Appendix 2

From: F.SALAWU.RL3E (NHS200) Delivered: Wed 19-Sep-90 16:39 BST Sys 10075 (388)
Subject: PLEASE BRING THE CONTENTS S MESSAGE TO THE ATTENTION OF UNIT GENERAL MANAGERS AS SOON AS POSSIBLE
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To: Regional General Managers
District General Managers
Managers of Postgraduate SHAs
Unit General Managers
General Managers of FHSAs

EL(90)185
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COMMUNITY HEALTH COUNCIL (AMENDMENT) REGULATIONS

1. Regulations to amend the Community Health Council Regulations 1985 mainly in consequence of the provisions of the NHS and Community Care Act 1990 were laid on 6 July.

2. They take account of the creation of NHS trusts by:

-adding directorship of an NHS trust as a disqualification from membership of a CHC;

-providing that DHAs are not required to consult CHCs where the establishment of an NHS trust is under consideration (RHAs will be consulting);

-enabling CHCs to inspect premises of NHS trusts within their district.

3. The relationship of CHCs to RHAs is broadened by permitting RHAs to consult, instead of DHAs or FHSAs where it is expedient so to do.

4. The attached guidance draws attention to the need for a consumer oriented strategy in Authorities, and summarises the existing procedures in the light of changes to the Regulations and the introduction of a contractual relationship between purchasers and providers.

5.HSC(IS)207, HC(85)11 and paragraph 8 appendix 4 of HC(81)6 are cancelled.

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NHS MANAGEMENT EXECUTIVE

This letter will be cancelled on 31 March 1991

CONSULTATION AND INVOLVING THE CONSUMER

1. This guidance summarises the existing procedures on consultation in the light of changes to the Community Health Council Regulations and the introduction of a contractual relationship between DHAs as purchasers of health services for their resident population and provider bodies. The principles are equally applicable to FHSAs in the management of the services for which they are responsible. Consumer involvement was a strong theme in "Promoting Better Health" and guidance specifically relating to those services was contained in Section IV of Circular HC(FP)(89)20.

2. Consultation with potential users of services should be an integral part of the management process. It enables Authorities and providers to obtain a better understanding of areas where the public perceives the pattern and quality of services to be good, it helps to identify aspects which may be causing dissatisfaction, and it responds to the desire of the public to be more informed about, and have influence in, the design and delivery of the services it receives. The provisions for formal consultation with local interests, including Community Health Councils, on proposals for a major closure, development or substantial variation of the service, are part of this process.

3. The principle of making the NHS more responsive to the needs of its consumers is central to the reforms announced in "Working for Patients". If NHS Authorities are to identify and obtain services that will most effectively improve the health of their local population, they should have positive consumer relations policies including effective two-way communications with the community and its representatives, mechanisms for finding out what patients and their relatives or friends think of their local health services and how they might be improved, and clear procedures for consultation in the planning of new, or the review of existing, services.

4. True consumer involvement is more than just a consultation exercise to "rubber stamp" a decision a DHA has, in effect, already taken. It involves DHAs in taking the initiative in forging links with their local communities in advance, before there are controversial plans in the offing; this will be best achieved by developing a shared understanding of:

-the DHA's objectives for health and quality improvements - which increasingly will be expressed in terms of outcome;

-the service strategies for achieving these objectives.

COMMUNITY HEALTH COUNCILS

5. CHCs were established to represent the interests in the health service of the public in their Districts. They provide a channel for local consumer concerns. Normally there is one CHC per District.

Role of CHCs

6. CHCs are there to help the public and to advise their local NHS authorities.

-A CHC's remit extends to all services purchased by the DHA (whether provided by a DHA managed unit, an NHS Trust, or the private sector).

-CHC offices are open for the public to obtain general literature and information about health services and to get specific advice in individual circumstances (such as help in making a complaint about the provision of health services).

-CHCs have no role in the relationship between a GP and his or her individual patient, nor in the use by fund-holding GPs of their funds to secure hospital services for their patients.

-To ensure that the public can be notified of issues of local concern and can be advised of actions being taken on their behalf, CHC meetings are normally open to the public.

Composition of CHCs

7. CHC membership should normally be drawn from the communities which they serve. Local authorities appoint half the membership. Nominations for the remainder are made by voluntary organisations and Regional Health Authorities.

8. Appointment is for a 4 year term and is restricted to no more than two consecutive terms.

9. Members of NHS Authorities and directors of Trusts cannot be appointed to CHCs. Nor can former NHS or Trust employees dismissed from NHS employment for reasons other than redundancy. Establishing authorities (ie RHAs) should have regard to whether there are any other conflicts of interest (for example a NHS employee being considered for appointment in the same area).

Establishing and funding CHCs

10. RHAs are the establishing authorities for CHCs. Each RHA is responsible for providing its CHCs with accommodation and supporting facilities including staff. Budgets are set by

RHAs and expenses must be approved by them. (NHS authorities may separately commission and pay for additional work not covered by budgets). Each year, every CHC must submit a report to the establishing RHA and copy it also to the matching NHS authorities.

The rights of CHCs

11. In order to support them in their consumer representative role, Parliament has agreed that CHCs should have rights

- to relevant information from local NHS Authorities,
- to access to certain NHS premises,
- to being included in consultation on substantial developments or variations in service,
- to meetings with matching NHS authorities.

CHC visiting arrangements

12. CHCs have the right to visit premises managed by their "home" DHA and those of NHS Trusts within the Districts to which they immediately relate. Where the DHA's residents are treated outside the CHC's own District, visiting rights are vested in the CHC in the District of treatment. DHAs should secure similar visiting rights for CHCs to private sector premises through contracts.

CHCs and their NHS Authorities

13. In addition to their day to day contacts with NHS Authorities, CHCs have the statutory right to meet with their matching NHS authorities once a year. They also have rights as do other members of the public to attend any NHS Authority or NHS Trust meetings open to the public.

14. It is a matter for decision by NHS authorities and NHS Trusts whether CHCs will be invited to address meetings which are open to the public or to attend meetings which otherwise are closed to the public.

Legislative provision for CHCs

15. The principal statutory instruments in respect of CHCs are:

The Community Health Councils Regulations 1985 (SI 1985 No 304) as amended by the Community Health Councils (Amendment) Regulations 1990 (SI 1990 No 1375) and.

The Community Health Councils (Access to Information) Act 1988.

PROCEDURES FOR CONSULTATION ON SUBSTANTIAL CHANGES IN SERVICE PROVISION

16. The pattern of NHS services does not stand still. Medical advance, population change, reviews of resource use and capital development all result in the possibility of change to the broad framework of the health care purchased by a DHA.

Local communities are affected by such change and DHAs, as purchasers rather than providers of health care, should take account of their views in planning developments in services.

Statutory requirement

17. DHAs are required by the CHC Regulations 1985 (SI No. 304), as amended, to consult the relevant CHC on proposals they are considering which would result in substantial changes to the services in the CHC's District. This applies equally if the changes are being considered as a result of changes elsewhere, such as a decision by an NHS trust to change the services it offers. Changes may be made without consultation if the Authority has expressly decided that, in the interest of the health service a decision has to be taken without allowing time for consultation. In this circumstance the DHA shall immediately notify the CHC of the decision and why consultation was not possible, and should implement the decision with a speed consistent with their decision. Regulations 19(1) and (2) do not distinguish between permanent and temporary closure - only "urgency" permits closure without consultation.

18. The Regulations (Regulation 19(2A)) now provide for an RHA to decide to undertake the consultation when it considers that it would be expedient in the interests of the health service for it to do so. Such a circumstance could arise for example, in the case, of changes to the provision of supra-district or regional specialist services.

Closures

19. It is for the Health Authority to decide whether the change it proposes constitutes a "substantial" development or variation. Such decisions can and have been challenged in the Courts, however, where their reasonableness has been called into question. (We have no reason to dissent from the view that there will be few instances in which the closure of facilities on a scale sufficient to save material amounts of money will not be a substantial variation.)

NHS Trusts

20. The Regulations apply only to developments by DHAs and not to those by NHS Trusts. Consultation on substantial changes in the pattern of services provided by NHS Trusts as a result of major changes in the contracts placed by DHAs will

be the responsibility of the purchasing authority.

Information requirements of CHCs

21. The Regulations lay on the DHA a duty to provide a CHC with such information about the planning and operation of health services in the district of that Authority as the Council may reasonably require in order to carry out its duties. The Authority is not required to provide confidential information about the diagnosis and treatment of individual patients or any personnel matters relating to its individual officers; the Authority may also refuse to disclose to a CHC any other information which the Authority regards as confidential.

22. In the event of a DHA refusing to disclose information to a CHC, the CHC has a right of appeal to the RHA; the RHA's decision on the matter is final.

Consultation

23. The essence of consultation is the communication of a genuine invitation to give advice and a genuine receipt of that advice. In order that this might be achieved, a DHA must give sufficient information and allow sufficient time for a view to be taken and advice to be formulated.

24. A DHA considering proposals for substantial development or variations in services will wish to initiate the consultation process at an early stage, it being more helpful for all parties if the consultations cover broad strategies for providing health care. In particular, the Management Executive would not expect DHAs to consult on the details of individual contracts, although they should do so on the strategies underlying those contracts.

25. Information about the proposed change should be provided to the relevant CHC and other interested parties, such as local authorities, and a date prescribed by which comments should be made. The DHA will then reconsider the proposal in the light of the comments and, if there is no objection from the CHC, may proceed with implementation.

26. The general principle should be that it is the Authority initiating the proposal that should lead the consultative process. Thus, in the context of the purchaser-provider functions:-

a) the purchasing Authority should consult on proposals it may have for substantial changes to services affecting its residents;

b) the managing Authority should consult on any proposals it may have for substantial changes resulting in closure of its buildings;

c)where these two Authorities are different, or other overlap occurs, consultation procedures should be agreed locally to avoid duplication as far as possible. But there need not necessarily be a presumption that changes at (a) will result in changes to the use of a building, as it would be open to the provider to seek other purchasers

27. Ministers wish to continue to reserve to themselves decisions on contested closures. Where a CHC wishes to object formally to a proposal involving the closure or change of use of a health building managed by a DHA (whether or not that DHA is the major purchaser of services provided in the building), the DHA shall refer it to the RHA. If the RHA supports the DHA's proposal, it will refer the proposal to the Secretary of State for final decision.

28. A DHA considering a proposal involving the closure or change of use of a health building which it manages (whether or not that DHA is the major purchaser of services provided in the building), will need to consult other purchasing DHAs as well as the CHC. Similarly, an RHA undertaking consultation under Regulation 19(2A) will need to consult any RHAs, DHAs and CHCs with an interest in the proposals.

Establishment of NHS Trusts

29. Under the provisions of the NHS and Community Care Act 1990, an RHA is required to consult the relevant CHC, and other persons or bodies it considers appropriate, on proposals to establish an NHS Trust and to forward the results of consultation to the Secretary of State.

Content of Consultation

30. It will be for each Authority to decide on the form, content, extent and timing of a consultation. The Courts will decide, in the last resort, whether the exercise was conducted with sufficient clarity and to a timescale and an extent that satisfied the requirements of the Regulations. The principle should be to ensure a full degree of involvement by interested parties, including consumers, at all stages of strategic and operational change.

Circulars

31. HSC(IS)207, HC(85)11 and paragraph 8 appendix 4 of HC(81)6 are cancelled.