The Operation of Community Health Council's from 1st April 1996:

Background

Community Health Councils (CHCs) were established by Parliament to represent the interest of the public in the health service in their districts. Health bodies should continue to support CHCs in carrying out this role. The new establishing arrangements for CHCs and structural changes for health authorities from 1 April 1996 do not alter the fundamental purpose of CHCs.

Developing relationships with purchasers

Purchasers should invite and facilitate CHCs to be involved in the purchasing process, focusing in particular on:

* needs assessment and priority setting within purchasing plans
* strategy underlying decisions on the placing of contracts
* the development of quality standards within contracts
* monitoring services in co-ordination with health authorities
* matching the services planned to the cultural, religious and other aspects of the health needs of the community

Purchasers and providers are encouraged to involve their local CHCs in monitoring *Patient's Charter* activity from the patient's viewpoint, and to involve CHCs when developing any local standards and goals. It is important that CHCs play their part in these processes and ensure that their input reflects patients' views.

Good practice between CHCs and health authorities has been established in their working together in responding to the views of patients and the local community. Guidance has also been published which encourages purchasers to involve CHCs as representatives of the views of patients. EL(94)79 - *Developing NHS purchasing and GP fundholding* published in October 1994, set out the role for the new health authorities in the development and implementation of a local strategy working in collaboration with GPs, NHS trusts, local agencies, including CHCs and local people.

Individual purchasers should make available information they hold which will enable local CHCs to fulfil their role. CHCs should reciprocate in the giving of information to NHS bodies eg. findings from CHC monitoring, results of patient and community surveys and broader issues identified in supporting complainants. The confidentiality of any patient information provided must, of course, be protected.

The *Accountability Framework for GP fundholding* published in April 1995 under cover of EL(95)56 sets out, amongst other requirements, the principles for GP fundholders' accountability to the public. GP fundholders are expected to publish key documents: major shifts in purchasing, annual practice plans, primary health care team charter (if

separate), and performance reports. These documents should be sent to CHCs either directly or via the health authority. GP fundholders should also ensure that these documents are available at the practice for consultation by patients.

Developing relationships with providers

In developing relationships with local communities NHS trusts should continue to recognise the statutory role of CHCs in representing local views. Trusts should invite CHCs to give advice or support when they are planning how to establish patient's views, eg through the setting up of patient representative groups. Many trusts have, as a matter of good practice, established liaison arrangements with CHCs in addition to the statutory requirements for access. Trusts should offer regular liaison opportunities for CHCs. This might be through attendance at board meetings or through some other regular forum.

Consultation and closures

The statutory requirement for health authorities to consult on substantial variations in service will continue for the new health authorities. However, from 1 April 1996, following the abolition of RHAs and the creation of Regional Offices of the NHS Executive, the procedures for handling contested closures/changes of use will alter. If a CHC contests a health authority's proposal and, after considering the CHC's objections, the authority still wishes to proceed the proposal will be referred to the relevant Regional Office which will put the proposal to the Secretary of State for final decision.

All contested proposals which have been considered by RHAs before 1 April 1996 should, as now, be referred by Regions to NHS Executive HQ which will be responsible for putting the proposal to Ministers. In addition there may be a small number of proposed closures referred to Regional Offices after 1 April which it would be inappropriate for them to handle, for example where the former RHA has already declared its own views in public and the Regional Office would compromise its impartial role by advising Ministers on the outcome. Such instances should be rare and if in doubt the advice of Executive HQ (Finance and Performance Directorate) should always be sought.

The Code of Practice on Openness

The Code of Practice on Openness in the NHS was issued on 1 June 1995 (EL(95)42). Its key purpose is to facilitate access to NHS information. It sets out the basic principles underlying public access to information about the NHS, including that the NHS must, except in specified circumstances, respond positively, quickly and helpfully to requests for information and give reasons for not providing information where this is not possible. These principles apply to CHCs themselves and to information requests from CHCs. CHCs should also comply with the provision of the CHC Access to Information Act 1988.

Community care arrangements require health and local authorities to work closely together in the planning and delivery of care. CHCs have no statutory power in relation to local authority social services departments (LASSDs); They can, however, discuss 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. CHCs can also liaise with LASSDs to arrange access to social services premises where an NHS patient is receiving care.

The inspection of social services includes the involvement of lay assessors to complement the work of professional inspectors and to make a distinct contribution from the perspective of users, their families and the wider community. Guidance contained in LAC(94)16 encouraged local authorities to make maximum use of lay assessors and sets out their general role. Lay assessors will have independent status, will play a full role in inspections and will have a right to have their views clearly incorporated into inspection reports.

Changes to the Regulations

From 1 April 1996 Community Health Councils will operate under the Community Health Councils Regulations 1996 (SI 1996 No 518). The main changes in the Regulations were set out in EL(95)142.

A further substantive change concerns members eligibility for reappointment. The intention on reappointment has always been that once a member had served two full terms of office they should not be eligible for further terms without a gap of four years. However, under the current Regulations membership could be extended beyond the intended eight year maximum for example, by the taking up of casual vacancies with nearly four years left to run or through resignation towards the end of the fourth year of a second term of office. This will not be possible under the 1996 Regulations as members who have served for, or in any part of, eight consecutive years will not be eligible for reappointment without a gap of four years.

It should be noted that this does not mean that members have to step down immediately, part way through a term of office on completion of eight years service. eg. where a member may have served a period of less than four years of a casual vacancy prior to two full terms of office.

Complaints

An important aspect of the role of CHCs is in relation to individuals who wish to make a complaint about the health service. CHCs and their officers supply information to the public about how to complain, provide them with support and act as the "Patient's Friend". CHCs can often therefore develop a clear view of the effectiveness of a particular service and the public's perception of it; they can also have considerable expertise in dealing with the public and handling complaints. NHS bodies can therefore benefit by involving CHCs in complaints related activity especially in terms of feedback on their services and skills for their staff.

Interim guidance was published in October 1995 (EL(95)121) on the new NHS complaints procedures which are to be implemented from April 1996. Final guidance will be published shortly. NHS bodies should already be involving CHCs in complaints monitoring and under the new arrangements they will have to publish annual complaints monitoring reports which must be copied to CHCs.

Complaints against CHCs

One way in which CHCs can be seen to be accountable is by providing a clear route for any expressions of dissatisfaction with any element of the work of the CHC, whether about staff, individual members, or decisions of the members acting severally as the Council. The Association of CHCs for England and Wales (ACHCEW) have produced guidelines for handling complaints about CHCs, which are simple, standard and speedy. These were agreed at ACHCEW's AGM in July 1995 and all CHCs have been invited to operate them.

They are based on the premise that complaints should normally be dealt with at the lowest level possible, and within the CHC. If it is not possible to resolve a complaint by internal investigation, the option remained available to take the complaint to the RHA as establishing body. From April 1996, the Regional Offices will continue to undertake this responsibility. Complaints referred for further investigation by the CHC, or by self-referral, should be addressed in writing or orally to the Regional Authorised Officer (RAO). There should not normally be a time limit.

In considering the complaint the RAO will decide whether an independent panel should be established to consider the case. The panel would report their conclusions and any recommendations to the RAO who would then reply to the complainant. The detail of the proposal will need to be agreed between the Regional Office and the CHCs in its Region, based on the ACHCEW proposals.

Regulations give the establishing body the power to terminate a CHC member's term of office if they are found to have been guilty of serious misconduct. Members are therefore advised to heed and act in accordance with the Code of Conduct for CHC members published in July 1995.

Liability

A CHC is not a body corporate but an unincorporated body established under statute. It therefore has no legal identity distinct from its members. As the Council it cannot therefore sue or be sued as a separate legal entity and any liabilities arising from action taken by members will attach to those members severally.

When helping members of the public with complaints, to ensure that individual members do not run the risk of legal liability CHC members and volunteers should guard against giving incomplete and/or inaccurate information and refer members of the public asking for advice directly to CHC staff.

Regional Offices (in consultation with NHS Executive HQ if necessary) should consider

costs or damages resulting from claims against individual CHC members. Each claim would have to be considered individually.

Legal Services for CHCs

Details of the proposed provision for a national legal guidance, interpretation and advice service are detailed in EL(95)142. That contract has now been let to ACHCEW, who will accept direct referrals. Approval for any CHC to proceed with litigation will be at the discretion of the NHS Executive, accessed via the relevant Regional Office.

Performance Review and reporting

Meetings between the CHC and the relevant Health Authority

CHCs will continue to have a statutory responsibility to meet once a year with the relevant health authority. The HA will be responsible for arranging, in discussion with the CHC, this meeting. However, this should form only one element of an ongoing dialogue and opportunity for debate and information exchange which should continue throughout the year.

Annual Report

The new regulations bring the reporting year for CHCs into line with that of other health service bodies, spanning April to March each year. Regional Offices will require each CHC to develop annual plans reflecting their agreed priorities, objectives, targets and work programme for this period, following discussion with the Region and local purchasers and providers. Progress against these plans should be reviewed annually and the outcome made known to the Regional Office and more widely. The CHC will continue to be required to produce a report on an annual basis.

The format of the report is a matter for individual CHC choice but the content should include both a review of the CHCs' achievements against its stated objectives or work programme for the previous year, and an indication of priorities and targets for the forthcoming year. Copies of the report, or a form of the report, should be made available to each relevant Regional Office, Health Authority, Trust, and local authority. Appropriate mechanisms for ensuring that the public also have access to the report, or to its contents in other ways, should be considered and put in place.

To allow for current variations, CHCs will be expected to adjust their pre-existing cycles during 1996 and to produce an annual report in line with the new year, as soon as reasonably practicable after 31 March 1997 and each successive year.

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