrutiny and protecting standards have been set up".

GP fundholders

The 1990 NHS reforms saw the introduction of GP fundholding. GP fundholders (GPFHs) were given responsibility for purchasing care and services for their patients. Fundholders are playing a growing role in the Health Service and in some areas fundholding has expanded to such an extent that health authorities are being marginalised. Many regard fundholders as being even less accountable than health authorities. This is despite the publication, by the Department of Health, of *An Accountability Framework for GP Fundholding*[7] which stressed that fundholders need to show their "accountability to patients and the wider public". Even CHCs who have a statutory responsibility to represent the interests of the public in the Health Service have no formal links with fundholders.

The results of a survey of CHCs in 1995[8] lend support to suggestions that fundholders are not accountable. The survey revealed that "CHCs have not found it easy to obtain even the basic information about fundholders' activities which is supposed to be freely available". If access to this information is difficult for CHCs how can ordinary members of the public be expected to gain access to it? The survey also found that consultation on fundholders' purchasing plans is rare and that fundholders frequently show little or no interest in working with CHCs.

Also in 1995 concern about the growing influence of fundholders over local health provision led CHCs to pass the following resolution at the Association's AGM:

"This AGM notes with concern that the widening and deepening of GP fundholding will adversely affect strategic planning and public accountability in the purchasing of health care. In the light of this, this AGM calls upon the Secretary of State for Health to ensure that the demands on fundholders to hold regular meetings in public, to consult the public on their purchasing intentions and to submit their contracts to quality monitoring should be at least as rigorous

as for health authorities. Fundholders should have relationships with CHCs comparable to those already existing with other purchasers and providers."

When asked to comment on this resolution the Department of Health wrote that the Accountability Framework "emphasises the importance of GP Fundholding accountability to the public and makes it clear that plans and performance reports should be made available to patients..." [9]

There is a problem in that the 'requirements' of the Accountability Framework are only requirements, they are not laid down in regulations and are not part of GPs' terms of service. ACHCEW has unfortunately reached the conclusion that "There is no good reason to believe that they [GP fundholders] do now, or will in future, uniformly respect the "requirements" laid down in the *Framework*"[10].

Would changes to the present system improve accountability?

It has been illustrated that the NHS is not fully accountable, least of all to the public, so there is a clear need for change.

The role of Community Health Councils

The role of CHCs should be strengthened so that they can provide an effective voice for users of health services and enable local people to participate in health care developments. To be effective watchdogs CHCs need increased resources. Limited resources mean that it is becoming increasingly difficult for CHCs to cope with their workload and as a result they are often reactive rather than proactive. CHCs need clearly defined rights rather than the present system whereby much of their work is based on 'good' relations with purchasers and providers not on formal rights. The remit of CHCs should be extended to primary care including GP fundholders, and community care. The rights of CHCs to speak at health authority meetings should be restored.

Because funding for CHCs comes ultimately from the Department of Health some believe that their independence and, therefore, their effectiveness can be compromised. There is a need to re-think further the establishing arrangements for CHCs. The accountability of CHCs could be enhanced by the introduction of some sort of independent monitoring of their work and systems to protect their funding.

NHS Boards

One commentator has suggested that the role of non-executive directors could be developed in the following ways:[11]

- Non-executive directors need to draw on views outside the executive group and should be encouraged to develop independent sources of information to enable them to provide more informed views on the board's business.

- Non-executive directors should develop links with community groups so that they are aware of the concerns of local people and they should ensure that the implications of major decisions on the community are discussed by health authorities.

Further suggestions for methods of improving the role and appointment of non-executive directors include:

- Making efforts to encourage people from a wider cross section of the community to put their names forward for appointment. More stringent appointments procedures should ensure that they can withstand independent scrutiny.

- An independent public appointments commission could be established. Such a commission should operate openly with clearly defined objectives and procedures.

- Non-executive directors could be co-opted to health authorities or sub-committees of the authorities from local interest groups. This would be a method of incorporating local views and bringing expertise to the health authority.

GP Fundholders

The Association of CHCs has made a number of recommendations which would lead to fundholders being more accountable[12]. These are:

- CHCs should have visiting rights to all premises occupied by GP fundholding practices.

- CHCs should have the right to be consulted on all significant changes to fundholders' purchasing intentions.

- Fundholders' patients should be entitled to bring CHC staff with them to any meetings convened to discuss complaints.

- Fundholding practices (singly or in combination) should be required to arrange meetings with Community Health Councils at least once a year.

- CHCs should be invited to attend regular review meetings between fundholders and health authorities.

- Meetings of fundholding consortia should be held in public and CHC representatives should be invited to participate as observers with speaking rights.

- The results of any health authority audit review of fundholding practices should be made available to CHCs.

Time for a major change?

The NHS is not fully accountable and the need for change is evident. However, the degree of change that would be necessary to improve accountability is not. It could be argued that quite simply what is required are ways to improve collaboration between the agencies involved in the present system which in turn would improve accountability. On the other hand it is argued that tinkering with the current system is far from adequate and that nothing less than a radical overhaul is essential.

Many feel that the time has come to look at the way in which the purchasing of health care is organised. They believe that the artificial boundaries between health and social care should be removed and that both areas of care should be the commissioning responsibility of a single agency. It is also argued that the system should be changed to increase accountability to local people and to develop services with an holistic approach which take into account prevention of illness and health promotion, not just the treatment of people who are sick.

Is there a democratic deficit?

The Association of Metropolitan Authorities (AMA) and others argue that the wider community does not have a direct role in the planning and provision of health services or in the determination of priorities. There is a democratic deficit.

The belief is that the agency responsible for taking decisions on health should be locally accountable. It is generally considered that accountability would be achieved by direct elections of local representatives. Elections would mean that individuals would have more direct influence on the workings of the Health Service and if they are unhappy with decisions that have been made the elected representatives can be voted out at the next elections. Elected members would be open to public scrutiny which, it is argued, would make the service more accountable to local communities.

It can, however, be argued that elections do not necessarily equate with accountability. Accountability may also be diminished if decisions are made by committees which are further removed from the public. The system of making decisions by committees has been criticised because the committees are open to undue influence by authority officers and officials. This can be said of both health and local authorities.

The AMA envisage, if local authorities took responsibility for commissioning health and social care, that there would be statutory obligations for them to consult with local communities about health care plans which would enhance accountability.

4. Unified commissioning

Does it make sense to have separate agencies sharing what are often common goals?

Responsibilities for the care of elderly people, and people with a mental illness, physical disabilities or learning difficulties have never been clear. Some care was provided by hospitals, some by independent GPs and some by community health services which until 1948 were run by local authorities. There were further complications in that care from local authorities was means-tested whilst care from the NHS was free.

Some of the problems evident at the inception of the NHS persist today in that health care can be purchased and/or provided by three distinct groups: health authorities, local authorities and GP fundholders. These groups all have the responsibility of planning and co-ordinating services for their populations. A task which is complicated by overlapping populations and organisational and geographical boundaries. It would seem to be logical to have a single commissioner. The AMA is in favour of local authorities taking responsibility for commissioning health care and believe that local authorities' experience of providing a wide range of public services and their ability to collect information on local needs will enable them to engage in forward planning. They criticise the present arrangements because of the domination of the internal market by short term concerns and activities "related to the outcome of treatment rather than the prevention of illness".

The development of community care illustrates the need for close collaboration between health and local authorities. However, collaboration between authorities is frequently beset by problems such as disputes about which authority should pay for various elements of service needs and cost shunting tactics such as shifting care from hospitals to the community or preventing people from being discharged from hospital to the community. As long as separate commissioning authorities with separate budgets exist there will always be the opportunity to pass the buck and deny responsibility. This is not in the best interests of patients and the public who inevitably get caught in the middle, or fall through the net and receive no care or services at all. This would be less likely to happen if responsibilities for commissioning lay with a single agency.

Allyson Pollock, a public health consultant,[13] argues that health and social care should be integrated under a unified authority where funding is allocated according to a unified, ring-fenced formula to prevent geographical inequities.

Under the present system money for social services is not ring-fenced so local authorities have the discretion to decide how much is spent on social care, who receives that care and how much they charge for care. Also, health and social services are increasingly being provided on the basis of eligibility according to local criteria and not on individual need. The result is that where you live determines what services you receive and what services you pay for.

The replication of services by health and local authorities and GP fundholders could be reduced if the commissioning role were to be unified. A single commissioner would also facilitate the development of seamless services that are so often talked about. In addition, the reduction from three commissioning agencies to one could result in savings because of the associated economies of scale.

How would commissioning be unified?

Unified commissioning could simply mean the commissioning of all health care by a single agency. Logically a health authority. On the other hand it could mean commissioning health and social care, or health, social care and other local authority services such as housing and environmental health. Given increasing dissatisfaction with the separation of health care from social care there is growing support for the integration of health and social care with both being commissioned by a single agency. Again, both could be commissioned by a health authority. If, however, unified commissioning also includes other local authority services it would make sense for the health function to be integrated with local authority services under the control of the local authority. (Options for commissioning are outlined below).

It is essential that any discussions about unified commissioning give consideration to how GPs, especially those who are currently fundholders, will be involved.

Discussions about unified commissioning generally accept that commissioning will be for the whole of a local population.

Options for unified commissioning

If it were accepted that unified commissioning would be a good idea it could be organised in the following ways:

1. A local government model would include the establishment of a committee of members who have been elected to the local authority reporting to the full council. The AMA believe this to be the most appropriate option and has based its proposals for a unified commissioner on this model.

2. A stand-alone committee/authority of directly elected health councillors. They would be distinct from the local authority but could be members of the authority. This arrangement would not readily allow the commissioning of health to be integrated with other local authority services.

3. A stand-alone health authority where members have been elected. Again, this would not readily allow commissioning of integrated services but the introduction of elections could improve accountability.

4. A regional consortium of delegates from health authorities within the region could be created to take responsibility for health commissioning. The disadvantages of this option are seen as being problems with remoteness from local communities; difficulties with communications and reporting back; and problems with accountability. Because the delegates would not be elected this option would not solve the problem of the democratic deficit.

5. A stand-alone authority responsible for commissioning health and social care where the members have been appointed rather than elected. This option would have some of the disadvantages as 4 above.

6. District health authorities, similar to those in existence before the NHS reforms in 1990, with Secretary of State appointed members including a number of elected members delegated from the local authority could be established. These authorities would be responsible for commissioning services. Those in favour of enhancing local democracy in the NHS would be against this option.

7. Local authorities could be given a statutory input to health authority plans.

In the options listed it is assumed that local authorities would not be both providers and commissioners. Details about existing models for organisation can be found in appendix 1.

Move from central to local government

There is some concern that allowing local authorities to take on the commissioning role would fragment the NHS, that is, it would no longer be a National Health Service. This need not be the case. The national framework could be retained by setting national objectives and minimum standards. When commissioning services local authorities would need to adhere to the national standards whilst taking account of local needs and priorities. Ring-fencing NHS funds would maintain a minimum guaranteed level of funding. There are also concerns that the move to local authority commissioning will present further opportunities for means testing and charging for the provision of services. Some of those against local authorities taking on the commissioning role argue that local authorities have been accused of mismanaging funds and running out of money. Similar arguments have been made about health authorities. The counter arguments are that care in the community funds were inadequate in the first place, and that local authorities are subject to expenditure capping by central government which will generally prevent them from making up any shortfall.

The problem of conflicts of interest could arise if local authorities were to take on the commissioning responsibility for health since they act as both purchasers and providers of services. In the proposed models local authorities would only be responsible for commissioning health care, they would not be providers.

The problem of party political bias cannot be overlooked. In answer to this Cooper et al[14] state that "It cannot reasonably be assumed that local party politics would be more detrimental to the work of health authorities than national party politics".

An Act of Parliament would be necessary to alter the statutory remit of local authorities to allow them to commission health care.

An holistic approach

It is generally accepted that the emphasis of the NHS should move away from being solely concerned with the treatment of illness to a more holistic approach which would take into account other factors that influence the well-being of the

population such as housing and environmental health. The objective should be a healthier population not just a better health service. The AMA believe that bringing health services under local authorities would facilitate the establishment of greater links with these services. Local authorities are already involved in health promotion as a result of the *Health for All 2000* initiative.

5. Conclusion

As a result of a resolution passed at the ACHCEW AGM (1995) a Working Party[15] was set up to consider whether or not the NHS is fully accountable to the public. Having examined the various ways in which the NHS is said to be accountable the Working Party has concluded that although the NHS is in some respects accountable, accountability is more often than not in an upwards direction. Rarely is accountability downwards. The NHS does not often give account of or explain its actions to the public.

It has been suggested that accountability in the NHS could be improved if a single agency were to be responsible for commissioning health services rather than health and local authorities sharing responsibilities. It has also been suggested that unified commissioning could in addition to health include the commissioning of social care services. If health and social care were to be commissioned by a single agency it would, it is thought, benefit those in need because it would facilitate the provision of seamless care and services.

The members of the Working Party agreed that unified commissioning would probably improve service delivery and accountability to the public but felt that all of the suggested models for unified commissioning have shortcomings. The Working Party did not, therefore, feel that it would be appropriate to put to CHCs, in line with the resolution, a policy for discussion and adoption. Instead, the Working Party agreed that it would be useful to present a paper to CHCs that could be used as the basis for future debate about the way forward.

6. Extending the statutory remit of CHCs

Part of the 1995 AGM resolution called upon the working party to "examine how the statutory remit of CHCs can be extended to enable CHCs to monitor care in the community services provided by Local Authorities". This section looks at the current remit of CHCs and considers how it might be extended.

The ever increasing workload of CHCs is evidence of the need for representatives of users of health services. Over the last few years health and local authorities have been urged to work together to achieve the best value for money and to provide seamless packages of care for those in need. To many, looking from the outside in, the need to achieve value for money appears to be the motivating factor with the care of vulnerable individuals being relegated to second place. For this reason the users of social services also need representatives to look after their interests.

CHCs have a well established record of representing patients in health service matters so it would seem logical for their remit to be extended so that they can monitor care in the community provision in the interests of service users.

The 1995 resolution is not the first to call for the statutory remit of CHCs to be extended. Resolutions calling for similar action include the following:

1993 "This Association calls upon the Government to... establish an independent body to monitor, in the interests of patients, provision of care in the community services, perhaps by changing the statutory remit of CHCs allowing them to monitor care in the community and to represent the interests of all users of services."

1990 "Given the changes proposed by the White Paper "Caring for People", we feel it incumbent upon us to express our dismay that Community Health Councils have not been given a broader remit with regard to representing the interests of users of services provided by or commissioned by Health Authorities, Local Authorities or both...Under the new proposals CHCs will have no right to visit those patients/residents in privately contracted and Local Authority establishments to take up issues on their behalf or to be consulted over proposed patterns of provision..."

1986 "As ever increasing numbers of dependent people are being discharged into community care other than that provided by the NHS, CHCs are concerned that there is no appropriate body to look after their well-

being...this AGM resolves that the remit of CHCs and their resources be expanded to enable them to fulfil this role..."

1979 "...In particular to ask local authority Social Services Departments to invite the participation of CHCs in planning new facilities and improving current provision; this involvement should include attendance at Joint Consultative Committee meetings and it should extend to visits to and discussion of Social Service facilities".

Health and local authorities are required to set up Joint Consultative Committees (JCCs) to advise the authorities on ways in which they can work together on the planning and operation of services of common concern to them. One of their main functions is to make recommendations for use of joint financing money. CHCs do not have a statutory involvement in JCCs but many are represented on them. Voluntary organisations must be represented by three members and CHCs often fill at least one of these appointments.

In 1994 the NHS Executive acknowledged that CHCs have a role to play with social services departments. EL(94)4 states "The new community care arrangements require health and local authorities to work closely together in the planning and delivery of care. CHCs are finding themselves dealing with issues that also involve local authority social services departments (LASSD) as well as the NHS. CHCs have no statutory power in relation to social services departments. However they may find it useful to discuss and agree with LASSDs the part they can play in joint health and social services arrangements such as hospital discharge arrangements, advocacy associated with complaints, feedback from users and the CHC contribution to community care plans." This guidance has been reiterated in EL(96)17 which in addition states that CHCs can "liaise with LASSDs to arrange access to social services premises where an NHS patient is receiving care".

Some CHCs have already established links with social services departments and, for example, hold regular meetings with the director of social services and/or arrange ad hoc meetings with officers if issues of mutual concern arise. Others, however, whilst wishing to establish such links have been faced with opposition from social services departments that believe that social services should not be the concern of CHCs and that they should stick to health matters. It is clearly not satisfactory that the involvement of CHCs in social services should be at the whim of the 'personalities' involved. If the remit of CHCs were to be extended their involvement would be as of right and not just on the basis of local agreement which could easily change as frequently as personnel change (including the CHCs).

Extending the remit of CHCs would not be without problems because of their composition. The majority of CHC members are local authority and voluntary organisation appointees including some local councillors. Conflicts of interest are bound to arise because CHCs would be bound to monitor voluntary sector providers some of whom may be represented on the CHC and local authority nominated members would also be called upon to monitor social services provision.

CHCs are already becoming involved with people who approach them with complaints about social services. The extent of this involvement varies from pointing people to the appropriate person to assisting the person to pursue the complaint. Thirty-six per cent of respondents to a survey of CHCs stated that they have a policy for dealing with complaints that relate to health and social services[16]. The main concern of complainants is to have their complaint investigated, they are not usually concerned with the 'artificial' split between health and social services. If the remit of CHCs were to be extended to include social services departments then CHCs could at least provide a seamless complaints service.

An extension of the remit of CHCs would not, it is envisaged, include all social services functions, for example, child protection work.

Extending the remit of CHCs would need to involve proper consideration of the resource implications - both human and financial. Suggested areas in which the remit of CHCs could be extended are as follow:

- CHCs should have a statutory right to representation on Joint Consultative Committees.

- The remit of CHCs should be extended so that they can support and represent social services complainants who have complaints that fall within the remit of the NHS and Community Care Act.

- In view of the growing number of people being placed in care homes CHCs should have a statutory right to visit all private nursing homes, regardless of whether the health authority has a contract with them, and all residential care homes.

- CHCs should have the right to at least an annual meeting with representatives of social services departments, particularly those involved with community care policy and provision. This meeting might also include representatives from health authorities who have a similar key involvement.

- CHCs should have the right to information from social services departments about plans and developments in care in the community.

7. CHCs working with health authorities and social services departments

Although the statutory remit of CHCs does not cover work with local authorities many CHCs do work with them. Because of developments in care in the community and the need for health and local authorities to work together most links have been established with social services departments (SSDs). Some CHCs have also become involved with the work of other local authority departments such as environmental health, housing and leisure in recognition of the impact that these areas can have on the health of a population.

The degree of involvement and the usefulness of any involvement with SSDs varies from CHC to CHC and department to department and in many cases relies heavily upon individuals rather than any official policies. In a survey of CHCs over a third of respondents stated that they have both formal and informal links with social services departments[17]. This section considers ways in which, in the absence of a statutory remit, CHCs might be able to establish links with social services departments and work with them and health authorities in the best interests of local people.

The following points may be a useful starting point when considering involvement with social services departments. They are based on a workshop - *Planning for Community Care* - held at the ACHCEW AGM in 1993.

- Is there a strong crossover between health and social services?
- Will the results of building links with social services justify the time and effort involved in terms of benefit to the community? There will be a need to re-evaluate projects to see whether continuing CHC involvement would be beneficial.
- Is there concern in the community?
- Will you change anything - have an impact?
- Is there any significant financial cost? CHCs might need to look for outside funding if there is a significant financial cost.
- Is there interest and commitment from members?

First, CHCs will need to identify what the strategic issues are by consulting

with, for example, users and carers, health authorities, social services and GPs.

If the CHC has identified a need to improve relations between health authorities and social services, the CHC role could include the following actions which are based on the current practice of some CHCs:

- Joint Consultative Committees (JCCs) have been set up to advise health and local authorities on ways in which they can work together on the planning and operation of services of common concern to them. CHCs could seek representation on JCCs or at least observer status and membership of joint planning groups.

  If the CHC does not have direct input to the JCC it may be helpful to establish links with the voluntary organisations that do so that it can be kept informed of developments.

- CHCs could seek to be involved with community care planning. This need not preclude them from being consulted on final policy documents.

- It would be helpful for the CHC to find out who the members of the social services committee are, in particular the Chair, and find out if they wish to receive copies of the CHC's agendas and minutes or relevant papers on an ad hoc basis. It would also be useful to make links with key social services officers who will have influence over policy decisions.

- Local authority appointees who are councillors are frequently members of social services committees. Many CHCs take advantage of the direct link between themselves and social services by using members as a way of exchanging and disseminating information and to raise awareness of the CHC. CHCs should be aware of the potential for conflicts of interest to arise.

- CHC members may feel they need more formal information sharing, in which case social services staff and health authority staff could be invited to attend CHC meetings to brief members on relevant issues.

- CHCs could seek to become involved, as the lay element, in inspection visits to nursing and residential homes made by the authorities.

- Complaints and Social Services Departments. Social services departments must have a designated officer to take responsibility for the day to day operation and management of the complaints procedure. For example,

responsibility for receiving complaints, investigating complaints and advising social services departments on responses to complaints.

Many SSDs will have information leaflets outlining the complaints procedures. CHCs should keep a stock of these to give to complainants.

CHCs should establish links with the designated officer so that members of the public can be referred to a named officer if they wish to make a complaint about social services provision. If complaints are referred to social services CHCs could ask to be notified of the outcome of any investigation. Where complaints involve an element of health and social care it may be useful for the CHC to liaise with the designated complaints officer.

If the CHC does not handle a complaint, as well as referring the complainant to the social services complaints officer, the CHC may inform the complainant about alternative sources of support , for example, local advocacy schemes.

Where more than one CHC relates to a single SSD it would be useful for CHCs to co-ordinate their approach so that the SSD is able to work with the CHCs at a single level. This avoids replication and confusion, and saves time.

Angeline Burke
4/96

Appendix 1

Models looking at unified commissioning

MODEL 1

Under the model proposed by the Association of Metropolitan Authorities[18] DHAs and FHSAs would be abolished and fundholders would eventually be phased out. The AMA consider that the reforms suggested in this model would provide definite benefits to the public. Reorganisation would make the health service more efficient and effective in terms of delivering national public health objectives and in terms of service delivery at the point of use.

Local authorities would be responsible for commissioning health services through an **Health and Social Services Commissioning Authority** (HSSCA). HSSCAs would consist of elected members from the local authority who would take a strategic overview of commissioning services and be responsible for approving the Integrated Community Care Plans and the service level agreement agreed with the **Health and Social Services Commissioning Executive** (HSSCE). The HSSCE would be an executive body of managers appointed by the members of the HSSCA. The HSSCE would be responsible for commissioning services in accordance with a service level agreement negotiated with the HSSCA. Services would be purchased from the full range of providers.

Providers. Under this model acute services would organised nationally and locally. National acute services would be provided by 25-50 **regional centres of excellence** (RCEs) each having independent Trust status. Board members would be appointed by the Secretary of State through the NHS Executive. Locally, acute services would continue to be managed on a Trust basis. Membership of Trust boards would be opened up to include locally elected members, GPs and others. The HSSCE would be free to purchase specialist services from any RCE in the country and from any health care Trust in the region.

Fundholding would be phased out and all GPs would form consortia for the purpose of commissioning and advising on general policy matters with the health commissioners in the local authority.

Community health services would be managed by local authorities.

Resources. Resources would be determined nationally according to criteria such as census data. In order to maintain equal access this money would be ring-fenced. Local authorities would, however, have the discretion to spend money over and above this allocation (eg money raised through Council Taxes) to purchase additional services according to local need. Any deficits in budgets accrued by RCEs would be protected by the NHSE and the finances of Trusts would be protected through the local service level agreements with the HSSCE.

Accountability. In this model there would be a two-way link provided by elected members between health services and the community. The public and service users would have two avenues to hold the service to account: firstly through their ward councillor and secondly through their MP. In addition they would have recourse to the Health Service and Local Government Ombudsmen.

MODEL 2

This model is discussed in the publication *Health Before Healthcare* [19] in which the authors propose that local authorities become commissioners of the whole range of health and social care. The authors state that "In the absence of unitary authorities, the opportunities for fragmented planning and delivery will remain. Indeed we believe they are likely to get worse".

Providers. Local authorities would fund chosen providers including specialist centres on a three year rolling programme. For an agreed sum of money there would be access to agreed services. GP fundholding would be abolished and in general GPs would continue to be independent contractors but their contracts would be with the local authority. Many of the contract details would be negotiated at a national level with some room for local incentive payments including, for example, payments for encouraging health promotion.

Providers would be required to provide purchasers with information that would allow them to plan service provision.

Accountability. Centrally, policy would come under a Cabinet health and social care committee with input from various central government departments to take into account the range of functions involved in health care and promotion. Services would be commissioned in accordance with nationally applicable minimum standards. Responsibility for setting these standards, together with responsibility for policy development and national priority setting would move to the Department of Environment. The idea behind moving responsibility to the Department of Environment is to broaden health policy by shifting the emphasis

towards health gain and to allow the determinants of health to be addressed and promotion of the role of prevention.

The Department of Health would be concerned only with national aspects of health care policy and the NHSE would continue to be responsible for the providers.

Resources. Funds would be allocated to local authorities via the revenue support grant (RSG) on a weighted per capita basis. Local authorities would be able to top up spending on health according to their priorities but within the limits of their local budgets.

MODEL 3

Proposed by Wandsworth Borough Council. FHSAs, DHAs and social services departments would be merged to form a single planning, commissioning and purchasing body with direct input from GPs. GP fundholders would be retained. Initially the local authority would be responsible for purchasing primary and community health care followed by acute care at a later stage. It is thought that under this model health authorities would be more accountable, less bureaucratic and more responsive to local needs.

The Council's proposal did not envisage wholesale implementation - only those authorities deemed to be competent would be allowed to take on responsibility for purchasing health care.

Appendix 2

Working Party membership

Jennifer Elliott (Chair)	Standing Committee
Avril Davies	Aylesbury Vale CHC
Mark Winstanley	Standing Committee
Joyce Struthers	Standing Committee
Ciaran Farrell	Standing Committee
David Cook	Standing Committee
Graham Girvan	Standing Committee
Dave Lee	Standing Committee
Toby Harris	ACHCEW
Angeline Burke	ACHCEW

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