COMMUNITY HEALTH COUNCILS IN ENGLAND

Consultative Paper on Role and Membership

DHSS

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COMMUNITY HEALTH COUNCILS IN ENGLAND: CONSULTATIVE PAPER ON ROLE AND MEMBERSHIP

INTRODUCTION

1. In July last year the Secretary of State for Social Services announced that Community Health Councils (CHCs) would be retained for the time being alongside the new District Health Authorities. The Department's circular* on the new structure also promised this consultative paper on the membership and role of CHCs. This paper is not however intended as the final list of subjects for discussion and Ministers will welcome views on any aspect of CHCs and their work.

2. The present legal provisions affecting CHCs are Section 20 of and Schedule 7 to the National Health Service Act 1977, and the National Health Service (Community Health Councils) Regulations 1973. Many of the changes discussed in this paper would involve amendment of the Regulations. Those discussed in Paragraphs 19-22 would require amendment of the 1977 Act itself. Others would not involve changes in the law, but only modification of the guidance which the Department has issued at various times on the role and working of CHCs.

ROLE OF CHCs

3. The 1977 Act provides that CHCs should represent the interests in the health service of the public in their district. Ministers see CHCs as local bodies, representing the interests of their local population in the health services, and not as having a role in the formation of policies at national level.

4. Since CHCs were established six years ago, there has been no lack of comment, in publications and in representations to Ministers and the Health Departments, about the way they have gone about their work. Many of the comments indicate support for the independent stand taken by many CHCs on important local issues. Particular attention has been drawn to the part played by some of them in developing effective local policies for prevention. But there has also been adverse comment, and undoubtedly there is a body of opinion that CHCs actually hamper authorities in providing or improving services, though it is not clear how much of this reflects legitimate differences of opinion about local health matters. Ministers believe that most CHCs carry out their duties in a responsible way, and that rigid guidelines would serve no useful purpose. But they would welcome constructive suggestions aimed at improving the way in which CHCs go about their task.

5. Paragraphs 6-18 below examine and invite views on some aspects of CHCs' role which appear to have presented problems, or which have been the subject of particular comment.

Consultation with CHCs

6. Area Health Authorities have a legal duty to consult the CHC concerned on any proposals they have under consideration for a substantial development of, or substantial variation in, the health service.** Exceptionally, the authority may take a decision without allowing time for consultation where it is satisfied that this must be done in the interests of the service, though in such circumstances it must immediately notify the CHC of the decision and the reason for the lack of consultation. The authority may set a time limit for consultation, but the CHC has a right of appeal to the Regional Health Authority if it considers the time allowed inadequate. In addition CHCs have a special role where a proposal for a permanent hospital closure or change of use is involved, in that their agreement is required if the proposal is to proceed without reference to Ministers (see Paragraphs 11-12 below). No change in these arrangements is suggested.

7. These provisions are however only minimum requirements. Ministers expect authorities to make every effort to consult CHCs on all matters of interest to them, to take a generous view of what constitutes a "substantial" development, and where urgency makes full consultation difficult, to do what they can in the time available. They do not, however, consider it necessary or desirable to give more detailed guidance than already exists, for example, in planning and closure procedures.

8. The suggestion has been made that Regional Health Authorities should be required to consult CHCs on some issues. Ministers do not think it would be appropriate to introduce such a requirement.

* **HC(80)8 "Health Service Development: Structure and Management".**

** **Following legal proceedings taken in 1979 against the Commissioners for the Lambeth, Southwark and Lewisham AHA over the consultation procedures involved in temporarily closing a hospital in that area, the Department has reminded health authorities that some temporary closures may come into the category of substantial variations in service for the purpose of the Regulations.**

Right to Information

9. It is vital that CHCs have the information necessary to do their job. This is particularly important in relation to hospital closures and changes of use (see below). Area Health Authorities have a duty under the Regulations to provide CHCs with "such information about the planning and operation of the health service as they may reasonably require", and Ministers expect CHCs to receive information in good time to consider it adequately. It would certainly not be feasible, however, to impose a duty on health authorities to supply any information CHCs may call for, or a time within which it must be supplied. A request for information must be reasonable from the point of view not only of the job which the CHC has to do, but also of the amount of other work being carried out by the authority.

10. This balance can only be struck locally. Ministers are, however, concerned at the view sometimes expressed that CHCs do not always have all the information they need. Views will be welcome on how serious a difficulty this is, whether for authorities or for CHCs, and on how it might be tackled.

Hospital Closures and Changes of Use

11. CHCs have a special responsibility in relation to proposals for hospital closures and changes of use. At one time, all such proposals had to be specifically authorised by Ministers. However, arrangements introduced soon after CHCs were set up enable proposals to proceed locally, where the CHC agrees. Where the CHC does not agree and has put forward a detailed and constructive counter-proposal, the original proposal cannot proceed without Ministerial agreement.

12. Ministers support this role of CHCs as a valuable aid to local decision-making. It is sometimes argued by CHCs that they do not have the staff to work up a detailed and constructive counter-proposal and may not always have the information needed to identify and look closely at all the options. Ministers recognise that there may be problems here, but they nevertheless consider that a CHC which objects to a proposal has a responsibility to respond in a constructive way. Some CHCs have produced valuable counter-proposals despite the difficulties. Views on these issues would be welcome.

Complaints

13. Most CHCs will advise members of the public how to make a complaint about the health service. Some CHC members and officers help individuals to draft and present complaints, but there appears to be wide variation in their willingness and ability to do this. From time to time there are calls for the role of CHCs in complaints procedures to be defined, and some far-reaching suggestions have been made. For example, the Royal Commission on the NHS suggested experiments with "patient advocates" on the lines of those in the USA.

14. CHCs' main job is to keep local health services under review. This is an exacting task and Ministers are concerned that CHCs should not be diverted from it. They do not consider that any extra NHS funds for CHCs would be justified (see Paragraph 40). Other sources of help are available to people who wish to pursue a complaint - personal friends, the complainant's Member of Parliament or local Councillor, Citizens' Advice Bureaux. Ministers do not therefore propose that CHCs should extend their role formally to providing an individual service to complainants, for instance, by writing to health authorities on their behalf or acting as "patient's friend" at an inquiry.

Attendance at Meetings of District Health Authorities

15. Each CHC has the right to send a member to meetings of the Area Health Authority to act as an observer, with a right to speak but not to vote. CHCs will have the same rights in relation to meetings of the new District Health Authorities. It is widespread practice for AHAs to admit CHC observers to the "closed" as well as the "open" part of their meetings, except when there is specific reason for exluding them (for example from discussion of staffing matters). Ministers support this practice.

Attendance at Meetings of Family Practitioner Committees

16. It is not compulsory for Family Practitioner Committees to admit CHC observers to the non-confidential parts of their meetings, though many now do. Ministers are in no doubt about the value of admitting observers and urge all FPCs to adopt this practice. However they recognise the feeling of some FPCs that compulsion would be damaging to goodwill and that harmonious relationships can be achieved in other ways. Ministers do not therefore intend to impose a formal requirement that FPCs should admit CHC observers. Views would be welcome on ways in which the important relationship between CHCs and FPCs could be further strengthened.

Miscellaneous Statutory Provisions Relating to the Role of CHCs

17. Each CHC has a right of access for the purpose of inspection, subject to certain safeguards, to premises controlled by the AHA. It has a duty to publish an annual report, and the AHA a duty to publish a reply. The CHC and AHA must also meet at least once a year to discuss matters of common concern. It is proposed that all these provisions should be retained in relation to the new District Health Authorities. Ministers have no proposals for new statutory rights or duties.

Private Hospitals

18. CHCs have neither a statutory interest in - nor, in consequence, any locus to visit - private hospitals. It has been argued that their remit should be expanded so that they can interest themselves in the whole of the health services available in their district. Ministers do not consider that there is any justification for giving CHCs a general interest in non-NHS services. Different considerations apply, however, in the case of a contractual arrangement under which NHS patients receive services from a private hospital. The Department will consult the appropriate private sector bodies about the arrangements which should apply in such cases.

MEMBERSHIP

Size

19. When CHCs were first established, it was expected that the great majority would have between 18 and 30 members. In England most are in the 24-30 range, but there are a few instances of CHCs with 36 or more members. Ministers are of the firm view that CHCs would be more effective if they were smaller, and do not think it right that they should have a membership substantially larger than that of the District Health Authorities to whom they will relate. These will normally have 16 members. It is suggested that the number of CHC members should not normally exceed 18, but might be greater - say, up to 24 - in a few large Districts. Views are invited on the suggested normal maximum of 18 and overall maximum of 24, both generally and in the context of the possible changes in the balance of membership which are set out in the following paragraphs.

Composition: Appointments by Local Authorities and Voluntary Organisations

20. Under the 1977 Act, half the members of a CHC are appointed by local authorities and one-third by voluntary organisations. Many people have argued that the local authorities' share of the appointments should be reduced. Local authorities are free to appoint whomever they wish, but in practice have mainly appointed councillors. Many councillors have made a considerable contribution to the work of CHCs, but others have not found it easy to combine CHC work with the many other demands on their time and energy. Moreover, councillors who lose their local authority seats have to give up their CHC membership. This has resulted in a higher level of turnover among members appointed by local authorities (but see Paragraph 28(i)). In the new structure, local authorities will continue to provide a proportion of the members of the health authorities themselves. With the increase in the number of health authorities, there will in total be more local authority members serving on District Health Authorities than are serving now on AHAs. This will increase the difficulty for local authorities of finding councillors willing and able to serve effectively on CHCs.

21. Members of voluntary organisations, on the other hand, tend to have more time and energy to devote to CHC work. Successive rounds of appointments have indicated that there is fierce competition for these seats in many localities. Moreover, there are clear advantages in a wide spread of such organisations being represented. In Ministers' view there is a strong case for reversing the proportions of members appointed by these bodies, so that at least half would be appointed by voluntary organisations, and about a third by local authorities. They would welcome views on the desirability of such a change, or on other possible patterns. Any such change would, however, need primary legislation and could not be introduced in 1982. To avoid undue disturbance, Ministers would propose not to implement any such change until 1984 at the earliest.

22. The definition of local authorities as applied to CHCs does not include parish, community or town councils. While it is open to a local authority to appoint members from such councils, few do so. Ministers would see advantage in having at least one member on each CHC who could represent the point of view of these smaller councils, particularly those in rural areas. It would be for the District or Area Committee of the County Association of Local Councils to agree who the member should be. Views would be welcome on whether such representation should be secured as of right within the proportion of members appointed by local authorities.

Composition: Appointments at Present Made by Regional Health Authorities

23. The remaining one-sixth of appointments to CHCs are made by RHAs. This small share of appointments has proved valuable in securing representation of organisations which might otherwise not gain a place, and generally in providing places for individuals who can make a special contribution but are outside the ambit of the other appointing bodies. It is suggested that this small "float" of members be retained. However, Ministers would welcome views on whether these appointments should continue to be made by RHAs, who are necessarily remote from the affairs of individual CHCs, or might better be made by the new, locally-based DHAs.

24. Since 1976 Trades Councils have had a guaranteed place on CHCs, as an RHA appointment. Trades Councils are undoubtedly an important and valuable source of CHC membership. But the reserved place has severely limited the scope of RHAs in making appointments to CHCs. With smaller CHCs, these difficulties would be exacerbated. Ministers consider that on balance it would be unfair to continue the reserved place for Trades Councils. Trades Councils would of course be included in the list of voluntary organisations invited to take part in making appointments.

25. When CHCs were first established, special arrangements were made by agreement with the Coal Industry Social Welfare Organisation for the direct representation of the mining industry on each CHC serving a health district containing a miners' rehabilitation centre. Similar arrangements were made to secure representation of special interests in some hospitals in London. The Department will be reviewing these arrangements direct with the RHAs concerned.

Term of Office

26. The normal term of office for a CHC member is four years, and under the Regulations where two consecutive terms of office have been served, a member is not eligible for re-appointment until four years have elapsed. This rule has been much criticised, particularly after the recent round of appointments where many CHCs faced the loss of founder members whose initial term of office had been for less than four years. It has also been found to have a harsh effect on members who fill casual vacancies for a short period.

27. Ministers recognise that new members must be brought on to every CHC periodically if it is to remain vigorous and effective. But the Regulation designed to secure this is uneven in its effects, and minor changes may only bring with them fresh anomalies and complexities. Views are invited on whether it is necessary to retain this rule or whether it could not be left to appointing authorities to decide whom to appoint or re-appoint, taking recent length of service into account along with other factors.

Eligibility

28. i. *Defeated Councillors.* Councillors who lose their local authority seats automatically cease to be members of the CHC. Views are invited on whether or not a local authority should have discretion to retain them on the CHC if it wishes, either indefinitely or until the next round of appointments.

ii. *Members of Health Authorities and Family Pracititoner Committees* are ineligible for CHC membership. These restrictions will be retained.

iii. *NHS Employees and Family Practitioners* are ineligible only if they are also members of Regional or Area Terms of Officers or District Management Teams. The restrictions on members of Officer Teams will be retained. Views are invited on whether other NHS employees should remain eligible to serve.

iv. *Age Limit.* Since 1976 appointing bodies have been asked not to appoint or re-appoint people over the age of 70, unless there is a special reason. Views would be welcome on whether this has proved unduly restrictive.

v. *Non-attendance.* Under the Regulations appointing bodies have a discretionary power to declare a member's place vacant if he has not attended a meeting for six months. Should such a member automatically lose his place (as is the case with health authority members) unless he can give a satisfactory explanation of his failure to attend?

APPOINTMENTS PROCEDURE

Voluntary Organisations

29. The appointments procedure for representatives of voluntary organisations is frequently criticised as over-complex and elaborate, and in some instances has been known to take a year to complete. Annexed is an extract from the Department's guidance on the procedure with a flow chart setting out the separate stages.

30. Much of this complexity arises from the principle that the voluntary organisations invited to take part should agree among themselves who should make the appointments. This usually involves organising some form of election, which takes time. However there is undoubtedly considerable scope for simplifying the procedure, while retaining this principle.

31. The most time-consuming stages of the procedure are those which precede the selection process itself. Establishing bodies are required to draw up a provisional list of voluntary organisations to be invited to take part, after consultations with co-ordinating bodies such as local Councils for Voluntary Service, and with CHCs themselves. They then notify organisations on the provisional list. The next stage is to advertise in local newspapers. After allowing one month for replies they draw up a final list in consultation with local authorities. Voluntary organisations who apply for inclusion are notified of the outcome. Before the actual selections are made, CHCs are given an opportunity to comment on the procedure and on the list of organisations taking part.

32. The requirement to draw up two lists, one provisional and one final, serves no useful purpose. Moreover, while consultations are necessary, the current procedure requires them to take place in several stages, and those with local authorities at a late stage where they are unlikely to have a material effect upon the outcome. Ministers therefore propose that establishing bodies draw up a single list of organisations to be invited to take part, on which there would be a single round of consultations. Where, when and how to advertise could be a matter for the establishing bodies' discretion.

33. Views are also invited on the requirement to give CHCs themselves an opportunity to comment on the procedure by which the voluntary organisations select which of them are to make the appointments and on the list of organisations taking part.

34. There have been instances where political parties have sought inclusion in the list of voluntary organisations invited to take part in the selection procedure. It was never the intention that political parties should be represented on CHCs in this way, and Ministers wish to make it clear that they should not be treated as "voluntary organisations" for this purpose.

35. It is possible under existing arrangements for a voluntary organisation to have more than one seat on a CHC. Ministers believe it is important for as wide a range of voluntary organisations as possible to be represented and it is suggested that a voluntary organisation should not be invited to participate in any round of appointments where it already has a member who is not due to retire until the next round.

36. Any other suggestions for improving the appointments procedure would be welcome.

Appointments by RHAs (or DHAs - see paragraph 23)

37. Regional Health Authorities have up to now been required to consult local authorities before making appointments to fill their residual one-sixth share of CHC places. Given that local authorities make their own direct appointments to CHCs and will continue to be consulted about the selection of voluntary organisations, it is proposed that this requirement should be removed.

RESPONSIBILITY FOR ESTABLISHING CHCs

38. For practical reasons Regional Health Authorities will retain the responsibility for establishing CHCs in England in 1982. However views would be welcome on whether this responsibility should thereafter be passed to DHAs.

RESOURCES

39. RHAs will continue to be responsible for determining CHCs' allocations, whatever decisions are reached on the matters raised in Paragraphs 23 and 38.

40. Ministers do not consider that there should be any general increase in resources for CHCs. RHAs must continue to decide this in the light of other priorities and cannot be expected to divert resources from direct patient services which are already tightly squeezed.

41. In line with the recent duty imposed on health authorities to keep expenditure within cash limits, Ministers propose that a duty be imposed on CHCs not to spend a sum in excess of the expenses approved by the establishing authority.

STAFFING

42. Comments are invited on whether to continue the present arrangements whereby CHC staff, though selected by and working under the direction of the CHCs themselves, are formally employed by the establishing authorities, or whether it would be preferable for the CHCs to employ their own staff. CHCs would need to look to the RHA or DHA for personnel advice and services.

ASSOCIATION OF CHCs FOR ENGLAND AND WALES

43. The Association has now been in existence for several years, though not all CHCs are members. The need for CHCs to have a national association at all is sometimes questioned. Ministers suggest that CHCs take the opportunity to consider whether the Association should continue.

TIMING AND TRANSITIONAL

44. Most DHAs are expected to come into formal existence on or before 1 April 1982. Ministers wish new CHCs to be ready to take their place alongside the corresponding DHAs as soon as the latter are established. Guidance on timing and transitional arrangements will be given when firm decisions are announced in the light of comments on this consultative document.

CONCLUSION

45. Ministers hope that this paper will stimulate useful debate and constructive comment on how CHCs can be made more effective. Comments should be sent as soon as possible and not later than 30 April 1981 to DHSS, Health Services Division 2D, Room 1123, Hannibal House, Elephant and Castle, London SE1 6TE.

ANNEX - EXTRACT FROM HC(76)25

PROCEDURE FOR APPOINTMENTS BY VOLUNTARY ORGANISATIONS

REVISING THE LIST OF VOLUNTARY ORGANISATIONS

1. As a first step, RHAs should revise their list of voluntary organisations to be invited to take part, following consultation with co-ordinating bodies such as local Councils for Voluntary Service, County Community Councils, Age Concern or Old People's Welfare Committees, and Community Relations Councils in districts with a large immigrant population.

2. The list should consist of organisations interested in health matters and active in a CHC's district or with a particular interest in a health service institution - such as a miners' rehabilitation centre - within that district. The CHC should be asked if it wishes to suggest any additions. The RHA should notify all organisations on the list at this stage.

3. Religious organisations, employers' organisations, women's organisations, youth bodies, immigrant's organisations and tenants' and residents' associations should be treated as eligible for listing as voluntary organisations, notwithstanding that such organisations are mentioned in paragraph 8 of the Circular as bodies to be considered when the RHA makes its own one-sixth of appointments. Trades Councils should not be included in the list of voluntary organisations because separate provision is made for their representation (see paragraph 7 of the Circular).

4. It is not necessary for the office of a voluntary organisation to be situated in the district concerned in order to be eligible for inclusion on the list for that district.

5. Voluntary organisations or groups of organisations which appointed members who are not due to retire at the next round of appointments need not on that account be excluded from the list of voluntary organisations invited to take part in appointments.

ADVERTISING FOR VOLUNTARY ORGANISATIONS TO PARTICIPATE

6. Under Regulation 7(1) the RHA must arrange for advertisements to be placed in the local press inviting voluntary organisations to apply. The RHA should consult the co-ordinating bodies of voluntary organisations on its arrangements under the Regulations.

7. A suggested model advertisement is at Appendix 4 of Circular HRC(74)4 which indicates the minimum content needed. RHAs should ensure as far as possible that all parts of the district are reached by these advertisements. It is open to RHAs to consider additional ways of attracting the attention of voluntary organisations to the appointing procedure.

8. The RHA should not close the list of voluntary organisations until it has received the replies to the advertisements, and must allow at least one month from the appearance of the advertisements for bodies to reply.

DECISION ON FINAL LIST OF VOLUNTARY ORGANISATIONS

9. The RHA's decision on the final list of organisations to take part in appointments must be taken after consultations with the appropriate district, county and borough councils (Reg 7(2)), and voluntary organisations should be given the benefit of any doubt by being included rather than excluded. It should therefore be rare for voluntary organisations which have asked to be included to be left out of the final list. A voluntary organisation which applies for inclusion on the list should be informed of the outcome.

SELECTION OF APPOINTING ORGANISATIONS

10. Once the list of voluntary organisations has been determined the RHA should invite these organisations to agree amongst themselves which of them should make appointments to the places to be filled. The places may be allocated to individual organisations or to organisations acting jointly.

11. In the large majority of districts a local co-ordinating body of voluntary organisations (eg the local Council for Voluntary Service) played an active and helpful role as agent of the RHA, in the arrangements for making the original appointments. Where this is appropriate and practicable RHAs are encouraged to invite a co-ordinating body to assist in arrangements for the next round of appointments. Expenses incurred by a co-ordinating body for this purpose should be reimbursed by the RHA. Arrangements for the approval and reimbursement of such expenses should be agreed at the outset.

12. A local co-ordinating body which agrees to assist in arrangements for making appointments should be provided by the RHA with the names and addresses of all the voluntary organisations on its list. The RHA should ensure that all voluntary organisations on the list are informed of the role of the co-ordinating body. (This might be conveniently done when voluntary organisations are informed of their inclusion on the list, whether under paragraph 2 or paragraph 9 above).

13. The RHA should also ensure that all voluntary organisations on the list have the opportunity to participate in the choice of which of them will make the actual appointments to CHCs. In practice this will usually mean organising some form of election, in which all the organisations on the list can take part. The arrangements should ensure that organisations with more than one branch in the district do not thereby have an advantage over other organisations in making appointments to the CHC.

14. The particular method of selecting voluntary organisations to make appointments to CHCs will need to reflect local circumstances and no fixed pattern is being suggested centrally. Detailed arrangements are for local determination and where the arrangements adopted in making the original appointments proved satisfactory there may be no need to change them.

15. Each CHC should be given an opportunity to comment on the procedure for making voluntary organisation appointments to that CHC, and on the list of voluntary organisations taking part, but should not play any part in the selection process. It is important that the selection of organisations to make appointments to CHCs should be, and be seen to be, impartial.

16. Provided all the voluntary organisations listed agree among themselves within a reasonable period, which could with advantage be fixed at the outset, the RHA has no part to play in establishing which voluntary organisations should make the appointments.

17. If unanimous agreement is not reached however it will fall to the RHA to select the organisations which individually or jointly are to appoint members (AHAs must take no part in this selection). The selection should take account of such agreements as may have been reached between groups of organisations. In selecting organisations, adequate recognition should be given to the needs of deprived groups within the community and to the need for a proper balance between voluntary organisations with a general interest in health services, those which seek to influence policies and those concerned with providing a service to the NHS. The RHA should also take into account the claims of organisations with special interests in particular institutions.

APPOINTMENTS

18. When the appointing organisations or groups of organisations have been unanimously agreed or, in default of agreement, selected by the RHA, the organisations so selected will be free to make their appointments, subject to arrangements agreed between themselves for joint appointments and bearing in mind the guidance in paragraphs 1-3 of the Circular. They should notify the RHA of the names of the persons appointed.

APPOINTMENTS BY VOLUNTARY ORGANISATIONS:
SUMMARY OF PROCEDURE