ASSOCIATION OF
COMMUNITY HEALTH COUNCILS
FOR ENGLAND & WALES

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24 October 1995 EC

To: Chief Officers of Member CHCs

Dear colleague,

DRAFT GUIDANCE ON THE FUTURE ESTABLISHING ARRANGEMENTS FOR CHCs

The NHS Executive have just sent us "for information" a copy of the "developing" guidance on the workings of the future establishing arrangements for CHCs. This guidance has been developed following the consultation exercise on the working group report and this draft has been sent to Regional Office Directors for their comments by the end of the month.

ACHCEW and CHCs are not being formally consulted at this stage, as the results of the earlier consultation have already been taken into account in the development of this draft. However, ACHCEW has been asked to submit "constructive comments" by 10 November 1995.

I enclose a copy of the draft guidance. As you will see, some parts of the draft are still incomplete or are provisional.

We will be framing comments over the next two weeks and I would welcome any observations you may have on the draft by 3 November 1995 if possible.

Yours sincerely,

Toby Harris

TOBY HARRIS,
Director.

Earlsmead House, 30 Drayton Park, London N5 1PB. Tel: 0171 609 8405 Fax: 0171 700 1152
CHAIR: JENNIFER ELLIOTT, DIRECTOR: TOBY HARRIS

DRAFT FOUR - OCTOBER 18 1995

Sections in italics are awaiting further clarification or confirmation from the Departments solicitors, or the outcome of the consultation on membership issues.

GUIDANCE ON THE IMPLICATIONS OF THE CHANGE IN THE ESTABLISHING ARRANGEMENTS FOR COMMUNITY HEALTH COUNCILS (CHCs)

1.0 THE ROLE OF THE NHS EXECUTIVE REGIONAL OFFICES

1.1 The relationship between the NHS Executive Regional Offices and CHCs should be based on seven key principles.

1.1.1 Understanding and respect for the CHCs' function and their independence from Health Authorities, Trusts and other providers

1.1.2 Broad consistency in the handling of CHC affairs by Regional Offices across the country.

1.1.3 Visible, open and clear lines of communication between the Regional Offices and CHCs.

1.1.4 Recognition by the CHCs that while responsible for managing their own day-to-day affairs, overall workplan, workload and resources, this is within the context of an accountability framework to the Regional Offices via performance, business and financial planning and monitoring processes.

1.1.5 'Light touch' management by Regional Offices in the context of provision of co-ordinated support to CHCs and the monitoring of their performance.

1.1.6 Willingness of CHCs to offer constructive criticism and comment on the Health Service and of the Regional Offices to consider it.

1.1.7 The Regional Offices' responsibility for and commitment to ensuring provision of and access to support and training for CHC members and staff.

1.2 The existing 'CHC Link Officers' group which meets regularly and has played an invaluable role in shaping the direction of the national approach to CHCs, will become a formally constituted NHS Executive 'CHC Policy and Liaison Group', chaired and supported by the NHSE HQ. Every Regional Office will be expected to send a representative to enable a coordinated approach to the development of NHS Executive policy of CHCs at national level and consistency of implementation at regional level.

1.3 The functions which NHS Executive Regional Offices will be required to fulfil in relation to CHCs are listed in detail in Appendix One, but the roles and responsibilities will include broadly:

1.3.1 Input to the NHS Executive CHC Policy and Liaison Group, and implementation of national policy and strategic development at regional level.

1.3.2 The fulfilment of all statutory functions as defined in the CHC regulations (as updated 1996) in relation to the establishment and support of CHCs, acting on behalf of the Secretary of State. This will include the role of establishing body in relation to Secretary of State appointments, and all administrative arrangements and responsibilities in relation to all membership issues, including decisions on eligibility, disqualification and termination of membership.

1.3.3 The management of the overall Regional CHC budget, including the allocations to and monitoring of individual CHC budgets, regional expenditure and the purchasing of support arrangements via contract or Service Level Agreement (SLA).

1.3.4 Ensuring that each CHC has annual workplans and appropriate performance review processes in place, and that relevant action is taken as necessary to promote enhanced performance.

1.3.5 Arranging for the provision of all appropriate support services in respect of property, personnel, paymaster and Information Technology (IT) functions.

1.3.6 The 'effective employer' role in employment matters including grievance and disciplinary, approval of Individual Performance Review (IPR) objectives for Chief Officers and the grandparent role in the IPR process.

1.3.7 Ensuring that all CHCs have access to opportunities for staff and member training and development

1.3.8 Providing a point of contact, and liaison on CHC matters within the Regional Office, providing guidance and acting as 'troubleshooter' as required to individual CHCS, *and including ensuring provision is made for external review arrangements in the event of complaints about CHCs.*

1.4 It is up to individual Regional Office Directors to determine the precise staffing structure necessary in order to carry out these roles, functions and responsibilities satisfactorily. However, each Regional Office Director will need to ensure that it is clear who has overall responsibility for CHC work, who is the main point of contact for each CHC, how overall management responsibilities are to be allocated, who is the Regional CHC budget manager, who is the Authorised Officer for the functions within the SLAs, who is responsible for membership functions and how administrative support will be provided. Attention should be paid to the need to allocate sufficient time, seniority, expertise, experience and knowledge of CHCs in total within the approach adopted. (The average regional workload is anticipated to require the equivalent of a whole time post at senior management level, plus administrative backup and director level support, as well as full-time administrative support on membership issues. This will of course depend on the number of CHCs in the Region and other factors).

1.5 Once finalised, the staffing structure and management arrangements in relation to CHC work need to be communicated both within each Regional Office, and between the Regional Office and the CHCs (and with other agencies where relevant). However, the adequacy and appropriateness of the structure should be open to regular review.

1.6 The role and responsibilities of the NHS Executive Regional Offices in relation to the support and development of CHCs will be further clarified through ongoing dialogue at national level in consultation with the CHC world, particularly in the context of the provision of support via the placement of external contracts and SLAs, and future national work on performance management and resourcing.

2.0 NATIONAL AND REGIONAL ASSOCIATIONS OF CHCS

2.1 Regional Offices should engage with their local Regional Association of CHCs, to review the support and resources offered, and required, to further develop the Regional Association's potential.

2.2 Regional Offices should work with Regional Associations and the Association of CHCs in England and Wales (ACHCEW) as appropriate, in order to explore opportunities for working in partnership.

2.3 Regional Offices should make provision in their budget to fully fund ACHCEW subscriptions payable by the CHCs in their Region.

2.4 Regional Offices should engage with any CHC staff associations in their Region and review the support which they may require to enable their effective operation.

3.0 FUTURE EMPLOYMENT ARRANGEMENTS FOR CHC STAFF WITHIN THE NHS

3.1 Regional Offices will need to take necessary steps to transfer the contracts of employment of all CHC staff, (plus Regional Association staff and ACHCEW staff as appropriate) to a Health Authority (HA) in the Region with effect from 1 April 1996. This should be done in consultation with the CHCs in each Region and particular note should be taken of the views of the CHCs relating to the HA proposed. If deemed more acceptable and appropriate, a Regional Office may choose to place the CHC staff employment contracts with two HAs in the Region.

3.2 The model SLA should be used as the basis of the arrangement with the HA(s), following discussion with local CHCs and the HA(s) concerned.

3.3 The Regional Office, acts on behalf of the SoS as the establishing body for CHCs and as such has the overall management responsibility for CHC staff and continues to have strategic responsibility for employment issues. The HA will legally be the employing authority but under the terms of the SLA would have no control over 'hire and fire' of CHC staff in order to preserve the independence of the CHCs

from potential HA control and protect the individual staff. The Authorised Officer of the Regional Office (RAO) would retain the responsibility and authority to instruct the HA to issue, vary or terminate contracts of employment. Such decisions would always be made in full consultation with, or at the request of, the CHC, as appropriate.

3.4 In order to work towards a clear and consistent approach to terms and conditions of employment for CHC staff, existing Regional policies will need to be reviewed and developed in consultation with CHC staff associations, and trade unions. As it may not be possible to complete this work prior to April 1996, staff should be transferred to HA contracts with protection of their existing terms and conditions.

4.4 Management arrangements for ACHCEW and Regional Association staff will differ and these will need to be clarified in the SLA where appropriate.

4.0 PROVISION OF PERSONNEL AND PAYMASTER FUNCTIONS

4.1 In consultation with the CHCs, each Regional Office will need to identify a HA (or HAs) to be responsible for the provision a combined personnel and paymaster service at an administrative and professional advisory level. This should be the same HA(s) as that holding the contracts of employment.

4.2 Regional Offices should negotiate and let, the provision of personnel and paymaster services on the basis of the model SLA provided. Precise details should be determined on the basis of consultation with the CHCs and negotiation with the proposed providers of the service. If the HA proposes to sub-contract any part of the service this should be done only following consultation with the RO and CHCs.

4.3 Each Regional Office will be responsible for consulting with its own CHCs and the Regional Association on the precise content of the SLAs and in doing so will determine quality standards, performance measures and monitoring and reporting mechanisms, and revise and incorporate these in the SLAs as agreed. However the overall framework and principles should not be altered, as the intention is to provide a broadly consistent type and level of support to CHCs nationally.

4.4 The Regional Office will retain responsibility for managing the oeverall regional budget including determining allocations to individual CHCs and managing the residual budget at regional level. The budget will be held and administered by the HA as part of the paymaster SLA at the direction of the RO's Authorised Officer.

4.5 The CHC Chief Officer will continue to be managerially responsible for their own staff, budget, premises and facilities maintenance and management, health and safety, and financial budget and systems management. Their responsibilities will be reiterated in the SLA.

4.6 The costs of placing support SLAs will be resourced at no detriment to the monies available for direct expenditure by and on CHCs.

5.0 CHC PREMISES AND ESTATES ISSUES

5.1 *As deeds and leases for CHC premises are currently in the name of the Secretary of State (SoS) they will remain in the ownership of the SoS and appear on the estates terrier (assets register) of the Regional Offices, managed by the Regional Office's NHS Estates Department. Regional Offices will thus continue to have the responsibility for acquiring, holding, maintaining and disposing of CHC properties on behalf of the SoS. The same principles apply irrespective of whether the SoS's interest in the premises is freehold or leasehold. (Pending final confirmation of this position.)*

5.2 Regional Offices will need to arrange for assessments of all CHC premises against the national standards (Appendix Two) *(to add)* and where they fall short, to establish a priority list for refurbishment, alterations or relocation over a period, taking into account unexpired terms of leases and anticipated capital and revenue costs. The national standards should be applied with immediate effect in relation to the acquisition of new premises, where a decision has already been taken to relocate or the process is already underway; and in the longer term in the review and future provision of premises.

5.3 Regional Offices will need to arrange the establishment of an estates terrier with all details of all deeds, leases, expiries, maintenance and decorating requirements within leases, rent review dates etc. where one does not already exist.

5.4 Regional Offices, in consultation with CHCs, and in conjunction with Regional NHS Estates personnel, will need to identify a source of the provision of all estates services as defined in the model SLAs, and in consultation with CHCs, let them via an SLA or contract. This provision may or may not be possible via the Regional estates function. Where not available in-house it may be contracted to an external agency.

5.5 Regional Offices should discuss with CHCs and agree what minor maintenance and domestic cleaning lies within their own authority and for which they should make local arrangements based on the model SLA, and for which regional SLAs may be negotiated. This should include appropriate guidance on identifying and placing contracts.

5.6 Regional Offices should calculate and reimburse individual CHCs with the full cost of such maintenance contracts as part of their budget allocation for premises costs.

6.0 PROVISION OF LEGAL GUIDANCE, INTERPRETATION AND ADVICE

6.1 *Dependent on the outcome of current discussions*, a national contract will be let by the NHS Executive in order to ensure the provision of a free legal advice service to all CHCs, independent of any advice provided to the NHS Executive, the Regional Offices, HAs, NHS Trusts or other providers/contractors. The service will be by direct access by CHCs, based on agreed criteria, thus avoiding the necessity to seek access via the Regional Offices.

6.2 The service will include legal advice and interpretation, access to a database and regular briefing papers on legal aspects of relevant subjects. It will also include guidance as to the necessity, advisability and costs of litigation. *The position on approval for, provision of and resourcing of litigation is currently under consideration and will be reflected in the contract.*

6.3 The national legal contract excludes legal services to Regional Offices on CHC matters. RO staff, being officials of the Department of Health will look to the Department's Solicitor (SOL) for their legal services. Where legal advice is required by the Regional Office in connection with a function of the SoS relating to CHCs (as opposed to advice required by a CHC for its own purposes) no conflict of interest should normally arise.

6.4 The national legal contract will therefore also exclude all advice or legal costs in relation to property matters, which will be covered as part of the Estates/Premises SLA. Where estates work is kept "in- house" by NHS Estates, legal services would normally be provided by the Department's Solicitors (SOL) under the existing SLA with NHS Estates. Where the RO's estates work is contracted out to an external agency, that agency would be expected to obtain its legal services elsewhere, but this requirement, including reimbursement of the costs, would form part of the SLA.

7.0 INFORMATION TECHNOLOGY SUPPORT

7.1 IT support will be arranged via, though not necessarily provided by, the Regional arms of the NHS Executive Information Services Directorate (ISD), co-ordinated by ISD at the NHS Executive HQ.

7.2 Regional Offices should arrange for an audit of IT hardware, software, systems, applications, and CHC staff's current skills and future training needs in order to assess the specific regional needs for support and development which need to be included in their region's IT SLA.

7.3 A national minimum standard will be developed *(..... with the support of ISD, building on the regional information available)* and CHCs will need to be assessed against this, in order to ascertain the priorities for development which need to be resourced and included in the SLA.

7.4 Regional Offices in consultation with their CHCs, should work with ISD at national and regional level to establish Regional IT SLAs which meet the requirements of the CHCs in the Region while aiming towards national consistency.

8.0 RESOURCING ISSUES

8.1 In order to work towards consistency in the medium term, from April 1996 there will be a national CHC budget held by NHS Executive HQ but with sub-budget holders in each Regional Office responsible for regional CHC budget management.

8.2 On the basis of current information on regional spend, Regions can take steps to identify and rectify inequities in the level of resourcing allocation to individual CHCs both within and between regions, and including regional support and development funding.

8.3 While there will not be any national guidance on staff gradings/structures prior to the outcome of further work on resourcing, staffing and performance, Regional Offices should not defer taking steps to increase staffing towards a minimum of three per CHC if they wish to make progress at this stage.

8.4 *Details of the process and timetable for determining regional allocations for 1996/7 will follow.*

8.5 Guidance will also be issued subsequently on the new system on which individual allocations to CHCs will be determined. This will address variations in CHCs including accommodation, staffing, scope and scale of the CHC's work, and the CHC's performance. This should begin to be operated incrementally from 1997/8.

8.6 Regional Offices should use their influence to encourage HAs, Trusts, other bodies, and Local Authorities to explore collaborative working with CHCs and to provide additional resourcing to facilitate this - preferably in the context of longer term commitment to avoid staff turnover and loss of expertise.

8.7 CHCs should develop clear protocols, in conjunction with the relevant bodies, for working with them on a contractual basis.

9.0 REGULATIONS - GENERAL

9.1 Updated Regulations will be issued with effect from 1 April 1996 which will include the following changes:

9.1.1 The term Chief Officer will replace Secretary.

9.1.2 The term 'area' will replace the term 'district', *meaning the geographical area encompassed by the CHC's boundary, and the population normally resident within that boundary.*

9.1.3 Regional Offices must consult CHCs about any changes to the numbers of members, the area covered by the CHC, and the provision of premises and resources.

9.1.4 A CHC will be allowed to appoint up to two Vice-Chairmen

9.1.5 The CHC reporting year (the period to be covered by the CHC's annual plans and objectives, the review, and to be covered by the Annual Report) will be defined for the first time, by bringing it into line with the NHS financial year, ie 1 April to 31 March in both England and Wales. *This will come into full effect from 1 April 1997 in order to give CHCs time to adjust (eg to shorten or lengthen their current cycle if necessary).*

9.2 In the light of the impending revision to the regulations from April 1996, Regional Offices are advised, as a matter of good practice, prior to April 1996:

9.2.1 to use the terms in 9.1.1 and 9.1.2 if not already doing so, in any documentation and common parlance.

9.2.2 to consult with the relevant CHCs in the interim with respect to any changes proposed as in 9.1.3

9.3 In the light of the impending revision of the regulations in 9.1.5, CHCs are advised that they should consider and begin to make the necessary adjustments to their planning and reporting cycles as soon as possible in order to be able to end a period on 31 March 1997.

10.0 REGULATIONS - MEMBERSHIP ISSUES

10.1 The updated Regulations issued with effect from 1 April 1996 will also include the following changes in relation to membership issues:

10.1.1 *The regulations will revise the criteria by which a person is rendered disqualified (ineligible) for membership. These will include members or employees of a health authority, an NHS Trust, a health authority contractor (which would include general and dental practitioners, opticians and pharmacists) or a person employed by a health authority contractor providing services under the NHS to the population served by the CHC in question. It will also include employees of voluntary, non-profit-making and charitable organisations providing services under contract to the NHS to the population served by the CHC in question.*

10.1.2 The period of non-attendance at CHC meetings will be reduced from six to four months after which that member's place be declared vacant. *This means non-attendance at either a full Council meeting or a meeting of any CHC committee during a four month period. Participation in other official CHC business (eg a visit) is discounted for purposes of defining non-attendance.*

10.1.3 Any former member whose term of office was terminated because of non-attendance or misconduct will be disqualified from reappointment for a period of four years.

10.1.4 *Dependent on the outcome of the current consultation on membership issues, the CHC membership year may also be adjusted to the same time scale, ie 1 April to 31 March, in both England and Wales, revised from 1 September to 31 August in England, and 1 July to 30 June in Wales. This will be operative from .....???!!!!*

10.1.5 The wording of the regulations will also be reviewed with respect to the definition of the length of time a member can serve on a CHC. *This will need clarification specifically in the case of members whose term of office is terminated prematurely if there are changes to the membership year, and generally in relation to members filling casual vacancies.*

10.2 Regional Offices are advised that pending the formal implementation of the regulation detailed in 10.1.3 from 1 April 1996, as a matter of good practice, prior to April 1996, that in the event of any casual vacancies arising, appointing bodies should avoid reappointing any former members whose membership has been terminated for non-attendance or misconduct within the previous 4 year period.

10.3 Regional Offices will be reliant upon individual CHCs to inform them as soon as possible after any member fails to attend for a 4 month period as defined in 10.1.2. However, as a matter of good practice, the Chair or an officer of the CHC would have been expected to contact the member following a period of non-attendance of 2 -3 months to establish the reasons for non-attendance. In the absence of any explanation which the CHC considered to be reasonable, then the member should be informed that the CHC would be obliged, under the terms of the regulations, to inform the Regional Office after the four month period, (unless they tendered their resignation in the meantime). There will of course be a number of circumstances which the CHC may consider to be a reasonable explanation, but an assurance should be sought that the member intends or will be in a position to resume full membership within a reasonable period.

10.4 In connection with the criteria for disqualification (eligibility) for membership as in 10.1.1, the 'Code of Conduct for CHC Members' (issued July 1995) provides guidance to members of voluntary or other organisations who may be involved in service provision, advising them to consider and declare potential conflict of interests. A register is to be held by each CHC for the purpose of recording such interests.The Code should be referred to for full details.

10.5 *Once appointed by a body, that body is not at liberty to terminate their representative's membership of the CHC other than if those conditions contained within the regulations apply. These are, non-attendance, misconduct, in the case of a local authority member who is a Councillor, the loss of their seat in an election unless, within 2 months, the Local Authority indicates to the Regional Office that they want their membership to continue, or the appointing body ceases to exist. (Clarification currently sought from SOL on position of retiring LA members i in Regulation 5.2.b.) There are no other circumstances, (other than resignation by the member) under which CHC membership may be terminated.*

10.6 The conditions and process for termination from CHC membership are laid down in the regulations. The Regional Office will retain the power to terminate a member's appointment following consultation with the appointing body and the CHC, on the grounds of non-attendance or misconduct. The Code of Conduct indicates the standards of behaviour expected of a CHC members and thus by implication, potential grounds for misconduct.

11.0 APPOINTMENTS OF MEMBERS

11.1 The memberships year will be changed *to .... from .... (pending)*

11.2 A CHC member specification *(Appendix 3)* forms the basic criteria for membership and should be made available as appropriate by the Regional Office, along with copies of the Code of Conduct and materials for prospective members, and distributed as required etc.

11.3 A standard application form (for SoS applicants) and notification form (for appointments by other bodies) should be distributed as appropriate by the Regional Office, distributed as necessary by the appointing bodies, and completed and returned by the individuals *(Appendix 4)*.

11.4 VOLUNTARY SECTOR ELECTIONS

11.4.1 Regional Offices should identify appropriate agencies to undertake voluntary sector elections, in consultation with the local CHCs. This will usually be the CVS but local circumstances may lead to an alternative being more appropriate. The agency should be reviewed at each round of elections (ie biannually.)

11.4.2 Broad guidelines will be made available *(to be agreed nationally with the CHC world)* and these should form the basis of the arrangements, which should be reviewed at each round of elections. This will include arrangements for monitoring/evaluating the service delivered.

11.4.3 Regional Offices should set in motion the elections in the relevant timescale. *(To be clarified following the outcome of the consultation on the membership year)*

11.4.4 Regional Offices should ensure that there is timely and adequate provision of publicity materials, information packs etc for prospective members/ organisations, along with the relevant forms and documentation. *(the latter form part of the current consultation on SoS appointments.)*

11.5 SECRETARY OF STATE APPOINTMENTS

11.5.1 Regional Offices should establish and operate the system for SoS appointments in line with the procedures in Appendix 5. *(Currently being consulted on)*

11.5.2 This should be done within the relevant timescale *(see above on outcome of membership year proposal)*

11.6 LOCAL AUTHORITY APPOINTMENTS

11.6.1 Regional Offices will need to liaise with Local Authorities to establish the impact of any proposed changes eg boundary changes to existing authorities, or dissolution of existing authorities and creation of Unitary Authorities, on CHC membership. They will be responsible for consulting on any proposed changes to CHC membership as necessary with CHCs, HAs, LAs and neighbouring ROs as appropriate.

11.6.2 *Where Unitary Authorities are being created, CHC members appointed by Local Authorities which cease to exist will become invalid, and Regional Offices will therefore need to liaise with Shadow Unitary Authorities prior to April (1996 and 1997 as appropriate) to ensure that new members are appointed in time (ie by 1 April) to avoid disruption to the work of the CHCs. The Department of the Environment will be advising on shadow Unitary Authorities' powers in this respect.)*

12.0 CHC OPERATION, PERFORMANCE AND REVIEW

12.1 The responsibility for ensuring that training for both CHC members and staff is available and provided to a standard, consistency and range, to be agreed with the CHC world, remains with the Regional Office. However the training may be organised and delivered by a variety of sources.

12.2 CHCs are expected to set their own objectives, annual work programme and performance criteria within an agreed national framework, and to review progress regularly, and to make the outcome of past work and intentions for future work, available to the public. (As laid down in regulations via the Annual Report and in EL(94)4.) However further work needs to be done on exploring mechanisms for setting and monitoring standards for CHC performance. This work needs to be led by the CHC world. *Complementary work on exploring the relationship between CHC operation, performance and resourcing is soon to commence, and guidance will be issued in due course. The precise role of the Regional Office will be further clarified once this work is completed.*

12.3 Where CHCs do not already operate within Standing Orders they should be introduced and operated. All CHCs should review their Standing Orders regularly.

13.0 FURTHER GUIDANCE

13.1 Complementary guidance will be issued shortly relating to CHC issues not affected directly by the change in establishing arrangements or membership issues. This will update and supersede EL(94)4.

APPENDIX ONE - NHSE REGIONAL OFFICE ROLE/RESPONSIBILITIES

1. **National representation and regional lead - NHS Executive CHC Policy and Liaison Group**

   - Participation in the NHS Executive CHC Policy and Liaison Group (formerly -known as the CHC Regional Links Group)
   - Inter-regional liaison
   - Contribution to development of national policies on CHCs
   - Reporting of regional progress and implementation of national policies
   - Contribution to body of good practice

2. Statutory functions

   - Ensuring fulfilment of statutory functions by RO on behalf of SoS
   - Liaison within RO to ensure relevant personnel are aware of CHC issues
   - Responding to CHCs Annual Reports

3. Membership

   - Provision of all administration relating to membership
   - Membership, establishing authority role in disputes, misconduct etc.
   - Secretary of State appointments procedures
   - Contracting of organisations to handle voluntary sector elections
   - Production and dissemination of materials for prospective members
   - Publicising CHC membership opportunities
   - Maintaining membership database
   - Maintaining database of prospective members for SoS appointments

4. Resources

   Regional -
   - Preparing regional bid against national budget
   - Preparing and approving individual allocations to CHCs and balance of budget
   - Distribution, and management of resources
   - Addressing national and local imbalances, supporting development
   - Managing top-sliced budget to target areas of need,development and contingency
   - Ensuring mechanism for managing Regional Association budget is in place

   Individual -
   - Monitoring individual CHC expenditure
   - Approval of carry forward underspends etc)
   - Considering bids against budget

5. Performance

- Ensuring CHCs have objectives and annual plans, and commenting if necessary
- Ensuring that there is a review and reporting mechanism for each
- Annual review meeting with each CHC Chair to receive review and look ahead
- Once linked to performance management, need to ensure resources allocated accordingly
- Confirming that CHCs are fulfilling core and statutory functions once redefined

6. Strategic development

- Ensuring national strategies for premises, IT, staffing, and resourcing are implemented at regional level, developed or modified as necessary, and implemented via SLAs where appropriate etc.

7. Property issues

- Acquisition, maintenance, upgrading and disposal of CHC properties as required on behalf of SoS
- Assessment against and compliance with national standards for premises and compliance with all building regulations etc.
- Responsible Officer for Health and Safety
- Policy decisions on priorities for development of premises and for preparing business case for resources as required
- Responsible for placing and monitoring SLA, in conjunction with Estates Department
- Approval and instructions to Estates Department/Estates contract/SLA

8. Staff and member training and development

- Responsible for ensuring training is provided on the basis of agreed standards and guidelines at all levels
- Approval for bids for personal development
- Approval for bids for members training and managing the training budget
- Ensuring co-ordination of opportunities for development with and alongside the NHS

9. Support SLAs for personnel, paymaster, and IT

- Placing and establishing contracts including provision of all set up data etc.
- Ensuring monitoring mechanisms set up and regular reports received from HAs and CHCs etc.
- Agreeing standards and services and reviewing regularly from CHC feedback

- Point of contact 'designated officer of the RO' as responsible person and point of contact for HAs and CHCs
- Approval for litigation and seeker of funding from Centre if necessary
- Liaison, approval and instruction to ISD on IT issues

10. 'Effective employer role'

- Approval of IPR objectives and grandparent role in IPR, agreement on PRP
- Approval of staff changes in line with national and regional policies and local needs
- Employer role in grievance and disciplinary
- Involvement in selection of COs
- Contribution to development of national staffing and employment policies

11. CHC Liaison, 'troubleshooter', and promotion of CHCs' role with other health bodies

- Ensuring consultation with CHCs as appropriate on regional/national issues
- Ensuring CHCs have access to relevant regional information
- Regular liaison with individual CHCs, Regional Council Chair and attendance at Regional Council meetings
- Ensuring Regional Council has the support required
- Point of contact for CHCs within and outside the RO
- 'Troubleshooter' for CHCs with problems, source of support, guidance and information
- Ensuring 'third stage - external review' processes in place for complaints about CHCs
- Encouraging HAs and Trust to work cooperatively with CHCs
- Monitoring local consultation to ensure that HAs and CHCs are consulting with CHCs as appropriate
- Ensuring that performance review mechanisms for HAs include measures of liaison, consultation and collaboration with local CHCs

APPENDIX TWO - NATIONAL CHC ACCOMMODATION STANDARDS

NATIONAL CHC ACCOMMODATION STANDARDS

The attached brief provides criteria considered essential (additional desirable characteristics in italics) for CHC premises to provide adequate facilities for staff, members and public.

The brief should be used to:

a) Assess existing premises.

Where they fall below, to either:

a) base development or refurbishment or modifications on,

or b) if premises cannot be brought up to standard, to be used to determine a priority order for relocation to suitable premises bearing in mind resource constraints and length of unexpired leases.

b) Use as a checklist to sift possible premises for relocation on the basis of a match, or potential to bring up to standard

c) In the latter case, as a design brief for commissioning works required

NATIONAL STANDARDS FOR CHC PREMISES

1 LOCATION

1.1 Within boundaries of the CHC area

1.2 City/town centre location, ideally in largest town in the CHC area in multi-population centre areas

1.3 Car parking facilities available nearby, including disabled parking (free or low cost)

1.4 On or near bus routes or local rail routes if appropriate

1.5 Good level of security during and after working hours (not isolated, good street lighting)

1.6 Accessibility to comply with Building Regulations

1.7 Near organisations with similar clients eg CAB

2 BUILDING

2.1 Freehold/long leasehold or leasehold premises

2.2 Non-listed building

2.3 Shop front

2.4 Dimensions/space

2.4.1 Minimum of 1000 sq ft (At least 600 of which to be on the ground floor)

2.4.2 Minimum of 16 ft wide (for shop fronts)

2.5 Adequate means of escape in event of fire (if more than 40 ft front to rear - rear exit to place of safety) and full compliance with fire safety regulations

2.6 Ease of access for people with disabilities (ie, ramps or no steps; door of certain width); colour definition/loop

2.7 Comfortable, well maintained environment; flexible arrangements of space

2.8 Good external and internal security,

2.9 In good repair and with low maintenance requirements

2.10 Dedicated adjacent parking for staff

2.11 Value for money based on comparability with similar accommodation in the area and within available resources, taking into account level of refurbishment, adaptation and commissioning costs required

3 INTERNAL LAYOUT

3.1 Good layout which can be modified to provide maximum security and protection of staff; panic buttons, burglar alarms, locks

3.2 Provides the right balance of work areas for the various functions of a CHC:

3.2.1 For public - all areas to be fully accessible

3.2.1.1 Comfortable reception area, combined with information area, with display, leaflets etc (Can be integrated into general office if partitioned to prevent unathorised access)

3.2.1.2 Comfortable counselling/interview room offering confidentiality for complaints with alternative exit, could be integated with Chief Officer's office

3.2.1.3 Access to disabled toilet *with baby changing facility*

3.2.2 For staff (full access to at least part of the staff areas with flexibility of designation of areas as appropriate)

3.2.2.1 Chief Officer private office

3.2.2.2 Work station for reception staff taking account of security needs/arrangements, eg barrier, counter etc

3.2.2.3 General office/administrative area including work stations for other staff plus working areas eg post area, photocopying etc in open area or individual rooms or partitioned/non-partitioned areas

3.2.2.4 Work stations for other staff within individual rooms, flexible screen/non-partitioned areas or general office

3.2.2.5 Staff engaged on complaints work to have permanent access to counselling room, or separate office

3.2.3 For members - all areas to be fully accessible

3.2.3.1 Meeting room for 10-16 people

4.3.2 Burglar alarm, fire alarm, panic buttons, personal alarms connected appropriate to police or security firm. Window bars, shutters etc as appropriate.

4.3.3 Blinds, screens etc to conceal evidence of IT equipment etc

4.4 Facilities and environment

4.4.1 Adequate and appropriate heating, lighting and ventilation arrangements taking into account likely position of work stations etc.

4.4.2 Sufficient electrical and telephone points taking into account workstation positions and otehr activities/facilities to meet relevant health and safety requirements

4.4.3 Good quality carpeting, standard of decor etc reviewed and renewed as needed or as per lease requirements

APPENDIX THREE - CHC MEMBER SPECIFICATION

(TO BE ADDED FOLLOWING CONSULTATION)

APPENDIX FOUR - CHC MEMBERSHIP APPLICATION/REGISTRATION FORM

(TO BE ADDED FOLLOWING CONSULTATION)

APPENDIX FIVE - SECRETARY OF STATE APPOINTMENTS PROCEDURE

(TO BE ADDED FOLLOWING CONSULTATION)

APPENDIX SIX - TIMETABLE FOR ACTION BY REGIONAL OFFICES

1. Establish and communicate RO staffing structure/support arrangements (as soon as possible if not already in place)

2. Membership appointments procedures to get into place some for April and some for August. *(Dependends on outcome of consultation)*

   Voluntary sector process to start December for September

   SoS procedures to start ?February? for September

   Unitary authorities to start November (for April change)

   Review of membership of any CHCs affected by boundary changes - December (for April change)

3. Set up SLAs

   Consult with CHCs on SLAs (October)

   Negotiate with HA(s) and set up and agree by December

   Set up procedures (establishing budgets and personnel databases etc - January to March

   Produce IT inventory by January

   Producing estates terrier - by March

4. *Determination of regional budget, with identified costs, and costs of SLAs by December.*

5. Liaison with and development of support for Regional Council - ongoing

6. Input into NHS Executive CHC Policy and Liaison Group, ongoing

7. All other current work

8. Agree mechanism for review of 1995/6 IPR and get mechanics and timetable in place and communicated to CHCs by December.