MEMBERSHIP OF COMMUNITY HEALTH COUNCILS

A.I ESTABLISHMENT

Community Health Councils were originally established under the terms of the National Health Service Reorganisation Act 1973 with every Health District having a CHC. They were subsequently restructured in 1982.

A.2 COMPOSITION OF MEMBERSHIP

As the establishing authority (under the terms of Statutory Instrument 2217) the South East Regional Health Authority decided that Councils in this Region should comprise between 18-24 members.

Ten members of each Council are appointed directly by Local Authorities, 4 being appointed by Lambeth Borough Council and the remaining 6 by the Southwark Borough Council. A further 7 members are appointed by Voluntary Organisations interested in health matters and active in the Council's district, or with an interest in a particular health service institution. The remaining 3 members are appointed by the Regional Health Authority, following consultation with various organisations.

A.3 NOMINATION PROCEDURE

Any individual who wishes to serve on a Community Health Council may submit her/his name to the Regional Health Authority for consideration, or may be nominated to that Authority by any organisation to which s/he belongs.

Alternatively, s/he may inform the appropriate Local Authority or any Voluntary Organisation of which s/he is a member that s/he wishes to be considered when appointments are being made to Community Health Councils. With regard to the appointment of representatives of Voluntary Organisations, the Southwark Council for Voluntary Services may hold elections in public, but a postal ballot may be held by SETRHA.

A.4 ELIGIBILITY FOR MEMBERSHIP

Membership of Community Health Councils, whether elected by Local Authorities, Voluntary Organisations, or appointed by the Regional Health Authority, are in general drawn from among residents in the Council's district. Individuals who work in the district and have a real knowledge of, and commitment to, the community and its needs are not, however, excluded.

People over the age of 70 are not normally appointed or re-appointed to the Council unless there are special circumstances such as an appointment by an organisation primarily concerned with elderly people.

A.5 BALANCE AND BACKGROUND OF MEMBERS

When making appointments to Community Health Councils, the Regional Health Authority considers the existing membership of each Council with a view to redressing any imbalance which may be apparent. The Authority aims to ensure a balanced membership for each Community Health Council with regard to the geographical, race, age and sex distribution of members, and a membership that is representative of the widest possible field of interests. In particular, the Regional Health Authority seeks nominations from such bodies as trade unions, women's organisations, youth bodies, tenants' and residents' associations and organisations representing ethnic minorities.

A.6 TERM OF OFFICE OF MEMBERS

Members are appointed to Community Health Councils for a four year period, with one half of the membership retiring every two years. The maximum period of office any member can serve is 8 years, following which there must be a break of 4 years before which s/he is again eligible for appointment.

The position may be different for a person appointed by a Local Authority, who may be - but need not be - a member of that Authority. If the appointee is in fact a Member of the appointing body, her/his membership of the Community Health Council will automatically be terminated 2 months after her/his membership of the appointing body ceases.

A.7 ELECTION OF CHAIR AND VICE CHAIR

Members of the Community Health Council elect a Chair and Vice Chair from among their own number, to hold office for a period to be determined by the Council at the time of the election.

A.8 CO-OPTION

A Community Health Council may co-opt individuals on to working groups of the Council if they have a particular interest, knowledge , or experience of the matter or matters under discussion, provided that - in general - at least two-thirds of all members of the sub-committee are members of the Community Health Council.

FUNCTIONS OF CHCS

B.I INTRODUCTION

The CHC is an independent organisation within the NHS, responsible for representing the interests of the consumer of services provided by a District Health Authority.

B.2 STATUTORY ROLE

The role as defined in Statutory Instrument 2217 (see Section V) states that CHCs should:-

(a) Keep under review the way in which the Health Service in its district operates, and

(b) Be consulted by its DHA on any proposals being considered by the Authority for substantial developments or variations in the local Health Service.

In order to carry out these two functions, the CHC has the following rights:-

(a) The Council can request of the DHA any information on the planning and operation of the Health Service (excluding, of course, confidential matters relating to patient treatment etc.)

(b) The Council has the right to enter and inspect premises controlled by the DHA.

These arrangements are left to local negotiation. In reaching agreement on arrangements, CHCs are required to take account of the pressures on medical and nursing staff and ensure that visits are fixed for times which will not interfere with the efficient running of services. The appropriate Consultant and nursing officer should be informed beforehand of proposed visits to wards, clinics, hospital departments etc. Staff residential quarters and premises or parts of premises occupied by practitioners for the purpose of providing family practitioner services should not be entered without the prior agreement of the staff or practitioner concerned.

(c) The Council has the right to appoint an Observer to the DHA who may attend DHA meetings and speak but not vote. In Camberwell, the Observer attends both Part 1 and Part II (confidential) sessions of the DHA meetings, but not Part III.

Additionally, Lambeth, Lewisham and Southwark Family Practitioner Committee has invited the CHC to appoint an Observer to its meetings.

The CHC is required to produce an Annual Report and the DHA is required to hold an Annual Meeting with the CHC. In Camberwell these events are usually joined.

B.3 REVIEWING THE LOCAL HEALTH SERVICE

The first function mentioned above is the requirement that the CHC should review the way in which the Health Service in its District operates. It can make recommendations and advise the DHA, RHA and DHSS on any matters it thinks relates to the operation of the Health Service.

Formal and informal monitoring of the health services can be undertaken in a number of ways, including the following:-

(a) Through the Council's Annual Report which may be discussed by the DHA and CHC together at the Annual Meeting.

(b) Through consideration of the papers for DHA meetings and through participation of the Council's Observer at these meetings.

(c) Through hospital visits by members.

(d) Through the Council's special Interest Groups.

(e) By organising conference and study days.

(f) By undertaking local surveys.

(g) By enabling the public to participate in CHC meetings.

B.4 CONSULTATION

There exists an obligation on the District Health Authority to consult the CHC on any proposed substantial change or variation in local health services. Although the word "substantial" has not been defined, it has been interpreted by both the DHA and CHC in a fairly wide sense.

The pattern is for the DHA and the Council to discuss informally any possible changes. This is followed by the formal presentation of a document to the DHA and, if agreed, a consultation paper is then presented to the Council setting out the reasons for the proposed change in service. The Council then has a period of three months, during which it will examine the proposals and consult with those organisations and members of the public who appear most directly affected by the proposed change. The Council may also wish to request additional information on the proposals.

At the end of the three month period, the Council is required to either agree with the proposal or to make an alternative proposal to the DHA. If the Council and Authority agree, then the change of service can be implemented immediately. If there is no agreement, the matter is passed to the Regional Health Authority whose view is sought. If the RHA agree with the DHA, and the CHC are not willing to change their view, the matter is referred to the Secretary of State for a final decision. If, however, the RHA agree with the CHC point of view, then the DHA will be requested by the RHA to re-consider.

The details of the consultation process are set out in Circular HSC(IS)207 - entitled "Closure or Change of Use of Health Buildings" and in Statutory Instrument 2217. Copies of these documents are attached.

STRUCTURE OF CHCs

C.I COUNCIL MEETINGS

At the present time the CHC meets bimonthly on the third Tuesday of each month at 6.30 pm. Meetings are usually at Kings College Hospital and the first meeting is held in January.

The Council's agenda, including minutes of the previous meeting and reports is given a very wide distribution and is received by members of the DHA as well as by a number of officers of the Authority, the press and some voluntary organisations and members of the public.

Items appearing on the agenda for Council meetings can be raised in a number of ways, including:-

Proposals from the DHA
Report from one of the Council's Interest Groups
Items raised by individual Council members
Report of Government Committee/proposals from the Secretary of State
Approach by local voluntary organisation or members of the public

C.2 PUBLIC SESSION OF COUNCIL MEETINGS

It has been the practice for Camberwell CHC to allow the public to participate in Council meetings so as to raise particular items or make comment on any issue concerning health services in the District. The Agenda always has a statement to this effect.

Attendance and participation by members of the public varies very considerably. If the Council is considering a "controversial" item there may be some members of the public attending and wishing to speak. For the more routine items there may be no members of the public present at a Council meeting.

C.3 WORKING GROUPS

Elderly	Acute
Mental Health	Executive
Child Health	Primary Care Group
Ethnic Minorities	Women

All members of the Council are encouraged to join at least 2 Working Groups. The meetings tend to be held bimonthly, (six times a year).

The Working Groups include as one of their jobs, keeping a watching brief on the work of their respective group of services. Up to now the Council has been invited to appoint a member to the Primary and Preventive Executive Team, the Maternity Services Liaison Committee and the Mental Health Member Group.

ROLE OF MEMBERS OF CHCs

D.I

In order for the Community Health Council to carry out its function effectively, members are expected to carry out the following roles:-

(a) Represent the consumers of health care, and in so doing obtain their views, needs, criticism and opinions and pass them on to the Council.

(b) Attend the regular meeting of the Council and serve on at least two of the Groups which are concerned with specific fields of health care.

(c) Visit Health Service premises and submit reports to the Council.

(d) Attend courses, conferences and seminars on health care at local, regional or national level.

(e) Serve on any special ad hoc committee appointed by the Council.

(f) Publicise the work of the Council,e.g. give talks on the role of the Council.

(g) Assist in the organisation of public events arranged by the Council, such as exhibitions, conferences, seminars etc.

D.2

It is fairly clear from the above that members need to devote a substantial amount of time to the work of the CHC. This, of course, will vary from member to member, but the CHC function can only be carried out by it being a joint venture between the members and the officers.

VISITING

E.I VISITING ARRANGEMENTS

The practice in Camberwell is for the Working Groups to arrange visits to hospitals. It is hoped that, as far as possible, members will also be allocated to health centres and clinics they would like to visit. Allocations are made on the basis of interest of members and geographical location of members' homes.

It would be helpful if, in the early stages of their membership, members could inform the Secretary of the hospital(s), clinics and health centres they would like to visit.

E.2 FREQUENCY OF VISITS

Each member of the Council should visit their health centre or clinic three or four occasions per year.

E.3 REPORTS ON VISITS

Either the Secretary or members produce a written report following their visits covering any aspects which they feel should be brought to the attention of the CHC and DHA. It is helpful if such reports can include a list of recommendations. Initially, the report is sent to the DHA and distributed to the officers concerned who produce a reply to the visitors' report. At this stage, the report and reply will be submitted to the Council as part of the Council's formal agenda. This gives visitors and other members of the Council an opportunity to debate matters in more detail and for a public debate to take place with the service providers.

E.4 NOTIFICATION OF VISITS

It is the usual practice for visits to be notified to the hospitals concerned from the Council's office. Members of the Council undertaking a visit should become closely identified with the hospital and will come to be known by the staff, in which case arrangements for visits can often take place on a more informal basis. It is normal for us to give reasonable notice of intended visits but it is of course in order for members to give shorter notice, e.g. twenty-four hours, or if it is felt appropriate in exceptional circumstances visits may be made without any prior notice. It is suggested, however, that in these circumstances, some consultation takes place with the Chair or Secretary of the Council prior to an unannounced visit.

E.5 EXPENSES

Expenses connected with hospital visiting are covered as part of members' reasonable expenses and should be included in members' expenses claims forms.

E.6 WHAT TO LOOK FOR WHEN VISITING

It is usual for members of staff to use the occasion of CHC visits to fight again those battles for further resources or improvements which they may have previously fought in other arenas. There are, of course, many occasions when such developments will be of considerable benefit to patients and may be considered by visitors to be of high priority.

The Kings Fund have produced a helpful guide for CHC visitors to hospitals and members will find this publication an extremely good introduction to their visiting function. Copies have been distributed separately to Members.

It is essential to use visits as an opportunity to identify malpractice, evaluate the quality of services and to discover the views of patients and relatives about the services they are receiving.

MEMBERS' EXPENSES

F.I INTRODUCTION

The Regional Health Authority is responsible for approving the budget of each Community Health Council and an allowance for the expenses of members is included in the budget allocated to each Council.

F.2 TRAVELLING EXPENSES

Members may claim travelling expenses which they have incurred in connection with their Council duties. If private motor vehicles are used, the amount payable is dependent upon engine capacity and additional payments are made for car parking expenses, the carrying of passengers, etc. Tf members travel by public transport the appropriate fares are reimbursed. **

F.3 SUBSISTENCE EXPENSES

Members are entitled to claim reimbursement for meals purchased in connection with their official duties, and the number of meals for which payment may be claimed is related to the length of absence. Subsistence expenses are also payable for day and night absences at rates which are specified nationally.

F.4 FINANCIAL LOSS

Members are entitled to claim an indemnity for financial loss according to the time period involved.

F.5 OTHER EXPENSES

Members may also incur expenses, including telephone, stationery and postage expenses. If Members are in any doubt as to whether they may submit a claim for any expenses incurred, they should contact the Secretary who will supply claim forms as appropriate and will be able to advise on the rates at which expenses will be paid: these are specified nationally and are, of course, subject to change.

** Details of current mileage rates etc will be circulated to members.

MATTERS OF GENERAL INTEREST

G.I FINANCE

An amount of money is allocated each year to the Council by the Regional Health Authority to cover staff salaries, travelling expenses, office services, accommodation expenses and publicity. Members will be notified of the budget available at the beginning of each financial year and it is usual for details of the spending pattern to be presented to the Council at intervals.

G.2 APPOINTMENT OF OFFICERS

It is open to the Council to decide in what way it will deal with the appointment of its officers. These are usually the Chair and Vice Chair and the District Health Authority and Family Practitioner Committee Observers. The Council has adopted a system of making these appointments on an annual basis at the May meeting of the Council.

G.3 SUPPORT SERVICES FROM THE COUNCIL OFFICE

The basic function of the office is to provide all the facilities necessary to Members to carry out their job. Members are encouraged to maintain close contact with the Council office and to be aware of the facilities available and the information held in the Council's files. The offices can cope with meetings of up to 8 people and Members are encouraged to use this facility for any appropriate gatherings. The basement should be developed to provide facilities for larger meetings.

G.4 DISTRIBUTION OF INFORMATION

A substantial amount of information is sent to Members of the Council in order to keep them up to date with developments in the National Health Service. A number of these items may appear to be unnecessary and if, after some experience, Members would prefer that the amount of information was limited, it would be of help if the Secretary could be informed of this. A news round up and collection of information is sent out each Friday and is called the "Friday Post".

G.5 CONFIDENTIALITY

Unless otherwise stated, all papers produced by the Council are available for public consumption, and do not need to be treated confidentially. Any papers which are required to be dealt with in such a way will be clearly stamped "In Confidence".

Membership and participation in the CHC does not carry with it any extended protective privilege beyond those existing in Common Law. Broadly speaking, it is unwise for individuals (eg doctors, nurses or patients) to be named in the course of the public sessions of the Council's meetings. It is also unwise for statements to be made whereby individuals might be identified.

NATIONAL AND REGIONAL CHC GROUPINGS

H.I NATIONAL

In 1977 a National Association for Community Health Councils in England and Wales (ACHCEW) was formed. Some 80% of CHCs were in membership as at September 1985. The Association is governed by a Standing Committee which meets on 4 or 5 occasions per year and includes a representative from each Region. The annual subscription varies depending on the allocation to each Council. In 1988/89 Camberwell was required to pay £525 subscription.

H.2 REGIONAL

The South East Thames Regional Association of CHCs meets several times each year to discuss matters relating to service provision throughout the Region. Adrian Pollit, the Director of Administration for the Region, attends these meetings as do Regional experts on the type of care under discussion.

APPENDIX 1

SUGGESTIONS FOR VISITORS

1 If visiting a hospital for the first time, see if the signs to a particular ward or department make sense.

2 Try to discover if patients are called by the Christian names as a matter of course, or given courtesy titles as a matter of course.

3 Ask for a patient's information book.

4 Ask to see the accident book (in long-stay hospitals).

5 Look at menus and ask patients about food choice.

6 Try to visit during different times of the day including meal times over a period of time.

7 Consider visiting at an evening or week-end especially in long-stay units.

8 Consider the occasional night time visit.

9 Check in bathrooms and lavatories for visitors as well as patients.

10 Avoid getting involved in disputes between ward sisters and nursing officers unless you feel it is directly in the patients' interests.

11 Check on discharge procedures.

12 What is happening to patient A. etc.

13 Style - Approach.

14 Health Service Commissioner's Reports.

PROBLEMS

1 Publicity - if publicity is not considered beneficial, members are asked to consider submitting reports in Part II or splitting reports between Parts I and II.

2 Members making statements to staff or patients which reflect their personal view but which is contrary to an agreed CHC policy.

APPENDIX I

THE REPORT SHOULD INCLUDE:

1 Name of hospital, date of visit, list of visitors, names and titles of staff involved (if relevant).

2 A note of the areas, wards etc, visited.

3 A clear statement of the views of the visitors.

4 Clear requests for further information.

5 A clear list of recommendations or suggestions which can be answered by the Unit General Manager.

6 Commendation of things thought noteworthy.

7 Thanks (where appropriate) to staff and others for help during the visit.

VISITS STEP BY STEP

1 Convenor liaises with UGM on date.

2 UGM will confirm visit dates in writing.

3 Visit.

4 Report submitted to office or prepared by Secretary.

5 Copy to UGM and staff met on visit.

6 Report and response to CHC.

7 Any further comments to UGM and/or DHA or DGM.

8 Discussion at CHC Meeting.