Meredith Vivian

see appendix 5

HC(74)4

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Alexander Fleming House Elephant and Castle London SE1 6BY

To: Regional Health Authorities
Area Health Authorities
Regional Hospital Boards
Boards of Governors
Hospital Management Committees
Executive Councils
Local Health Authorities
Joint Liaison Committees
Metropolitan and non-Metropolitan County Councils
Metropolitan and non-Metropolitan District Councils
London Borough Councils
The Common Council of the City of London

In England

January 1974

COMMUNITY HEALTH COUNCILS

Introduction

1. This circular gives guidance on the arrangements for establishing Community Health Councils, and on the role of these Councils in the reorganised National Health Service.

Purpose of Community Health Councils

2. Community Health Councils will provide a new means of representing the local community's interests in the health services to those responsible for managing them. In the reorganised National Health Service management of the service and representation of local opinion will be distinct but complementary functions, entrusted to separate bodies but working in close relationship. Successful administration of the service will depend on a continuing and constructive exchange of ideas between Area Health Authorities (AHAs) and the Community Health Councils (CHCs); the AHA will then be aware of local opinion on needs and deficiencies in the Service, and the community through the CHC will know of the actions and intentions of the AHA and of the problems and constraints with which it is faced. To be effective this relationship will call for positive effort and goodwill on both sides. The Secretary of State believes that this system will be seen to be mutually beneficial, to those who operate and plan services and to those who use them. Membership of the Councils will give a worthwhile and satisfying role to many of the public-spirited people who take a particular interest in the running of their local health services.

Statutory Provisions

3. The provisions of Section 9 of the National Health Service Act 1973 are set out in Appendix 1 to this circular and copies of the Regulations will be forwarded under separate cover as soon as they have been laid before Parliament.

Establishing Community Health Councils

Regional Health Authorities' responsibilities

4. Regional Health Authorities (RHAs), which are responsible for establishing CHCs in their regions (Regulation 3(1)), are asked to aim to complete the initial arrangements for the appointment of members by 1 April 1974, and not later than 30 April. A summary of the action required is at Appendix 2.

Number and size of CHCs

5. Each RHA must determine (in accordance with Regulation 4) the number of CHCs in its Region and the "district" and the size and composition of membership of each. Before doing so it must consult any appropriate District, County and Borough Council as defined in Regulation 2.

6. In defining the districts for which each CHC is established, the RHA must ensure that there is a CHC for every part of its Region and the districts must be continuous (s.9). Save in the most exceptional circumstances there should be a single CHC for each health district, ie CHCs should match District (or Area) Management Teams one for one. The same principle should apply if the health district for which a single DMT is responsible overlaps area boundaries. (Where a health district overlaps regional boundaries, the Secretary of State will give a direction to one of the RHAs concerned to enable it to establish the CHC for that district).

7. The Regulations place no upper or lower limit on the size of CHCs but the Secretary of State expects that the great majority of Councils will have between 18 and 30 members; probably most Councils will be at the upper end of this range but it should be exceptional for any Council to have more than 30 members. Factors which RHAs should take into account in determining the total number of members of each CHC are:-

i. the need to cover as broad a span of interests as possible but at the same time to keep the Council small enough to be an effective working unit;

ii. the number of district councils: and the size and geographical distribution of their respective populations in the CHC's district;

iii. the number and relative importance of voluntary organisations with an active interest in the health service in the district;

iv any special interests in the health district such as those of war pensioners, denominational hospitals and miners' rehabilitation centres (see paragraph 15);

v. any special features of the health district, such as a high immigrant population, or a considerable seasonal fluctuation in population eg in university towns;

vi. the need to keep sufficient places for the third category of members prescribed in the Regulations, whatever the pressures for places in the second category.

8. It will be convenient for the total number of members of a CHC to be divisible by 2 or 3, but Appendix 3 of this circular gives appropriate allocations of places on Councils of different size.

9. The number of CHCs in the area of each AHA, and the size of membership and the composition of each CHC should be kept under review by the RHA and modified, if necessary, after appropriate consultations, to meet changes in local circumstances. It will usually be convenient to consider the need for any such modifications in good time before expiry of the terms of office of members.

Eligibility for membership of CHCs

10. Members of Regional or Area Health Authorities or of Family Practitioner Committees are not eligible to be members of a CHC (Regulation 9). If a CHC member accepts appointment to any such authority his membership of the CHC automatically lapses. It will no doubt be unusual for any of the appointing bodies to invite any NHS employee or a person providing family practitioner services within the area of the relevant Area Authority to accept appointment to a CHC; the Secretary of State would certainly expect any member of a Regional or Area Team of Officers or District Management Team to decline service on a CHC if invited. People over the age of 70 should not normally be appointed or reappointed as members of CHCs.

Appointment of members (at least one half) by relevant local authorities

11. When the number of members to be appointed to a CHC by each relevant local authority has been determined, the RHA should invite the authorities to proceed with the selection and direct appointment of

those members (not less than one half of the total membership of the CHC). The local authorities may appoint councillors or non-councillors as they wish, and in making their appointments it is of course open to them to consult, amongst others, parish councils. The relevant local authorities should notify the RHA of the names of their appointees as soon as possible.

Appointment of members (at least one-third) by voluntary organisations with an interest in the NHS

a. *List of voluntary organisations invited to take part in appointments*

12. Any voluntary organisation active in a CHC's district (whether or not its office is situated in that district) or with a particular interest in a health service institution within that district can apply to take part in appointing members to the CHC. It is for the RHA in consultation with each appropriate County, District and Borough Council to decide which of the organisations that wish to take part in appointing members should be invited to do so. To this end RHAs should draw up, with the primary assistance of AHAs, and in consultation with such co-ordinating bodies as local Councils of Social Service, Age Concern or Old People's Welfare Committees and Local Authorities' Voluntary Bodies Liaison Committees, a provisional list of voluntary organisations which might be invited to take part. It should consist of organisations which have a strong active interest in health matters or which have a special interest in an NHS institution or institutions, in each Council's district.

13. In addition to these consultations the RHA must (under Regulation 7(1)) advertise in the local press inviting voluntary organisations to apply, a suggested model advertisement is at Appendix 4. It would be helpful if the RHA were to inform the organisations it has already listed before the advertisement is published. The RHA should not close the list until it has received and considered the replies to the advertisements and must allow one month for this purpose. (It will no doubt be necessary to bring the list up to date from time to time; and the list should in any case be reviewed (and the process of advertising for applicants must be repeated) every two years when approximately half the places on the CHC fall vacant). The final decision on the list of organisations to be invited to take part in appointments must be taken after consultation with the appropriate District, County and Borough Councils.

b. *Selection of appointing organisations*

14. Once the list of voluntary organisations has been determined it will be for the RHA to invite these organisations to agree among themselves how the places to be filled by them should be allocated. The places may be allocated to individual organisations or to organisations acting jointly. Local co-ordinating bodies of organisations affiliated to the National Council of Social Service may be willing to take the initiative in consulting affiliated organisations on the selection of members to represent them in each district; Age Concern or Old People's Welfare Committees may be able to act as co-ordinating bodies for voluntary organisations concerned with old people. Other voluntary organisations may wish to join with these or to form their own co-ordinating groups.

15. If unanimous agreement between all the voluntary organisations listed is not reached within a reasonable period, it is for the RHA to select the organisations which individually or jointly are to appoint members (AHAs should take no part in this selection). The selection should take account of such agreements as may have been reached between groups of organisations. It should give adequate recognition to the needs of deprived groups within the community and should include voluntary organisations which influence policies as well as those concerned with providing a service to the NHS. In some districts it will be necessary for RHAs to honour the Secretary of State's obligation to allocate places on CHCs to certain organisations in order to ensure continued representation of special interests in particular institutions, such as miners' rehabilitation centres, denominational hospitals and seamen's hospitals, about which the Department is writing separately to the Authorities concerned.

c. *Appointments*

16. 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 appoint whomever they wish (subject to arrangements agreed between themselves for joint appointments). They should notify the RHA of names as soon as possible.

Appointment of remaining members

17. The proportion of members to be appointed under Regulation 4(6) should normally amount as near as is practicable to one-sixth of the total membership of the CHC. These members will be appointed by the RHA, after consultation with the appropriate local authorities, and such other organisations as it sees fit. The intention is that these should be individuals who have a special knowledge of the health service, eg: former members of Hospital Management Committees, Boards of Governors or Executive Councils, and representatives of bodies such as women's organisations, trade unions, the Churches, and youth and immigrant bodies, who might not otherwise be appointed. RHAs will wish to wait until the names of members appointed by the relevant local authorities and by voluntary organisations are known before finally settling their own selections for the remaining seats on each Council.

Convening first meeting of CHCs

18. When the members of a CHC have been appointed, in accordance with Regulation 14(1) the RHA should convene the initial meeting of the Council, which should be held as soon as possible after 1 April 1974.

Staff, premises and expenses of Councils

Staff

19. The RHA will control the staff establishment of CHCs and appoint their Secretaries (Regulation 15(1)). The staff eventually required for each CHC will probably vary according to the size of the Council and the nature of its activities. Initially each CHC will need a secretary supported by a clerk/typist and by office services. The Secretary will usually be whole-time but in some areas it may be practicable for him to serve more than one CHC. The Secretary and any other staff are to be employed by the RHA or AHA (as convenient) on the appropriate NHS terms of service including superannuation (Regulation 15(2)). In fixing a grading for any CHC Secretary post RHAs should take account of the grading of other administrative staff with comparable responsibilities and Departmental guidance on the establishment of posts.

20. The arrangements for staffing should be made only after consultation with CHCs but RHAs are asked to give preliminary consideration to this matter before Councils are set up. The Secretary may, initially, be found from one of a number of sources: NHS officers who would wish to undertake the duties of CHC Secretary as part of their normal career development; officers recently retired from local health authority or other NHS work whose experience of the service would be valuable to the new Councils; other people from outside the NHS, perhaps with experience of voluntary work in the health or social services field, who would be interested in holding a CHC Secretary post for a limited period.

21. It is important, in the Secretary of State's view, for a close working relationship to develop between the CHC secretariat and health service staff working in the district, and for the staff of the CHC to feel that they are making an important contribution to the Service as a whole and, especially if they are young, to feel they are not cut off from opportunities for normal career development and career counselling. There would thus be advantages in considering whether there are officers already serving within each region who wish to be considered for an appointment with a CHC in their own, or another, Area. This source may not necessarily provide a suitable short-list and in addition, or alternatively, it may be convenient to advertise the post more widely with a view to considering candidates from outside the region, or from outside the NHS, including retired officers with recent NHS experience. The NHS Staff Commission should be consulted in advance in any cases where it is proposed to advertise outside the service.

22. Where an officer already serving within the region is appointed as CHC Secretary it would be convenient for him to be seconded by his existing employing authority for a defined period, normally of one to three years. He would remain on the pay roll of his existing authority, but would be accountable to the CHC for the performance of his duties. Where a person from outside the NHS, or a serving officer from outside the region, is appointed he should be employed by the establishing RHA. Short-listing and selection for CHC Secretary posts should in all cases be carried out by a committee on which representatives of the CHC participate, and no officer should be appointed or seconded who is not acceptable to the CHC.

23. Until permanent staffing arrangements are agreed with the CHC and implemented, the RHA should be responsible for making temporary arrangements for such secretarial assistance as the Council may require. The RHA should on request arrange for temporary assistance to cover the regular staff's holiday or sick leave.

24. The staffing arrangements of all CHCs should be reviewed at the end of the first year, and as may be necessary thereafter.

Premises

25. The RHA must provide each CHC with accommodation and supporting facilities (Regulation 16(1)). It may enlist the assistance of AHAs to the extent provided for in Regulation 3(3) and as described in paragraph 27 below. It is for the RHA to decide what is necessary but it must consult the CHC and should meet reasonable requests. It might for example reasonably provide a small suite of rooms for the chairman, secretary or a clerk/typist and the use, as often as required, of a room for meetings of the Council (with enough space for a small number of members of the public and for the press). The CHC should have its own telephone number. (The Secretary of State sees no objection to the offices being in NHS premises but if this is impracticable or unacceptable to the CHC, the RHA should arrange the purchase or lease of separate premises under the normal arrangements for acquisition of property).

26. There are various possibilities for meetings of CHCs (including use of local authority or hospital committee rooms or, when this is impracticable or unacceptable, provision by the RHA of a conference/general purpose room for the use of the CHC).

Expenses

27. i. The RHA is responsible for approving the budget of each CHC and for providing the funds from the Regional allocation. Generally it would be more economic for the relevant Area Authority to administer arrangements for accommodation; pay the salaries of staff of CHCs; provide such additional secretarial and office services as may be required; and meet any other approved expenses of the Councils. Subject to considerations of economy, the wishes of CHCs should normally be met.

ii. The CHC should look to the Area Treasurer for any assistance or advice on the formulation of estimates. The RHA should inform the Area Authority and the Council of the approved estimates and should allocate the requisite funds to the Area Authority. The RHA itself should monitor the expenses of the CHCs.

iii. The payment and accounting facilities of the relevant Area Authority should be used and a separate bank account should not be necessary.

Information about the NHS for CHC members

28. Although it is likely that some members of CHCs will have considerable previous knowledge and experience of the health services, a number may not and RHAs should consider, in consultation with the Councils and their relevant Area Authorities, the need to offer seminars or other arrangements by which new members can be informed about the NHS and its management arrangements. It might be convenient to arrange a series of half-day sessions and visits. The object should be to supplement the information provided by Area Authorities (paragraph 32) and to cover such subjects as the organisation and functions of the new health authorities, financing the health services, planning systems, manpower problems, and studies of particular services.

Matters for consideration by CHCs

29. It will be for each CHC to decide how best to fulfil its role of representing to the relevant Area Authority the interests of users of health services in the district (Regulation 19). All CHCs can make an important contribution to the way in which health services develop after reorganisation. That will not simply

be a matter of conveying to the relevant Area Authority the community's views and suggestions; equally important will be the Council's complementary role of helping the Area Authority to interpret its objectives, its plans and its priorities to the community.

30. A list of matters to which CHCs might wish to direct their attention is appended to this circular (Appendix 5).

31. The relevant DMT and Area Authority should respond promptly to requests from CHCs for information, explanations and access which they may reasonably require in order to carry out their functions. The Secretary of State hopes, however, that CHCs in making such requests will recognise that the first duty of all NHS staff - professional and administrative - is to meet the needs of patients; and that in the period immediately following reorganisation AHAs will be incompletely staffed and under heavy pressure.

Consultation with CHCs

32. The relevant Area Authorities should provide the CHCs in their area with basic information about the health services in the area, for example, the names of chairmen and members of the Area Authority and of members of the DMT and ATO; lists of NHS institutions (with brief details of facilities provided) in the area; and appropriate statistics, including national and regional comparisons.

33. The relevant Area Authority has a duty to consult the CHC on any substantial development of the health services in the Council's district (Regulation 20). Information about plans for development of health services, and in particular about any important variations in services affecting the public such as the change in the location of a department, the opening of a new service or the closure of an existing service, should be given freely to the CHC. It is important that the CHC should be brought in during the formative stages of development proposals, including the preparation of district plans for submission to the Area Authority. Guidance to be issued on the planning system will include advice about consultation with CHCs. The CHC should also be given the opportunity to comment formally on development proposals which are put to the Area Authority and the CHC's views should be considered before the proposals are approved. It will often be necessary for the Authority to ask the CHC to comply with a specified time-table for consideration of proposals.

34. The Secretary of State hopes that the DMT, and other officers of the district, and members of the CHC and its secretariat will develop a friendly and co-operative relationship with each other and will be ready to participate in informal discussions. The CHC, for its part, will be able to provide the DMT with local views on the needs and problems of the community served by the health district. The relevant Area Authority should give the CHC copies of minutes of meetings of the Authority relating to the health services in the Council's district; and copies of such papers prepared for these meetings as may be of assistance to the Council in exercising its functions.

35. Confidential information about the diagnosis and treatment of individual patients or any personnel matters relating to individual officers employed by a health authority should not be disclosed to the CHC and the Area Authority will have discretion to decide whether other information which it may regard as confidential should be disclosed to the Council. Councils have a right of appeal to the RHA about the refusal of the relevant Area Authority to supply particular information requested (Regulation 21).

36. The relevant Area Authority (or not less than one-third of the members of it) are required to meet each CHC in the area at least once a year (Regulation 23). The Secretary of State hopes that the chairman and members of the Authority will establish continuing informal contact with the chairmen and members of the CHCs in their area.

Visits to premises controlled by relevant Area Authority (Regulation 22)

37. The relevant Area Authority should allow access to all reasonable times consistent with the effective management of the service, by arrangement, to members of CHCs who wish to visit and on behalf of the

Council inspect premises under the Area Authority's control, such as hospitals, offices, clinics, health centres, staff residential accommodation, canteens etc. The clinician and nursing officer in charge should be informed beforehand of proposed visits to wards, clinics, hospital departments, etc and the timing of such visits should take account of the pressures on staff. In their visits CHCs will also wish to have full regard for the privacy of patients. Staff residential quarters should not be entered without the prior agreement of the staff concerned. Similarly premises, or parts of premises, eg in health centres, which are controlled by the relevant Area Authority but occupied by practitioners for the purposes of providing family practitioner services, may be entered only with the prior agreement of the practitioners concerned. There is no right of inspection of premises controlled by other health authorities, although, of course, CHCs may visit such premises by arrangement with those Authorities.

Reports by CHCs

38. It is open to CHCs to publish at any time such reports and statements as they see fit but they are required to make once a year a formal report to the establishing RHA on their activities, to send a copy to the relevant Area Authority and to publish it. The Area Authority is required to comment on these reports and its response, which should include a record of any steps it has taken in consequence of advice given on proposals made by the Council, should be furnished to the CHC and published. (Regulation 18).

Publicity arrangements

39. The CHCs will be responsible for their own public relations. The Secretary of State expects each Council to endeavour to ensure that the public it serves is aware of the names of the chairman and members of the Council and the address and telephone number of its office; and that publicity is given to the Council's activities.

40. The provisions of the Public Bodies (Admission to Meetings) Act 1960 apply to CHCs. The public, including the press, will therefore normally be admitted to meetings of the Councils. The public may be excluded if a CHC resolves in respect of particular business that publicity would be prejudicial to the public interest by reason of the confidential nature of the business, or for other special reasons which must be stated in the resolution. Where meetings are open to the public the Council will have a duty to give public notice of the time and place of the meeting normally three clear days at least before the meeting; to furnish for the benefit of any newspaper a copy of the agenda for the meeting; and to provide accredited representatives of the press, so far as practicable, with reasonable facilities for taking a report of the meeting.

National Association of Community Health Councils

41. The Secretary of State has powers under Section 9(6) of the Act to provide for the establishment of a national body. He considers however that it is for the Councils themselves to decide, when they have settled down, whether they want a national association and to propose, in the light of their own experience, what should be its form and functions.

42. Copies of this circular and of the Regulations should be provided to each CHC when it is established.

From

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Alexander Fleming House
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London SE1 6BY

Tel 01 407 5522 Ext 6329

J/N179/156

Further copies of Reorganisation Circulars may be obtained from:-

Central Store
DHSS Depot
Primrose Mill
Clitheroe
Lancashire BB7 1BP

Telephone 0200 2 2187

NATIONAL HEALTH SERVICE REORGANISATION ACT 1973: SECTION 9

COMMUNITY HEALTH COUNCILS ETC

9. (1) It shall be the duty of the Secretary of State to establish in accordance with this section a Council for the area of each Area Health Authority or separate Councils for such separate parts of the areas of those Authorities as he thinks fit; and such a council shall be called a Community Health Council (and is hereafter in this section referred to as a "Council").

(2) The Secretary of State may if he thinks fit discharge the duty aforesaid by establishing a Council for a district which includes the areas or parts of the areas of two or more Area Health Authorities; but the Secretary of State shall be treated as not having discharged that duty unless he secures that there is no part of the area of an Area Health Authority which is not included in some Council's district.

(3) It shall be the duty of a Council -

(a) to represent the interests in the health service of the public in its district; and

(b) to perform such other functions as may be conferred on it by virtue of the following subsection.

(4) Provision may be made by regulations as to -

(a) the membership of Councils (including the election by members of a Council of a chairman of the Council);

(b) the proceedings of Councils;

(c) the staff, premises and expenses of Councils;

(d) the consultation of Councils by Area Health Authorities with respect to such matters and on such occasions as may be prescribed;

(e) the furnishing of information to Councils by Area Health Authorities and the rights of members of Councils to enter and inspect premises controlled by Area Health Authorities;

(f) the consideration by Councils of matters relating to the operation of the health service within their districts and the giving of advice by Councils to Area Health Authorities on such matters;

(g) the preparation and publication of reports by Councils on such matters and the furnishing and publication by Area Health Authorities of comments on the reports; and

(h) the functions to be exercised by Councils in addition to the functions exercisable by them by virtue of paragraph *(a)* of the preceding subsection and the preceding provisions of this subsection;

and the Secretary of State may pay to members of Councils such travelling and other allowances (including compensation for loss of remunerative time) as he may determine with the consent of the Minister for the Civil Service.

(5) It shall be the duty of the Secretary of State to exercise his power to make regulations in pursuance of paragraph *(a)* of the preceding subsection so as to secure as respects each Council that -

(a) at least one member of the Council is appointed by each local authority of which the area or part of it is included in the Council's district and at least half of the members of the Council consist of persons appointed by those local authorities;

(b) at least one third of the members of the Council are appointed in a prescribed manner by bodies (other than public or local authorities) of which the activities are carried on otherwise than for profit;

(c) the other members of the Council are appointed by such bodies, in such manner and after such consultations as may be prescribed; and

(d) no member of the Council is also a member of a Regional Health Authority or Area Health Authority;

but nothing in this subsection shall affect the validity of anything done by or in relation to a Council during any period during which, by reasons of a vacancy in the membership of the Council or a defect in the appointment of a member of it, a requirement included in regulations in pursuance of this subsection is not satisfied.

(6) The Secretary of State may by regulations -

(a) provide for the establishment of a body -

(i) to advise Councils with respect to the performance of their functions and to assist Councils in the performance of their functions, and

(ii) to perform such other functions as may be prescribed; and

(b) make provision as to the membership, proceedings, staff, premises and expenses of the said body;

and the Secretary of State may pay to members of the said body such travelling and other allowances (including compensation for loss of remunerative time) as he may determine with the consent of the Minister for the Civil Service.

(7) In this section -

"local authority" means the council of a London borough or of a county or district as defined in relation to England in section 270(1) of the Local Government Act 1972 or of a county or district mentioned in section 20(3) of that Act (which relates to Wales) or the Common Council of the City of London; and

"district", in relation to a Council, means the locality for which it is established, whether that locality consists of the area or part of the area of an Area Health Authority or such an area or part together with the areas or parts of the areas of other Area Health Authorities;

and the district of a Council must be such that no part of it is separated from the rest of it by territory not included in the district.

APPENDIX 2

SUMMARY OF ACTION REQUIRED FOR INITIAL ESTABLISHMENT OF COMMUNITY HEALTH COUNCILS

NOTE 1. *THE ACTIONS REQUIRED ARE LISTED IN SEQUENCE BUT MANY OF THEM WILL NEED TO BE CARRIED OUT CONCURRENTLY IF THE OBJECTIVE OF HAVING COUNCILS IN OPERATION IN APRIL 1974 IS TO BE ACHIEVED.*

NOTE 2. IN VIEW OF THE NEED TO SET UP THE COUNCILS QUICKLY INFORMAL CONSULTATIONS SHOULD BEGIN AT ONCE BUT WHERE SUCH CONSULTATIONS HAVE BEEN COMPLETED BEFORE THE DATE WHEN THE RELEVANT REGULATIONS COME INTO OPERATION IT WILL BE NECESSARY, IN ORDER TO SATISFY THE REQUIREMENTS OF THE REGULATIONS, TO CONSULT FORMALLY THE BODIES CONCERNED. IT WILL SUFFICE IF IN THESE CASES RHAs ISSUE A FORMAL CONSULTATION LETTER AS SOON AS THE REGULATIONS COME INTO OPERATION AND REQUEST A REPLY WITHIN 10 DAYS CONFIRMING OR VARYING THE AGREEMENT OR RECOMMENDATIONS ALREADY MADE. REGIONAL HEALTH AUTHORITIES SHOULD ENSURE THAT THE ADVERTISEMENTS REQUIRED UNDER REGULATION 7(1) DO NOT APPEAR IN THE PRESS BEFORE THE REGULATIONS COME INTO OPERATION.

1. Regional Health Authorities (RHAs) determine, after consultation with the appropriate local authorities:-

   i. the number and districts of the community health councils (CHCs) to be set up in the region (paras 5-6 of circular);

   ii. the size and composition of each CHC (paras 7-8 and Appendix 3).

2. RHAs, with the assistance of AHAs and appropriate local authorities, compile lists of voluntary bodies with an interest in the National Health Service in each CHC's district (para 12).

3. RHAs publish advertisements inviting applications for inclusion on the list.

4. Consider replies to advertisements and, after consultation with local authorities etc, determine which voluntary bodies are to be invited to take part in appointing members (para 13).

5. RHAs invite selected voluntary organisations to confer in order to determine which of their members shall make appointments.

6. Voluntary organisations determine allocation of places (or refer to RHA for decision) (paras 15-16).

7. RHAs invite local authorities and voluntary bodies to appoint the appropriate number of members to each CHC (paras 11 and 16).

8. Local authorities appoint their members, after agreeing among themselves on the allocation of seats between the local authorities concerned, and notify RHA of names of members (para 11).

9. Voluntary bodies appoint members and notify RHA of names of members (para 16).

10. RHAs select and appoint remaining members of each CHC, after consultations with local authorities and others (para 17).

11. RHAs, with assistance of AHAs, draw up proposals for accommodation, staff and supporting services for each CHC (paras 19-26).

12. RHAs convene first meetings of CHCs as soon as possible after members have been appointed (para 18).

13. CHCs meet and appoint Chairmen and Vice Chairmen (Regulations 12-13).

14. RHAs consult CHCs on premises, staff and budget (paras 19-27).

APPENDIX 3

NHS REORGANISATION ACT:

COMMUNITY HEALTH COUNCILS: ALLOCATIONS OF MEMBERS IN ACCORDANCE WITH SECTION 9(5)

Total	Local Authorities (at least half)	Voluntary Bodies (at least one-third)	Others
18	9	6	3
19	10	7	2
20	10	7	3
21	11	7	3
22	11	8	3
23	12	8	3
24	12	8	4
25	13	9	3
26	13	9	4
27	14	9	4
28	14	10	4
29	15	10	4
30 (normal maximum)	15	10	5
31	16	11	4
32	16	11	5
33	17	11	5

APPENDIX 4

Model advertisement (see paragraph 13 of this circular)

NATIONAL HEALTH SERVICE
COMMUNITY HEALTH COUNCILS

Members to be appointed by voluntary organisations

Community Health Councils [are to be established to] represent the interests in the Health Service of the public in the following districts of the area of the - Area Health Authority:

[name and description of district(s)]

In accordance with the provisions of Section 9(5)(b) of the National Health Service Reorganisation Act 1973, at least one third of the members of each Council are to be appointed in a prescribed manner by bodies (other than public or local authorities) of which the activities are carried on otherwise than for profit.

Voluntary organisations active in these districts with a strong active interest in health matters, or which provide a service for NHS patients, or which have a special interest in a particular NHS institution or institutions in these districts, are invited to apply for inclusion in the list of voluntary organisations which are to be asked to appoint members to the appropriate Community Health Councils.

Applications should be forwarded as soon as possible and no later than - to the Regional Administrator, Regional Health Authority -

(telephone no - - - - - - - - - - - - - - - - - - -)

APPENDIX 5

MATTERS TO WHICH COMMUNITY HEALTH COUNCILS MIGHT WISH TO DIRECT THEIR ATTENTION

(i) General: the effectiveness of services being provided in the health district, and their adequacy in relation to health care needs. The relevant AHAs will consult Councils about their plans and intentions, but Councils will not be expected to wait until consulted; they may advise and make representations to the AHA on their own initiative.

(ii) Planning of services: criticism and constructive comment on AHA plans for provision of and development of services.

(iii) Changes in services: comment on AHA plans for important variations in services affecting the public, eg new services. Closures of hospitals or departments of hospitals or change of their use.

(iv) Collaboration: the effectiveness of co-operation between the health services and the related local authority services.

(v) Standards: assessment of extent to which district health facilities for patients conform with published Departmental policies in their administration and practices; the extent to which facilities match up to recommended standards (where these exist) or national or regional averages, eg numbers of hospital beds in particular specialties per 1000 population, average number of patients on family doctors' lists, number of persons per dentist (statistical and other information will be provided by the AHA on request); the share of available resources devoted to the care of patients unable to protect their own interests, especially those living in hospital for long periods or indefinitely.

(vi) Facilities for patients: eg hospital visiting arrangements for patients (including open visiting for children, facilities for mothers to stay in hospital with young children); waiting times and accommodation for patients in out-patient departments; amenities for hospital patients; arrangements for rehabilitation of patients.

(vii) Waiting periods for in-patient and out-patient treatment; and for domiciliary services.

(viii) Quality of catering in health service institutions in the district.

(ix) Complaints: the volume and type of complaints received about a service or institution. The investigation of individual complaints will be a matter for the health authority and its staff or (where appropriate) for the Health Service Commissioner or Service Committee but Community Health Councils will be able, without prejudging the merits of individual complaints or seeking out the facts, to give advice, on request, on how and where to lodge a complaint and to act as a "patient's friend" when needed. A CHC will also wish to bring any potential general causes of local complaint to the notice of the AHA.

(x) The CHC might wish to ask some of their members to take a special interest in a particular part of the district, or in particular institutions within the district.

(xi) Health care groups: similarly, a CHC might decide that sub-committees of the Council should take a special interest in services provided for particular health care groups, eg health services for the mentally handicapped.

(xii) Reports to the public: Councils are required to publish at least once a year reports on their activities and they will wish to ensure that these are made widely available to the public.