
MOVING TOWARDS WORLD CLASS?

A Review of Community Health Councils in Wales

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FOREWORD

Community Health Councils (CHCs) are now 38 years old – probably the longest-surviving of any NHS body. While England and Scotland have both abolished their equivalents of the CHC, they remain in Wales as the prime way to ensure ‘more effective engagement with patients and the general public in planning service provision and changes to services’¹.

Despite this long-term commitment to CHCs in Wales, they have been subject to several reviews over the years, and even today there remain concerns about many aspects of their organization and performance. It is striking how persistent some of the issues appear to be – over the size and composition of the membership, variable performance, their public profile, how they fit together with all the other health bodies, and how influential they are. It would appear that everyone accepts the need for independent bodies committed to understanding and championing the needs of the patient and the public in health matters, but that there is less consensus over much of the detail of how this should be delivered.

For this review, it was very helpful that the Minister began with her commitment to the future existence of CHCs in Wales – people have not felt the need to be defensive. This has allowed us to have very frank and reflective discussions with almost 200 people across Wales during the last three months. The review draws on these contributions, and on the large amounts of documentation, the literature, and other models of patient and public representation which we have considered. Our aim was a simple one: to collect together the evidence relating to our terms of reference, and to suggest options for the future, so that the public consultation which follows is as informed as it may be.

It was a real pleasure to spend many hours over the last three months listening to talented, enthusiastic and generous people who all share a passionate commitment to making the NHS in Wales serve its patients even better. There is clearly scope for further improvement, and the evidence is here.

The NHS in Wales is committed to providing ‘services best suited to Wales but comparable with the best anywhere’ i.e. world class.² The question is: how do we deliver world class patient and public engagement?



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¹ This is taken from the Minister’s Foreword to the last consultation document on the future of CHCs, published in January 2009.

² Bevan Commission (2011) *2008-2011 NHS Wales: Forging a Better Future* Cardiff: Welsh Government

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We are very grateful to all those people across Wales, many of them volunteers, who gave so generously of their time to talk with us and share their experiences and aspirations. We are also very grateful to CHC staff, in every CHC and at the national Board, who collected together the evidence we had requested, and spent many hours talking through it with us. Finally we are grateful to all others who shared their perspectives, in Local Health Boards, Healthcare Inspectorate Wales, Welsh Government and elsewhere. As always, we could not have done the work without them, but responsibility for any errors remains with us.

EXECUTIVE SUMMARY

INTRODUCTION

This review was commissioned by Welsh Government, and followed a commitment by the previous Minister that the 2010 reform of Community Health Councils (CHCs) would be reviewed after two years. Our terms of reference are set out in Appendix 1, and required an examination reaching into most aspects of the work of CHCs, including their governance, 'professionalism', relationships with other health bodies, value for money, adoption of good practice, their role as 'critical friend', and complaints advocacy.

The review was conducted between April and June 2012 by a team from the Welsh Institute for Health and Social Care, University of Glamorgan, led by Professor Marcus Longley, with substantial input from all CHCs and NHS bodies in Wales, and a wide variety of other stakeholders. In addition to meeting each CHC Chief Officer, their staff, Chair, Vice Chair and representatives of each Local Committee, the team conducted a number of open access interviews across Wales, met with representatives of each Local Health Board and Trust, hosted an on-line survey, and had a variety of inputs from many other individuals and organisations. In total, we received evidence from 43 organisations and an additional 44 individuals.

This report summarises the evidence received, and draws conclusions relating to each of the terms of reference. It concludes with 17 recommendations, divided into short-, medium- and long-term.

CHCs: TAKING STOCK

CHCs' performance over the past two years can be divided into three broad categories: strong, just needing further consolidation; substantial progress, some changes required; and persistent weaknesses, new thinking required:

AREAS OF STRENGTH – FURTHER CONSOLIDATION REQUIRED

There are several areas where the current arrangements serve the people of Wales well, and are clear strengths of CHCs. Where there is an effective relationship between the CHC and health bodies (LHBs, Trusts, primary care, regulators etc), important deficiencies in the provision of services are promptly brought to the attention of the relevant body and remedial action is taken; the health needs of communities who would not otherwise have a powerful voice are heard and acted upon; service plans are improved from an early stage by the CHC championing the patients' perspective; a host of decisions taken by the LHB and others are improved because they are conscious that they may subsequently be scrutinised by the CHC; and local communities have greater faith in the NHS because they feel that CHCs give them a voice. In addition, individual complainants get effective, empathetic and efficient support from the CHCs' complaints advocacy service which delivers the best possible outcome for them. CHCs mobilise well in excess of 200 volunteers across Wales every year to improve local services, making a total of around 13,000 days of effort, equivalent to about 60 paid staff.

AREAS OF SUBSTANTIAL PROGRESS – SOME CHANGES REQUIRED FOR PROGRESS TO CONTINUE

There are a greater number of areas where substantial progress has been made since 2010, but where change needs to be made at this point in order to continue the process of improvement:

Number and categories of CHC Membership - many very good members have now been recruited, but other concerns merit further attention within the current regulations, including persistent unfilled

vacancies, delays in appointing Welsh government members, insufficiently creative use of the voluntary sector membership, and variable input from local authority members.

Universal adoption of good practice - there are some good examples of CHCs adopting the good practice of others, but the mechanisms for identifying such practice and then ensuring its adoption are inappropriately *ad hoc*.

Training - the training of staff is informed by a regular appraisal process, but there is no clear development programme for the small team of senior CHC staff as a whole. The quality and appropriateness of training of Members is too reliant on a small national training resource which has not always been available.

Prioritisation of work - the effectiveness of future workload planning varies between CHCs. Some are better than others at appraising the relative value of different areas of their work (visiting premises, scrutiny, public engagement etc) and re-prioritising accordingly.

PERSISTENT WEAKNESSES – NEW THINKING REQUIRED

There are other areas, which were priorities in the 2010 reform of CHCs, where progress has been disappointing, and where new approaches are now required if they are to be properly addressed:

Consistency of performance - the way in which CHCs discharge their responsibilities varies substantially across Wales. CHCs' current performance management arrangements are far too focused on process issues and not enough on outcomes. When serious problems arise in particular CHCs areas, they are either addressed too slowly or not at all.

Diversity - CHC Membership remains disproportionately white, older and middle class. This lack of representativeness is an important weakness in any Member-led organization, particularly one which relies heavily on its members to carry out much of its work. There are good examples of innovative engagement processes in some parts of Wales, but more is certainly needed.

Public knowledge and understanding of CHCs - public recognition and understanding of CHCs is very low. There is little doubt that they could perform their functions more effectively – and address other issues such as diversity of membership – if they were better known.

National role - the Board of CHCs is not yet discharging its two key roles as effectively as possible: leading the internal development of CHCs (ensuring consistently high standards of performance), and representing the collective voice of patients and the public to the Minister and the wider world.

Nursing homes - CHCs have not systematically involved themselves in the NHS-funded services provided by registered nursing homes. This was intended to be an additional area of responsibility for CHCs following the 2010 reform.

CONCLUSIONS

The conclusions in relation to each of the eight main terms of reference are summarised below:

1. GOVERNANCE OF CHCs

A. Operational structures

The co-terminosity of CHCs and LHBs is working satisfactorily, but two structural issues deserve attention: the existence of two CHCs in Powys, and the bureaucratic burden associated with the existence of numerous Local Committees.

B. Lines of accountability

Individual members – in most CHCs, the arrangements for ensuring the proper accountability of individual Members have worked effectively and appropriately, usually through the action of the Chief Officer, supported as necessary by the involvement of senior Members. In a minority of cases, however, these arrangements have not worked satisfactorily, despite the adoption of the Code of Conduct, and there has been some anxiety about issues such as the proper declaration of conflicts of interest, the ambiguities associated with individual Members' association with outside interests which may coincide with their role as a CHC Member, and about what constitutes appropriate behaviour in the public domain.

Individual members of staff – the national-local link is considered below. At the level of the CHC itself, there is some evidence – again in a small minority of CHCs – that the staff team does not always operate cohesively. This is a matter for on-going staff development and appraisal.

Welsh Government – links between the Government and CHCs are generally satisfactory, but Welsh Government appears to be involved in various matters which are more operational than policy matters, and could therefore be more appropriately delegated. The accountability of the Director to the Chief Nursing Officer is perceived by some as undermining the independence of CHCs themselves. We have found no evidence that this line of accountability does *in fact* compromise the Director's ability to act appropriately, but the impression persists.

C. Director of the Board

The Director has a significant leadership role, including the line management of CHC Chief Officers. In most cases, this has been an unproblematic relationship, but there have been some instances where it has been complicated by the Chief Officer's dual accountabilities to the Director and his/her CHC, and the perceived conflict between them. Where these arrangements have been put to the test in controversial circumstances, there has been a reluctance to make and abide by collective decisions. The result has contributed to a continuing, unsatisfactory working relationship between the Board and the individual CHCs concerned, and between the CHC and its LHB, which none of the parties involved seeks to condone.

D. Membership and appointments

Issues associated with the Membership continue to cause considerable concern within CHCs:

Lack of diversity in membership – discussed above.

Delays in appointing Welsh Government Members – there was widespread concern at the length of time taken to appoint Members in the most recent recruitment round. These arrangements have now been simplified.

Onerous nature of the Welsh Government appointments process – concerns remain that the process is not well-designed to increase diversity.

Inadequate overall number of Members – many CHCs reported that they had insufficient Members to carry out their core functions. However, in the absence of effective priority-setting (see below), it remains unclear just how many members are required.

Eight-year maximum service rule – there is a life-time limit of 8 years on CHC Membership. Although this has led to the loss of some experienced Members, it nevertheless strikes a pragmatic balance between a reasonable length of service and the need for new Members.

E. Third sector and Local Authority Membership

The three Members of each local committee nominated from the voluntary sector do provide a useful way of increasing diversity of membership, but this flexibility is not always used to maximum effect. Local authority members provide a variable level of input, and many are either not appointed, or filled by Councillors with limited availability to contribute to the work of the CHC.

2. 'PROFESSIONAL' ORGANISATIONS

CHCs are improving their ability to gather evidence robustly, and are working with other agencies. They are getting better at using their different sources of intelligence to target their work, and are becoming more proactive in choosing the most important areas on which to focus. All of these initiatives are valuable, and more are needed. It is also important that CHCs achieve *consistently* high standards in these areas (see below).

3. CHC AND HEALTH BOARD/TRUST RELATIONSHIPS

In most parts of Wales, effective and mutually respectful relationships exist between the LHB/Trusts and CHC, with an appropriate level of robust scrutiny, and support from the LHB. In a small number of places, however, such good relationships do not always exist. Relationships can continue to improve with greater shared understanding of the respective roles of the CHC and LHB/Trust and how they should complement each other; improved coordination of the work of CHCs and HIW; work better targeted on issues of prime concern; better use of available intelligence and evidence, with support from the LHBs/Trusts; and more insightful and rigorous scrutiny.

4. VALUE FOR MONEY

CHCs have an annual budget of approximately £3.8m, or £1.27 for each person in Wales. The use of volunteer input significantly increases the impact of this expenditure. There are still some apparent anomalies in the distribution of some of these resources which merit further consideration. There is also further scope for using the skills of individual CHCs to provide all-Wales leads on particular issues. The universal adoption of good practice is considered below.

Underpinning any approach to maximising value for money must lie a robust and appropriate system of performance management. At present, the system in use focuses almost exclusively on process measures, and gives little attention to outputs or outcomes. The targets are not always explicit or sufficiently demanding, and the process for ensuring compliance is somewhat unclear.

5. GOOD PRACTICE

It is clear that many CHCs are developing innovative ways of performing their roles, but it is also clear that staff and Members' knowledge of what is going on elsewhere is limited. This somewhat parochial approach, combined with the lack of robust performance management information discussed above, is ill-designed to encourage the adoption of good practice.

6. 'CRITICAL FRIENDS'

As discussed above there is still some work to be done, in some parts of Wales, to ensure that Members and staff of CHCs have a shared view of their role and how it should be most appropriately discharged. This needs to be developed jointly with LHBs and Trusts, and to go beyond the statement of high level principle to the application of those principles in challenging real-world situations. Once agreed, these norms need to be enforced, locally and nationally.

More specifically, CHCs' work on the healthcare environment, and visits to premises, needs some further refinement. A proportion of this work is still focused on relatively mundane matters, with limited attempt to prioritise, and therefore too often is not taken seriously by LHBs.

7. RELATIONSHIPS WITH OTHER BODIES

Helpful understandings have now been developed between CHCs and most of the other health-related bodies with whom they need to cooperate. There is still some work required to make a reality of perhaps the most important of these, the link with Healthcare Inspectorate Wales (HIW). Currently, Powys teaching LHB provides financial and other technical support to the CHCs. While this arrangement has generally worked quite well, there may now be merit in transferring this function to another NHS body (e.g. Velindre NHS Trust).

8. COMPLAINTS ADVOCACY

The Complaints Advocacy service is now well-established in each CHC, providing a timely, appropriate, empathetic and effective service for about one in nine of the people who complain about NHS services in Wales. There are some areas for further development which are set out in the report.

RECOMMENDATIONS

The first two sets of recommendations below (1-16) are intended to make the most of the current arrangement of CHCs, bringing all up to the level of the best, and establishing a more effective national Board. Recommendation 17 is bolder. It addresses the more challenging question: how could Wales move towards 'world class' patient and public engagement (including all elements of CHCs' current role), ensuring the best influence for patients over the care they receive, and services which are truly designed for the needs and wishes of all our communities?

IMMEDIATE IMPROVEMENTS Implementation timescale: 6-12 months

Recommendation 1 The Role of the CHC Board should be re-affirmed and endorsed by CHCs

Recommendation 2 Roles and Functions: (a) Clarify the role and function of CHCs; (b) make links to the Code of Conduct ; and (c) explore range of options for joint working with LHBs.

Recommendation 3 The CHC Board should adopt a more transparent and outcome-focused approach to the performance management of individual CHCs, using SMART metrics and an effective process to ensure that performance is acceptable.

Recommendation 4 The CHC Board should be more proactive in identifying and sharing good practice between CHCs, and in facilitating learning amongst staff and Members

Recommendation 5 The CHC Board should ensure that CHCs use their business planning processes to identify and prioritise themes and issues to be explored proactively, on both a local and national basis, so that a higher proportion of their total workload is determined in such a fashion

Recommendation 6 The Complaints Advocacy function within CHC should be further strengthened and developed

Recommendation 7 The Board of CHCs should resolve the position regarding visiting Nursing Homes, and CHCs start such visits as a matter of urgency

Recommendation 8 The agency arrangement for financial, HR and other support, and the division of administrative responsibilities for CHC, should be reviewed

Recommendation 9 CHCs should make much greater use of electronic communications technology

SUBSTANTIAL IMPROVEMENTS Implementation timescale: 12-18 months

Recommendation 10 Appoint the Chair and non-executive members of the Board of CHCs

Recommendation 11 Improve the diversity of CHC membership: (1) Welsh Government should make increased diversity of membership an immediate priority; (2) the Board of CHCs should immediately review the reasons for lack of diversity in applications and retention of CHC Members; (3) in the light of the above, each CHC should discuss with local partners in the voluntary sector and local government how to increase and retain greater diversity of Membership; and the rules on local authority members should be changed; (4) CHCs should develop different ways of allowing people to become involved in their work.

Recommendation 12 The CHC Board should review the overall balance of CHC activity

Recommendation 13 Establish Powys as a unified CHC

Recommendation 14 Minimise the bureaucratic burdens of separate Local Committees

Recommendation 15 Review CHC financial allocations and budgetary management arrangements

Recommendation 16 Consider changing CHCs' names

RE-DESIGN: TOWARDS 'WORLD CLASS' Implementation timescale: 2-3 years

Recommendation 17 Undertake an inclusive process of deliberation to define what would constitute 'world class' in this context (our 'aspiration'), and then to bring forward specific organisational recommendations to help bring it about.

1 INTRODUCTION

1.1 INTRODUCTION

This report outlines the findings of the Review of Community Health Councils (CHCs) in Wales, undertaken between April and June 2012. This work follows the announcement made after the reorganisation of CHCs in 2010, which stated that a review would be undertaken two years after their inception. It is anticipated that a consultation process, based on the recommendations, will follow.

1.2 TERMS OF REFERENCE

The review was commissioned by the Minister for Health and Social Services in Wales. The terms of reference of the Review were as follows:

Working with stakeholders, including Community Health Councils, Local Health Boards and Trusts, Local Authorities, the Third Sector, NHS Confederation, Health Bodies such as PHW, Healthcare Inspectorate Wales, the Care and Social Services Inspectorate for Wales, the Children's Commissioner and the Older People's Commissioner, the review will:

- undertake a root and branch review of the governance of Community Health Councils and, in particular, to make recommendations on
 - the operational structure
 - lines of accountability including links to the Welsh Government
 - the role and responsibilities of the Director of the Board of Community Health Councils
 - the membership structure and the appointment processes
 - making effective use of Third Sector and Local Authorities membership
- recommend where and how we need to develop Community Health Councils, including the members, into 'professional' organisations which fit the strategic needs of 'Together for Health'
- review how Community Health Councils and Health Boards are working together for the benefit of people in Wales including how they fulfil their statutory obligations
- review what we are getting for our money and where Community Health Councils can be more efficient
- identify good practice examples within the Community Health Councils which need to be more widely adopted and how this can be done
- review and make recommendations on any future developments on their "critical friend" role in relation to Health Boards, including acting as the 'patients' voice
- consider their relationship with the Welsh Government and other bodies including Healthcare Inspectorate Wales, the Care and Social Services Inspectorate for Wales, the Children's Commissioner and the Older People's Commissioner
- consider how the Advocacy Service should be provided in the future.

1.3 METHOD

The review has been carried out in three phases, timetabled approximately as follows, with each of the Terms of Reference being explored in each phase:

| Phases of work | Time Period | Key Activities |
|--------------------------------------------------------|-------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Phase One – Literature Review and Call for Information | April 2012 | <ul style="list-style-type: none"> ○ Review of relevant literature – legislative, policy, academic ○ Collection and review of relevant documentation from CHCs and other stakeholders in Wales |
| Phase Two – Data Collection and Analysis | May 2012 | <ul style="list-style-type: none"> ○ Engagement with all CHCs and LHBs/Trusts ○ Engagement with other relevant stakeholders ○ Evaluation of good practice examples ○ Evaluation of relevant work outside Wales |
| Phase Three – Consolidation and Reporting | June 2012 | <ul style="list-style-type: none"> ○ Engagement with stakeholders on emerging issues ○ Reporting interim findings ○ Preparation of draft report ○ Preparation of final report |

The review began with a request for information from CHCs, the National Board of CHCs, LHBs/Trusts and HIW. The call for information requested evidence and documentation across a number of key areas including details of operational structures and lines of accountability, examples of good practice, examples of joint working, and budgetary statements (for a full list see appendix 2).

A key objective was to give anyone who so wished a good opportunity to engage with the review, and a mix of proactive and open access methods were adopted in order to achieve this:

1. The team met with each of the 8 CHCs, speaking with Chief Officers, CHC staff, Chairs, Vice Chairs and their members (with representatives from every Local Committee across Wales) via one to one interviews and larger discussion groups.
2. Open access surgeries took place in each CHC area, offering individual appointments to members, ex-members, members of the public and other interested parties from the local area.
3. The team liaised at length with the Director, staff and the (out-going and in-coming) Chair at the National Board of CHCs via interviews and discussion groups, as well as via the telephone and email.
4. A half day workshop was held with representatives from the Local Health Boards and Trusts in Wales. Some Health Board representatives also contributed via email, telephone or one to one meetings.
5. A survey (in both English and Welsh, and hosted online) gave individuals an opportunity to comment against the terms of reference anonymously. In total 30 responses were submitted online, and a small number were received via the post. The survey was structured around the terms of reference. See appendix 3.
6. Lastly, there was an open call for information, offering all stakeholders and interested parties the opportunity to contribute to the review via email, post, completing the questionnaire, meeting with a member of the team, or speaking with them via the telephone. A 'flyer' (see appendix 4) was distributed to raise awareness of the review and to encourage people to get in touch.

It is estimated that across the few weeks, the WIHSC team have engaged with a total of 43 organisations. A full list of these organisations is shown in appendix 5. The table below shows a breakdown of this total, by stakeholder type:

Table 1: Numbers of organisations engaged

| Organisation Type | Number |
|-------------------------------------------------------|-----------|
| Community Health Councils (inc. National Board) | 9 |
| Local Health Boards/Trusts | 9 |
| Stakeholders (HIW, CSSIW etc) and other organisations | 25 |
| TOTAL | 43 |

In addition to this, 44 individuals contributed to the review, including survey respondents.

Where possible, all discussions were audio transcribed, and electronic notes were taken. This methodology resulted in a significant volume of data. The team has undertaken a thematic analysis of the qualitative data using NVivo 9.0 which allows for the organisation, management and analysis of all types of such information. The research findings chapters of this report provide a detailed narrative of this qualitative analysis, supported by the various other information and documentation received since April 2012.

1.4 SOME CONTEXT | PATIENT INVOLVEMENT IN THE UK

Lay people have been members of health service management or governance bodies in the UK since laymen founded non-religious hospitals in the 18th century – a tradition which continued when the NHS took over hospitals in 1948.³ In 1974, Community Health Councils (CHCs) were created, so that patients' interests could be kept separate from the managerial responsibilities of governance. CHCs, set up in each health district/local health service in England, Wales and Scotland, were to represent the interests of patients and communities to their local health service management or governance bodies. Since the formation of CHCs in 1974, there have been developments in the mechanisms by which patients interests are voiced in the UK, most notably in England and Scotland.

1.4.1 Developments in England

Patient and Public Involvement Forums (2003-08)

The Health and Social Care Act 2001, which gave the NHS a duty to involve the public, paved the way for a new system of patient and public involvement in England, and extended local authorities' Overview and Scrutiny Committees' remit to healthcare. In 2003, CHCs and their national body (the Association of Community Health Councils for England and Wales) were abolished. New local forums had volunteer members, with statutory powers including:

- The right of access to some healthcare premises

³ Charlotte Williamson (2010) Towards the Emancipation of Patients: Patients' experiences and the patient movement, Bristol, The Policy Press, p.137

- The right to request written information from trusts and PCTs, which have a duty to respond to such requests within 20 days;
- The right to refer matters to the local OSC⁴

Over 570 forums were created across England (prior to the reconfiguration of Primary Care Trusts), working with local NHS Trusts. The Commission for Patient and Public Involvement in Health (CPPIH), an independent body, was also established in January 2003 to set up and support Patients' Forums.

Local Involvement Networks (2008-12)

The Local Government and Public Involvement in Health Act 2007 enabled Local Involvement Networks (LINKs) to be established and in 2008 they replaced the Patient and Public Involvement Forums. LINKs covered the commissioning, provision, and scrutiny of both health and adult social care services – a marked change from their former bodies. There was no set structure for a LINK, but the idea was that a LINK would only work effectively if it involved the whole community – representing the views of patients and voluntary bodies. LINKs were more inclusive and flexible in this sense. Anyone could join a LINK, including individuals (such as carers or service users) and groups (such as faith groups or business federations). Each LINK was able to decide its own priorities and how they would operate. Independent of the Government, their funding came from local councils, and a contract 'host organisation' was set up in each local authority area to support the LINK. The NHS Centre for Involvement was appointed by the Department of Health as the lead organisation for guidance about LINKs.

*Current Developments - HealthWatch (2012)*⁵

In 2012, there are set to be further changes to such structures in England. It is proposed that HealthWatch will replace LINKs and be the new consumer champion for health and adult social care in England. It will exist in two distinct forms – local HealthWatch organisations at local level, funded by and accountable to the public via local authorities, and HealthWatch England at national level, which will enable the collective views of people who use the NHS and social care services to be gathered to influence national policy. HealthWatch England will be a statutory committee of the Care Quality Commission (CQC), with a Chair who will be a non-executive director of CQC. HealthWatch England will have its own identity within CQC, but it will be supported by CQC's infrastructure and it will have access to CQC's expertise. HealthWatch England will have three main functions:

- It will provide leadership, guidance and support to local HealthWatch organisations;
- It will be able to escalate concerns about health and social care services raised by local HealthWatch to CQC. CQC will be required to respond to advice from its HealthWatch England subcommittee;
- It will provide advice to the Secretary of State, NHS Commissioning Board, Monitor and the English local authorities, and they are required to respond to that advice. The Secretary of State for Health will be required to consult HealthWatch England on the mandate for the NHS Commissioning Board.

Other

There are other mechanisms which support the involvement of patients. For example, Patient Advice and Liaison Services (PALS) were set up in England following the government's NHS Plan (2000). The Independent Complaints Advocacy Service (ICAS) assists patients or carers in pursuing a complaint about

⁴ House of Commons Healthcare Committee (2007) Patient and Public Involvement in the NHS: Third report of session 2006-07, London, The Stationery Office Limited, p.21

⁵ Care Quality Commission 'Preparing for HealthWatch: CGCs plan to set up HealthWatch England' available from http://www.cqc.org.uk/sites/default/files/media/documents/preparing_for_healthwatch.pdf [accessed on 29/6/12]

NHS care. It is funded by the Department of Health, is free to patients, and is independent of any individual NHS organisation.

1.4.2 Developments in Scotland

Scottish Health Council (2005-present)

The Scottish Health Council (SHC) was established in April 2005 to promote public involvement and a patient-centred approach in the NHS in Scotland. It is a committee of Healthcare Improvement Scotland (previously NHS quality Improvement Scotland), but has a distinct identity, with direct access to the Cabinet Secretary for Health and Wellbeing, and a ministerially appointed Chairman. The SHC core functions and structure were revised in 2010, moving away from a regional focus to establish functional teams with national responsibilities. It is now based on the following functions⁶:

- Community Engagement and Improvement Support: A stronger focus on community engagement; proactive and tailored support for NHS Boards; promoting the development of Public Partnership Forums (see below)
- Participation Review: Supporting NHS Boards to use the new Participation Standard to improve the way they work with patients and the public; establishment of a national team to report on how NHS Boards consult on major service change; providing secretariat and support services to Independent Scrutiny Panels
- Participation Network: A gateway service for NHS Boards to share good practice and develop new approaches to involving people; producing standards and guidance; influencing the development of national policy

The Scottish Health Council is also responsible for providing secretariat and support services for independent scrutiny panels. These are expert panels set up by the Scottish Government to consider proposals for major changes in local NHS services in Scotland.

Community Health Partnerships and Public Partnership Forums (2006-present)

The NHS Reform (Scotland) Act 2004 placed public involvement and equal opportunities duties on NHS Boards. This Act also required NHS Boards to establish Community Health Partnerships. CHPs, set up in 2006, are responsible for delivering all local (non-acute hospital) health and social care services in an area. There are 40 across Scotland and each is comprised of staff from the NHS Board, the Local Authority, and other local planning bodies. Public Partnership Forums (PPFs) are networks of patients, carers, community groups, voluntary organisations and individuals who are interested in the development and design of both local health services and social care services. Anyone who lives or works in an area can be a member, and can take part as much or as little as they like. They provide the main link between local communities and Community Health Partnerships (CHPs).

Local Advisory Councils (2005-2011) and Future Volunteering

Until recently the SHC was comprised of Local Advisory Councils (LACs) in each health board area. They were comprised of around 10 voluntary members, and met on a regular basis to discuss issues pertinent to public involvement and engagement. Roles and functions of LACs included supporting staff with monitoring public involvement activities, serving on NHS working groups and committees, and acting as the SHC's 'eyes and ears' for public engagement in local communities.

⁶ Scottish Health Council 'Volunteering within the Scottish Health Council' available from http://www.scottishhealthcouncil.org/patient_public_participation/volunteering_in_nhsscotland/volunteering_in_nhsscotland.aspx [accessed on 29.6.12]

A working group was established in 2008 to review the LAC role. The review found that volunteer roles were duplicated by staff, by Public Partnership Forums (PPFs) (see above) and other lay involvement structures.⁷ Taking account of the feedback received from the working group the position and role of a Local Advisory Council member ended on 31st March 2011. According to proposals set out in the discussion document 'Volunteering with the Scottish Health Council', the system of local groups is to be replaced by a single pool of volunteers, which would be connected to specific activities on an 'as required' basis. The intention is that the volunteers will have a dual role offering an internal view on the SHC activities and functions as well as providing views on national health policy issues.

Other

The Patient Rights (Scotland) Act 2011, which gained Royal Assent on 31st March 2011 aims to improve patients' experiences of using health services and to support people to become more involved in their health and healthcare. The provisions of this Act include a duty to publish a Charter of Patient Rights and Responsibilities and the establishment of a Patient Advice and Support Service (see below). Work is currently underway to implement the Act.

Citizens Advice Scotland also runs the Independent Advice and Support Service (IASS). There are IASS caseworkers in every Health Board in Scotland who deal with concerns and complaints about any NHS service. IASS is available for anyone who uses the NHS and supports patients, their carers and families in their dealings with the NHS and in other matters affecting their health.

1.4.3 Developments in Northern Ireland⁸

The Patient and Client Council was established in 2009, replacing four Health and Social Services Councils. It is a regional body with 5 local offices. The role of the PCC is:

- To represent the interests of the public by expressing their views on services.
- To engage with Health and Social Care (HSC) organisations to ensure that the needs of the public are addressed by HSC services.
- To promote the involvement of patients and the public in the planning and delivery of HSC.
- To assist individuals in making complaints regarding their healthcare or social care.
- To promote advice and information to the public concerning HSC.

The Patient and Client Council has a Board made up of a Chair and sixteen non-executive directors, recruited from across Northern Ireland under the Public Appointments Process. The role of the Board is to set the policy and direction for the Patient and Client Council as well as monitoring its progress and performance.

Membership is open to anyone living in Northern Ireland and individuals are able to sign up on line. Local Advisory Committees have been set up in the five Health and Social Care Trust Areas. Each committee is chaired by a member of PCC Board and is made up of 8 local people, whose role it is to advise the Patient Client Council on issues in the local area.

1.5 COMMUNITY HEALTH COUNCILS IN WALES

Community Health Councils in Wales have remained since their establishment in 1974. However, they have been subject to a sequence of reviews and re-organisations.

⁷ Scottish Council Foundation (2008) The Local Advisory Council Role of the Scottish Health Council: Submission to the Chairman's working group, available from <http://www.scottishhealthcouncil.org> [accessed on 29.6.12]

⁸ About the Patient and Client Council available from <http://www.patientclientcouncil.hscni.net/about-us> [accessed on 29.6.12]

CHC Federations

In 2000 the National Assembly for Wales introduced a new structure for the CHCs in Wales – CHCs were grouped together into nine Federations as follows:

- North West Wales Federation
- Conwy Federation
- Clwyd Federation
- Dyfed Federation
- Powys Federation
- Iechyd Morgannwg Federation
- Gwent Federation
- South Bro Taf Federation
- North Bro Taf Federation

Shortly following this, After Today Management undertook a review to assess the effectiveness of the Federation models. The review found that the work of the CHCs varied remarkably across Wales, the implementation of the Federation concept had been very difficult and that there was very little, if any, monitoring to demonstrate what value for money the communities received. The review argued that the predominance of loose or non-effective Federation arrangements illustrated that, when given discretion and in the absence of direction/prescription, the majority of CHCs sought to minimise change and as far as possible maintain the status quo.⁹

2010 Re-structure

Until 2010, there were 19 CHCs in Wales. However, the Community Health Councils (Constitution, Membership and Procedures)(Wales) Regulations 2010 replaced these by 8 CHCs. In 2009 the Minister for Health and Social Services in Wales proposed the need for a more consistent approach, which was fit for purpose within the new NHS in Wales. Initially it was proposed that 7 new CHCs were to be created, and supported by 23 'Area Associations' that would have strong local links.¹⁰

However, the notion of 'Area Associations' were rejected. Following two consultation phases in Wales, the initial proposals were amended and the following key changes were included in the proposals¹¹:

- The dissolution of 17 of the existing 19 Councils.
- The creation of six new CHCs, one in each of the new LHB areas (with the exception of Powys), the boundaries of the CHC to be co-terminous with those of the LHB.
- Each of the six new CHCs to consist of Local Committees, the boundaries of each Local Committee to be co-terminous with its corresponding Local Authority. Each of the six new CHCs to delegate functions to its Local Committees.
- Each Local Committee to have twelve members, and members of the Local Committees to be members of the CHC.

Table 2 below provides a summary of the 8 CHCs which remain today:

⁹ After Today Management (2002) National Assembly for Wales Independent Review of the Structure and Staffing Arrangements for the Community Health Councils in Wales: Report

¹⁰ Welsh Assembly Government (2009) Proposals on the Future of Community Health Councils in Wales: Consultation Paper

¹¹ Welsh Assembly Government (2010) The Reform of Community Health Councils in Wales: Consultation Report

Table 2: A Summary of the 8 Community Health Councils in Wales

| Community Health Councils (CHCs) | Local Committees | Office Premises | Members | Staff ¹² (WTEs) | Population | Complaints Advocacy Budget | Total Budget ¹³ |
|----------------------------------|------------------|-----------------|------------|----------------------------|----------------|----------------------------|----------------------------|
| Betsi Cadwaladr | 6 | 3 | 72 | 16.59 | 681800 | 248399 | 788619 |
| Brecknock and Radnor | 0 | 1 | 12 | 2.33 ¹⁴ | 131700 | 58226 | 248796 |
| Montgomeryshire | 0 | 1 | 12 | 3.39 ¹⁵ | | | |
| Abertawe Bro Morgannwg | 3 | 1 | 36 | 9.43 | 502900 | 118230 | 403760 |
| Hywel Dda | 3 | 3 | 36 | 10.26 ¹⁶ | 374600 | 92405 | 456932 |
| Aneurin Bevan | 5 | 1 | 60 | 11.7 ¹⁷ | 560400 | 133849 | 503689 |
| Cwm Taf | 2 | 1 | 24 | 5.22 ¹⁸ | 290100 | 63745 | 272436 |
| Cardiff and Vale of Glamorgan | 2 | 1 | 24 | 7.83 | 470800 | 99970 | 366545 |
| TOTAL | 21 | 12 | 276 | 67.18 | 3012300 | 814824 | 3040777 |

Following the restructure of 2010, the Minister for Health and Social Services stated her intention for the arrangements to be reviewed after two years of operation. This report outlines the findings and recommendations from this review.

1.6 STRUCTURE OF THIS REPORT

The remainder of this report falls into two sections. Chapters 2 to 10 summarise the evidence collected by the team, drawing on all the material described above. Chapter 11 draws conclusions from this evidence, relating to each of the terms of reference, and Chapter 12 make a total of 17 recommendations.

¹² Includes complaints advocacy staff

¹³ Includes complaints advocacy budgets

¹⁴ Includes 0.5WTE CO / Does not include IMCA/Mid Wales Advocacy as not funded by CHCs/WG

¹⁵ Includes 0.5WTE CO (share CO with Brecknock and Radnor CHC)

¹⁶ Includes 1 WTE Office Manager on career break

¹⁷ Includes projects managers (2x7.5hours)

¹⁸ Amendment made – removed 0.43 WTE office manager

2 ROLES AND FUNCTIONS OF CHCS

According to the Regulations governing the operation of CHCs, there is a clear definition of their functions. Paragraph 26 (1) states that:¹⁹

It is the duty of each Council to scrutinise the operation of the health service in its district, to make recommendations for the improvement of that service and to advise relevant Local Health Boards and relevant NHS Trusts upon such matters relating to the operation of the health service within its district as the Council thinks fit.

More specifically Paragraph 26 (2) goes on to identify three specific functions that were laid down after the reorganisation of CHCs in 2010. Thereafter each CHC must have regard to the need:²⁰

- a) *for systematic, continuous engagement with the local population and community groups within its district, in order to appropriately represent the public's view on the operation of the National Health Service within that district;*
- b) *to consider any proposed new service or service change within the context of such current priorities, resources and governance structures as are notified to it by the Welsh Ministers; and*
- c) *for constant evaluation of existing health services in its district.*

But doubt remains in some areas about what is *really* required of CHCs, and therefore about how they should perform their role: *The principles have been blurred. I'd have to ask what does the Welsh Government want the CHC movement to be? What does it really want from its CHCs? (CHC Member²¹)*. It is to this question and a consideration of the benefits and weaknesses inherent in how the three principal areas of CHC activity are currently discharged to which the rest of this chapter focuses.

2.1 SYSTEMATIC, CONTINUOUS ENGAGEMENT

In respect of the requirement for systematic, continuous engagement with the local population and community groups within its district, in order to appropriately represent the public's view on the operation of the NHS within that district, Members stressed the importance of local connections:

Once people have found out I'm part of CHC, in my village, people stop me to complain, in the Post Office etc. where I live. People are concerned. It is a remote area. (CHC Member)

The informal relationships that we have are the crucial things – people know me in my community and will raise with me issues. You need to build hard on your personal contacts. (CHC Member)

Our take is informed by the communities and people that we interact with and this is added to our professional skills – so what we bring is an amalgam of skills. (CHC Member)

¹⁹ Welsh Statutory Instruments (2010) *National Health Service, Wales: the Community Health Councils (Constitution, Membership and Procedures) (Wales) Regulations 2010 No.288 (W.37)* HMSO: p.23

²⁰ Ibid. It should be noted that this chapter does not concern itself with any of the complaints advocacy functions that are a core part of the offer that CHCs make to their local populations. All matters concerning these functions are addressed in a separate chapter.

²¹ Quotations in this report are taken from interviews conducted by the team and from survey responses and other written sources. They are attributed to CHC Members and staff, stakeholders, LHB/Trust representative and others.

Being *at the interface between providers and users (CHC Member)* affords CHC Members the opportunity to combine two roles – *we mediate and reflect to the health board the views of the public – and in addition we reflect the health board proposals and communication to the public (CHC Member)*. It was noted that there are tensions involved in doing this job appropriately: *our job is not to remain dispassionately objective, but to be professional. Not a campaign group, but to form a judgement about the nature of the evidence, the method of communication, and to engage in a constructive dialogue about change that takes into account the needs and wishes of local communities (CHC Member)*. There is good practice in evidence (see boxes below), but respondents were open about some of the issues connected with effective PPE. The emphasis post-2010 has meant, as one Member put it, that: *The whole idea of the CHC changed with the last Minister. Prior to that, it was a bit of a box-ticking exercise. But she had a vision that we should be engaging with the public more – the problem with this is that people tend to focus down on single issues (CHC Member)*. There were two particular consequences identified from this shift. The first related to problems with the capacity and enthusiasm of some CHC Members to undertake the PPE work, and provide credible evidence on the back of it:

It horrifies me that the percentages of activity are so low for PPE activity. Members see the visits as the primary reason for their existence – they are afraid of engaging with groups in their communities and I don't know why. (CHC staff)

I would like to see every community to have a CHC Member there – we are way off that. It would really allow us to find out what local population really think – having ears on ground intelligence gathering. (CHC Member)

The second issue identified related to the training needs of CHC Members to undertake these tasks credibly and in a robust way: *Nowhere in the CHC material does it say that you will be a 'community activist' and have a role in engaging people locally. Also it can be rather frightening at times, so if we are expecting people to do this then they need to be supported and trained to do this. There are some officers and members who are nervy and remain behind the stand (CHC Member)*.

Good Practice Example 1: Health Focus Groups in Brecknock and Radnor (ongoing)

Objective

To establish a mechanism which promotes engagement with service users, allowing them to influence healthcare provision and access to services in their area.

What they did

A Health Focus Group was set up which determines its own work programme by taking particular account of feedback from local people and of major changes/developments. The membership reflects a broad cross section of the community in age, social status, social and medical need. They choose their own chair. The CHC provides support to the forum by providing a suitable venue, producing reports, assisting with surveys and any other Focus Group activities. The CHCs in Powys also provide training to Health Focus Group Members.

What they achieved

The Health Focus Group considers health related issues which are relevant and of concern to the local people. They provide reports and minutes to the CHC for action, encouraging better partnership working with the CHC and the LHB, and improved public engagement.

2.1.1 HARD TO REACH GROUPS

One Member put this problem very starkly: *are we getting in touch with and response from the people that we want? (CHC Member)*. On the basis of the evidence received it is difficult to be certain. Notwithstanding the good practice example in the box below, and that these are problems that also affect the health board and the range of public sector bodies in Wales, CHCs seem particularly to struggle with hearing from a number of specific groups:

Good Practice Example 2: Public engagement in Aneurin Bevan CHC (2010)

Objective

To make it easier for the public to engage with the CHC and to enable a forum by which they can provide feedback on local healthcare services and health related matters.

What they did

The CHC have a Patient and Public Involvement Committee which focussed in 2010 on developing the website as a tool for the public to feedback and comment on various local healthcare issues. Online surveys were posted relating to specific topics. In addition, they have a continuous open online survey inviting the public to give their opinions and experiences of local healthcare provision. The surveys were publicised through local media.

The Impact of what they did

The survey findings were report to the LHB and reports were received on actions being taken to address patient concerns.

What would you spend more time on? Engagement in some of the harder to reach groups would be good. An awful lot of work has to be done but [some groups] are very difficult to engage. The level of engagement you need to make them feel safe, and pursue those issues for them, with no ramifications is massive! Representation on the membership would not solve this problem. As an indication, the number of complainants from [ethnic minority] community in past is very, very few. There is a fair bit of work to be done on the ground with these communities. (CHC staff)

I'd like to see greater engagement with public, in wider capacity. We should have appropriate training to do so, for example – working with deaf communities. (CHC Member)

The key thing is that people have to represent a community. We don't do well at representing any number of different groups, and I doubt that we could even lay claim to being able to have contacts with groups that are able to represent and reach out to them. This is an incredibly hard thing to achieve – but CHCs should be given a target of reaching these communities by a certain date, and if they fail to achieve that then the function of engaging with communities should be taken away from the CHC. I would want to be assured that contacts are being made. (Other)

They have done work with [ethnic minority] groups. I haven't seen them work with homeless or drug and alcohol. We find it hard. (CHC Member)

By way of an explanation for this situation, the demographic profile of the current Membership was often pointed to as one of the key factors: *Because of the average age of the membership of the CHC we focus tremendously on elderly issues, and although there are some who can see other groups, these are in the minority. I totally agree that we need to monitor elderly services, but we need to do more to monitor children's services and many, many others, for example (CHC Member)*. In terms of resolving these problems, working in partnership was offered as a potential solution, particularly given the reach that CHCs

have into local voluntary sector groups: *we have encouraged them to go around third sector partnerships. They are meeting but not doing enough. None of us are doing it enough. We are trying to. We are getting better. In context of engagement this is something for us all to look at. We could do it in partnership in future – getting out to these groups (CHC Member).* Rather pragmatically, one Member suggested that whilst aspirations for a more inclusive dialogue were right and proper, a more needs-based approach to the problems was appropriate: *If we are going to be representative of [ethnic minority] communities there are ways to link in to find out. We don't need everyone around the table – we just need to be switched on to their needs (CHC Member).* Others, however, contested whether the current homogenous CHC Membership would understand the needs of different communities, and why such an approach (inevitably second best) should be accepted. These issues are explored further in the discussion on membership.

Good Practice Example 3: Engaging with hard to reach individuals and groups in Cardiff and Vale CHC (2011)

Background and Objective

The previous Minister for Health and Social Services requested that CHCs engage with individuals and groups who find it difficult to have their views heard or have the ability to influence healthcare provision. The CHC has tried to engage with these groups in society and in particular with the homeless to try to gain an understanding of their particular health related issues and how this client group access healthcare provision.

What they did

The Chief Officer visited a night shelter and breakfast run and spoke with service users on their experiences of healthcare. The CHC, in partnership with the Wallich Charity, developed a survey to ascertain the homeless views on their experiences of accessing healthcare and health related issues over the last twelve months. The survey was distributed across the night shelters in the area. The survey was spun out to other CHCs – although some were unable to participate at this time due to pre-existing planned activity.

Impact of what they did

A report on the findings made six recommendations on how to improve access to health care services for the homeless in the Cardiff and Vale of Glamorgan UHB and Cwm Taf LHB areas. The report also suggested that CHCs identify mechanisms to monitor services for the homeless and that further work be undertaken on how they can access secondary care without having a permanent address. It is hoped that this survey will be carried out all Wales basis in the future.

2.2 SCRUTINISING PROPOSED NEW OR CHANGED SERVICES

In terms of considering proposed new services or service changes, there was again a mixed report on the effectiveness of the current discharge of this function. At the heart of being able to deliver good quality scrutiny of the kinds of changes health boards are currently making, was the ability to analyse proposals independently. For most Members, maintaining such independence was not difficult, but a minority struggled with what they saw as the tension between operating 'within the NHS', and yet being critical of parts of it:

Can you be member-led and a statutory body at the same time? No, because there are limitations and boundaries on what members can do. There's also always the chance that you can 'go native'. (CHC Member)

The health board is responsible for giving the information – but we need to have the information from all points of view so that we can offer a balanced view to people. But we need to guard

against being an apologist for the health board, because you are trying to explain a variety of different points of view. You rarely say ‘the CHC think...’ because we don’t frequently have a line on something. It puts us in a rather ambivalent role. (CHC Member)

How can you be a critical friend and work to align ourselves with ‘Together for Health’? We are not the puppets of the Welsh Government, and we are fiercely independent. This is part of the problem – we are not here to bomb out everything that the Government is trying to do and we recognise that things are difficult (CHC Member)

The scrutinising role played by CHCs was likened both to the tasks allocated to the House of Lords in respect of new laws that are potentially coming into statute – *we’d look at anything proposed, evaluate it and see whether there are positives and whether there are unseen negatives, it’s independent scrutiny a bit like the House of Lords does with legislation (CHC Member)* – and slightly more prosaically to the job of those governing educational establishments – *a lot of good work is done in a non-confrontational way, it’s a role very similar to a school governor (CHC Member).*

Both health board and CHC respondents identified that these scrutiny relationships often work best when there is a degree of engagement at an early stage in planning processes which allows CHC Members to comment to best effect and avoid potential problems that can come later: *they [CHC] are part of the planning group and this is much more professional. They made comments on our operational plan. Some of it is about infrastructure – when they have given comments it’s been pretty good and valuable. They have sought clarity on some issues. This is good because these are documents for the public domain. It improves our communication with the community (LHB/Trust representative).* Indeed on occasion the timing of a challenge from people outside the health board scrutinising data can be very effective:

Picking up trends is important. They [CHC] come to a sub-committee of board, identifying a trend of things not being dealt with which are a major issue for staff. In this way they [CHCs] can be a very powerful tool. You have to be careful and question the validity of what they say but if you pass this test it can be very helpful. Where were the red flags in Mid Staffs? When you’re in the environment it’s easy for people to become desensitised to things. CHC help this and there is value here. (LHB/Trust representative)

2.3 CONSTANTLY EVALUATING HEALTH SERVICES

CHC Members and staff often report that the constant evaluation of the quality of local health services is their core *raison d’être*:

We should be about the views of the patients. You need to do this in a critical way and focus on their experience – this is a big part of what we do. (CHC Member)

The role of CHC is to monitor, talk to those lying on trolleys, to go in and speak to them. We get intelligence from speaking to people – intelligence that the health board hasn’t got. (CHC Member)

If the NHS was a profit making concern, the customers would be the most important source of information on how to make the product more sellable. That is what the CHC does, it makes the connection so the product is a better fit for the consumer (CHC Member)

We’ve got to get back to why we’re here. We’re here for the patient and we have a statutory responsibility to make sure that the needs and voices of all patients are heard. You need the local knowledge in order to represent the patient’s voice. (CHC staff)

A crucial part of this work centres on the formal annual Hospital Patient Environment (HPE) survey that the Welsh Government requires all CHCs to undertake, and more locally determined monitoring visits to hospitals, GP surgeries, pharmacies, dentists and other premises that CHCs make, often to follow-up on the HPE visits. There was a variety of viewpoints about these types of visits. The following three quotations –

one from a CHC Member, one from a CHC Member of staff, and one from a stakeholder – are broadly representative of the views of many others. Two are in favour of such visits, and one less so:

To be the public guardian and to look after patients' interests, we do need to make these visits – it is very important, perhaps now more than ever, that we go in unannounced, and not that we give five days notice. (CHC Member)

One to one of inspections are invaluable. Its information you couldn't get in any other way. When you triangulate what information the members get from staff – crucial information that doesn't come through the NHS – and match this with complaints and enquiries it's powerful. For example we had a number of enquiries from people telling me they had to sleep in their coats because it was so cold. We can get in there straight away. (CHC staff)

There may be a role but I'm not sure it's an inspection role. There is a place for bringing fresh air and a different perspective from volunteers. If they did scrutiny rather than inspection that would be better. They could develop a sense and feel for an organisation without a clipboard. Could they do something to pick up on the look, smell and feel of the organisation? It would be about taking this intelligence and then doing a dip-test. (Stakeholder)

There was one particular issue raised in relation to this area of CHC work – the ability of CHCs to hear more of the 'patient voice' in their activities. This was felt to be crucial in order to add to and go beyond what is currently being done in order to enhance the quality of their work: *one of the things missing from the HPE survey is the voice of the patient. The truth is that we might do better with speaking to patients about their experience rather than looking at the environment of the place. We should speak more to patients about how their experience has worked for them (CHC Member)*. However, there were two problems identified with doing this effectively. The first concerned the timing of the activity, and the acknowledgement that patients *don't like to complain when they are on the ward (CHC Member)* and that this has an impact on the way in which data can be collected. Suggestions were made for gathering information at a later date – *it would be good to have the ability to see people after they have been discharged...so that you lose the 'halo' effect (CHC Member)* – or by using proxies for the patient when it was not possible to speak directly to them – *sometimes patients can't speak because of their conditions, so we could communicate with the patients' relatives a lot more (Other)*. However, as with PPE, there appears to be concern that these data gathering visits are not as inclusive as they should be, and struggle to hear all voices equally:

There is a need to record the 'minority' opinions whose voice is rarely heard mainly because they are never asked and where they are approached there are no appropriate procedures to be able to meet their communication needs. All patient monitoring exercises must proactively seek and record the views of non-white, and non-English or Welsh speaking patients – in relation to the demographic of its area. At such visits, BSL and relevant language interpreters must be available to communicate with patients whose first language is not English or Welsh. (Stakeholder)

2.4 NEW AREAS OF ACTIVITY

On the fringes of these three core areas of activity, the Review team heard about the willingness of CHCs to move into new areas of activity, but with some significant barriers blocking their progress. One such area concerned NHS patients who are residing in nursing homes, a group which was included under CHCs' remit in the 2010 reorganisation. There have clearly been some legal issues in relation to this, but Members expressed impatience with the time taken to resolve these problems, and a desire to get a much better idea about what is happening with this important group as soon as possible – *this a big chunk of what is missing (CHC Member)*. In addition, engaging with the full range of NHS 'premises' was also seen as important:

We know that we have to do more with GPs, dentists, pharmacies and care homes. We get some co-operation but not compliance. There are always things within the gift of organisations to change rather than putting up barriers to change. (CHC Member)

It is difficult to engage with practice managers and get meeting with the right people. It takes a very long time to build up the kinds of relationships you need for people to take you seriously – we need to move past the ‘busybody’ label which just gets in the way. Things like equalities duties can actually help the GP surgery and we can help them to help the patients. (CHC Member)

Finally, the integration of health and social care was also noted as a challenge and an area for future development of CHC activity: *there is a much broader agenda than just health – it’s health, well-being and social care. We need to be careful that we’re not just perceived as an organisation that deals with monitoring and inspecting health institutions. There is an argument that we should be looking at social care – with appropriate resources (CHC Member).* Others argued, however, that there was still much to be done within the NHS without extending the remit of CHCs further afield.

2.5 CONCLUSIONS – PRIORITISING EFFECTIVELY

Whilst a range of views were offered on the pros and cons of current activity, it was difficult to quantify the resources that CHCs devote respectively to their three core CHC functions. However, Betsi Cadwaladr CHC keeps accurate records across their six local committees of the activities of Members. They categorise Members’ work as follows:

1. Attending conferences or workshops;
2. Working at home reading documents, working on reports etc.;
3. Attending CHC meetings whether for the full Council, or other sub-group meetings;
4. Going to locality meetings which typically are the local committee meetings;
5. Attending any other meetings with organisations outside the CHC;
6. Undertaking monitoring visits and related activities;
7. Working on the annual Hospital Patient Environment (HPE)²² survey whether in respect of planning, undertaking visits or doing follow-up work;
8. Doing Patient and Public Engagement (PPE) events or other PPE work; and
9. Attending training sessions.

Looking across these categories, Table 3 provides an indication of the proportion of time spent against each of these nine categories – Figure 1 underneath represents the same data graphically.

This data is instructive and whilst it would be tempting to extrapolate these figures to the rest of Wales in order to see how Members nationally are spending their time, caution needs to be urged – the different priorities of the CHCs would probably lead to different patterns and priorities. However this is an interesting insight into where the resource of time is being used in one CHC, and the breakdown between the three core responsibilities as identified in the Regulations.

Whilst it is not possible to report on the specific circumstance of other CHCs, it is fair to say that there was considerable discussion of the relative priorities afforded to different areas of the current CHC work programme. Opinion on this matter was divided. Some respondents spoke out strongly for the current emphasis on HPE, visits and monitoring: *we need to be careful about how we think about the role of CHCs. It easy to think that we only focus on low-level issues, but it only takes a couple of systemic failures –*

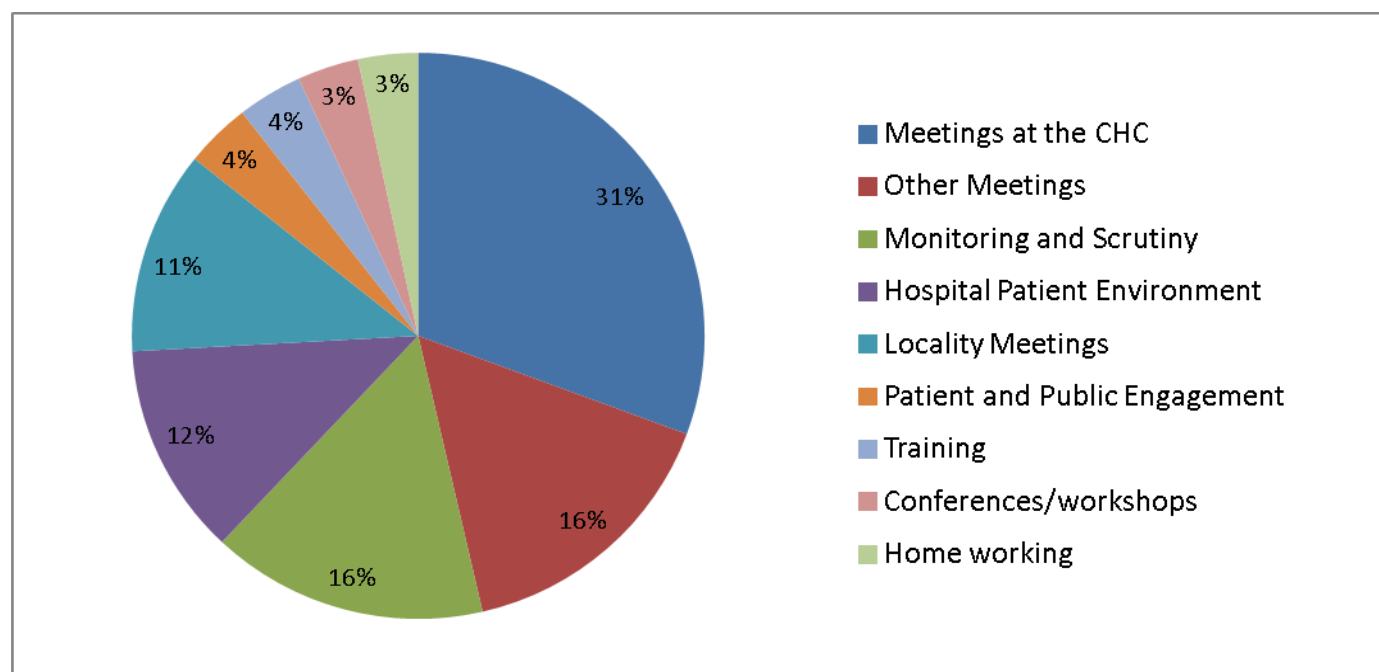
²² It should be noted that CHCs are required to undertake the annual HPE survey by the Welsh Government.

nursing issues, skills mix ratios etc – before things escalate very quickly. We're good at bringing people on board and using their insights and for the CHCs to try and get in there (CHC staff). However the majority felt that the current split of resources (both time and financial) needed to be reconsidered in order to optimise the impact that CHCs could make:

Table 3: Allocation of members' time by activity for Betsi Cadwaladr CHC, 2011-12

| Activity | Hours spent (total) | Proportion of time (%) |
|-------------------------------|---------------------|------------------------|
| Meetings at the CHC | 2276.2 | 30.6 |
| Other Meetings | 1171.0 | 15.8 |
| Monitoring and Scrutiny | 1163.3 | 15.7 |
| Hospital Patient Environment | 899.2 | 12.1 |
| Locality Meetings | 862.6 | 11.6 |
| Patient and Public Engagement | 275.7 | 3.7 |
| Training | 274.2 | 3.7 |
| Conferences/workshops | 257.8 | 3.5 |
| Home working | 252.3 | 3.4 |
| TOTAL | 7432.2 | 100.0 |

Figure 1: Proportion of members time by activity for Betsi Cadwaladr CHC, 2011-12



Source: Betsi Cadwaladr CHC

The key role is to try and make things better for the patient, even though many would see their role as trying to stop things getting worse for patients. Much of the activity and many of the things that are done in meetings is fundamentally not about achieving this aim and CHCs need to look at all of their activity and ask if it will help patients, and if not, then not do it. (CHC Member)

There's a danger that we spend far too long picking up the bits that nothing need be done about – the trivia. We always ask the nursing staff whether there was anything they want to be put down on the form that would improve the patient environment. (CHC Member)

In terms of the monitoring and visits, it is difficult to know whether we are getting the best return out of what are relatively low-level issues. (CHC staff)

Should we be focusing more on the response to the service people get and gathering evidence, and spending less time and resource on HPE? (CHC Member)

We can only achieve a visit to a GP surgery every three to four years which isn't going to make much difference. (CHC Member)

Overall, and whatever the relative priority given to different activities, there was a strong feeling that making best use of the evidence collected was an over-riding concern: *we need to do a better job in balancing the evidence that we hear and we have to get smarter about having regular dialogue with different sectors of the community and using the evidence intelligently to maximise the impact (CHC Member).*

3 OPERATIONAL STRUCTURES OF CHCS

The first of the terms of reference asked that the Review team ‘undertake a root and branch review of the governance of Community Health Councils and, in particular, to make recommendations on the operational structure’. There is much to consider in this regard, and therefore the focus in this chapter is upon CHCs themselves; structural issues at the national level are considered in a different chapter.

Two particular issues are addressed here. The first concerns whether there should be any changes to the current structures, including the lack of co-terminosity between Powys tLHB and its two CHCs, and the structure of Local Committees. The second considers whether the current operational structures enable or inhibit optimal ways of working – both within and between CHCs.

3.1 POSSIBLE CHANGES TO CURRENT OPERATIONAL STRUCTURES

3.1.1 POWYS

There are currently two CHCs in Powys. This is a long-standing arrangement which the consultation paper on the last reorganisation of CHCs set out to address. The document from January 2009²³ proposed that the two CHCs covering the geographical area of Powys – Montgomeryshire CHC and Brecknock and Radnor CHC – should be merged to become Powys CHC constituted of the North Powys and South Powys ‘Area Associations’.²⁴ After the consultation period the response from the then Minister identified that:

*Having listened carefully to what has been said, and in the absence of any strong consensus around any one particular model for change, I am persuaded, for the time being, that CHCs should be allowed to develop proposals for joint working and be given time in which to demonstrate that they can work together. That will require the collaboration of those CHCs that lie within each proposed LHB area. I will therefore be asking all CHCs to come forward, by the end of July, with proposals for joint working that will be operational by October, and I will expect to see workable solutions. I will also exempt the Powys CHCs from these immediate requirements because of the particular issues under discussion between the county council and the local health board, although I will expect them to continue to develop joint working as they would normally.*²⁵

On the basis of a mixed response and a lack of clear consensus, in December 2009, the Minister then opened another consultation period and by that stage was resolved to dissolve: *seventeen of the existing nineteen Councils. It is my intention to leave the arrangements for the two existing CHCs in Powys in place for the time being while the details of the future working relationship between the Local Health Board (LHB) and the Local Authority there are developed.*²⁶ It was emphasised in the Consultation Report that followed that despite representation from those in similarly rural parts of Wales to Powys that they should retain their CHCs, this was refuted:

²³ Welsh Assembly Government (2009) *Proposals on the Future of Community Health Councils in Wales: consultation paper* WAG: Cardiff – January <http://wales.gov.uk/docs/dhss/consultation/090130communityhealthcouncilsen.pdf> - accessed June 2012.

²⁴ The proposed ‘Area Associations’ from January 2009 evolved through a variety of processes to become the current ‘Local Committees’.

²⁵ Welsh Assembly Government (2009) *Proposals on the Future of Community Health Councils in Wales: consultation report* WAG: Cardiff – May, pp.6-7. <http://wales.gov.uk/docs/dhss/consultation/090604consultationreporten.pdf> - accessed June 2012.

²⁶ Welsh Assembly Government (2009) *Consultation on the Reform of Community Health Councils in Wales* – Letter from Edwina Hart AM, Minister for Health and Social Services, dates 7th December: <http://wales.gov.uk/docs/dhss/consultation/091209chcconsultationletter.pdf> - accessed June 2012.

The proposal for the retention of existing CHCs arrangements in Powys attracted some comments with some respondents suggesting that similar arrangements should be retained in other rural and dispersed areas of Wales. We should re-iterate that the rationale for the keeping the two existing CHCs in Powys is that the plans for the future working arrangements between the LHB and the Local Authority there are currently being developed. Following the outcome of those deliberations, we will give further consideration to the CHC structure in the area.²⁷

As of now, it appears that little has happened in substantive terms regarding the merger of the health board and local authority in Powys, and this is no longer under active consideration. The rationale for the retention of the two CHCs therefore no longer applies. In addition, the Review team heard from a variety of different people that there was seemingly little reason why the two CHCs in Powys should remain in their current form. It was argued that the two could easily become one CHC, with the caveat that the two areas retain local committees and as such benefit from 24 Members across the county:

In manpower [sic] resource terms there's a general view that there should be one CHC in Powys. There should be two offices, and two area committees – it's the best way forward. (CHC Member)

I see both Powys working more closely now. I can't see any reason to have the two. (LHB/Trust representative)

It's not about empire building. For some reason, Powys wasn't part of the restructuring. At the time there were some pretty strong members, and a reformation would not have worked. This is maybe why. That logic doesn't apply now. The one health board might find it easier to work with one CHC. Personalities have enabled us to work well with them well. Powys hasn't experienced what larger CHCs have. I have not witnessed reluctance in existing members travelling, but I'd say you still need two physical offices. Spending time travelling isn't the most efficient use of time. A base close to the health board is important, but a base in the north is useful. So one CHC, two local committees, but not necessarily using traditional boundaries. (CHC staff)

Is there a need to have two separate CHCs in Powys? It would not cause problems to formalise the change that has happened informally. (CHC Member)

3.1.2 LOCAL COMMITTEES

For a number of CHCs in Wales, the local committee structure works well, allowing representation from relative geographically dispersed populations to contribute to the collective decisions of CHCs. However, for those CHCs that are more spatially compact – particularly Cardiff and the Vale, Cwm Taf and to a limited extent certain others – there is a case that was put to the Review team that the local committees have become an administrative hindrance rather than an enabler. There were three reasons given as to why there should be much greater discretion and flexibility over the structure and number of local committees. The first concerned the current diseconomies of scale associated with having too many committees in too small an area:

We started off with a local committee every month – with the full council bi-monthly. It was a bit of a waste. We'd go through the agenda but didn't feel like we were getting to grips with anything. Now the local committees only meet on six monthly basis and I think we are going the right direction. (CHC Member)

Local committees might be fine in certain areas, but one of my issues would be the prescriptive nature of them. We are required to have them and when you have a relatively compact area like

²⁷ Welsh Assembly Government (2010) *The Reform of Community Health Councils in Wales: consultation report* WAG: Cardiff – January, p.7. <http://wales.gov.uk/docs/dhss/consultation/100102chcconsultationreporten.pdf> - accessed June 2012.

ours the local committees duplicate things. It needs to be changed – it is not helpful – we want members to work as one team. For every 1 CHC Member in [area] there is 4,000 population. Whilst [area] only has two members – 1 for each 50,000! The structure is a nonsense. (CHC staff)

All the staff moved to one site in December 2010 including the advocates. We saved nearly £75,000 when we moved. We have a streamlined structure now and it is a natural progression and evolution for us to become one organisation. The advocacy service has always been across the two and it has all helped bond team together. The members work across whole patch and we are one cohesive team that integrate fairly well. That is why the members are of the view that they don't want local committees – the rationale for two has gone. They think its duplication of effort, discussing the same things at meetings. For example, the business manager spends 98% of her time typing minutes. She has five committees to look after. (CHC staff)

Finally, it was noted that there are considerable similarities across these areas – and that the ties that bind are much more powerful than any perceived differences that are reported to exist:

Do you need local committees? We're relatively close and working together anyway? I know they say there are issues to your specific patch but if I'm absolutely honest I'm not convinced. (CHC Member)

Having two local committees is nonsense. We're serving the same population at the end of the day. (CHC Member)

I came to the CHC two years ago. We're still not there as a cohesive unit. The issues are not that vastly different. I'm sure the same health concerns are there. We need to get rid if this. Whilst we have two local committees we are still holding on to this. We are one CHC, we need to be one CHC. (CHC Member)

3.1.3 HOST ORGANISATION

Because of their particular legal status, CHCs need a 'host' organisation to ensure proper accountability for public funds, to act as the employer of CHC staff, and to provide certain specialised support functions such as Human Resources and Finance. The support provided in finance generally appears to have worked well, but HR support has sometimes struggled to be timely and appropriate to the unique circumstances of CHCs. The situation has been further complicated by the distance between staff in Powys tLHB and the national Board (with whom they relate most often):

We're hosted by Powys health board and it's not ideal given that we are based in Cardiff. It's a logistical issue really. Velindre could be a better option. If have to get their HR to look at things it's very difficult because they are so far away. We can only support CHCs to certain point because of this. (CHC staff)

There has also been some ambiguity about the level of service to be provided under the service Level Agreement which governs this relationship, and also about respective roles:

Leases are currently signed off via the Welsh Government. This is in the regulations but could it be delegated to Powys? I don't know – would they have expertise? Yes perhaps. How would they do searches? But it could just be another thing they wouldn't do that well for us. We have had problems in past with them with HR. They are not that supportive. (CHC staff)

There may be merit now in exploring whether another NHS organisation could provide more appropriate support for CHCs.

3.2 CULTURE OF WORKING WITHIN AND BETWEEN CHCS

More broadly, there were a number of issues raised on the subject of the prevailing ‘cultures’ of the CHCs. There were three ways identified in which tensions and other problems arising from these different methods of working came to fruition.

The first of these concerned the way the different approaches of local committees affected the overall performance of CHCs. Of particular concern was the fact that the ‘them and us’ mentality that might have characterised the pre-2010 structure has not resolved itself satisfactorily. That is not to say that this is a problem everywhere for that would be to significantly overstate the case: *the biggest thing for us was that we had to get in our head that we are no longer [locality]. We joined as supporters of our own area. Personally, I found it difficult but I am embedded in now. We would have preferred to stay separate. It was a bit of struggle at first, but I feel like we have got there. I’ve come in and feel integrated as a [CHC] member (CHC Member)*. Others have been able to work across thematic areas – *one example of how we’ve come together is the mental health group – we’ve set one up across the CHC local committees, and there is potential for others such groups to be set up across the CHC (CHC Member)* – however it is a fact that where extant internecine conflicts have developed unchecked, there are some significant problems in the Local Committees working together as a corporate whole:

Tensions are still there across the localities in the CHC. In the past, the whole CHC would vote on service change. Now the executive do this. [Area] never understood/accepted that the executive had this function. In [areas] there’d be a good structured debate and they would put forward a good case to the executive. So they would be hard pushed not to go with local views. (CHC Member)

The current configuration doesn’t work – it’s politically pretty but the locality issues are so different, and the communities so varied that this renders a unified and agreed CHC position untenable. It’s just too difficult to get people to sign up to a line. The structure gets in the way of people wanting to talk to the CHC – ‘how can we talk to you when you think something that is so difficult for us to think about?’ The advantages of the CHC as currently configured are not worth the disadvantages that are inherent in the system. This is partly a function of the cultural barriers that people put up – members are very locally focused and even though there may be a compelling case for change, it is somewhat tribal. This is exacerbated when you appoint people to a locality – when the executive sits it feels that three different areas each fighting for their corner and when we get into the difficult decisions, this could be a recipe for disaster. (CHC Member)

The size of the organisation and having local organisations is a weakness. We don’t like the ‘us and them’ thing that has happened. We have tried to set up a virtual single office so that people coming into us have a single entry point. People still think about a [local] CHC, which is an annoyance. (CHC staff)

There are clearly structural and organisational reasons to account for these tensions, but there are also much more deeply embedded cultural factors that contribute in certain parts of Wales: *There are two parts to the CHC and we haven’t overcome this – the Welsh part of the council and the English part of the council. It may not be a problem for [local committee] but this is an issue when we come to the full council. If you are more comfortable in speaking, thinking, feeling and conversing in Welsh then you should be allowed to. There is a perception among the CHC Members that speaking in Welsh is a cost and that we are made to feel that we shouldn’t be using Welsh. There has been very little cohesion between the different parts of the council, and it is difficult to ensure that we are representing the views of the whole (CHC Member)*.

The second set of issues that stem directly from the current organisational structure focused on the ‘Member-led’ nature of CHCs. The two quotations are representative of the ‘schools of thought’ on

this matter – there are those that feel the balance is too heavily in favour of the Membership, and others who feel that the relationship between staff and Members is somewhat sub-optimal:

Being “member-led” is a problem – we need more staff to lead the work and then who could draw upon a volunteer workforce accordingly, because at the moment you are bound by members interests, far too much of which is on the ‘holy city’ syndrome of the hospital. This wouldn’t need to extra money – some of it could be found from doing less chasing around and management of volunteers. (CHC staff)

I resigned as a member after one year because I was so frustrated. I actually saw nothing done in that period. The reasons for this enormous failure are linked to the organisation. The paid officers state that as a “member-led-organisation” they cannot order anybody to do anything and the old-hand members remind them that the officers are subservient – sometimes in a very rude and unacceptable manner. (CHC Member - retired)

Finally, there were a number of people who commented on the ‘cross-border’ issues that face both CHCs and their concomitant health boards, and indeed the positive way in which issues can be dealt with: *the CHC structure reflects that of the health boards in Wales...the fit is not, of course, perfect. For example, [area] patients are cared for in facilities managed by [health board]. This has been dealt with through discussion between the relevant CHCs (CHC Member).* Issues have arisen recently in the context of the South Wales service plan, where the CHCs of the region are in the process of developing an appropriate means of coordinating their input. Another challenge is of longer standing, where a population routinely depends upon more than one LHB to meet its healthcare needs: *when I’ve tried to engage people locally there are some problems at the boundary between [health board] and [health board] because they can’t see the relevance. Issues at the boundary are always interesting and patients in those localities will need to look both ways – and so do we. These boundaries will always be problematic, and these are internal and external to the health board and the CHC (CHC Member).* Another dimension centres on the issues that cross not just health board but both disciplinary and national boundaries:

Each area has its own problems and with a board that is trying to see the whole piece, this is irreconcilable. It’s just too diverse – in the south we should be linked more to Bristol and in the north to Liverpool rather than linked all together. We’ve all got different problems and therefore very different solutions – the variation of problems means that people will see things differently. (CHC Member)

I have found that health board structures restrict the CHC’s work – two examples of this are below. The first is to do with representing the interests of [area] patients in the reorganisation of [health board] services. This is difficult because the respective responsibilities of the health boards are indistinct. The tone of the relationship between the boards is competitive (for resources, self-determination) rather than collaborative (finding a solution which serves a community’s needs). The second is to do with the way [health board] is organised. It is structured around clinical disciplines which run across the entire organisation. I understand the reasons for this. But the people and structures which bear responsibility for delivering local services are still at a very early stage of development. This means any query about local services has to go to a Board manager and is then farmed out to another quite senior person for a response – which is sometimes delayed, often quite formal and over complicated. People expect the CHC to be able to find out about operational problems: we need to be able to make ‘question and fix it’ calls to someone who is in a position to respond immediately. (CHC Member)

3.3 CONCLUSION

In general, the transition from 19 to 8 CHCs, and the creation of local committees, has worked well, and the difficulties anticipated by some observers in 2010 have been avoided. However, the different

circumstances of different parts of Wales – such as varying population density, travel times, degree of shared NHS provision – have led some CHCs to struggle with conflicts of local identity, and to evolve different ways of working within common structures. The anomalous position of the Powys CHCs now requires resolution, and there is merit in considering how the relationship with the ‘host’ organisation for CHCs – the Powys tLHB – might now be improved.

4 COMMUNITY HEALTH COUNCILS – THE NATIONAL ROLE

4.1 INTRODUCTION

When CHCs were re-organised in 2010, the roles and responsibilities of the national Board were clarified and strengthened. The consultation document made clear that the Board would have a governance role, ensuring that individual CHCs discharged their functions appropriately, and would also coordinate the work of individual CHCs to address issues of all-Wales significance:

The Minister is of the view that the Board of Community Health Councils in Wales continues to have a key role to play in ensuring that:

- *CHCs have consistent standards in collecting and disseminating information;*
- *CHCs are supported in carrying out their functions by robust governance arrangements, including policies and procedures;*
- *collective decisions taken by the Board are accepted and acted upon by all CHCs – whilst this cannot be enforced in regulations, CHCs would be expected to abide by collective decisions unless there were clear and reasonable grounds for not doing so;*
- *an all-Wales response can be delivered in applicable circumstances;*
- *assistance is available in the resolution of difficulties;*
- *problems that cannot be resolved locally are referred to the Minister; and*
- *staff and members are treated fairly and given the support they need to carry out their role.*

It would be the responsibility of the Chair of the Board of CHCs in Wales to advise the National Advisory Board of the key issues of concern to patients and the public with respect to the planning and delivery of health services in Wales²⁸.

In short, CHCs were to be largely self-governing, with the Board providing the key overarching mechanism for this, so that the Minister did not need to intervene in the work of CHCs.

This chapter reviews what is now clear about the reality and perception of the roles of the Board, how it has discharged these functions, about the composition of the Board, and about areas for possible further development.

In relation to the Board's governance role, the section of the consultation document quoted above also pointed to an issue that has subsequently become a point of contention: while CHCs were expected to follow the leadership of the Board, this would not be required in Regulations. Accordingly, in due course, the Regulations stated that the role of the Board in relation to governance was primarily to monitor, advise and assist:

- advising Councils with respect to the performance of their functions;*
- assisting Councils in the performance of their functions;*
- representing the collective views and interests of Councils to the Welsh Ministers;*
- monitoring the performance of Councils with a view to developing and ensuring consistency of standards by all Councils;*

²⁸ Welsh Assembly Government (2009) *Proposals on the future of Community Health Councils in Wales Consultation Paper* Cardiff: WAG pp 12-13

- e) *monitoring the conduct of members appointed under regulation 3 with a view to ensuring appropriate standards of conduct;*
- f) *monitoring the conduct and performance of officers employed under regulation 23 with a view to ensuring appropriate standards of conduct (32(2))*

This apparent gap between the intention and the word of the Regulations is also explored in this chapter.

4.2 WHAT SHOULD BE THE ROLE OF THE BOARD?

There is general support for the existence of the Board, and acceptance that its functions are those set out in the consultation document and Regulations: ensuring the optimal functioning of individual CHCs, through a mixture of developing and sharing good practice, training, and regulation; providing a national voice for patients' and the public's interest in health services; and coordinating and developing the work of individual CHCs to maximise collective efficiency:

I view them [the Board] as quite positive – 1. They are there as the national voice (we are not always best equipped to do that in local CHCs) and 2. They're there as a buffer to the Minister (CHC Member)

There is considerable disagreement, however, about how - and how well - several of these functions have been discharged, and therefore about how they should now be improved, and about how the Board would be best constituted.

Each of the main functions of the Board is now explored in turn.

4.3 GOVERNANCE

4.3.1 How should governance be exercised at the national level?

While there is general acceptance of the need for a national body of some sort, there is marked disagreement about precisely what role it should perform. Broadly, there are two alternatives. The first is essentially a 'bottom up model', which stresses the accountability of the national board to local CHCs, and measures its value largely in the extent to which it supports the work of individual CHCs:

I understand that Welsh Government and other organisations find it useful to have a single organisation with which to 'speak' and the Board fulfils that function. But the Board has to be of value to CHCs as well and it is not, in my view. I believe it would be more effective to establish a common services agency for CHCs which would provide corporate functions (financial management, HR, communications, procurement, training) and support CHC policy development on an all-Wales basis. (CHC Member)

The role, as presently operated, means that CHCs have very limited room for independent action. In the past two years I have asked for some movement of funds between budget heads, the creation of a communications post from part of a vacant administrative post, amendments to the person specification for a post, for member involvement in the staff appointments process, for very basic financial management information – all of which have been denied because the Board 'does not allow for that'. There has been at least one occasion when the Board has issued a news release on a controversial matter without telling local CHCs what it was saying, much less asking whether they agreed (we did not)... I understand why it is helpful to have an umbrella organisation – but if it does not serve CHCs well, then it is just a convenient arrangement for Welsh Government and other national stakeholders. I believe that CHCs would benefit from having a common services agency. A service level agreement would set out the expectations of CHCs and the agency. The terms of the agreement could be amended, where necessary, to suit the requirements of different CHCs. There

are a number of options for then collating and representing the views of CHCs in Wales, and for sharing effective practice between CHCs. (CHC Member)

There is very little value in the National Board – what does it actually do for us? Why should it continue? It needs seriously to be reshaped for purpose. It needs to pay much more heed to the local issues that inform what the purpose of the CHC organisation actually is. It needs to do much better at sharing good practice. (CHC Member)

Proponents of this view are often disturbed by the fact that the Board Director is managerially accountable to a senior civil servant (the the Government's Chief Nursing Officer), seeing this as incompatible with 'bottom up' accountability.

The alternative view – more 'top down' - is that the national Board should so brigade and direct the work of CHCs that they operate as a cohesive whole – almost as one CHC for Wales:

If it were one CHC for Wales, you'd need to work at the locality level to think about the relationship with health boards. I'm thinking in this way because I want a very strong national organisation. As long as you've got a local presence and a locality presence, that's all that matters.(CHC staff)

The former values local independence and action, the latter the gains that come from collective action:

I think there is value in saying we don't do things by consensus – we performance manage. We would gain from more powerful central direction. (CHC staff)

In reality, of course, the Board as it is currently constituted is neither wholly one nor the other, but a bit of both. Its composition – for example, most members are there by virtue of being CHC Chairs – emphasises the consent of the CHCs (bottom up), while the regulations and Ministerial pronouncements tend to emphasise the need for uniformity of standards and the value of coordination (top down). This element of institutional schizophrenia has made the Board rather timid in the past two years, with neither camp satisfied with the result.

4.3.2 How well has governance been exercised since 2010?

The national Board has not exercised decisive leadership over some of the more contentious governance issues. For some, there has been progress in the past two years:

The restructure has been a good thing... [the Board] makes it easier to advise, assist, negotiate the eight CHCs. [I've] noticed a significant difference. A lot more on Board, doing things nationally....I've seen a dramatic difference (CHC Staff).

But for many others, the Board itself has operated ineffectually, with little clear sense of its role, and an inability to address the most contentious governance challenges it has faced:

The role of the National Board is not at all clear. The members who were on the National Board treated it as a glorified talking shop. But the real problem is that the officers feel that the National Board is for them, and not for the Members, which is a real problem. (CHC Member)

The CHC National Board meetings are ineffectual – they do nothing in any strategic manner or do anything to tackle the governance issues. The role of the CHC National Board and the Director needs to be much more clearly defined, and in this instance the CHC National Board has not even discussed this issue let alone be proactive in trying to do anything to make things better. (CHC Member)

The National Board is a glorified and vacuous talking shop – it can give some good presentations – which is yet again being dominated by Chief Officers. As a member-led organisation the Chairs are recognising that if it is a talking shop (which is the perception) they will not bother going. (CHC Member)

The Board is not fit for purpose. It doesn't meet as 'board': you have an audience and presentations. This is not what board should do – it should be there to make strategic decisions and set direction. I felt it needed to be structured' (CHC Member)

The dilemma facing the Board can be seen in the way in which the issue of individual CHC Members' conduct has in some cases not been satisfactorily resolved. For the vast majority of members, of course, no issues of conduct have arisen – and where they have, most have been dealt with immediately, either by the prompt advice and guidance of the Chief Officer, or occasionally through a mechanism whereby senior Members convene and offer their advice. However, where this has not occurred, and the Board Director and Chair have become involved, issues have still not been resolved. There have been disagreements about the extent to which CHC Members can be active participants of local health campaign groups, and over what constitutes a declarable 'conflict of interest'. The position of local authority-nominated CHC Members has been contentious in a small number of cases:

The issue is about the way in which CHC Membership is reconciled with other alliances or 'memberships' – how do you deal with a county councillor speaking as a county councillor, even though he happens to be a CHC Member? Where do you draw the line in governance terms? Carol had taken legal advice and this didn't provide clarity (CHC Member)

There is a real tension between holding personal views about certain issues and then being required as a CHC Member to be impartial... Many of the people who belong to pressure groups have a genuine concern. The complication of local authority members is not insignificant either, especially given the timing of the recent local elections... It is very difficult to answer when personal views become incompatible with CHC Membership, but there has to be a process for deciding – and at the moment there is an unhelpful relationship with the National Board [which] doesn't do anything to resolve and clarify the situation.(CHC Member)

The Board certainly has tried to resolve these issues, but as a result of the different perspectives on the issue (which in turn reflect the different views on CHCs outlined above), and insufficient traction, the issues remain.

Another example of the Board's inability to provide leadership has been in the use of individual CHC performance indicators. These should be a key mechanism by which the Board discharges its responsibility in the Regulations to *monitor[...] the performance of Councils with a view to developing and ensuring consistency of standards by all Councils*. Unfortunately, in practice, the indicators in use focus on process measures rather than the impact of the CHC, are poorly quantified and expressed (making measurements very difficult), and are not part of an effective planning and monitoring regime:

The performance indicator document has no quantitative performance indicators! They're just statements of complaints. It's rubbish. The Minister couldn't judge CHCs on this. I'd be terribly embarrassed if it were mine. You could easily have a score card for each CHC and engage in friendly competition. There's money to be saved! (CHC Member)

I am on the working group that set them up – there are still holes in them... there's nothing here about the impact we are having... We approved these, we have to start somewhere, but it's difficult to get one size which fits all... I think what we need to do is have a performance tool of what we have... achieved for patients. (CHC staff)

The assessment of CHC performance should focus on the influence a CHC has on the development and quality of health services, and on the way it has gone about that work. At present, performance assessment is based on processes (is there a business plan?) and the quality of relationship with the health board – as self-reported by the health board and the CHC! At present, the answer to the question ‘what are we getting for our money’ can only relate to these narrow, and not very helpful, measures. That said, our CHC has tried to devise performance measures which might stand up to some scrutiny from the public and to collect information which would allow it to demonstrate its value for money. (CHC staff)

I have no idea how they are performance managed, whether they have targets. As a member of the public I’d want to know if the CHC are doing a good job, but there’s no way of showing me this – there’s nothing to judge them on in my area. (LHB/Trust representative)

Many senior staff described a performance management approach with undemanding indicators and little sense of central accountability, which gave considerable latitude to individual Chief Officers, and in practice was not capable of holding CHCs to account:

I think there is value in saying we don’t do things by consensus – we performance manage. We would gain from more powerful central direction. If you had one person line managing all the Chief Officers, it doesn’t stop a degree of local determination. That’s part of normal process of objective setting and corporate business. (CHC staff)

Amongst most members with whom we spoke, the level of awareness and understanding of the role of the national Board was low:

If I’m honest we have no knowledge what board does and how they affect us. (CHC Member)

This perhaps in part accounts for the lack of interest in – or in many cases even awareness of – the recent (uncontested) elections for Chair and Vice Chair of the Board.

4.3.3 How should governance now be improved?

Many of the people who discussed these governance issues with us were clear that the Board needed to use its authority to inspire and challenge CHCs to improve their performance. This should embrace particular ‘techniques’ such as the use of effective performance indicators, but many of the comments were also directed at the style of leadership of the Board:

I don’t think the idea of governance is resolved... The Chair of the National Board needs to be much more proactive. (CHC Member)

You get strong individuals who seem to run the show, with their own issues, but also there are individuals who need training in governance. They are appointed from very different areas of work, with no idea of how governance works (CHC Member).

If this CHC does not do what it’s meant to do, the Board should see to it. Processes – such as the code of conduct for members and Chief Officers – none of these have been invoked. The solution - you have to have the courage of your convictions, that leadership is so crucial. Timidity is the issue (CHC staff)

This should also include a systematic assessment of whether CHCs were following good practice:

Central to them all is an explicit framework for quality assuring practice (i.e. making sure that the practice really is good), measuring the extent to which organisations adopt and sustain good practice, with associated and relevant rewards and sanctions. (CHC Member)

The other key question was whether the Regulations, with their emphasis on assistance and advice, effectively tied the hands of the national Board and deprived it of the authority it needed to exercise its governance functions. Most people recognised the strength of this issue, and accepted that the current Regulations were not ideal:

There are some problems with the line management of the Chief Officers – does the Director have a strong enough hand and able to deal with the issues of autonomy? Initiatives have failed in the past because of these problems. (CHC staff)

The Director can't say you MUST do this. The Board decision should be final. But CHCs can turn around and do something different. (CHC staff)

The regulations as they currently stand leave the National Board in a bit of a hole – they don't give the Board sufficient powers – it says 'assist' not 'direct' and if they are to be the parent, let them be the parent rather than the collegiate approach that we have at the moment. (CHC Member)

However, many also felt that this limitation could perhaps be reduced with the sort of clear and determined leadership described above:

The issues that we have experienced here could have been resolved with a more forthright approach... in getting the right people around the table, drawing a line in the sand, and then making the key players work together – it wasn't managed appropriately. (CHC Member)

Several people also made the point that more decisive language in the Regulations would not on its own endow the Board with authority: it would still need to be earned through effective leadership. It was also clear that the resolution of some of the more difficult relationship issues between CHCs and LHBs also required action by the LHB concerned – and some LHBs were more effective than others in developing these constructive relationships.

4.4 COORDINATING AND DEVELOPING THE WORK OF CHCS

In addition to its governance role, the national Board is also charged with helping CHCs carry out their work more effectively and efficiently. Three aspects of this have become important in the past two years, in addition to administrative support: coordinating the efforts of individual CHCs (so that learning is shared and impact multiplied), providing added value services which can be used by all CHCs, and the training of members.

There have been some good examples of coordination of effort, where one CHC has pioneered work in a particular area, which has then either been used by others, or repeated where local information was required. But there are relatively few such examples:

We have done this work on stroke services, which was extremely well received and mentioned in 'The Telegraph'! Next we're going to do frailty. The CO of ABM approached us to say he was interested, and the two areas are working together very well. But this is an isolated example.... this comes once again back to the board - so much could be done. Having been in senior management...one gets cross – it's a missed opportunity! (CHC Member)

Good practice includes the excellent survey work undertaken by AB CHC in stroke care, the interface between Complaints trends and monitoring in AB CHC, and the involvement with BME communities in CAVOG CHC. Much good practice is already shared on a national level through the work of the Board, the all-Wales management Team and other staff fora. (CHC staff)

In other examples, individual CHCs have decided to pioneer work in particular areas with very little communication with the Board or other CHCs, with the danger that good experience will not be effectively shared.

There's a gap in our knowledge – you would expect that the National Board of CHCs could have shared good practice around things like dealing with significant issues like distance and complexity (CHC Member)

Chief Officers meet once a month. We do share best practice but we don't have anyone bringing it together. We are local, and we can't be expected to know what's going happening on a national basis. We can highlight trends, they will go to the national board and they will contact others elsewhere to see if there is anything else. We did this recently with waiting times. There has been an issue collating the data. So whilst we share best practice but there isn't that cohesiveness across the rest of Wales. There's enough of a workload locally! (CHC staff)

There have also been some 'added value' developments pioneered by the national staff. A lot of work has been done successfully to provide ICT links and shared platforms between CHCs, for example, and there has been some interesting exploration of the use of 'e-members' – people who are prepared to share their experiences and views with the national staff using email and other links. There is certainly much scope in this latter initiative to provide a cost effective and more inclusive basis for engagement with the public than would be possible in other ways, although the development has not had sufficient resources to exploit its potential to the full:

There were at one stage 300 e-members, obtained from variety of sources. [We] use ex citizens panels, and have worked with local authorities to do this. Whenever a consultation comes through [we] let these people know. But it's a scatter gun approach – no resources to find out anything about them as [we] only have an email address. When they have a view they will get in touch. Get between 2-7 responses per consultation. (CHC staff)

The development and coordination of the national Hospital Patient Environment External Assessment Programme (separately funded by Welsh Health Estates) has been another major example of a national initiative (see good practice example 4).

Good Practice Example 4: Hospital Patient Environment Assessment Report

Background/Objective: The Hospital Patient Environment External Assessment Programme was set up in 2003 following the publication of the document *Improving Health in Wales*. All Welsh CHCs were tasked with monitoring non clinical criteria in a hospital setting and reporting their findings to the Minister for Health and Social Services. The assessment is undertaken from a patient perspective and considers how their experience could be improved.

How it works: The assessments are undertaken by voluntary members of the CHC with support from HPE staff. The assessment is undertaken on an annual basis and assesses eighteen acute hospitals and a selection of minor acute and community hospitals. The assessment covers five main areas: External areas; Entrances and main reception areas; Corridor, lift and stair areas; Wards; and Department areas. The chosen criteria to be assessed are announced to the hospital on the day of the assessment. After the initial assessment, if an area scores unfavourably the CHCs agree with the NHS organisation what action needs to be taken and a timeframe in which to achieve this.

Benefits of the HPE: A comprehensive annual report is published on the findings of the assessment and suggests recommendations on improving the patient experience in the five areas assessed. The CHC undertake follow up activity with the NHS organisation to ensure progress is being made in areas of concern within the agreed timescale. If progress is not being made, and CHCs have exhausted engagement at a local level, CHCs can escalate the respective issues to the Welsh Government for assistance in bringing about a resolution – although to date this has not happened. The HPE Assessment programme has dealt

with a whole range of issues since its inception in 2003, and has sought to improve issues, from a patient perspective, such as cleanliness, public transport, security, smoking in entrances, signage, helpfulness of support staff etc.

Training of members is the other main function discharged by the Board on behalf of all CHCs. Much of the training is provided centrally to a common curriculum, and this is supplemented locally. In general, Members value the training they receive, while having various suggestions for its further improvement. The principal weakness has proved to be the reliance on a small staff resource to deliver much of this training, which has led to significant gaps when the member of staff most involved has been off sick:

Training is an issue as we only have one training officer for the whole of Wales. I was trained immediately when recruited but a delay in being trained can hinder people's involvement. (CHC Member)

We should have a requirement that there is a 3-month period when the initial training has to take place. This is softened by the fact that we 'informally' train people locally and they are supported and mentored. (CHC staff)

We need local and flexible induction packages, and not necessarily by the national trainer from the national board. (CHC Member)

The national staff also lack any depth of expertise in analysis and research skills, a function which could prove useful to CHCs. The Board used to employ a researcher, but more recently there has been little attempt to forge links with others – such as HEIs – to fill this gap:

We don't have staff with a research capability... They wouldn't have the capacity to take on lots of different bits of work from different CHCs. (CHC Member)

4.5 THE NATIONAL VOICE OF PATIENTS

The final element of the Board's role is to present a collective view on issues of health policy and delivery to external stakeholders, including Welsh Government, regulatory and inspection bodies of various sorts, and the public and media. The Board has responded successfully to many requests for help in this regard, providing timely, reliable and efficient feedback, including on the recent consultation on changing the law on organ donation, and the GMC's work on fitness for practice:

The... Board has been hugely supportive of the work of the GMC in regulating doctors and ensuring good medical practice in Wales. The Director... has sought to give the CHCs, and therefore patients, a voice in GMC work and activity, for which we are very grateful. (GMC)

The national board of CHCs has been very good in being part of Healthcare Summits. (HIW)

There have been fewer examples of the Board taking a more proactive role, placing items on the national agenda which have emerged from CHCs' own intelligence and analysis. There is some frustration that CHCs are not as effective as other bodies in this regard, and are not capitalising on their unique intelligence basis and local knowledge:

Not enough published by the Board – for example, the Ombudsman's case book is really useful. We don't see the same from CHCs. There is no national picture or trends document. It gives it teeth if it comes back nationally, collating intelligence. (CHC Member)

The [Older Peoples Commissioner's] Dignified Care Report – we go back to this all the time. It was well written. Local, national, balanced. CHCs could have written that years ago, but didn't. (CHC Member)

The Board is not influencing at a national level. We have moved some things on but its issue based and process stuff. Not policy. Each HIW report, for example – it has very different impact/status. We can't do this because they get too bogged down by local issues. (CHC Member)

There is a concern that the Board's evidence base is often not sufficiently robust and credible, and evidence not well enough presented, to ensure that its voice would be respected and influential:

To produce a Dignity in Care report you need authority, accountability and autonomy. We don't have all three... As a national body they don't take that on. Have to be given platform for that. We cannot have local issues (lady down the road) discussed nationally. Comes down to what data they have – needs to be evidence based. (CHC Member)

[Name of organisation] welcomes the role of the BCHCW in representing the collective views of the CHCs to the Welsh Government. CHCs have the potential to provide significant and useful feedback about the impact of government health policy for policy makers and politicians. What is less clear is the extent to which this feedback has been delivered in a systematic fashion and in a form that is transparent and accessible to patients and other citizens. (Stakeholder)

The lack of a national work plan may also undermine the ability of CHCs to capitalise on their inherent strengths:

I think partly it is the tension between local and national. We don't pick up national issues. it is one of big issues that bugs me. We don't say our theme this year is X. Aneurin Bevan looked at stroke service, no one else did. and stroke should be one of our major areas – it's a big issue in Wales. Golden opportunity to have single issue. We should be pooling resources – the Board could drive that a bit more. (CHC Member)

4.6 COMPOSITION OF THE BOARD

Many of the people who discussed these issues with us as part of this review argued powerfully that the composition of the Board was an obstacle to the optimal discharge of its functions. In part this was an argument about ensuring that the Board had the right mix of skills and experience to carry out a high profile and complex set of responsibilities, combining difficult governance issues with ensuring an effective external face, and a concern that the current system could not be relied upon to deliver this demanding mix. Several people argued that the Board should, in part, be appointed:

If you're going to be a Board you have to have the right skills set and the balance of representation – but the members of the Board should be partly appointed. You need to establish the core values that you need, and the proportions between elected members of the Board and the appointed members of the Board can be decided. (CHC Member)

This is a function of the set-up of the board as well as the lack of leadership skills across the national board staff ... Should the Chair of the CHC Board be a public appointment? Maybe, because the current situation is one of weakness. If the right person was appointed this could work.

I couldn't disagree with appointing the chair of the Board idea. We should have somebody to front up the organisation who is well known, well respected (CHC Member)

A strong appointed Chair to the National Board would help the Director of the Board by leading them and providing cover for making very difficult decisions (CHC Member)

You'd have to have a big hitter at head of the organisation... That is the Chair, not the Chief Exec. There is a role for a 'patient commissioner'. You'd need to look very hard about what would happen locally but publically appointed patient commission would be very good. Being public spokesperson

doesn't always sit nicely with running organisation – need a model with a manager working with them (CHC Member)

We need to be national brand, household name; a person can be the brand (CHC Member)

There was a more specific concern that the current arrangement, whereby the eight CHC Chairs are joined on the Board by a directly-elected Chair and Vice Chair, can lead to three people sitting on the Board from a single CHC area. Appointing the Chair would also address this issue:

We've had a chairman and vice chair from same the same CHC, plus a representative on the Board from that CHC. They had 3 votes out of 8/9 people, which is not appropriate. This has changed now, but this could happen again. Yes it would be fine to have a Chair not involved in a CHC, having someone independently appointed would be feasible... (CHC staff)

There was also some concern that the Board Director was managerially accountable to a senior civil servant (the Chief Nursing Officer), which some argued might (in reality, or in appearance) compromise the Director's independence:

The governance at this level is frankly unbelievable – you cannot have a Director who is line managed by someone who is looking at their next career step within the NHS or civil service. This doesn't work well for either party – if this relationship became public knowledge this would fundamentally challenge the position of CHCs as an independent voice, which would be detrimental. (CHC Member)

Finally, there was some concern about resources: did the national Board have sufficient staff to carry out its role? Opinions were divided on this issue, with some Members and staff arguing that, if resources were scarce, they should be dedicated to the *local* work of CHCs, while others pointed to the pressures on the current national staff, including the lack of a Deputy to the Director. However, until the issues about role definition, priorities and relationships are addressed, it is difficult to determine appropriate staffing levels.

4.7 CONCLUSION

The national Board is one of the more controversial aspects of the 2010 CHC reorganisation, with much evidence that it has not performed its key functions – governance, coordination and development, and providing a national voice for patients - as well as might have been hoped. This is clearly in part because of the way it has been established – the Regulations are not entirely consonant with the Minister's original objectives, it is not lavishly resourced, the composition of the Board is not ideal, and the relationship with key external stakeholders on matters of administration and HR have not always been efficient. The result has been a leadership which has not always felt itself able to tackle key issues, and has not asserted its responsibility to hold CHCs to account for their performance. This has been compounded by a culture described to us by one insider as more resembling 'a gathering of feudal barons' than a unified movement collectively responsible for speaking up for patients and the public in Wales. Despite all this, the Board and its staff have responded well to requests for patient and public engagement at the national level, have provided a well-regarded training function for Members, and have facilitated some joint working and learning from experience.

Finding a satisfactory resolution to these problems is now one of the key elements in helping CHCs to improve their collective performance in the future.

5 MEMBERSHIP

5.1 INTRODUCTION

The terms of reference asked that the Review team ‘undertake a root and branch review of the governance of Community Health Councils’ and, in particular, to make recommendations on both the ‘membership structure and the appointment processes’ and ‘making effective use of Third Sector and Local Authorities membership’. The review heard more about membership than any other single issue, and therefore much of this chapter is based upon data collected via interviews and site visits. There was a range of topics underneath this broad heading including the different categories of members, the diversity and number of members; and the recruitment and appointments process. Thoughts about new forms and types of members were also shared with the review team and are discussed below. Where appropriate, reference is also made to the Regulations (2010) and the evidence submitted to the Review team.

5.2 NUMBER OF MEMBERS

5.2.1 Allocation of Members

The number of members allocated for each CHC across Wales, following the restructure of CHCs in 2010, raised concerns within CHCs – particularly around the reduction in numbers, but also the allocation of members across the areas which are geographically very different. For example one member stated that ‘Cardiff has 350,000 population, much bigger than other areas...[it is] so blindingly obviously wrong’ (CHC Member). Others comments focused on the demands of large and rural areas:

Because of the size of the travelling and the size of the area that we cover the number of members is not sufficient. (CHC Member)

The reorganisation of CHCs means that one local committee (Gwynedd) is not responsible for the work of two predecessor committees. It covers a very large geographical area and there are simply not enough people, even with co-optees. (CHC Member)

Table 4 below demonstrates the relationship between population size and number of members for each CHC:

Table 4: CHC populations and membership

| Community Health Council (CHC) | Local Authority Area/Local Committee Area | Population ²⁹ | CHC Population | CHC Members | Population per member |
|--------------------------------|-------------------------------------------|--------------------------|----------------|-------------|-----------------------|
| Abertawe Bro Morgannwg | Bridgend | 134200 | 502900 | 36 | 13969 |
| | Neath Port Talbot | 137400 | | | |
| | Swansea | 231300 | | | |
| Aneurin Bevan | Blaenau Gwent | 68600 | 560400 | 60 | 9340 |
| | Caerphilly | 172700 | | | |
| | Monmouthshire | 88000 | | | |
| | Newport | 140400 | | | |
| | Torfean | 90700 | | | |

²⁹ 2009 mid-year estimates, Source: Office for National Statistics

| Community Health Council (CHC) | Local Authority Area/Local Committee Area | Population ³⁰ | CHC Population | CHC Members | Population per member |
|--------------------------------------|-------------------------------------------|--------------------------|----------------|-------------|-----------------------|
| Betsi Cadwaladar | Anglesey | 68800 | 681800 | 72 | 9469 |
| | Gwynedd | 118800 | | | |
| | Conwy | 114400 | | | |
| | Denbigshire | 96700 | | | |
| | Flintshire | 149900 | | | |
| | Wrexham | 133200 | | | |
| Brecknock and Radnor | Powys | 131700 | 131700 | 12 | 10975 |
| Montgomeryshire | | | | 12 | 10975 |
| Cardiff and Vale of Glamorgan | The Vale of Glamorgan | 124600 | 460800 | 24 | 19200 |
| | Cardiff | 336200 | | | |
| Cwm Taf | Rhondda Cynon Taf | 234400 | 290100 | 24 | 12088 |
| | Merthyr Tydfil | 55700 | | | |
| Hywel Dda | Ceredigion | 76400 | 374600 | 36 | 10406 |
| | Pembrokeshire | 117400 | | | |
| | Carmarthenshire | 180800 | | | |

There was much discussion about the appropriate ratio of members to population, with many arguing that the key issue was the balance between resources as a whole (including Member numbers) and ‘workload’, the latter being a function of a complex set of factors including population size and diversity, travel times, and volume of NHS provision. No easy solution emerged, since ‘workload’ was difficult to measure, and there was little consensus about what level or type of workload was optimal.

5.2.2 Capacity Issues

Capacity was evidently a significant issue across many CHCs due to long standing vacancies and inactive members. At site visits the review team were informed of large numbers of vacancies across the CHCs. It must be noted that in part, this was a result of the delay in completing the current appointment process (which is discussed later in this chapter) and because of the transition period during the local elections (delaying the re-appointment of Local Authority members). To exemplify, Betsi Cadwaladr reported a total of 24 vacancies across its CHC (a third of its membership) and Aneurin Bevan reported 12 (one fifth of its membership). The following quotes illustrate the issue further:

There are not enough members locally – we have five fewer members than needed and this is because we are waiting for appointments to be made. We’ve never had a full complement of members so we don’t quite know how effective we could be. (CHC Member)

If anyone resigns [the place] stays vacant....don’t know when the next recruitment will take place. (CHC Staff)

County Councillors are often clashing with the CHC meetings [so] you lose a quarter of the membership...the voluntary members often have competing priorities...you find yourself with a shortfall (CHC Member)

³⁰ 2009 mid-year estimates, Source: Office for National Statistics

It was not just vacancies that created capacity issues within the CHCs. In fact, there were many members who contributed less time than their colleagues to the work of the CHC. This resulted in excessive workload for others, who commonly worked over and above the notional 3-5 days per month; *A critical mass of 8 or 9 members seem to be doing most of the work...it does rely on totally dedicated volunteers (CHC Member).*

Several members argued that a larger membership would not only help the CHC to perform its functions but could also help increase the diversity and representativeness of the CHCs.

Co-opting members helped CHCs combat their capacity issues to an extent, but this arrangement was unsatisfactory. Co-opted members needed to be re-appointed each year, and some felt 'second class' to full members. Anyway, the co-option category was not intended in the Regulations as a way of boosting *general* membership, but was reserved for situations where CHCs needed specific additional skills or capacity.

5.3 DIVERSITY OF MEMBERSHIP

5.3.1 Current Diversity

The Minister was clear in 2010 that in future CHCs would 'need to be more consistently representative of the public they serve ... drawing on the talents of more local people from all sectors of the community'.³¹ This recognised that lack of diversity in membership is a long-standing problem for Welsh CHCs.

However, it is evident that CHC Membership still remains disproportionately white, older and middle class. The review team was not able to access specific data on the current diversity of CHC Members as this information is not routinely collected by the Board or Welsh Government. However, Welsh Government did confirm that the latest round of public appointments had failed to attract or appoint a diverse range of members: *The vast majority of people were older, usually retired and predominantly female (Welsh Government).* In addition, there was unanimous agreement from those that contributed to the review that the following groups in society were largely unrepresented on CHCs: young people, black and minority ethnic groups, and the unemployed. It was commonly heard that members were typically white, elderly, and retired, with a professional, and well-educated background.

The review identified several possible barriers to greater diversity in CHCs including the appointment process and the nature of the contribution required:

The process at the moment is too restrictive and excludes groups of people within the community due to the need to meet stringent Public Appointment criteria. (Other)

Despite the rhetoric, membership will likely never be truly representative of communities – typically middle aged to older adults in social classes ABC1 are those with the sufficient interest, time and knowledge to participate. I would reiterate my support for a balanced arrangement between the formal structure and facilitation of local health focus groups. (Other)

The team heard evidence from former CHC Members who were from minority ethnic communities. They described a positive attempt to broaden recruitment, using the County Voluntary Council, but joined a CHC which they then found to be unaware of the experiences of minority communities, and unable to effectively champion the needs of those communities. They resigned from the CHC before their term of office had expired, and were not confident that their experiences were now being used to address the identified problems.

³¹ Welsh Assembly Government (2009) *Proposals on the Future of Community Health Councils in Wales*, Ministerial foreword, p3
Cardiff: Welsh Assembly Government

A further obstacle to diversity was the apparent lack of awareness that working individuals can claim loss of earnings for their work within the CHC; *This is not a well known fact! (CHC Member)*. Even with this knowledge, some felt it was unlikely to work in practice for those in full time employment; *if you were to say to your employer I am a member of a CHC and can I have some time off please...they don't know what CHCs are. They would say do it in your own time. (CHC Member)*

5.3.2 Added Strength of Diversity

A small number of people argued that CHC Membership did not necessarily need to be representative of its community:

Most of us our age have experienced childbirth, hospital...we have experienced life... (CHC Member)

We are a diverse group of people and we understand the different groups of people that we are interested in. That's why we do this – not for any reward but to represent the views of the people. (CHC Member)

There are ways to link in to find out. We don't need everyone around the table. We need to be switched on. (CHC Member)

A more common line of thought was that although it would be an advantage to have a representative CHC, it was not a priority: *You probably can do the task to a large extent without that diversity. Diversity offers an additional strength. (CHC Staff)*

However, the current lack of diversity in the CHCs is a fundamental weakness – a view supported by many CHCs and stakeholders:

I don't think we have enough insight into their views. I went to a meeting yesterday and...I was the only white elderly middle class person. I became so aware of so many problems that people from ethnic minorities have, from general conversations. How can we represent those people? (CHC Member)

They tend to go to their peer group...on whole they are more comfortable engaging with over 50. (LHB/Trust representative)

The type of people who are engaged with the CHC has a significant bearing on what drives meetings....not always balanced. (LHB/Trust representative)

Members are not best placed for PPE and consultation (CHC Staff)

5.3.3 Improving Diversity

A few tried and tested methods for attracting new members were shared with the review team, but the examples given suggested that the task of improving diversity was seen as too challenging. For example, a Junior CHC was set up in one area, but 'died a death' *when they realised it was going to be a bit unexciting...then they dropped away (CHC Member)*. Nothing has been established in its place.

A few possible solutions were put forward in relation to the representativeness of CHCs. A number of people suggested the use of exit interviews to better understand why those who are more commonly underrepresented choose to withdraw from the CHC. It was recognised that increasing the use of social media would attract younger age groups, and good partnerships with employers and schools were important in reaching the unrepresented. Some recognised a need for CHCs to work in new ways, and for the current structures to be more flexible, if greater diversity were to be achieved:

It may be worth revisiting consideration of the 'Area Association' model whereby a core of 12 CHC Members...work with staff to facilitate looser groupings on a locality basis...there needs to be a balance between the present , formal arrangement and a more flexible arrangement which can get closer to the (nigh on unachievable) desired 'true representation' of a community. (Other)

5.4 THE RECRUITMENT OF MEMBERS

5.4.1 Issues

CHCs and Stakeholders acknowledged the importance of a rigorous recruitment process in achieving a CHC Membership base that was both committed and capable. However, it is evident that the onerous requirements of the Commissioner for Public Appointments' Code of Practice for Ministerial Appointments to Public Bodies necessitates an unduly protracted process for the appointment of volunteers:

I want to simplify the application forms, simplify the interview system. We are applying for voluntary posts...we all live in the community and can bring things. (CHC Member)

The recruitment process is not really appropriate...it was like I was going for a grand job for an executive...was far too over the top (CHC Member)

If I volunteer to do something, I want to make a difference. Putting obstacles in the way are not helping people deliver what they want to. (CHC Member)

The process was described as both 'frightening' and 'onerous' by respondents. In fact, many felt that the process was responsible for the low numbers of applicants and the current lack of diversity within CHCs in Wales:

The recruitment process is questionable...we keep recruiting the same types of people..what about heard to reach....and not just single issues. It is something about the interview process. (LHB/Trust representative)

We haven't had a problem getting in co-opted members, but we have with full members. People see the process as quite onerous. The local paper ran a piece and we had over 100 expressions of interest for 19 vacancies...but many didn't proceed to full applications. (CHC Staff)

The long heralded need to reach out to all elements of the community is not something that can be easily achieved and will certainly not be achieved by the stringent standards imposed by public appointments (Other)

5.4.2 Some Improvements

On the whole, the review team heard from respondents that the 2012 recruitment process had improved upon earlier years. For example, CHC staff were now involved in the selection process, and interviews were now framed as 'conversations with a purpose':

The 2012 process...the criteria was [sic] much tighter, the questions were better, the style and approach worked out. (CHC Staff)

The application form was horrendous before, the interview and form this time round was much better. (CHC Member)

However, the new process was not without fault; *Public appointments are all in place pretty much but the process whilst better overall, was beset by tremendous delay (CHC Staff)*. In relation to recruitment and appointments, the recent delay in appointing new members was clearly uppermost in people's minds, and

the process was criticised for seemingly unexplained problems. It was noted that the delay devalued volunteers and had negative consequences for the capacity of CHCs in the run up to a major consultation period in Wales: *One of the problems is that the delay may well cause people to be lost...because in the time it takes to be ratified, people will often have found something else to volunteer for and to do (CHC Member).*

Following enquiries, the review team were informed that in the future the process will take no longer than two months. The requirement for the involvement of staff external to the Welsh Government, after the interviews have been conducted, has now been removed.

5.4.3 Some Suggestions

An indirect criticism of the recruitment process, and an issue closely related to numbers of members (discussed earlier in this chapter) is the level of awareness of CHCs: *Recruiting rather than retaining is the big issue. I'd argue that CHCs are the best kept secret in Wales, and if you're not known, you won't get people interested (CHC Staff).* Following this argument, if the CHC 'brand' improves and awareness increases, then this would in part solve some of the issues raised above. This issue is discussed in greater depth in the professionalism chapter of this review.

One line of thought suggested that the recruitment process be more of a rolling programme, so that there are not large numbers of people joining and leaving at the same time. One advantage of this would be that there would be fewer issues regarding long standing vacancies: *One or two did resign shortly after, but we can't refill them until the next public appointment process. If we could recruit people locally....we know what skills we want, we know what we are looking for. We have work plans ready for them (CHC Staff).* Finally, there was a suggestion that CHCs should work more closely with their local CVCs in order to improve their recruitment processes.

5.5 THIRD SECTOR AND LOCAL AUTHORITY MEMBERSHIP

CHCs are composed of three categories of membership:

1. Three members of each Local Committee are appointed by the relevant local authority; 'A person appointed in accordance with this regulation must be a member of the local authority which appoints him or her'³²
2. Three members of each Local Committee are appointed by voluntary organisations within their area; 'A member appointed in accordance with this regulation must be a member of or connected with the voluntary organisation which appoints him or her'³³
3. Six members of each Local Committee are appointed by the Welsh Ministers.

The feedback received during the review suggested that the appropriateness and the effectiveness of this model, and the local authority and voluntary membership categories in particular, was a much talked about issue and had been for some years: *criticism of the contribution that local authority and third sector members make to CHC work has been an undercurrent of CHC life ever since they were created (CHC Member).* There were a spectrum of comments about the relative merits and demerits of both 'categories' of member. These are discussed below.

³² Regulation 6(2), Welsh Statutory Instruments (2010) *National Health Service, Wales: the Community Health Councils (Constitution, Membership and Procedures) (Wales) Regulations 2010 No.288 (W.37)* HMSO

³³ Regulation 7(5), Welsh Statutory Instruments (2010) *National Health Service, Wales: the Community Health Councils (Constitution, Membership and Procedures) (Wales) Regulations 2010 No.288 (W.37)* HMSO

5.5.1 Added Value

It must be noted that not all of the comments about the different categories of membership were negative. In fact, it was a varied picture; *Overall there are about a third of local authority members that are good, a third are a waste of time, and the others are OK. This is totally out of our control and depends heavily on the make-up of the Councils. (CHC Staff)*

In some areas the potential for local authority and third sector members to add significant value to the workings of the CHC was recognised and the principle of having such members unquestioned: *Healthcare services should not be used in a vacuum and the input of the third sector organisations and local authorities is increasingly important to the work of CHCs and the development of health care services in Wales. (Other)*

It was recognised that third sector membership could prove a useful way to increase diversity and improve wider patient and public engagement:

Voluntary sector representatives work well, and we've got some younger members there. (CHC Staff)

CHC's should increase liaison and consultation with third sector advocacy and support organisations. More often than not these organisations are working with people who have direct and regular contact with services. (Other)

Similarly, local authority members were identified as important links, locally; *I wouldn't necessarily advocate the quota but it's nice to have a stakeholder link and a foot in the door of the local authority. (CHC Staff)*

5.5.2 Commitment

Despite the recognised value of such categories of membership, it was evident that the full potential of these members were not being fully exploited. One of the dominant issues that emerged was the varied level of engagement and commitment from both categories of membership. This appeared to be an even more pressing issue with the local authority appointed members. It was recognised that these individuals may be faced with significant workload pressures and the demands of competing priorities. Inevitably, the absence of members negatively impacted on the workings of the CHC, with many areas coping with long standing vacancies:

Over 9 years I have never known...Councillors coming along or doing any visits...they work full time. It is just too much....we are wasting...three members. [It] puts burden on those [members] which are left. (CHC Member)

There are too few boots on the ground, especially given that the local authority membership is not as present in meetings as others. (CHC Member)

The importance of an interview process was stressed by some, as a means of ensuring a certain level of commitment from members:

If they has some sort of interview process and they were told of the sort of commitment...3-5 days is nonsense...this should all be brought to the attention of voluntary sector members and local authority members. (CHC Member)

5.5.3 Role Clarity and Conflict

Closely related to levels of commitment were issues around role clarity and conflict. In some cases a conflict between roles within the CHC and other responsibilities was alleged:

They talk about their specific localities and bring in political influence... they are not seeing the wider picture. (CHC Member)

The tripartite system was fine in 1974 but I no longer think that CHC Members should be drawn from local authority elected members. They can be torn between different priorities and loyalties. (CHC Staff)

Having County Council members on the CHC can lead to politics playing out in service development decisions or information provided being used for political purposes. Political members will always struggle to remain apolitical. (Other)

People are often linked to one group, with a narrow view. (CHC Member)

Others argued that many of these issues could be effectively resolved by more assertive local leadership and chairing of meetings.

It was noted that there was a level of confusion about the role of the third sector member in a CHC, and that there was a case for greater role clarity: *Voluntary sector will have expertise in a particular service...the (CHC Member) role is very broad...and the expert bit doesn't sit in this very well. I am not sure you can be a generalist as well. (Other)*

5.5.4 Some Suggestions

Individuals put forward a number of solutions for what they saw to be the problems around local authority and voluntary sector appointed membership. Suggestions included appointing more appropriate individuals, providing CHCs with additional powers to fill vacancies, and allowing local authorities to nominate whoever they felt to be appropriate, without the requirement that they be sitting Councillors:

Consideration should be given to different formal roles for the category of members rather than having a one-size fits all – e.g. third sector members should be able to make use of their networks in PPE capacities. Local authority members are positioned to represent the interests primarily of their local ward. (Other)

Where local authority members present a problem frequently, the Chief Officer should have right and power to fill that vacancy in some way. (CHC Member)

I would dump the three Councillors from the CHC...maybe nominate a local authority officer...you could allow the local authority to nominate whoever they want. (CHC Staff)

Some alluded to the potential which different types of engagement could make, in addition to the role of full CHC Members (see next section):

The concept is wrong. If you want local authority input...there are so many other forums that exist (CHC Staff)

I'd be more inclined to have a pool of third sector experts that could be brought in on their issue, and work across areas if they wanted...a voluntary sector liaison committee would be a good idea. (Other)

5.6 NEW TYPES OR FORMS OF MEMBERSHIP

As alluded to previously, in the present system individuals may be discouraged from volunteering for CHC Membership for a number of reasons. Therefore, there is merit in considering alternative ways for people to become involved in the work of CHCs, and adapting current ways of working to improve inclusivity, capacity and diversity:

At the moment we make very little use of volunteers beyond members. We could use people for contained pieces of work. We have a university on our doorstep with lots of undergraduates doing work in social sciences and health. We haven't used this resource. Ideally, I'd like to look for volunteers, but cash issue. (CHC Staff)

Why can't we have arm chair members? Or e-members? [People] we can contact on a regular basis for their views...we would expect them to go to meetings. (CHC Staff)

There were some initial concerns at the prospect of 'non-members' becoming involved with CHC activity: *As a member, you have a code of conduct....you have control over them in terms of what they say in public. My concern would be that if you had a new level of membership you would have issues – patient confidentiality, supervision etc. We are dealing with lay people (CHC Staff).*

To some extent, there is a less 'formal' type of membership – co-opted members. The review has found that CHCs have relied on and valued co-opted members, especially in times of vacancies and inactive members, but the disadvantages of this approach are discussed elsewhere.

5.7 OTHER

5.7.1 Paying Members

Even given some of the difficulties mentioned in this chapter, when asked, the majority of CHCs and stakeholders did not feel that members should be paid for their efforts:

I don't think you can take the volunteer bit away. It is very important. They want to do that...they feel it is their duty. We are trying to build a society that reinforces that. (LHB/Trust representative)

Personally, I would not want to go down the route of members being paid. If that day comes, I'll be off! I joined to make a difference and do something voluntary. (CHC Member)

5.7.2 Eight Year Rule

Regulation 10(2) imposes a life-time limit of 8 years on CHC Membership³⁴. There was some discussion about the perceived effects of this rule:

We have experience, continuity and ability. There should be some flexibility [to the 8 year rule]....you are losing that experience and capability. (CHC Member)

You have lots of corporate memory and skills...you should be able to be some sort of quasi member or associate. (CHC Staff)

³⁴ Regulation 10(2), Welsh Statutory Instruments (2010) *National Health Service, Wales: the Community Health Councils (Constitution, Membership and Procedures) (Wales) Regulations 2010 No.288 (W.37)* HMSO: p.13

5.8 CONCLUSION

This section has discussed a range of interrelated issues in relation to CHC Membership. In some respects, members are one of the CHCs greatest successes – representing well over 200 volunteers who work to improve services across Wales every year. However, the review has found that the membership base of CHCs is not optimal on a number of fronts - it is not representative of the community it serves, there are capacity issues due to persistent vacancies and the input from both voluntary sector members and local authority members is variable. Many of the issues around membership are closely related to how they function and how they are structured.

The lack of diversity in membership is a particular – and long-standing – weakness, which the Minister specifically charged CHCs with addressing. It is disappointing that it has received little determined attention from CHCs, and the lack of monitoring data on diversity is an indication of the priority which this issue has often received.

6 'PROFESSIONALISATION' OF COMMUNITY HEALTH COUNCILS

Another of the terms of reference asked that the Review team 'recommend where and how we need to develop Community Health Councils, including the members, into 'professional' organisations which fit the strategic needs of "Together for Health"'. Before engaging with the substantive content of this chapter it would be fair to note that there was a small number of respondents who felt that their role was not to 'fit' the strategic needs of the Welsh Government, however defined. The people who raised this issue argued that the independence of CHCs should not be compromised by needing to be aligned alongside public policy with which they may disagree.

There were a number of issues raised under this very broad term of reference. In particular there was considerable evidence that the general public were not as aware of CHCs as they should be. There was also discussion about two other areas – the management of Members including their professional development and training; and the mix of qualities and skills that the CHCs have at their disposal.

6.1 RAISING THE PROFILE OF CHCS

As mentioned above, there were many comments about how far the branding and marketing of CHCs had been effective in raising the profile of the role and work of CHCs amongst the general population. There were two principal areas about which the Review team received comments: awareness and visibility; and the name and brand.

6.1.1 Awareness and visibility

There was considerable negativity expressed about the fact that CHCs are not well known, and that the public are confused about their purpose. This is compounded by the fact that respondents typically felt that that CHCs – either locally or nationally – are not doing enough proactively to alter this situation:

We do need to raise our profile and I'm very frustrated. We do what we can and what we signed up to but I don't feel anything is progressing. I don't feel we are very effective and we are not listened to. We're only doing half a job. (CHC Member)

If people say I'm a magistrate, they know who you are. Not for CHC Members. (CHC Member)

There is a real problem about the lack of knowledge that patients have about the role of the CHC, what we are there to do, and whilst if you have time you can explain to people, there is a missing connection and recognition – we're not a household name. This has never been as crucial as it is now. Having never heard of the CHC, it was only after joining the organisation that I have come to realise what the key job of the CHC is. There is very little presence of the CHC in the local press, whereas the pressure groups get column inches. We need to do more about blowing our own trumpet. (CHC Member)

Some people do go out and speak to schools and mothers' groups, but many people are poor at public speaking. But we've not got enough good speakers, and we've not had the right kind of training to give them the confidence to go and speak to patients. Which means it is not effective. (CHC Member)

This lack of public recognition has important consequences. Firstly, there was a broad feeling that whilst CHCs could operate 'under the radar', this was distinctly sub-optimal: *Can we do our job if we're not well known? Yes, but couldn't we do a better job if we were? (CHC Member)*. There was also concern that the

lack of profile means that a good number of people who need the services that the CHC can offer are either not getting these, or they are not getting them at the right time:

Everyone knows the Citizens Advice Bureau because of advertising campaigns. We can't do this and don't get anywhere. It does matter. People might find us if they need us but not always on time. I would like to put adverts in the press. (CHC staff)

I don't know if the public know what CHCs do. I don't think we are really helping this. Judging by the number of concerns via CHC then perhaps they don't know. Other than that, I don't think they understand. (LHB/Trust representative)

In addition, there were also concerns that being unaware of CHCs put in place an unnecessary barrier when it comes to members of the public making contact: *If people knew who we were they would be more relaxed when they speak to us. We go out with stands but no one has heard of us (CHC Member)*. Finally, it was noted that this lack of profile has a knock-on for Membership applications: *You can't apply if you don't know what it's all about. People are always asking what we are and what we do – in the last 18 months or so, we've been much more proactive about spreading the message especially with hard to reach groups, although the easy to reach are still not quite getting it (CHC Member)*.

Thinking more positively, several solutions were identified. Good practice (in addition to the box below) included using the 'captive audience' within hospitals more effectively – *we're using the hospital radio to play a range of snippets about issues that patients have and also publicising the CHC that way (CHC Member)* – or using online methods – *we've developed our website and made links to other websites. The website is pretty good. We've had a fair few hits and done it so that within two clicks you will have the info you need (CHC Member)*. More ambitiously some respondents commented that much more needs to be done at the national level to register CHCs in the public's mind:

A visible national champion would be great. Other organisations are acutely conscious of their publicity and presence. A new identity that says what we do would strengthen the public voice. (CHC staff)

We could do with a national campaign to make clear that we are independent bodies – people don't question our independence given that we are not elected. There is no evidence about the public awareness and knowledge of CHCs, but plenty of anecdotal evidence to suggest that the majority of people don't know about us. (CHC staff)

Good Practice Example 5: Montgomery CHC raising CHC awareness and patient forums

Background and Objective

The CHC's programme of publicity had to be reduced due to budget constraints which also resulted in fewer members. Raising public awareness of the CHC remained a priority and so it was necessary to find new ways to achieve this. Engaging the public and finding a useful way to exchange information was also considered important.

How they achieved this

To raise awareness of the CHC and its work, members manned a stand at both the Dyfi 50+ Forum and Communities First events. They gave out free promotional material to the public. Members are also actively encouraged to place CHC publicity material in their localities. The Chief Officer and Chairman give regular presentations to Community Councils and community groups. During the public consultation on NHS proposals to change how and where some specialist hospital services are provided in Shropshire and Telford and Wrekin, the CHC organised three public

meetings. Over 700 people attended these meetings. The CHC links in with four active Patient Forums which are useful tools for information to be exchanged between the providers and commissioners of health services and patients.

Good Practice Example 6: Raising awareness in Betsi Cadwaladr CHC through 'easy to read' literature

Objective

To raise public awareness of the work of the CHC and encourage feedback on how they are achieving their objectives.

How this was achieved

The CHC produced an 'easy to read' leaflet which clearly and simply states the objectives of the CHC, what it does and how it can help. It also invites the public to give feedback on how they feel the CHC is performing and provides the necessary contact details.

6.1.2 Name and brand

A very small minority of respondents felt that the name and brand of CHCs was positive: *CHC has a certain kudos (CHC staff)*. However, the overwhelming majority of respondents who raised this as an issue remarked on the perceived confusion that the current name of CHCs produces. There were two significant objections.

Firstly, in giving CHCs the same name as health boards ('Betsi Cadwaladr', 'Hywel Dda', etc), confusion was created in the public mind about whether CHCs are a formal part of the health boards that they are there to scrutinise. Secondly, the term 'Community Health Council' is also unhelpful in that there is a potential for misunderstanding in respect of the role and function of the local authority. Finally, the acronym 'CHC' also means 'continuing health care' which additionally creates problems. The following quotations are indicative of many similar ones:

When we speak to people, they say 'you are one of them'. In no small part this is due to the name of the health board being the same as that of the CHC. (CHC Member)

There's the question of what the CHC is – they either think it's either the county council or the health board. (CHC Member)

People tend to have lost confidence in us as members of CHC. People say things like 'oh you're part of health board aren't you?' This is the biggest stumbling block for us. (CHC Member)

The issue of nomenclature was raised at the time of the 2009/10 reform of CHCs. At that time the then Minister reported that she has received mixed messages on the topic. In the first consultation exercise the proposal was to adopt 'geographical' names for the CHCs, but there was no clear support for this. Subsequently, in the report following the second consultation exercise, the following conclusion was reached:

A number of respondents said that giving the CHCs the same name as their corresponding LHB (e.g. Betsi Cadwaladr CHC, Betsi Cadwaladr LHB) would have a negative impact on the public's perception of CHCs' independence. There were suggestions that the CHCs' names should be based more on the geographical area which the CHCs represent (for example, West Wales). The Minister had proposed this approach in the first of the public consultations on CHC reform in January 2009. At that time those proposals drew criticism from a number of respondents. Having listened to that feedback the Minister has proposed a set of names intended to provide clarity around the CHCs' role by specifically identifying which CHC will act as the

watchdog for which LHB. Ultimately, CHCs will demonstrate their independence through their actions rather than through their names. However, the Minister has decided that, where CHCs think that it would be helpful to their local communities, they may add the geographical area which they cover to their names, for example, Hywel Dda, The West Wales CHC. The CHCs' legal names will remain as set out in the draft regulations.³⁵

To a considerable extent this resolves the problems identified by respondents, and it was clearly within the gift of CHCs to resolve this issue before now. In addition, it was noted that breaking the link with the health board may not actually go far enough for some, given the inherent barriers that such jargonistic language immediately throw up: *if it's called a 'council' or a 'board' then it's not for normal people. The Health Watchdog for [area] would be a much better potential title. If you are a watchdog you should be listened to and the culture of not responding and needs to be shaken up. We don't want to be tarred by the [health board] brush (CHC Member).* Other suggestions centred on a change of name to reflect much more precisely the job that CHCs are there to do:

It is difficult to change a name but it might be easier to add a strap-line – 'the voice of patients in Wales?' We need to subtly build in what is it we do. The majority of people have never heard of us. We want something more catchy and memorable. (CHC Member)

CHCs have traditionally been in place to provide the important link between patients and statutory health services but we feel that their purpose and influence has become somewhat diluted over recent years. We believe therefore that change is needed to modernise these bodies to meet the changing landscape of the NHS. As a suggestion, it may be that a change in name to something which more clearly conveys their 'raison d'être' could act as an important catalyst for change, clarifying their position as the voice of patients across the entire NHS and as bodies that will listen to patients and take their concerns about services to the most senior levels. (Other)

6.2 MANAGEMENT OF MEMBERS

A second set of connected issues was raised in respect of the management of the Members. All of this was set in the context of the fact that Members are volunteers, and need to be managed as such. It was however acknowledged that this status has both strengths and weaknesses: *I would be very happy to see more professionally managed CHCs. They would encourage and support local people who are willing to give time to help improve their health services. They would be able to promote the real needs and views of local people in decisions about services (CHC Member).* These issues are part of a broader concern over the management of CHCs – whether at local level, or through the activities of the national organisation. Whilst considerable developments have been seen in this area, the team heard numerous concerns that these processes were not yet robust enough. These concerns were particularly acute in respect of the underperformance of Members, and more specifically in relation to the Code of Conduct.

The relatively simple task of performance managing Members poses a challenge for officers: *Getting rid of underperforming members is an issue – we can't do it. I've had 'conversations with a purpose' and one or two who did resign shortly after, but then we can't refill them until the next public appointment process (CHC staff).* In part this was a reflection of the fact that *we do ask a lot from volunteers and so we struggle sometimes with what we get back (LHB/Trust representative),* but for others it was more of a comment on the broader issue that the 'modus operandi' of CHCs needs to be rethought:

There are 'lower level' issues that in theory are dealt with by having annual or bi-annual meetings with the Chief Officer, but there are individuals who can play the system and avoid any disciplinary

³⁵ Welsh Assembly Government (2010) *The Reform of Community Health Councils in Wales: consultation report* WAG: Cardiff – January, pp.8. <http://wales.gov.uk/docs/dhss/consultation/100102chcconsultationreporten.pdf> - accessed June 2012.

action. This is not satisfactory, given that in the situation of not having enough members on the books, there are not enough people pulling their weight. (CHC Member)

It is difficult to run meetings in a business-like way and it's difficult then sometimes to come up with results that influence the health board in a credible and professional way. The model of getting members along to committees on the basis that they will impart some 'community' nuggets is flawed. (CHC staff)

On the Code of Conduct for Members, opinions were divided. Some felt that the extant 30-paragraph document provided sufficient clarity and clout to resolve problems in order to safeguard the effective and professional performance of CHCs, and there were many examples of CHCs which had effectively used the Code: *there's a clear expectation for us in terms of how we conduct ourselves under the CHC banner. If you are there as a representative of that CHC you go as member of the CHC. If you have different view you have to go as an individual. If we are engaging with the health board or in internal meetings there is no muzzle on us but there is when we are talking to public. There are several instances where this has not actually worked though. I can think of two specific instances where members stood up in public with opposite views to the CHC and also said 'I sit on the CHC'. It was brought to the executive and it was resolved. In one example we asked someone to resign (CHC Member).* There is some good practice evident (see box below). In other instances, however, it was clear that issues with members' conduct had not been resolved in a timely manner, and this was often as a result of ineffective local processes:

We've got the Code of Conduct and procedures around that but it may not always resolve issues, even when Members breach it. (CHC staff)

We've had an issue with a local member in [area]. The system has been put to the test by someone who couldn't be dealt with informally. We didn't have a structure in place to deal with errant members, so we put in place a 'standards committee' made up of the local committee chairs...everybody is now a bit clearer about how to do things off the back of this should this situation arise again. Mostly you can talk to people and resolve things, but in this situation you couldn't. I would hope this would never happen again but I can't be confident. (CHC staff)

We have to recruit Members to our CHC is on the basis of their merit and what value they can add. What they do outside the meeting is their business, as long as they do not break the terms of the Code of Conduct. However if you do infringe the Code of Conduct you then have to face the consequences which should be clearly spelled out in the document. The Code of Conduct is not sufficiently helpful, and it is not enforced properly. The process of implementing the Code should be taken out of the local CHCs hands and over to an internal Standards Committee – the body should be independent of the local CHC. It is not acceptable that members countermand a view that the CHC has agreed – you have to resign from the CHC before you say these things once there is an agreed CHC position on certain matters. Up until that point there should be much more flexibility, and as long as they don't break the rules of a tightened Code of Conduct I think that we should be allowed to say certain things. (CHC Member)

Where local processes appeared deficient, there was a lack of resolute action from the national Board to resolve the matter:

We feel they break their Code of Conduct. The CHC nationally had the option to enforce but chose not to. We are talking about an extreme situation but you have to deal with difficult situations that come up. You have to have robust conversations. CHCs haven't had these with the CHC nationally. They need a protocol for dealing with these and it takes a lot of skills to deal with these issues. I don't know if the CHC board has these skills. (LHB/Trust representative)

In addition to these broad concerns over the management of Members, specific issues were raised over declarations of interest, given that in one staff member's view: *there are no clear statements about declarations of interest (CHC staff)*. This issue was particularly raised in respect of a small number of Members whose interests are not always declared as fully as they may be:

There should be declaration of interest and for people who are running care homes and like the person who runs the shop at [hospital] who are on the CHC. They should be made to declare this as an interest. Why are these not declared? There is no pro forma that people fill in on which they declare their interests which should be addressed. (CHC Member)

Good Practice Example 7: Guidance and support for members in Cardiff and Vale CHC Published (May 2011)

Objective

To ensure members receive guidance and support on NHS change in approaches to engagement and consultation.

Description of what they did

The CHC produced a comprehensive document for members providing guidance on engagement and consultation changes.

What they achieved

The guidance document is a useful referral guide for its members outlining the relevant legislation and provides clear information on what is expected from them as a CHC Member.

6.3 PROFESSIONAL DEVELOPMENT

The final substantive set of issues raised can be summarised as the ongoing 'professional' development of the Membership. Recruitment of members and categories of membership are discussed elsewhere in this report.

6.3.1 Qualities, Skills and Knowledge

Much of this discussion began by considering the current calibre of the Membership of CHCs. The tenor of the majority of these responses was positive, reflecting on the quality of inputs that Members can bring:

We have a knowledgeable executive and Membership as a whole. We engage with the health board and they appreciate what we do. It's the calibre and professionalism of Members here. We have a good cross section/calibre of membership – it's by chance that we have a very good mix. It would pay for backgrounds to be taken in to account in the interview/recruitment process. (CHC Member)

I think it's the quality of people which is really important – we have a very good lay committee. We have a very diverse set of people. People bring different skills and talents – we all do different things. Here, we sit in lots of meetings and I do hope something can be done about that. We are all volunteers. (CHC Member)

A couple of people on the CHC are very influential – the Chair in particular. Not because he's the Chair but because he is influential in his topic. You know when they speak that the committee listen. (LHB/Trust representative)

The direction of travel was also thought to be positive with respondents noting the *much more professional approach (LHB/Trust representative)* being taken to matters like the planning groups that have been set up locally. Broadly speaking, there were benefits identified of having a 'lay' input to very professional environments like hospitals: *there is a shock that can happen when you go and visit in your 'professional' capacity and the picture that has been seen when you visit as a member of the public – you see very different things happening (CHC Member)*. The added value of lay people – *someone to go in without jargon and see how things really are (CHC Member)* – was also readily identified. One potential threat that could undermine the value of the independent lay person was noted by health organisations. CHC Members who were former healthcare professionals were exhorted to leave their previous training and skills set to one side in their new roles, which can, it was suggested, unbalance and distort the independence and value that CHCs can bring: *One thing we do find is that we can tell where Members used to work from their comments. There are people on missions like retired nurses. They need a broader representation or at least to be a bit more objective in their views. (LHB/Trust representative)*

There was also considerable discussion about the blend of different qualities, knowledge and skills that CHCs are able to offer. Overall, there was an identified need to ensure that the right types of Members are carrying out the right types of roles at the right time – and that these individuals are selected on the basis of their appropriateness to undertake a task and not just their availability:

Of the existing set there are few who are hands-on who like going out there, but less who are able to sit down and critically analyse. We don't have enough at this level. If you look at non-execs of the health board there is a good high level academic or service background. This is not to belittle members – their instinct and perception of issues is important, but this can mean that they are less skilled in challenging the health board. (CHC staff)

In terms of Welsh Government appointments, the calibre of people is mixed. There are some astute and clever people coming through that route, and there are others who wish to do good and are gentle. Whilst they are good at some things, you need to recognise that they can make contribution – they are hands-on often and go and do visits and inspections. There is an issue of balance and getting the right numbers of each. We have to have the right people who have the ability to deal strategically with the kinds of issues that the health board is coming forward with. (CHC Member)

Some individuals are great at going around, and great at speaking to people. There are quite a lot of members who are good at talking and producing some really good stuff. Very few are able to do this along with the analytical roles. (CHC staff)

Not enough of the members understand the nature of the health system adequately and whilst you can train them to address some of this, that requires further draw down on their time. Having pools of expertise that you can call upon – a little like the Scottish model – would be very helpful. We need to do more with our links into the voluntary sector so that we can draw upon these skills and knowledge. (CHC staff)

CHCs do not currently operate a system of regular appraisal of Members, so any assessment of developmental needs and capacity are usually rather *ad hoc*, with little systematic attempt to improve Members' performance. This also makes effective targeting of training and support more difficult.

6.3.2 Training and Mentoring

One way to ensure that right blend of skills is present is to train people. In the Board of CHCs Annual Report for 2010-11, there are a series of graphs which provide data on the amount of training provided in the last year. However it is unclear whether these data refer to numbers of days provided or numbers of

people trained and have therefore not been reproduced here.³⁶ That said, the Review team heard lots of comments about the training and mentoring of Members and staff. It would be fair to say that notwithstanding short-term problems associated with the lack of access to the central training resource offered by the Board of CHCs, there were a number of concerns expressed over the nature, duration, appropriateness and flexibility of the training that staff and members receive. In the first instance, issues were identified over the capacity of Members in particular to attend the number of training sessions required, especially given their status as volunteers:

In the past CHCs haven't been happy with national training – it could be condensed. (CHC staff)

In the last round they had three national induction days which were centrally delivered but it is difficult because they are volunteers. If they are local authority Members they can't always make the time. It's a difficult one. Sometimes someone is incredibly efficient but they are lacking in time. (CHC staff)

The training needs to be improved. The three days of induction could be shortened to one day, as they're padded out with long breaks. Also we could do some more specialised training. We've got lots of experience within our CHC that we could use much more effectively. We could be effective as a CHC in relation to primary care, but there's a load of training needs about how to understand this. (CHC Member)

In addition to these issues around capacity, questions were asked about the appropriateness of the training on offer. These concerns ranged from how the training was pitched – *the training is very high level, although a combination of this kind of training and more practical 'on the job' training would be good. The standard was not very professional and it didn't meet my high expectations (CHC Member)* – to worries over the areas that are, and are not, covered. In one instance, a respondent identified themselves as a qualified person to deliver training on disability equality, something they considered to be essential for all: *new CHC Members should be trained in disability equality. I have skills as a disability equality trainer, so why not use me, who is currently sitting around the table? Why didn't they look at the database of the skills of members that they collect to fill the gap? Even if the training officer was available this training should be delivered by someone who is disabled, so it was wrong to give it to the national board trainer anyway (CHC Member)*. More troublingly, an incident was reported wherein a training session discussed the issue of Human Rights. It is not repeated here but served to the Review team as an example, albeit perhaps an extreme one, of poor practice in challenging entrenched viewpoints.

More positively, the role of mentors within the CHC was praised when, and if, these are available. Especially for new Members, working closely alongside established colleagues can serve to reduce the feeling of isolation and nervousness that often accompanies being a new Member on a first visit to a hospital or other healthcare premises:

When you are going on to a mental health ward if I had to sit and talk to someone on that ward on my own I would have been very nervous and uncomfortable. In GP surgeries it's easier to speak to people in waiting rooms. But in mental health wards for example, you can't just go in and sit down – you need a mentor, but you don't always get one because of a shortage of members. This is terribly off-putting for new members. (CHC Member)

Having mentors is fine if there are enough experienced people to do this but if you don't have enough you can struggle. You also need to make sure that the right people are the mentors so that you don't pick up on bad habits. (CHC Member)

³⁶ For the graphs see Board of Community Health Councils in Wales (2011) *Annual Report 2010-11* – pp.37-40. See <http://www.wales.nhs.uk/sitesplus/documents/899/ANNUAL%20REPORT%202010-11%20-%20%20ENGLISH.pdf> – accessed June 2012.

I had Hospital Patient Environment training pretty quickly and locally. I went along with experienced member and it was helpful to have a mentor and someone to go with – you don't want to overstep the line. (CHC Member)

6.3.3 Leadership

In order to address some of these shortcomings, respondents were keen to point to the need for much greater leadership in respect of the professional development of CHCs. There were two aspects to this. Firstly, the professional development of the group of Chief Officers was rather *ad hoc*, with little attempt to identify and address collective developmental needs:

There's no formal development programme for Chief Officers which isn't a major problem and we've had some training as a team but it's not structured. The problem is that we as Chief Officers are just using our skills from our previous roles and bringing that to bear on this new job. We're having some training from NLIAH and the Involvement Institute. But we don't sit down and work through issues as Chief Officers – there's no time-out sessions, no development plan, no structured gap analysis for our own training needs (CHC staff).

The Chief Officers should be given an action learning set, with coaching and mentoring support, by an arm's length organisation in something like the CHC Development Unit. (CHC Member)

In addition, there was scope identified for much greater delegation of training and development of Members to individual CHCs: *there's scope for training the trainers in-house, and there is the possibility that Chief Officers could be dedicated leads for leading on certain areas. There is a dedicated lead for advocacy, for disability equality, for monitoring. There is also the potential that Chief Officers should cascade the training down to their Members. There's the potential for us to have a call-off contract of training providers, which is particularly relevant in that the training officer has been dragged into different areas of work other than training which has taken away some of the capacity (CHC staff).* This was combined with a sense that national events represented somewhat of a lost opportunity to learn from one another – both in terms of actual skills, but also in terms of approaches to training and development:

Why aren't there annual staff days? Why not reconfigure the national conference to be more focused on discussing things and sharing information? (CHC staff)

There are some real problems in learning from each other – we learn from each other here locally – and whilst the CHC conference is there it's more about individual speakers coming in to talk to us rather than us using each other and learning from our peers. How do others do their visits and training? The set-up is very different across Wales but there are commonalities. (CHC Member)

6.4 CONCLUSION – GETTING THE BALANCE RIGHT

It is clearly very difficult to strike the right balance in a 'Member-led' organisation between the needs to become more 'professional' and retain a sense of scepticism about being too close to, and becoming part of, the 'system'. The following two quotations from respondents bring this chapter to a conclusion very neatly. They point out both the potential benefits (the first), and possible drawbacks (the second) of CHCs taking a more 'professional' approach to their work, reflecting different conceptions of the proper role of the CHC:

This all comes back to what you want CHC to be. Is it a collection of all views or snapshots? At the moment it is snapshots. I want to have an influence that will drive improvement and get results. If the NHS is ready for retirement in its current form, so is the CHC. I'd like to see us far more business orientated, offering audit like an accountability body, and build on some of the complaints. At the moment only four or five Members or staff can that have discussion about business matters. Ideally we would need the Membership to do that. CHCs should be given a target of reaching targets by a

certain date, and if they fail to achieve that then their function should be reviewed. If we are going to professionalise and make it more business-like I would want to be assured that targets are being met. (CHC Member)

'Together for Health' only makes a single reference to Community Health Councils – with an expectation that the NHS engages with them as part of its engagement with local communities. CHCs face the challenge of developing into organisations that are reliable and consistent in communicating feedback about the performance of the NHS in Wales, while retaining the patient experience at the centre of their concerns and the lay view of health bodies at the core of their activity. This is not necessarily compatible with the conventional view of what a 'professional' organisation should look like. Consequently CHCs should be wary of the bureaucracy and protocol that can accompany a 'professional' organisation and develop in ways that place power and influence with patients and other citizens rather than in structures and hierarchies. This kind of organisation is one that could complement, rather than duplicate, the work of the inspectorates and the Welsh Government. (Other)

7 RELATIONSHIPS WITH LOCAL HEALTH BOARDS AND TRUSTS

7.1 INTRODUCTION

The relationship between each CHC and its Local Health Board – and to a lesser extent with the three NHS Trusts in Wales – is a crucial one. The situation varies across Wales, with some partners (both CHC and LHB/Trust) describing their relationship as good, and others much less so. In all parts of Wales there are areas of concern, particularly over how effective the relationship is in improving services for patients. There is also much food for thought in this chapter about issues such as the respective roles of CHCs and LHBs/Trusts, and about how those roles should be delivered and by whom.

7.2 OVERALL ASSESSMENT

In some parts of Wales, both CHC and LHB are clear that their relationship is a good one, and serves the public well. The phrase ‘critical friend’ was often used:

The point is the CHC act as a critical friend to that Health Board – ‘have you thought about?’ LHBs are slightly removed from community – the way CHC operated, it quickly became apparent to local communities that there was someone looking out for them. (CHC Member)

It’s more than just challenging the Health Board...it’s about working with the Health Board, even though the members might hate me saying that. It’s the little voice on the shoulder, the critical friend saying ‘nice idea but have you thought about...’. (CHC Member)

Others can detect modest improvements:

They should think of us as people who won’t take prisoners. We have made a difference, and there have been some superficial improvements. We need to be realistic about the nature of the improvements, but they do not see us as the patient voice. (CHC Member)

In other areas, there is widespread and serious dissatisfaction:

We’ve gone through every single method of trying to engage with the Health Board – we’ve tried every single thing that you could think of to try. The approach is the same with the health board employees as it is with the CHC – they are just scared of opening up the conversation. But equally there is a culture of fear among the staff to speak out. Is this explained by the take of the Minister saying ‘you have to do it this way’? (CHC Member)

The new hierarchy in [] have not worked with CHCs much in the past and we’re seen to be a nuisance and they won’t speak to us. Instead of being inclusive and having conversations at all levels, we only know about things that have stopped because members of the public are telling us about the closure of beds and other things. In the previous scenario we were involved and now we’re not being informed at all. (CHC Member)

Because the relationship has been so poor with the Health Board, this has had an impact on the morale of the group. We’ve lost the good links that we used to have with the previous health authority, but there is a point of hopelessness sometimes because you feel that nothing is going to be done at all. (CHC Member)

Some CHC Members accept that part of the responsibility for this situation lies with them:

‘Good’ relationships are usually described in terms of the following characteristics:

7.2.1 Trust

Mutual trust is important:

Six weeks ago we met the service planning group. We gave them a presentation. Told them it was confidential. We have that honesty at the moment with our CHC. We have that level of trust. (LHB/Trust representative)

We are maturing – these things are still developing. We are having much better conversations before pen is put to paper. Maturity of these relationships – so much depended on trust. Takes time to build trust. Money well spent. (LHB/Trust representative)

But it cannot be taken for granted:

We've got a drift in our relationship, and that's not good. It means we're not trusted and we don't get the information we need. All this leads to is 'them and us'. None of this helps the situation. (CHC Member)

I think we're playing the catch-up game with the Health Boards, because we are not being given the information early enough. I've said as soon as it's a gleam in the eye we need to know about it – and there may be a little truth in the fact that some of it has been leaked – but I do not trust the Health Board and I feel that we have been deliberately deceived. (CHC Member)

7.2.2 Mutual value

If the leadership of the organisations value the contribution of the other – and make this clear – the impact is considerable:

We've seen a big improvement in the fact that the Health Board is now listening to what we say. This all stems from the top – and whether the Chief Executive values the contribution of the CHC. (CHC Member)

We were tolerated for the first few years, but I have to say that the new [] Chief Executive has been wonderful – we have been included in their discussions. There is much more point to the membership, because our voice is being heard. (CHC Member)

Relationship between CHC and UHB – interesting. I think they try. It is often personalities, so dependent on personalities. [] has virtually been to all our meetings – UHB is trying. We are hypercritical of them at times. We haven't got a perfect relationship – but don't think we ever would have.... My own feeling – not that negative here. There seems to be a readiness on both sides. (CHC staff)

Good practice example 8 demonstrates how such relationships can develop in practice.

Good Practice Example 8: Joint working between Cardiff CHC and Cardiff and Vale University Health Board

Background and Objective: Cardiff and Vale CHC has established good working relationships with Cardiff and Vale University Health Board and in particular in respect of the work the UHB has undertaken on service change. Both organisations are keen to develop joint working further, specifically in information sharing, collaboration and arrangements for engagement and consultation.

How this was achieved: Representatives from the CHC attend all UHB Board Meetings and Stakeholder Reference Group meetings. The Health Board is represented at all CHC Council meetings, and Executive Level Planning Meetings. The UHB has worked productively with the CHC on a range of

service change issues, including two formal public consultation processes. To demonstrate the continued commitment the two organisations have to joint working, a Memorandum of Understanding was drawn up in April 2012 and will be reviewed annually.

The Benefits: The CHC and UHB have agreed a set of guiding principles against which all proposed service changes are benchmarked for coherence and consistency. This has facilitated open and honest dialogue about the nature and impact proposed service changes and has ensured that the focus of service change on improved clinical and patient outcome is reinforced. The success of the UHB/CHC relationship in terms of managing service change effectively has been predicated on a mutual commitment to openness and transparency, recognition of mutual roles and responsibilities and a high degree of personal and organisational commitment to building constructive relationships on both sides. The CHC input in to the Stakeholder Reference Group helps to achieve its aim of providing a balanced opinion to inform the UHB's decision making process.

7.2.3 Credibility

There is often a perceived imbalance between the capacity of the CHC and that of the LHB, which undermines the work of the former:

Brand still remains important – CHC has a certain kudos. But at same time, we are holding to account a multimillion pound business. We are relatively small organisation, we are having to act as a critical friend – act as a counter balance to big... well expertise, slick, professional organisation. This is still an issue – still small guys against big guys. (CHC Member)

I think its first of all forging a partnership – who is the greater or lesser partner!?! It would seem they hold the power because they are the large animal. They also have the perceived professional expertise, the mystique around medicine – makes them quite powerful. Then you have us – a bunch of lay people coming along and saying, hang on I don't think that is quite right. That shifts balance of power. We are able... to challenge. You have to have people who are able to sit up and challenge. (CHC Member)

The influence of the CHC is often contrasted unfavourably with that of other bodies:

There is an element of discounting from the HBs – I have seen reports like that. Vast number of reports that have real concerns. Even the serious things – we might have initial response to say that they are being dealt with but then big delay. You have to take their word for it that these are being dealt with. Is this something to do with who is dealing with it in the Health Board? We have picked up on real issue reports, waited a long time, year down the line HIW went in and it was picked up in the press! Their report wasn't even as damning as ours. Its politics! HIW seem to be perceived as serious where as we are possibly seen as lightweight. (CHC Member)

For some, the answer to this imbalance is for the CHC to focus on its role, and not be diverted into attempting tasks which are beyond it:

CHCs should not be forced to take into account the fine details of the proposals like the finances – our job is a bit like the House of Lords where it simply points out things that are wrong, and that it won't work for our communities. This would get us past thinking that the CHCs are micro managers if the NHS. I've always maintained that there should be no duty on the CHCs to come up with an alternative – we are not professionals, and indeed as professionals are not allowed, nor should we be charged with the duty of these people. (CHC Member)

On the other hand, the roots of the CHC into the local community can be an asset, especially where the CHC highlights issues which were not obvious to the LHB:

Transport issues. Big issue. LHBs don't necessarily put transport at top before anything else. It's a shame CHCs are not involved more in that strategy... I know people's actual problems and views. We need to be involved right at the start. One of our main strengths, we interact on the ground... need to be involved at START of thinking. (CHC Member)

7.2.4 Mutual support

Good relationships between CHC and LHB/Trust are often characterised by a recognition that both parties have a responsibility to help the other do their job. This might be in terms of information provision...

Mutual responsibility for health between providers and public – helping to bridge or finding language to bridge. We all know what's coming over horizon – do CHC know that? Not sure they have been doing much of that. It's role of LHB and Trust as well as CHC. BOTH. (LHB/Trust representative)

or help in communication:

There is a degree of paranoia about how they communicate – we've been to meetings where they have point blank refused to take questions from the floor, and we've been told in meetings that we're not allowed to write anything down. The difficulty is this creates so much anger – especially when people are being stonewalled and trying to offer legitimate views. (CHC Member)

This is helped where each party is clear about how their separate roles come together – in this case, the duty of both LHB and CHC to engage with the public:

Throwing money at the same problem isn't going to help. Something about role of HBs. [CHCs] are valuable because you need independence. But I do think we also have obligation to do these things ourselves. [CHCs] have their own agenda – using a middle man is flawed. Need honest broker not just a broker. (LHB/Trust representative)

An example of this relationship working well is shown in good practice example 9.

Good Practice Example 9: Consultation on Adult Mental Health Services by Cwm Taf CHC (June – October 2011)

Background and Objective: Cwm Taf Local Health Board produced a public document setting out proposals for service changes to local mental health services. The LHB indicated there would be a six week consultation period. CHC Members felt the likely changes would be substantial and so a longer consultation period was necessary.

What they did: The CHC Chairman and Chief Officer met with the LHB Managers and it was agreed the consultation period would be extended to ten weeks. The CHC also requested that two additional public meetings be scheduled. The CHC ensured the public meetings were well located, properly advertised and appropriately staffed by the LHB to facilitate meaningful discussions. The CHC also chaired these sessions. The public raised concerns over the proposed new model and the CHC advised that certain weaknesses in the proposed service model would result in substantial legitimate reasons for the CHC to object.

Impact: The LHB revised their proposal and utilised the two additional public meetings requested by the CHC at the outset to consult upon their improved model. The CHC has ongoing involvement in overseeing the implementation of the service changes.

7.3 IMPACT

Where relationships are working well, a variety of different outcomes are reported. Impact on the patient environment is the most commonly cited example, and often the cumulative effect of a number of small changes:

Biggest achievements – there's lots of small things and the GP side of things... The most important thing is that it's lots of small things together. The Health Board know we are here. They are thinking 'what will the CHC think about this?'. A lot of the issues revolve around access. We have pushed things. We do get them to think slightly differently... (CHC Member)

A colleague of mine noticed filthy areas of []...said there was a need for power washing. [It] was done by next visit... When we have made valued comments they have responded. This Council has a really good relationship with the Health Board. (CHC Member)

HPE [Hospital Patient Environment visits] is a good example – annual visits. I know recently we went back [] to see what has been actioned, or if not. They were telling us the reasons why. Further prompt for them. Confident that when we flag up an issue they will resolve it or there will be a good reason why not. I think they take our input seriously. I know when we first started, the managers were aware we were going... But, all visits now are unannounced so don't get this opportunity. (CHC Member)

CHCs often find gaps between the stated intention of the Board and the reality 'on the ground':

They put in new linen process, the chap managing that had chapter on verse how it should work, but no one checked how it was or if it was working.... 'Free to lead, free to care' is great in concept but takes a while to break out. Still large cohort of 'this is not my problem.' (CHC Member)

CHCs have also carried out substantial reviews of whole areas of service provisions – notably the review of stroke services in Aneurin Bevan (see Good Practice Example 10)

Good Practice Example 10: Review undertaken by Aneurin Bevan CHC of Stroke Services provided by the Aneurin Bevan Health Board April 2011- March 2012

Background/Objective: The CHC agreed that a formal review of existing stroke services provided by the Aneurin Bevan Health Board would be undertaken. The purpose of this review was to determine how stroke services compared with the National Standards for Stroke Care and to highlight improvements made to the stroke service or areas which required further development or action.

What they did: The Committee researched information on stroke services available to the public and to compare ABHB's performance with other similar organisations ABCHC undertook a literature review. Comparisons were then made with stroke services within across Wales, and stroke services In England and Northern Ireland. A Scrutiny Committee reviewed evidence and information from a wide range of sources, met with ABHB to gain a full understanding of services provided previously, currently available and proposed future changes. ABCHC designed a semi-structured questionnaire on the patient experience of stroke services and ABCHC Members visited a number of out-patient clinics in the ABHB health area where stroke patients would receive follow up appointments or treatment. The survey was also posted on the ABCHC website inviting response and The Stroke Association provided access to one of their co-ordinators.

What they achieved: A report was published showing that ABHB had significantly improved stroke services since 2009 with full compliance for most of the Stroke Intelligent Targets. The report made nine recommendations on how the service and patient experience can be further improved.

Some parts of the NHS are less easily accessed by the Board, one example being primary care. The contribution of the CHC here can be particularly valuable, although caution is expressed about the ability of the CHC to engage with all sections of the patient community:

Primary care visits, very detailed reports. Really, really good. We use that. Uniformly good. Good system. We do the QOF visits – theirs adds more detail to it. They spend time speaking to people in surgeries. In these they don't tend to get young people. Tend to go to peer group. That is where the membership is issue. On whole they are more comfortable engaging with over 50. Issues about age and ethnicity. (LHB/Trust representative)

Where impact is less satisfactory, there is often a concern from LHBs that the CHC focuses too much on relatively minor issues (small faults with the fabric of the building, for example), and attributes too high a priority to their rectification. In one example, the LHB had agreed with the CHC that the frequency of window cleaning would be reduced because it was not a priority when budgets were constrained. Frustration was then expressed when the CHC repeatedly criticised dirty windows during their visits. The response from the CHC was that they should report what they find. For CHCs, this sort of relationship can become one in which the LHB does not take their concerns seriously:

We don't get the impact back from the Health Board that we should from the HPE. The staff like the fact that we listen to them, but on a follow-up visit last week there was 'no change' ticked almost all the way along the form. We know that we have to be persistent in making the points and even though there are things that are deemed to not be a priority, we have to keep pushing hard to get the Health Board to listen. (CHC Member)

There's a danger that we spend far too long picking up the bits that nothing need be done about – the trivia. We always ask the nursing staff whether there was anything they want to be put down on the form that would improve the patient environment. (CHC Member)

There is something about the nature of HPE visits that makes you question 'what's the point?' It's a tick box exercise which is ignored by the Health Boards, and which changes each year so that there is no comparability. Often we are commenting on structural changes to the building, which Health Boards have no money to address and do something about. If we had confidence that the Welsh Government were going to act on the observations that we make that would be one thing. The problem is that if you hammer on about the things that Health Boards can't do anything about they will reject our visits. (CHC Member)

about a third of issues from visits are resolved. Sometimes the recommendation comes back saying there is issue between builders, contractors etc. (CHC Member)

Again, CHCs' lack of resources can be a limiting factor. For example, when CHC Members talk to patients on a ward, there is a natural reluctance on the part of the patient to express criticism:

It would be good to have the ability to see people after they have been discharged – but you need to do that in addition to the care that they have received – and you would space that out over time so that you lose the 'halo' effect. (CHC Member)

7.4 WHO SHOULD DO WHAT?

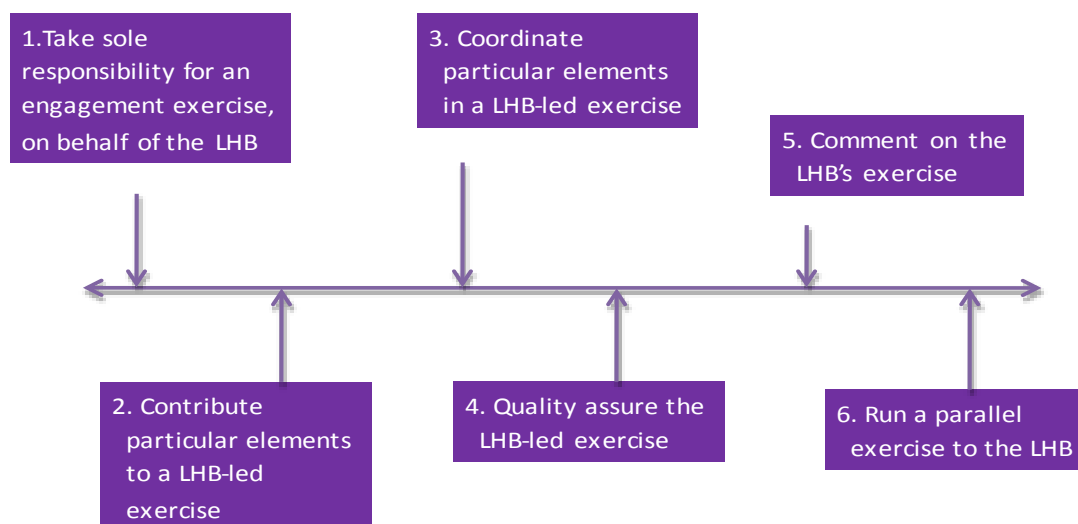
There is no clear demarcation between the roles of the CHC and LHB: almost all of the key functions of the CHC (public engagement, improving the patient experience, scrutinising performance and plans) also have to be done by the LHB:

We cannot allow Health Boards to devolve the responsibility for the things that they should know and be doing something about. (Stakeholder)

The only obvious exception to this is independent complaints advocacy, which almost by definition cannot be done in house by the LHB.

Each LHB/Trust and CHC therefore needs to agree who is to do what. In theory, there is a range of possibilities, from duplication (both parties doing it) through to the CHC doing it on behalf of the LHB/Trust (Figure 2):

Figure 2: LHB/Trust and CHC joint working: a spectrum



Source: derived from M Longley, M Llewellyn, A Simpson et al (2010) *Influencing Commissioning in Health and Social Care*. Birmingham: Birmingham Local Involvement Network

The choice in any particular case will depend upon a variety of factors, including capacity, expertise and skills, and governance considerations. There is a need to maximise the ‘system effectiveness’ of the approach taken – capitalising on the natural strengths of each party. The LHB, for example, is far better resourced and has access to information and specialised knowledge which is not at the disposal of the CHC. Of particular importance for CHCs are the need to maintain both the reality and the appearance of independence, including maintaining access to their own sources of intelligence:

At one level I don't have issue with contracting [with the LHB to engage on their behalf], but I think we need to be very clear – if we as a CHC think there is a problem there, we will go in on an unannounced visits and tell execs what they probably don't want to hear. Some think it might compromise this. Others say we are working in vague terms so difficult to say if it would be compromised. We definitely couldn't be paid for monitoring visits!! We need to protect our independence - it would have to be project work. (CHC Member)

Additional resources, from the HB? It has been a no-no here, my fault. The public have confidence in us because of our independence. This is crucial. If we were to take an SLA from the NHS that would then capture us to deliver to their tune. You can't justify to the public that you are independent, and then take money off the NHS. If they said I can employ 2 PPE officers for you, then we do some work on service change... then... who is the master?!(CHC staff)

We have the forum for CHC and LHB in each area – the public are getting used to us being there and having a viewpoint there. What's the added value? Independence! The general public realise we are not in the LHB's pocket. We represent Joe Public. We are in a position to scrutinise/check up. It does pay off. (CHC staff)

LHBs also recognise the potential difficulty:

Difficult for CHCs – seen as patient and public advocates. But then we want to work with them to implement changes public don't want. Difficult. CHC had difficult time last year – very emotive subjects. They had a lot of hassle and were jittery about confirming their position. Put them in a difficult position sometimes. 'Patient advocate' on the one hand and 'work in collaboration with NHS and their changes' on the other. (LHB/Trust representative)

But others advocate a more radical approach:

LHB's should use the CHC as the independent "head" of any PPI or ISUE network, instead of trying to do it itself. (CHC Member)

There may also be a reluctance to work in unfamiliar ways, with CHC Members being used to environmental visits, but less familiar with, and confident in scrutinising the engagement activities of the LHB. This caution may be well placed, and CHCs may need further guidance and support in developing an approach which is orientated more towards scrutinising the work of the LHB, as opposed to getting out and doing it itself.

7.5 OTHER ISSUES

Two other specific issues have arisen in this part of the review. The first is the need for further revision of the concept of 'substantial change' i.e change requiring formal consultation with the CHC:

One of the things which has caused a lot of conflict concerns our right to be involved in discussions about the diminution or cessation of services which are called by the Health Board an 'operational' matter, which is something that we can't be involved in – we can only comment on 'substantial changes of services'. (CHC Member)

We have recently had discussion with the LHB – how do CHCs carry out their functions when there is a lot of subjectivity around things e.g. 'substantial' change. What does that mean? There are different views. For example – we transferred a respiratory ward from [] to []. Some CHCs would see that as substantial. I disagree. All we have done is change its location and improved service. I know our CHC have been criticised for letting things happen which perhaps other CHCs wouldn't. 'You should have forced them, you are in their pockets'. (CHC staff)

The second is the challenge of issues which cross LHB boundaries. This has arisen recently in the context of the South Wales service plan, when the CHCs of the region are in the process of developing an appropriate means of coordinating their input. Another challenge is of longer standing, where a population routinely depends upon more than one LHB to meet its healthcare needs:

I have found that Health Board structures restrict the CHC's work – two examples of this are below. The first is to do with representing the interests of Meirionnydd patients in the reorganisation of Hywel Dda services. This is difficult because the respective responsibilities of the Health Boards are indistinct. The tone of the relationship between the boards is competitive (for resources, self-determination) rather than collaborative (finding a solution which serves a community's needs). The second is to do with the way BCUHB is organised. It is structured around clinical disciplines which run across the entire organisation. I understand the reasons for this. But the people and structures which bear responsibility for delivering local services are still at a very early stage of development. This means any query about local services has to go to a Board manager and is then farmed out to another quite senior person for a response – which is sometimes delayed, often quite formal and over complicated. People expect the CHC to be able to find out about operational problems: we need to be able to make 'question and fix it' calls to someone who is in a position to respond immediately. (CHC Member)

7.6 CONCLUSION

There is still some way to go before any CHC:LHB partnership has evolved the optimal way of working, but some clearly have much further to go than others. Three issues arise from this. First, there is a governance challenge for the 'health system' where relationships have deteriorated and have defied local resolution: the relationship must be repaired. Secondly, there is a considerable developmental agenda, designed to build capacity and to share successful ways of working. Finally, there is much more thinking needed at a system level about how to improve the current level of patient and public engagement from what is, at best, satisfactory, to a level of which Wales can be justly proud.

The question of impact is not straightforward, as this discussion between senior LHB staff in one of our workshop sessions highlights:

Director 1 There are huge tensions. Something about effectiveness – are we just ticking a box? It's where you place it in the priorities list. If our internal processes were correct you'd hope 95% [of what CHC identify in visits would be] picked up. Confident ward managers would pick it up. But CHCs picking it up it might not change priorities.

Director 2 I'm not sure I'd agree. We use CHCs as a proxy for public. We have examples of where they have picked something up. Not big stuff but it is influential... Whether that is right? Not to have it would take away some value.

Director 3 I'm not sure they pick things up we didn't already know.

Director 4 They probably doesn't change things as often as they should. They might not realise how major things are and request short time frames. We let them know and they are fine. You tend to get used to things – you don't notice from another perspective.

There is also substantial dissatisfaction among many of the leading figures in CHCs about the effectiveness of their contribution:

I've recently been appointed Chair [of the CHC] – I have 12 months to make a difference. This review is ideal. Someone needs to decide what they want the CHCs to do.... if they are happy with what they are doing at moment, I won't be. We are not driving the improvements we need... I don't see a continuous improvement cycle. I see lots of individual issues fixed, but no sharing of ideas. (CHC Member)

8 RELATIONSHIPS WITH OTHER BODIES

8.1 INTRODUCTION

The terms of reference asked that the Review consider the CHCs' relationship with bodies such as Healthcare Inspectorate Wales (HIW), the Care and Social Services Inspectorate for Wales (CSSIW), the Children's Commissioner and Older People's Commissioner. The review discovered evidence of both formal and informal links between such organisations and the CHCs, and in particular the importance of the extant relationship with Healthcare Inspectorate Wales (as defined in part by the Memorandum of Understanding).

8.2 HEALTHCARE INSPECTORATE WALES

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of all health care in Wales, with a core role to review and inspect NHS and independent organisations, providing assurance that services are safe and of good quality. Given that CHCs have a statutory function to scrutinise and constantly evaluate the existing health services in their districts, with powers to enter and inspect premises for this purpose³⁷, coordination with the work of HIW is clearly important.

Despite their overlapping roles, CHCs and HIW take very different approaches in their work. For example, members claim that they are able to work much more frequently and personally with local services than HIW: *HIW parachute in...undertake an inspection...then parachute out. The CHC are always there, and a relationship develops between the Health Board and the CHC because they are permanently there. Staff can often 'tip us the wink' and show us things that they wanted to be changed, because they know that we can help. (CHC Member)*

Perhaps the most fundamental difference was the perceived professionalism of HIW, who were seen to have greater authority and 'more teeth' compared to that of CHCs. This is illustrated in the quotes below:

HIW have more teeth and more respect...and more respect because of more teeth...We are purely volunteers, and they are paid..They are quality assured. We look more at fabric of place, rather than the care. We don't want to interfere with that. (CHC Member)

HIW can evidence things and they are extremely professional... I relish the amateur-ness of the members – they don't lie, they don't have a professional career dependent on saying the right thing...they say what they see and what it seems like. This is really important. Perceptions are important. (CHC Staff)

8.2.1 Framework for Joint Working

Given the close nature of their work, a framework for joint working between HIW and CHCs in Wales has been established. Firstly, a Concordat between bodies that inspect, regulate and audit health and social care services in Wales provides a framework for signatories to coordinate external review activity and share information. Secondly, a Memorandum of Understanding (MOU) between HIW and the Board of Community Health Councils has been developed (further details below).

³⁷ Regulation 29(1) and 26, Welsh Statutory Instruments (2010) *National Health Service, Wales: the Community Health Councils (Constitution, Membership and Procedures) (Wales) Regulations 2010 No.288 (W.37)* HMSO: p.23 and 26

Good Practice Example 11: CHC Board and Healthcare Inspectorate Wales Memorandum of Understanding

Objective

To establish a framework for improved joint working between Welsh CHCs and Healthcare Inspectorate Wales.

How this was achieved

A detailed Memorandum of Understanding was drawn up between Healthcare Inspectorate Wales, the Board of CHCs, and the CHCs. The MOU outlined processes for improved joint working and covered areas such as information sharing, undertaking joint investigations, potential areas for collaboration, cross referrals, sharing resources, disseminating good practice and commissioning research and reviews. It is reviewed annually.

A further mechanism for joint working between the organisations is via a joint appointment: *Since agreeing the MOU in 2011, one of the key ways in which we have sought to ensure that it is implemented in practice is through the joint appointment of a secondee from the CHCs. Based at HIW, but working across our two organisations, the post holder is helping to ensure strong liaison and the fostering of effective working relationship at both strategic and operational levels. [Stakeholder]*

8.2.2 Implementing the Framework

The existing formal frameworks (and most notably the Memorandum of Understanding) are helpful, but the extent of cooperation and coordination between CHCs and HIW appears to be limited. There were some promising examples of where the two organisations had shared intelligence: for example through joint participation in the annual programme of Healthcare Summits and HIW's use of the Hospital Patient Environment programme to inform and target their Dignity and Essential care spot checks. However, from speaking to people within CHCs, the impact of the MOU in reality was less encouraging:

We have an MOU...but, there is no value without actions against it...it needs more than an MOU to take it forward. (CHC Staff)

HIW didn't talk with us when they were going in – we were working in parallel rather than in partnership. (CHC Staff)

There is a memorandum of understanding with HIW but it doesn't practically mean much on the ground. (CHC Member)

Others stressed the potential for further development: *We have an MOU with them and it is operational...It could be tightened up a lot more.... we are building month on month [CHC staff/Member].* The potential for optimising the joint working between the two organisations was widely recognised, and opportunities included:

- a) Coordination of timetables and schedules - to avoid duplication of efforts
- b) Sharing of intelligence – to help set priorities
- c) Joint inspections of premises – to provide both a professional and lay member perspective, gaining both greater capacity and 'more teeth'
- d) Joint training – to support the CHCs to become more 'professional'

Despite the frameworks that were in place for joint working, the review team were aware of some anxiety around the prospect of closer working practices between the two organisations. For example there were concerns about the skills and training available to CHC Members: *Im not sure they would have the consistency they want... some of my members probably wouldn't make the grade .. they have never seen an assessment centre... they might fail on not being able to see bigger picture (CHC Member).*

Perhaps more controversially, the case was made that CHC Members should not have an inspection role:

We feel that they shouldn't really be doing the HPE survey and the local monitoring – both are limited in their impact in feeding back to the local community the findings of what they define as one of the key aspects of their work. All of this activity should stop, and this would free them up to do other things that statutory agencies could not do...There are potential skews that can be brought to bear in these visits and monitoring – they are not necessarily doing these from a neutral starting point. There is a naivety in some of these activities...Understanding of context is limited, and this impedes how well they can do their work. Different clinical environments have different demands and a simple check-list does not work – the NHS environments are not one-size fits all. [Stakeholder]

...there may be a role for them in scrutinising [HIW] and [its] inspections, rather than actually being involved in hands-on inspections of premises.... There is a place for bringing fresh air and a different perspective from volunteers. If they did scrutiny rather than inspection that would be better. They could develop a sense and feel for an organisation without a clipboard. [Stakeholder]

On the other hand, the benefits were realised by LHB representatives:

HIW reviews at the moment are done by clinical staff. It is important to have a working professional's view of things...But, the independence of CHC added to that would be great. It would be so much more helpful if they came together as one....lots and lots of visits sometimes get watered down... it would be more powerful if they came together. Instead, we respond to less with more focus and concentration. (LHB/Trust representative)

Something about CHC...if it was made up of different people it could make a big impact...get them connected to HIW and CSSIW. (LHB/Trust representative)

There was considerable interest in the prospect of a small number of CHC Members (perhaps two from each CHC) receiving training from HIW and becoming actively involved as the 'lay' element of their inspections, thereby also providing an effective channel of communication and mutual understanding between HIW and the CHCs.

8.3 CARE AND SOCIAL SERVICES INSPECTORATE WALES (CSSIW)

CSSIW is responsible for registering, inspecting and regulating services that include care homes with nursing care. Such services can also be visited by CHCs in their role in inspecting health services on behalf of patients; However, CHCs are not currently performing this role due to historical issues (described elsewhere in this report). Like with Healthcare Inspectorate Wales, an MOU has been developed between CHCs and the Care and Social Services Inspectorate in Wales. However, this has not yet been formally ratified and it is unclear why this is the case.

There was some evidence of joint working, most notably in Cardiff and the Vale CHC, where the two were working together to devise a joint methodology for the inspection of nursing homes. There is recognition that further work is required to improve relations between the two bodies: *we are ready to work with the BCHCW in comparing and analysing the implications of the information that we are each accruing on the patient/service user experience of health and social care. [CSSIW]*

8.4 OLDER PEOPLE’S COMMISSIONER AND CHILDREN’S COMMISSIONER

Links between CHCs and the Older People’s Commissioner have developed recently, following the involvement of a leading CHC figure in the Commissioner’s review of dignity and care in in-patient settings. Discussions have subsequently taken place on how CHCs can continue to monitor progress made by LHBs and Trusts in implementing the Commissioner’s recommendations. This is a useful demonstration of how the CHCs’ on-going local intelligence and presence can be harnessed to monitor progress on issues identified by others.

Links with the Children’s Commissioner are not yet as well developed.

8.5 OTHER

8.5.1 Voluntary Sector and Local Authorities

Community Health Councils are linked to the voluntary sector and local authorities, in part, by their membership structure. However, as alluded to in the membership chapter of this report, these links are not always fully exploited:

We feel that the relationship between CHCs and the voluntary sector should be expanded and that signposting, joint working, contracting out of service provision, and direct referrals should be explored in order to ensure NHS users are actually getting the support that they need and are entitled to. [Third Sector representative]

County Voluntary Councils and CHCs share a common interest in supporting the engagement of local people. Given the similarities, the need for greater joint working has been acknowledged:

It is important that CHC and CVCs work together and respect their differing roles and the areas where they overlap. There needs to be mechanisms in place by which they share information. Regular meetings, clarifying the role of the third sector members and developing a local CHC and CVC Memo of Understanding which builds on the centrally developed MOU would help. (Other)

The relationship with the voluntary sector really worries me. The voluntary sector needs to have a voice into the NHS, and for many groups this is their only way in. This could be better – but much of this is down to finances. The CHC in Ceredigion meets the CVC four times a year, but I’m not sure the same is true for Pembrokeshire and Carmarthenshire. For some of the voluntary sector groups who have an existing relationship with the health board – like the Red Cross – they need to have a voice through the CHC too. (CHC Member)

Given that CHCs have a relatively small staff base, there might be opportunities to expand capacity by supporting volunteers in roles other than that of Members. (Other)

8.5.2 Professional Bodies

A strong case was made for the strengthening of relationships between CHCs and professional bodies, including the Royal Pharmaceutical Society, to allow CHCs to receive advice on professional issues relevant to the delivery of health services in Wales:

We advocate that capturing intelligence about health professional working practices through working with professional bodies should also be considered important in the formulation of CHC responses and approaches to Health Boards while acting as the patient’s voice. An understanding of health professional regulation should also support CHCs in advising patients on issues they may have as well as ensuring CHCs can form well considered views on a wide range of issues e.g. an issue raised to a CHC on medication administration or dispensing may require a thorough

understanding of pharmaceutical regulation and advice should be sought from the General Pharmaceutical Council (GPhC), the independent regulator for pharmacists, pharmacy technicians and pharmacy premises in Great Britain (Other).

There is some evidence that nationally, the CHC has worked to secure a positive relationship with the General Medical Council:

The Board and wider CHC's have always engaged positively with the GMC. They have an effective approach to consultation and have ensured that many views from across Wales have been incorporated into GMC standards and ethics work, such as our 'Raising and acting on concerns about patient safety' guidance for doctors. The Director of the Board has been hugely supportive of the work of the GMC in regulating doctors and ensuring good medical practice in Wales. The Director understands the significance of our work and the importance of it to patients in Wales. She has sought to give the CHC's, and therefore patients, a voice in GMC work and activity, for which we are very grateful. (Other)

8.5.3 LHB Stakeholder Reference Groups

Stakeholder Reference Groups were established in 2010, and there appeared to be some duplication and overlap with their role and that of CHCs. The role of Stakeholder Reference Groups is unclear to many stakeholders, and as a consequence so is the relationship between the groups and CHCs. Greater clarity is required about the purpose of the SRG and where it can make a difference to the CHC: *The SRG is a very strong group, very high powered, bring perspectives .It is a reference group.....the people round that table would make significant difference to CHCs. (LHB/Trust representative)*

8.6 CONCLUSION

This section has provided an overview of the current relations between CHCs and key stakeholders such as Healthcare Inspectorate Wales and the Commissioners in Wales. Although the potential opportunities for further coordination between CHCs and other organisations have been identified (for example in MOUs), the evidence collated throughout this review suggests that they have a way to go to optimise these relationships. Whilst the contribution of Community Health Councils in Wales is unique, in many respects they share similar responsibilities with other bodies. Whether it is patient and public engagement, or scrutiny of health services, CHCs would benefit from closer partnership working. More joined up working could lead to a more efficient and influential delivery of their core responsibilities.

9 ADVOCACY SERVICE

The final term of reference entreated the Review team to ‘consider how the Advocacy Service should be provided in the future’. Perhaps more than in any aspect of their work, the advocacy services run by local CHCs are seen as universally delivering important services effectively to patients across Wales.

By way of context, the *Complaints Advocacy Service Report 2010-12* provides a number of helpful tables, data and information about the advocates.³⁸ Figure 3 on the following page is taken from the report and provides an indication of the amount of complaints received and the cost of the service by each CHC. In addition, Table 5 below takes the cost of the advocacy service for 2011-12 and divides that by the population in each area to give a per capita equivalent cost per CHC.

Table 5: Amount spent on advocacy service by CHC and population, 2011-12

| Community Health Councils | Population | Average core advocacy hours (weekly) | Cost of Advocacy Service (£) | Cost per head of population (£) |
|-------------------------------|------------------|--------------------------------------|------------------------------|---------------------------------|
| Betsi Cadwaladr | 681,800 | 140.25 | 248,399 | 0.36 |
| Brecknock and Radnor | 131,700 | 37.38 | 58,226 | 0.44 |
| Montgomeryshire | | | | |
| Abertawe Bro Morgannwg | 502,900 | 90.2 | 118,230 | 0.24 |
| Hywel Dda | 374,600 | 75.0 | 92,405 | 0.25 |
| Aneurin Bevan | 560,400 | 100.34 | 133,849 | 0.24 |
| Cwm Taf | 290,100 | 45.0 | 63,745 | 0.22 |
| Cardiff and Vale of Glamorgan | 470,800 | 66.68 | 99,970 | 0.22 |
| TOTAL | 3,012,300 | | 814,824 | 0.28 |

Source: Board of Community Health Councils in Wales

There were inevitably a range of views expressed after the broad endorsement of the service. Three areas in particular emerged. Firstly, there were comments received about the visibility of the service and a range of views expressed about the relative strengths and weaknesses of being a formal part of CHCs given the lack of awareness that patients and the public have of them on the whole. Secondly, issues were raised in relation to the quality of services provided and the variation thereof, with concerns raised about the distribution of the resource across Wales, and whether the available capacity is in direct relationship with local need. Finally there was a degree of discussion about the effectiveness of links with the local and

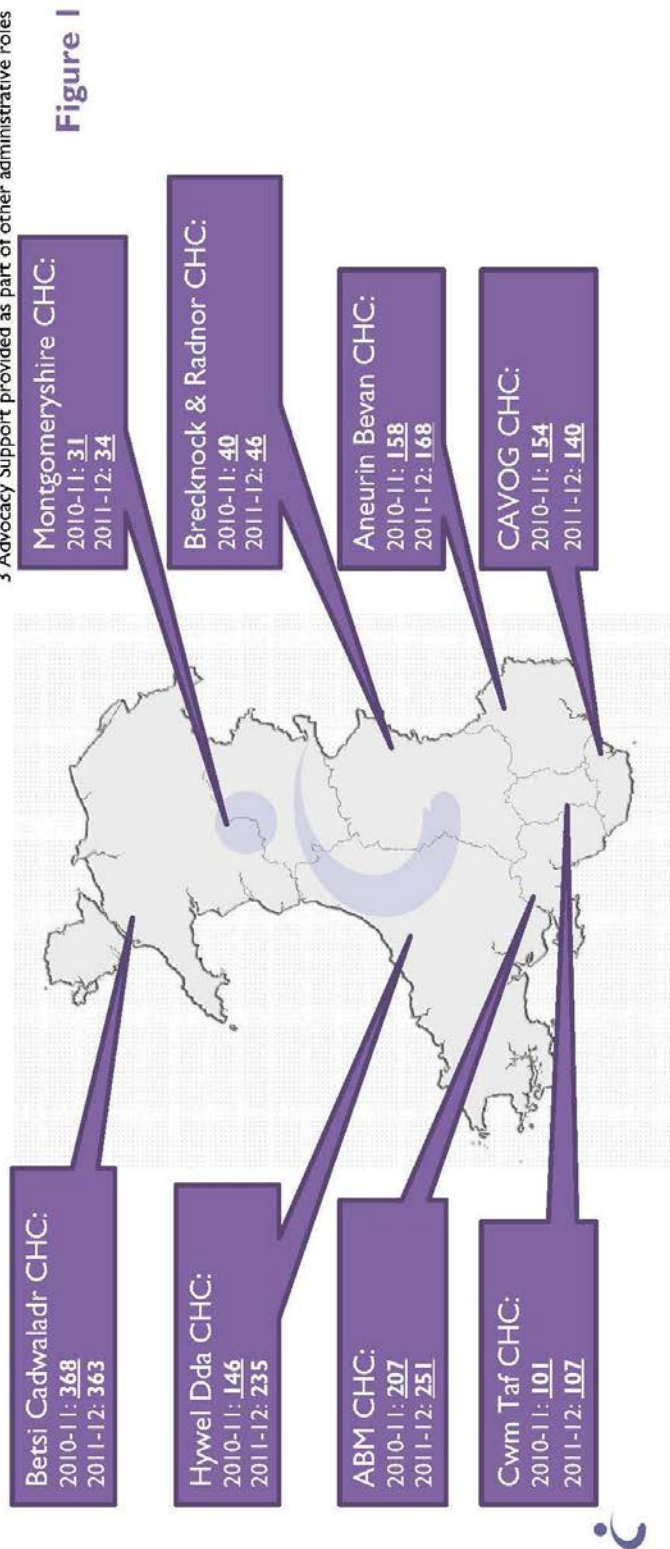
³⁸ Board of Community Health Councils in Wales (2012) *Complaints Advocacy Service Report 2010-12* – see: <http://www.wales.nhs.uk/sitesplus/documents/899/BCHCW%20Complaints%20Advocacy%20Annual%20Report%202010-12%20FINAL.pdf> – accessed June 2012.

national CHC bodies, and other organisations – principally Healthcare Inspectorate Wales, but also (in respect of nursing homes) the Care and Social Services Inspectorate for Wales. In some instances these relationships were very well established and there are others where this is less so.

Figure 3: Distribution of complaints across Wales, 2010-12

| CHC COMPLAINTS ADVOCACY SERVICE | Population (2010 Public Health Observatory Wales) | Average Core Advocacy Hours (weekly) ¹ | Average Core Support Hours (weekly) ¹ | Annual fixed Costs Expenditure (average based on 2010-12) | Annual variable Expenditure (average based on 2010-12) | Total No. of Complaint Rec'd 2010-12 |
|---------------------------------|---------------------------------------------------|---------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------|--------------------------------------|
| ABERTAWA BRO MORGANNWG | 504,457 | 90.2 | 46.75 | £106,461 | £4,009 | 458 |
| ANEURIN BEVAN | 561,420 | 100.34 | 37.5 | £120,186 | £8,615 | 326 |
| BETSI CADWALADR | 678,461 | 140.25 | 110.5 | £220,332 | £15,747 | 731 |
| BRECKNOCK & RADNOR | 53,882 | 19.26 | 12 | £53,399 ² | £3,887 ² | 86 |
| CARDIFF & VALE OF GLAMORGAN | 466,030 | 66.68 | 37.5 | £96,415 | £2,908 | 294 |
| CWM TAF | 290,008 | 45 | 29 | £55,537 | £4,512 | 208 |
| HYWEL DDA | 374,741 | 75 | 28.75 | £79,755 | £6,460 | 381 |
| MONTGOMERYSHIRE | 48,910 | 18.12 | 27 ³ | £53,399 ² | £3,887 ² | 65 |

¹ Average hours calculated from HR records dated Jan 2011 and Feb 2012
² Please note that Brecknock & Radnor and Montgomeryshire CHC Advocacy are budgeted together as Powys Federation
³ Advocacy Support provided as part of other administrative roles



9.1 VISIBILITY AND PROFILE

It is fair to state that some respondents felt that there were no problems at all with the profile of the advocacy service – *When I'm ringing organisations, I say I'm from the CHC. There is definitely an open door when I say that. It gives us integrity, respectability and credibility (CHC staff)* – and indeed that there are distinct advantages in terms of visibility for being integrated within CHCs:

It's an advantage that we are a formal part of the CHC – people can ring up in a flap and when we mention that there are people here to support complaints, they are delighted. It's not necessarily easy for people to get directly to us, and if they are connected to other agencies we have good networks so they might be referred to us. (CHC staff)

That said, and mirroring the concerns expressed earlier about CHCs as a whole, the majority of comments were rather more negative in tone about the awareness that members of the public, patients and other organisations have about advocacy services across Wales:

The advocacy service is poorly advertised and poorly promoted as are CHCs on the whole. No-one knows about us. (CHC staff)

We deal with 11% of the overall number of complaints that go into [area], which I think is not enough. If we're only attracting 11% we're missing a chunk of people who we could help. (CHC staff)

Public awareness MUST be increased. People will only use it if they understand it. (Other)

I know this works but there's not enough public profile. The general public don't know they are there. It's about word of mouth not leaflet...CHCs need to talk to more groups. There are lots of people who don't know where to turn and dreadful things have happened to them. (Other)

Again, as for CHCs, the issue of nomenclature was raised as a barrier to the successful engagement of patients and the public: *they think we are part of problem not the solution – it does so much damage to our credibility (CHC Member)*. On the more positive side, the recent 'Putting Things Right' project (explained in the box below) has helped with recognition and profile:

We're flagged up on the new 'Putting Things Right' leaflets which has been an improvement in the way things used to be run. (CHC staff)

I think we get a lot from our website – there are certainly lots of client compliments. Health professionals refer via this route too. We are getting better known because we are mentioned in the 'Putting Things Right' booklet. Solicitors refer a lot, and wards request our leaflets. (CHC staff)

It was suggested that the fact the service is not well-known actually saves it from being overwhelmed. It currently deals with around 11% of the overall numbers of complaints to the NHS, but staff were fearful that if awareness were raised they might be unable to deal with the consequences: *I would like us to advertise advocacy more but I don't know if we could handle more complaints (CHC staff)*. Overall, there was a feeling that with or without awareness raising activities, very soon advocacy services were going to run short of capacity: *we are approaching a tipping point where our waiting list is soon going to be rather long (CHC staff)*.

An identified solution to that potential problem centred on whether volunteers could be used more extensively in what has been to date, for very good reasons, a service provided entirely by CHC staff. Opinion was divided. There were those who could immediately identify where volunteers could add value to the current offer: *a volunteer advocate could be very useful in helping to promote the service. We don't use Members to do this awareness raising and this would be a good role for volunteers to engage with. The talks do generate issues, so the volunteer would need to be sensitive (CHC staff).*

Good Practice Example 12: Putting Things Right

The 'Putting Things Right' (PTR) Project was established by the Welsh Government with the NHS and other partners, to look at how the NHS in Wales could improve its response to people and provide effective redress when things go wrong. PTR provided an opportunity to examine what happens now in complaints, claims and risk management, and to help shape developments for the future. The underlying principle of PTR is that whenever concerns are raised about treatment and care, whether through a complaint, claim or clinical incident, those involved can expect to be dealt with openly and honestly, receive a thorough and appropriate investigation and a prompt acknowledgement and detailed response about how the matter will be taken forward. PTR aims operates on the rationale of "investigate once, investigate well". It acknowledges that one-size does not fit all; the level of investigation should be appropriate to the issue being looked at.

The role of CHC Complaints Advocates is enshrined within the legislation, which provides for them to continue in their essential role in providing free, confidential and independent advice to patients and the public. Full information on PTR can be obtained from www.puttingthingsright.wales.nhs.uk.

Others were more guarded in their support, suggesting that whilst there could well be a role for volunteers to help with the demands placed on advocacy services, this would need to be carefully handled: *there might be a lot of issues with volunteers engaging in advocacy. They would need to be very well monitored, supervised and managed – I wouldn't shut the door on it entirely but it would need to be done delicately. However a volunteer who could handle the simpler issues and cases would be very welcome – one example would be in providing people with feedback should they want it. This would be a very good way in for people – they could do the qualification whilst they are doing these types of cases. It would need to be thought through carefully but there is real prospect in this (CHC staff).* There were others, however, who felt that the negatives outweighed the positives when it came to using volunteers – in whatever capacity – within the advocacy service:

There is a high level of skills needed, and volunteer advocates might not work as well it might be. There is a massive burden of time and training that would be needed. This could work as long as the quality of the service was not diluted. One of the problems might be with the churn that volunteers go through and the lack of continuity that it built into this. It's a balance of risks and benefits. This would need to be a function kept separate from the membership though. Much of this is about the knowledge base that you have. (CHC staff)

I think volunteer advocates would be very difficult without a fair amount of training and development. There is too much of a cross over – it's hard to divide tasks. In [CHC] they have an enquiries officer and we would welcome that here. We have it here to some extent with a complaint support officer but they are staff not volunteers. Most members are aware of the complaints procedure and I think quite often they will give advice. (CHC staff)

A second identified solution focused on whether there was spare capacity anywhere within the current allocation across Wales, which could be redistributed on the basis of a needs assessment, or which could simply be used to provide cover in the event of staff absence: *there may be benefits of a pooled resource in relation to advocacy (CHC Member).*

9.2 QUALITY OF SERVICE

During discussions, respondents identified a number of different dimensions that they felt constituted currently, or needed to be implemented in order to constitute, a quality advocacy service.

9.2.1 Qualifications and Accreditation

One of these elements concerned the qualifications needed for advocates and whether the service should be accredited. The majority of respondents were positive about these issues:

City and Guilds accredit what we are currently doing. We're 'clinically' supervised as well as line managed by the Chief Officer. This keeps us up to scratch, and keeps the client safe. (CHC staff)

The only qualification for advocacy is a City and Guilds but it is one of those qualifications that you need to be doing to get it. As people come into the service I feel they should be working towards it and at the moment this is not a requirement. Previous experience if not directly in advocacy but at least a related field is very important – the qualities of making sure that things are done in an appropriate way. (CHC staff)

The 'Action 4 Advocacy' quality mark is something that we've discussed and a paper has gone to the board, but nothing has come back yet. This would be a really good thing for us to work towards. (CHC staff)

These sentiments were by no means universal – there was a degree of ambivalence among other respondents: *specifically in terms of advocacy and its qualifications, you don't have to have a bit of paper. There's a City and Guilds in Complaints Advocacy but none of us [in this CHC] have done it – and there's no absolute requirement for us to do this I think. If there was a new person coming to the job it would be useful to them, but because we've got lots of knowledge and skills the actual qualification wouldn't do anything to add value to our skills. In terms of professional development, this has been very good and we're not convinced that we need a certificate. We have regular appraisals within the CHC, and this is augmented by the network that we've had – we had lots of really useful presentation from solicitors, the ombudsman. The network works – every CHC is represented even if every advocate can't be there. The crucial thing is about having the right skills to do the job – and these skills are transferable. We work well as a team because of our different backgrounds (CHC staff).* In addition, there was concern expressed about the nature of the 'generic' skills that the CHC advocacy services offers, as opposed to the very 'specialist' skills that certain advocacy services can deliver. Striking the right balance between these different skills, to ensure that the right kind of advocacy is always offered to patients was suggested:

We believe that it is sensible for local NHS complaints advocacy to be provided through CHCs as part of a local "one stop shop" for patients and the public. However, we think it may be unrealistic to expect CHCs to be "all things to all men". A model whereby the CHC provides generic NHS complaints advocacy, but can draw on more specialist advice or advocacy providers where needed, would be appropriate. This is particularly the case in some aspects of mental health, and in connection with the "redress" considerations as part of the "Putting Things Right" initiative. This is a more specialist role requiring knowledge of medico-legal issues. Rather than expecting CHCs to acquire this, commissioning an outside agency to work with CHCs would be more appropriate. This model was anticipated when WAG was developing "Putting Things Right", but this has still not been put into place. (Other)

9.2.2 Supervision and Leadership

Secondly, there were a number of responses about the need for the advocacy service to be adequately supervised, and with the right kind of leadership. On the adequacy of the current supervision arrangements, there was a mixture of views expressed:

I'm more than happy about the supervision I get from [Chief Officer]. Supervision is two way – I can seek advice, he can monitor, and he also goes through two cases with me each time. The networking group is there which is good. The type of advocacy that the service offers is procedure bound. I haven't seen an issue come up where there is uncomfortable situation where a lay person is line managing it. (CHC staff)

Having a supervisory role for advocates would be good for professional development. We could prepare people for the role and then deploy them as appropriate. We wouldn't want to lose the good status that the HB holds us in, so people would need to be selected very carefully. (CHC staff)

Supervision has been an issue that has been raised in the advocacy networking group. It is sometimes quite difficult. How can they be best place to support us? The job can be quite upsetting and it is draining sometimes. We lack the support of people saying 'are you ok?' At the moment we use each other a lot. It's important we have access to somebody – our line manager is the Chief Officer but there are limitations to that. (CHC staff)

Having professional development sessions with these people is limited. It would be good to have a mentor when people start which may not happen nationally. Having appraisals done by a specialist in advocacy would be better than the current arrangements. One of the functions of the supervision relationship with the Chief Officer is to help with the judgements about how and when to withdraw. I've also got a colleague who is quite useful as a sounding board for this. (CHC staff)

9.2.3 Variations in Services across Wales

Inevitably the variations above coupled with the specific challenges of local circumstances meant that respondents reported that there was some variation in practice across Wales. In no small part people identified the lack of standardisation in key processes at the centre of much of this:

The complaints advocacy service should be more standardised across the whole of Wales. But you also have to look at the needs of the population you serve – but a uniform approach to case management would be helpful. This would help with efficiency. (CHC staff)

I'm not sure that the new things that arise from the network are always being taken up in a uniform way. For example, there is variation in domiciliary visits – in some places you get a home visit and in others you don't and this is a bit of a problem. The advocacy service needs more leadership and vision, and even though that might require individuals to lose a bit of autonomy to guarantee uniformity this might well be worth doing. (CHC staff)

In particular their work on complaints advocacy and trends identification are truly having outcomes which benefit the patient. It is working less well in some other areas where there has been a breakdown in the relationship between health board and CHC. (Stakeholder)

In the last two years the complaints advocacy services across Wales have seen an average of a 30% increase in the numbers of complaints coming into the service, hence the shift of these services towards offering early resolution. Each service is delivering on this in slightly different ways dependent on local service provision and locality need. (CHC staff)

We have heard talk of need for standardisation for couple of years now but we're still not all doing it. For example in relation to home visits there are different views – should we be doing them? It is not the same in each CHC. Here, we agree a small number of complainants need home visits and we do the risk assessment and use normal lone working policies. But in another CHC the Chief Officer will not authorise home visits. (CHC staff)

These differences might be entirely acceptable were it not for the fact that there was evidence submitted to the Review team that the lack of a standardised approach is acting as a barrier to the adoption of good practice. The Aneurin Bevan CHC advocacy service is an apposite example, aiming to provide mediation and facilitation. Their enquiries officer (a non-advocate) has reduced by 30% the number of cases that come to the advocates by dealing with complainants at an early stage and triaging effectively, thereby releasing capacity in the system. However as the respondent below noted, there should be more of a requirement to adopt good practice when it is obvious that it is being demonstrated somewhere in Wales: *Aneurin Bevan CHC has a good four-stage model but this has not been issued nation-wide. There is an inherent problem in the CHCs because it is unclear whether the Chief Officer is accountable to the local board, national board or the lead Chief Officer for that area. For example, in terms of advocacy it's left up to individual Chief Officers to run with particular initiatives, and there's no requirement to do things (CHC staff)*. This is not to suggest that advocacy services do not deliver tangible and meaningful outcomes – for complainants and indeed the health board that they are complaining about –as the evidence (in the quotation and the box below) makes clear:

The health board acknowledge that complaints handled by an advocate are much more straightforward, much less messy, and we are able to ask the right questions – so we provide a much more efficient service. This leads to more satisfied complainants, and far fewer people who drop out of the complaints process. Sometimes the successes are very intangible – some people just want to be able to meet with the key staff and share insights. There's something about awareness – the numbers of cases are going up and up, and it would be good if there were more advocates here. We get very good feedback from people – they are reassured by the fact that the CHC can offer a continued monitoring function and make sure that things are followed through. (CHC staff)

Good Practice Example 13: Letters received in recognition of the Complaints and Advocacy Service – Hywel Dda CHC

"I am taking this opportunity to commend the staff with the highest praise for their professionalism, efficiency and compassions. I can only offer my gratitude for their swift and effective actions on the my behalf"

"I would like to thank everyone concerned for the swift, efficient and polite manner in which my complaint was dealt with"

"We would like to express to your our warmest thanks for all the time, effort and understanding you have given to us regarding the complaint and for your warm and friendly manner. We have found our experience with the Community Health Council to have been outstanding, thanks to you and your team"

9.2.4 Resource Implications

There are clear and obvious resource implications of providing a professional advocacy service.

There are however several problems with both the resource allocation system in Wales and how effectively money is spent on advocacy that were brought to the attention of the Review team. Set against a context of stretched finances and competing priorities, rational and robust allocations systems, or the lack thereof, attracted some sharp criticism:

We have never had good model of distributing resources for CHCs. There's no breakdown of actual need, and advocacy is under enormous strain. Resourcing was historically done on the basis of the confederations, but now the number of hours you get is a function of the effectiveness of the case that you put forward and then the allocation will come. There needs to be a review of the number of the advocacy hours that you have per compliant per patch. (CHC staff)

It is difficult to determine whether advocacy services provide value for money. Table 5 points to considerable variation in the cost of these services per capita, with the most expensive costing double that of the least expensive. There are, inevitably, a number of reasons to explain this variation, but it is incumbent on CHCs to ensure that everything that can possibly be done is being done to reduce such inequities.

9.3 LINKS WITH THE CHC AND OTHERS

9.3.1 Links within CHCs

The advocacy service is potentially a valuable source of intelligence for the CHC in its other roles:

We share information about the change in services. Intelligence passes from one to another within the CHC which informs our work. Services changes in the health board have to come through the CHC and that allows us to target our services knowing that there are likely to be problems in making the changes that the health boards want to. There are lots of times when some general news items have informed our work, our work has informed the Chief Officer and that has then been taken to the Medical Director and a new pathway has been established. Without the complaints advocacy service, the CHC would generally be less well-informed about the day-to-day running of the NHS. (CHC staff)

The advocacy service should firmly remain within the remit of CHCs. The great strength of locating the advocacy service within CHCs is the seamless link between complaint trends and monitoring activity/dialogue with health boards. Situating the advocacy service elsewhere would break this logical link – see the work on the situation in England following abolishing CHCs. (Other)

The full potential of the intelligence sharing function may not always be realised: *we are not using intelligence from cases as well as we could be. We could be informing the monitoring side of things better than we are. We have developed a monitoring form, for the monitoring team to check progress at visits but the health board do not always give us specific detail about what will change as result of complaint (CHC staff).*

One of the other positives of the link between advocacy services and CHCs was that this leads to 'early intervention' which has the impact of resolution being achieved before things escalate unnecessarily: *the fact that complaints advocacy is in the CHC means we can do the job more effectively. We can feedback to members and Chief Officers and we have been doing joint workshops with the health board to get to know the people who are dealing with complaints. It's a good relationship. We can resolve issues before they become complaints this is good (CHC staff).* There was, however, a feeling that things could be improved. It was noted that better sharing would lead to improved outcomes – *we could do more good practice sharing and it should be the case that we are very open to each other (CHC staff)* – and that considering giving the service a stronger individual identity would ensure that it has a greater impact – *I've heard bad things about the fact that they felt they couldn't take cases further. They don't have enough teeth (CHC Member).*

9.3.2 Links with Others

9.3.2.1 Healthcare Inspectorate Wales (HIW)

From both the CHCs and HIW, there were comments that the relationship, whilst founded on the principles of the Memorandum of Understanding, has the potential to improve. An advocate commented that there are some channels to communicate information, but that these are limited: *Serious incident reviews go to HIW, but lower level stuff doesn't go across – those mechanisms don't exist to transfer intelligence about these less significant complaints and problems. We need to meet with HIW to explore and find out which bits would be useful. Joint visits can happen but I'm not sure how routinely these happen (CHC staff)*. From HIW, there was support for the advocacy programme, but a broader range of concerns about its visibility:

There's strength in the advocacy programme and there are some excellent examples of good practice. But the public don't often know that the service is there for them. Lots of people contact us with individual complaints, and we then signpost people onto the complaints advocacy services within the CHC, and they typically say that they didn't know about the CHC and what they do. (Stakeholder)

9.3.2.2 Care and Social Services Inspectorate Wales (CSSIW)

In terms of the links with CSSIW, there was broad support for the advocacy services offered, especially given that CHCs have not fully discharged their duties in relation to NHS-funded patients in nursing homes:

Not surprisingly we support any development which delivers effective advocacy for people who use services. The complaints and advocacy service provided by CHCs has the potential to empower citizens – some of whom will be using a service regulated by CSSIW or caring for an individual who uses such services. We would welcome any future development that puts together the intelligence from engagement and advocacy across health and social care. More specifically, we are ready to work with the national board in comparing and analysing the implications of the information that we are each accruing on the patient/service user experience of health and social care. (Stakeholder)

9.3.3 Other Links

Other organisations either made comments about the links between their functions and advocacy services, or were named by others in their responses. Such organisations included the Public Services Ombudsman for Wales and the General Medical Council (GMC):

It would be good to look at what the added value of involving the advocacy service is, especially for organisations like the Ombudsman, because I would hope that the cases we pass to them are better because we've got good paperwork. (CHC staff)

CHC advocacy needs to be alert to the role of the GMC, especially our fitness to practice procedures for doctors. Staff need to be able to identify serious professional concerns and ensure that the GMC, via the GMC's Welsh Office and the local Employment Liaison Adviser, are alerted to those. We would encourage regular meetings between CHC advocacy staff and the GMC Wales team. We would also find it helpful to work more closely with CHCs and HIW on formalising data on patient concerns/complaints. (Other stakeholder)

The Public Services Ombudsman reported positive working relationships with CHC advocates, and commented favourably on their professionalism.

Finally, and similarly to more general CHC activities, it was suggested that the advocacy service needs to be acutely aware of the complaints that cross CHC and national borders: *Our advocacy service negotiates with*

Chester as they would with a Welsh hospital. The advocates do not stop at border but complaining across borders is difficult and the new guidelines are a challenge (CHC staff).

9.4 CONCLUSIONS

The Complaints Advocacy Service is well-regarded by clients and all stakeholders. While there are several areas where performance could be further improved, there is no obvious case for fundamental changes in the way the service is structured or provided.

The contrast with the experience elsewhere is interesting. Despite sharing broadly similar aims and ethos around valuing patient feedback, learning, supporting complainants with independent advocacy, the governments in both Scotland and England have decided to find alternative ways to provide advocacy, choosing to out-source these functions to agencies and charities who are experienced in providing advocacy. In Scotland, there is one contract for the Independent Advice and Support Service (IASS) with Citizens Advice Scotland, and there are three commissioned providers of the Independent Complaints Advocacy Service (ICAS) in England: POhWER provides ICAS services in the East of England, West Midlands and London regions; SEAP (Support, Empower, Advocate, Promote) provides ICAS in the South East and South West of England; and The Carers Federation provides ICAS in the North West, North East, East Midlands and Yorkshire and Humberside. Both systems are working with a different legislative framework and both IASS and ICAS are hoping to ensure professional, effective, and equitable services with rigorous quality assurance and feedback learning loops. It is still early days, and the services appear to be working well, especially in Scotland. What these different paths point to is that there are clearly a range of ways of providing advocacy services and it is well-worth keeping a watching brief on the impacts, outcomes and resource implications of these approaches. But there is no evidence to suggest that these systems are obviously better than the arrangement in Wales, which has the added potential for intelligence sharing across the range of CHC activity.

10 VALUE FOR MONEY

10.1 INTRODUCTION

The terms of reference asked that the review consider 'what we are getting for our money and where Community Health Councils can be more efficient'. Discussions about the overall 'value for money' provided by CHCs were heard, and the issue of budgets and their allocation was raised. This section provides an insight into these discussions, supported by an analysis of the budgetary information submitted to the review team by the Board of CHCs.

10.2 BUDGETS

10.2.1 Management and Allocation of Budgets

The combined budget for CHCs in Wales in 2011/12 is approximately £3.8million, the equivalent to about £1.27 per person. The annual budget for CHCs in Wales has increased by 20% since 2006/7; *In terms of the budget it has been a typically roll-over budget...you get the same this year as last...I'm a bit surprised that we haven't been subject to the 5% cost improvement savings that other organisations have been. (CHC Staff)*

Table 6: Budget Allocation to CHCs, 2006/7 to 2011/12

| Financial Year | Annual Budget |
|----------------|---------------|
| 2006-2007 | £ 3,099,721 |
| 2007-2008 | £ 3,362,107 |
| 2008-2009 | £ 3,669,504 |
| 2009-2010 | £ 3,648,621 |
| 2010-2011 | £ 3,667,000 |
| 2011-2012 | £ 3,853,000 |

There are some apparent anomalies in the distribution across Wales - see table 7. For example, in Powys the allocated budget equates to £1.89 per head of the population, and in Cardiff and the Vale CHC each person receives less than half of this – 80p per head of the population. This seemingly unequal distribution of the budget was a much discussed issue throughout the review. Whilst much of the way in which the fixed and variable costs of CHCs have been calculated is historical, it became clear that no formal mechanism for allocating budgets on the basis of need has been established, and no rational case has been expressed to explain the variation seen in budgets across Wales. It would appear that individual CHCs' allocations owe more to historical accident than a rational process of determining need.

Table 7: Analysis of CHC budgets 2011/12

| COMMUNITY HEALTH COUNCIL | SUMMARY | | | | FIXED COSTS | | | VARIABLE COSTS | | | FIXED AND VARIABLE COSTS | | | COMPLAINTS ADVOCACY COSTS | | TOTAL COSTS | | |
|--------------------------------------|-----------------------|------------|----------------|-------------|-------------|-------------------------------|-------------------|----------------|-------------------------------|-------------------|--------------------------|-------------------------------|-------------------|---------------------------|-------------------------------|-------------------|-------------------------------|-------------------|
| | Local Authority Area | Population | CHC Population | CHC Members | Fixed Costs | <i>per head of population</i> | <i>per member</i> | Variable Costs | <i>per head of population</i> | <i>per member</i> | Sub Total | <i>per head of population</i> | <i>per member</i> | Complaints Advocacy Costs | <i>per head of population</i> | Total local costs | <i>per head of population</i> | <i>per member</i> |
| Abertawe Bro Morgannwg | Bridgend | 134200 | 502900 | 36 | 254174 | 0.51 | 7060 | 31356 | 0.06 | 871 | 285530 | 0.57 | 7931 | 118230 | 0.24 | 403760 | 0.80 | 11216 |
| | Neath Port Talbot | 137400 | | | | | | | | | | | | | | | | |
| | Swansea | 231300 | | | | | | | | | | | | | | | | |
| Aneurin Bevan | Blaenau Gwent | 68600 | 560400 | 60 | 325875 | 0.58 | 5431 | 43965 | 0.08 | 732.8 | 369840 | 0.66 | 6164 | 133849 | 0.24 | 503689 | 0.90 | 8395 |
| | Caerphilly | 172700 | | | | | | | | | | | | | | | | |
| | Monmouthshire | 88000 | | | | | | | | | | | | | | | | |
| | Newport | 140400 | | | | | | | | | | | | | | | | |
| | Torfaen | 90700 | | | | | | | | | | | | | | | | |
| Betsi Cadwaladr | Anglesey | 68800 | 681800 | 72 | 461535 | 0.68 | 6410 | 78685 | 0.12 | 1093 | 540220 | 0.79 | 7503.1 | 248399 | 0.36 | 788619 | 1.16 | 10953 |
| | Gwynedd | 118800 | | | | | | | | | | | | | | | | |
| | Conwy | 114400 | | | | | | | | | | | | | | | | |
| | Denbighshire | 96700 | | | | | | | | | | | | | | | | |
| | Flintshire | 149900 | | | | | | | | | | | | | | | | |
| | Wrexham | 133200 | | | | | | | | | | | | | | | | |
| Brecknock and Radnor | Powys | 131700 | 131700 | 12 | 96406 | 1.21 | 8034 | 15363 | 0.24 | 1280 | 111769 | 1.45 | 9314.1 | 58226 | 0.44 | 248796 | 1.89 | 10367 |
| Montgomeryshire | | | | | | | | | | | | | | | | | | |
| Cardiff and Vale of Glamorgan | The Vale of Glamorgan | 124600 | 460800 | 24 | 237820 | 0.52 | 9909 | 28755 | 0.06 | 1198 | 266575 | 0.58 | 11107 | 99970 | 0.22 | 366545 | 0.80 | 15273 |
| | Cardiff | 336200 | | | | | | | | | | | | | | | | |
| Cwm Taf | Rhondda Cynon Taf | 234400 | 290100 | 24 | 192585 | 0.66 | 8024 | 16106 | 0.06 | 671.1 | 208691 | 0.72 | 8695.5 | 63745 | 0.22 | 272436 | 0.94 | 11352 |
| | Merthyr Tydfil | 55700 | | | | | | | | | | | | | | | | |
| Hywel Dda | Ceredigion | 76400 | 374600 | 36 | 319797 | 0.85 | 8883 | 44730 | 0.08 | 1243 | 364527 | 0.97 | 10126 | 92405 | 0.25 | 456932 | 1.22 | 12693 |
| | Pembrokeshire | 117400 | | | | | | | | | | | | | | | | |
| | Carmarthenshire | 180800 | | | | | | | | | | | | | | | | |

In addition, shortcomings in the budget management process were expressed to the review team. The Board, through its Director, has responsibility for the national allocation to CHCs as a whole. The review team heard how some local CHCs were unsatisfied by the management of the budgets centrally:

Since 2007 at least, the funding determined by the National Board has not been quick or transparent... As of today the funding is still not an easy matter to follow. (CHC Member)

There appears to be no governance.... [We have been] left high and dry gasping for money and they have lost it because they haven't sorted it before end of financial years...[there is] unspent money in their budgets at end of year (CHC Member)

Table 8 below shows the central budget allocation for 2011-12:

Table 8: Central CHC budget allocation 2011/12

| Central Costs | Annual Budget |
|--------------------|-----------------|
| Training | £30,270 |
| Marketing | £1000 |
| Members Assistance | £4000 |
| Contingency | £196,014 |
| Conference Costs | £1700 |
| Consultations | £0 |
| IT SLA | £77,770 |
| Legal Services SLA | £19,000 |
| Management SLA | £99,150 |
| HPE | £20,000 |
| TOTAL | £448,904 |

The review team heard concerns that local CHCs experienced capacity issues, despite there being no overall reduction in the budget for Wales. In part these capacity issues were related to the allocation of resources across Wales; *I don't have enough capacity to do everything that we want to do. We have 4.0wte less capacity than other CHCs, for a similar population. If you look at the numbers across Wales some CHCs are well-blessed and others are less so (CHC Staff).*

Some argued that given the power to do so, they would do things differently locally with their budgets: *The fixed costs are the office accommodation and staff... structures have been set but it doesn't mean they can't be reset. I'd say in this CHC that losing staff would mean I couldn't do certain things [but] other areas might be overstaffed. With the whole budget and a blank sheet [of paper] I would probably do things differently. (CHC Staff)*

10.2.2 Efficiency and Economies of Scale

Improving the efficiency of CHCs was part of the national and local agenda, especially given that some areas were already struggling with apparently inadequate capacity, and there was uncertainty around the future of the CHC budgets. First, it was recognised that the 'meeting' culture of CHCs was not necessarily the most efficient way of working:

We invested in video conferencing to reduce time out of office. But there are too many meetings and not enough out on ground for members. This is shown by the numbers that don't turn up to meetings! (CHC staff)

An example of money saving[would be] having more internal meetings. It save on venues and stationery. But, we couldn't cut meetings any more than we do now because they would lose their connection...we need five [local committees]... it is a large rural area etc... In the valley's communities people think differently. (CHC Staff)

There was some discussion about improving economies of scale, and rebalancing local and national operations:

If you look around at CHCs, they are all very small providers. If you could all share architecture in time you can all tender to same person which would deliver economies of scale. (CHC Member)

From a board level – CHCs are pretty small. As satellites out there this prevents economies of scale and makes transparency difficult...They are small islands of inefficiency... It is clearly important for a local interface (front of house) but important you bring 'back of house' centrally...You could do more centrally than with these silly little satellites. (CHC Member)

Efficiency could be achieved by considering a restructure as 'branches' of one national organisation. This would require plenty of planning time including appropriate job evaluation and consideration of outcomes rather than process. Great strides have already been made in terms of centralising IT and ensure that confidential data is hosted securely. It also has allowed for introduction of a videoconferencing system which is extremely easy to use, and has already reduced travelling expenses and time. (Other)

There was a notable lack of clarity about the relationship between the Board and Powys tLHB as CHCs' 'host organisation. It was unclear how the annual payment of £99,000 for this service was calculated, or what CHCs could expect from the service.

10.3 PERFORMANCE MANAGEMENT AND VALUE FOR MONEY

The majority of feedback centred on the fact that CHCs do offer value for money but, when pressed, contributors found it difficult to point to specific and concrete ways in which this could be demonstrated. The current performance management system, as discussed previously in the review, gives little attention to outputs or outcomes, making it impossible to consider whether CHCs deliver value for money: *At present, performance assessment is based on processes ... and the quality of relationship with the health board – as self-reported by the health board and the CHC! At present, the answer to the question 'what are we getting for our money' can only relate to these narrow, and not very helpful, measures. (CHC Member)*

10.4 CONCLUSION

The current allocation of budgets across Wales is unsatisfactory, relying more on historical accident than rational determination. Furthermore, the current failings in the performance management of local CHCs make it impossible to establish to what extent CHCs offer value for money. There remains scope for improved efficiencies through adoption of good practice, sharing and coordination of support effort between CHCs, and greater clarity in the relationship with the host organisation.

11 CONCLUSIONS

11.1 INTRODUCTION

Our terms of reference are set out in Appendix 5. They required an examination reaching into most aspects of the work of CHCs. This chapter summarises the evidence presented above against each of those terms of reference. It takes stock of what CHCs have achieved in the last two years, and the next chapter makes recommendations for the future.

11.2 CHCS: A BALANCED SCORECARD

In order to set the conclusions in context, it is helpful to begin with an obvious question: ‘What are CHCs good at, and where do they need to do better?’ This section is a stock-take, looking at the evidence on how well the ambitions of the 2010 reform are being realised. It should not be taken as praise or criticism of particular individuals: the reasons for the current performance, together with recommendations for improvement, follow in the next chapter. It considers three aspects of current performance – areas of:

Strength – where further consolidation is required;

Substantial progress – where some changes are required for progress to continue; and

Persistent weaknesses – where new thinking is required

11.2.1 AREAS OF STRENGTH – FURTHER CONSOLIDATION REQUIRED

There are several areas where the current arrangements serve the people of Wales well, and are clear strengths of CHCs:

1. Where there is an effective relationship between the CHC and health bodies (LHBs, Trusts, primary care, regulators etc):
 - I. important deficiencies in the provision of services (which had not been discovered in other ways) are promptly brought to the attention of the relevant body and remedial action is taken;
 - II. the health needs of communities who would not otherwise have a powerful voice are heard and acted upon;
 - III. service plans are improved from an early stage by the CHC championing the patients’ perspective;
 - IV. a host of decisions taken by the LHB and others are improved because they are conscious that they may subsequently be scrutinised by the CHC; and
2. Local communities have greater faith in the NHS because they feel that CHCs give them a voice.
3. Individual complainants get effective, empathetic and efficient support from the CHCs’ complaints advocacy service which delivers the best possible outcome for them

CHCs mobilise well in excess of 200 volunteers across Wales every year to improve local services, making a total of around 13,000 days of effort, equivalent to about 60 paid staff. There is, however some undesirable variation in the performance of these functions across Wales which is considered in section 11.2.3 below.

11.2.2 AREAS OF SUBSTANTIAL PROGRESS – SOME CHANGES REQUIRED FOR PROGRESS TO CONTINUE

There are a greater number of areas where substantial progress has been made since 2010, but where change needs to be made at this point in order to safeguard the improvements seen.

- **Number and categories of CHC Membership** - Membership of CHCs has been a frequent cause for concern for many years, and few would argue that the current arrangements are yet optimal. There are some fundamental issues, which are addressed in 11.2.3 below. Many very good members have now been recruited, but other concerns merit further attention within the current regulations:
 - Persistent unfilled vacancies;
 - Delays in appointing Welsh government members;
 - Insufficiently creative use of the voluntary sector membership; and
 - Variable input from local authority members
- **Universal adoption of good practice** - There are some good examples of CHCs adopting the good practice of others, but the mechanisms for identifying such practice and then ensuring its adoption are inappropriately ad hoc. There is also generally little awareness amongst Members of what is happening in other CHCs. In addition, there are relatively few examples of an organised 'division of labour' between CHCs, where for example one CHC takes the lead on a particular issue on behalf of the others.
- **Training**- The quality and appropriateness of training of Members is generally of a good standard, but is reliant to a large extent on a small national training resource which has not always been available. The training of staff is informed by a regular appraisal process, but there is no clear development programme for the small team of senior CHC staff as a whole, which meets their common needs and realises the value of collective development. This is particularly important, given that the overall performance of the CHC is to a significant extent determined by the ability of its Chief Officer, who has a crucial role inter alia in marshalling the activities of the Members and staff, and forging effective relationships with the LHB and others.
- **Prioritisation of work** - The effectiveness of future workload planning varies between CHCs, with some having a clear annual planning process which allows for the resources of the CHC to be deployed according to a well-informed system of needs and risk assessment. These comments relate both to the local and the national board of CHCs who do not, *prima facie*, identify a coherent work programme as effectively as might be anticipated. Some are also better than others at appraising the relative value of different areas of their work (visiting premises, scrutiny, public engagement etc) and re-prioritising accordingly. The extent to which CHCs brigade their resources to investigate a particular 'theme' also varies. While a proportion of their work is quite appropriately designed to monitor and appraise reactively, another very effective approach is proactively to identify a 'theme' – perhaps a patient pathway (such as stroke) or a service area (such as learning disability) – and systematically scrutinise it.

11.2.3 PERSISTENT WEAKNESSES – NEW THINKING REQUIRED

There are other areas, which were priorities in the 2010 reform of CHCs, where progress has been disappointing, and where new approaches are now required if they are to be properly addressed.

- **Consistency of performance** - The way in which CHCs discharge their responsibilities varies substantially across Wales. Some of this variation is desirable, and reflects local needs. But other aspects are difficult to justify. These include unproductive relationships with LHBs, dissatisfaction amongst members, inconsistent adoption of good practice, and varying levels of innovation. Some CHCs are clearly performing well, others substantially less so. As the Minister pointed out in 2009: 'CHCs are a valuable

resource, unique to Wales, but there is a need for a more consistent approach, fit for purpose within the new NHS in Wales'.³⁹ CHCs' current performance management arrangements are far too focused on process issues and not enough on outcomes. When serious problems arise in particular CHCs areas, they are either addressed too slowly or not at all.

- **Diversity of Membership** - The Minister was also clear in 2009 that in future CHCs would 'need to be more consistently representative of the public they serve ... drawing on the talents of more local people from all sectors of the community. I attach significant importance to the involvement of all citizens at a local level.'⁴⁰ This has two aspects: the diversity of CHC Membership, and the other approaches taken by the CHC to reach out to all sectors of the community. On the latter, there have been good examples of innovative engagement processes in some parts of Wales; but more is certainly needed. On the former, CHC Membership remains disproportionately white, older and middle class. This lack of representativeness is an important weakness in any Member-led organization, particularly one which relies heavily on its members to carry out much of its work.
- **Public knowledge and understanding of CHCs** - Although we are not aware of any recent survey data on public knowledge of the existence and role of CHCs, the evidence from this Review and elsewhere suggests that public recognition and understanding is very low. This has been a frequent observation for many years. To some extent, one may argue that people don't need to know about CHCs until they need them, and certainly the publicity given to their advocacy function in NHS complaints literature has increased recently. However, there is little doubt that they could perform their functions more effectively – and address other issues such as diversity of membership – if they were better known. It is also clear that their name – Community Health Council – does not help in gaining public recognition and understanding. This is exacerbated given the fact that CHCs share their names with health boards which creates a degree of confusion among the public about their role and independence.
- **National role** - The Board of CHCs was substantially changed in 2010 and charged with both leading the internal development of CHCs (ensuring consistently high standards of performance), and representing the collective voice of patients and the public to the Minister. In practice, it does not appear to have discharged either of these functions as well as was expected. The governance challenges highlighted above have not been proactively or adequately addressed by the Board, and many CHC Members are unclear about its role and the value which it adds to their work. It has also not effectively capitalised on its unique intelligence networks and statutory independence to shape the national agenda for the NHS in the interests of patients and the public.
- **Nursing homes** - CHCs have not systematically involved themselves in the NHS-funded services provided by registered nursing homes. This was intended to be an additional area of responsibility for CHCs following the 2010 reform, on the basis that such care deserved independent scrutiny at the local level.

11.3 ISSUES TO BE ADDRESSED

The stock-take highlights many of the issues which now need to be addressed if we really are to move towards world class patient and public engagement. It is striking how similar this 'scorecard' is to that of previous reviews of CHCs. While progress has clearly been made, fundamental issues still remain.

These issues are discussed through taking each of the terms of reference in turn:

³⁹ Welsh Assembly Government (2009) *Proposals on the Future of Community Health Councils in Wales*, Ministerial foreword, p3
Cardiff: Welsh Assembly Government

⁴⁰ Ibid.

11.4 GOVERNANCE OF CHCS

11.4.1 Operational structures

The co-terminosity of CHCs and LHBs is working satisfactorily, and there are diminished grounds for concern (as was originally feared by some) that the larger CHCs created in 2010 are unable to reflect the needs of their constituent communities. In fact, there is now evidence for reviewing whether Local Committees are still necessary in their current form, especially in those CHCs which are relatively geographically compact and have few such committees. The rigidities associated with their statutory existence place considerable demands on Members to attend meetings and on administrative staff to support these activities, which to some extent run counter to the need for the flexible deployment of Members across boundaries, and may serve to weaken collective deliberation across the whole area served.

Powys was made a special case in the 2010 organisation, being the only example of a LHB with more than one CHC. It is difficult to see the case for this to continue, given that the explicit rationale for that exclusion – the proposed merger of the LHB and the local authority – has not come to pass. Separation into two CHCs potentially dislocates staff support, increases administrative costs, and complicates relationships with the LHB and others. In practice, both CHCs have been successfully served by one Chief Officer for the last few months, and the benefits of shared staffing arrangements are already apparent.

11.4.2 Lines of accountability

Several lines of accountability need to be amended; those relating to the Director are considered under 11.4.3:

- **Individual members** – in most CHCs, the arrangements for ensuring the proper accountability of individual Members have worked effectively and appropriately, usually through the action of the Chief Officer, supported as necessary by the involvement of senior Members. In a minority of cases, however, these arrangements have not worked satisfactorily, despite the adoption of the Code of Conduct, and there has been some anxiety about issues such as the proper declaration of conflicts of interest, the ambiguities associated with individual Members' association with outside interests which may coincide with their role as a CHC Member, and about what constitutes appropriate behaviour in the public domain. Each case obviously raises issues unique to that case, and our terms of reference did not include detailed consideration of such matters. On occasion, formal, external (to the local CHC) mechanisms were invoked to resolve the issue. In certain instances these issues were satisfactorily resolved (although the process was rather protracted); in others, local stakeholders remained dissatisfied with the outcome, or believe that it has not been resolved. Underlying several of these cases are different understandings of the role of the CHC itself and therefore of the behaviour expected of individual members; a lack of early, appropriate and effective local intervention to resolve issues before they escalate; and then a lack of effective intervention from the national level to correct the issue. They are often set against a background of difficult relationships between the CHC and the LHB, aggravated by controversial issues in the provision of local services. Where these problems exist and persist, the current arrangements are not satisfactory.
- **Local Committees** – Local Committees are both accountable to the whole CHC, and themselves hold the CHC to account. In most CHCs, these relationships work well, and considerable effort has been expended by all concerned to develop a productive and collegial relationship between Local Committees and – through the executive committee – with the CHC as a whole. This is not, however, uniformly experienced throughout Wales.
- **CHCs** – the accountability of CHCs to the Minister is kept deliberately 'light touch', consistent with the need for CHCs to be – and be seen to be – independent. In most cases, the Board exists to

exercise governance functions without the need for the Minister to become involved. The role of the Board is considered below.

- **Individual members of staff** – there is clear line managerial accountability from the Director, through Chief Officers, to all CHC staff. Again, this arrangement has usually worked well. In two areas, however, there is some cause for concern. The national-local link is considered below. At the level of the CHC itself, there is some evidence – again in a small minority of CHCs – that the staff team does not always operate cohesively, and that performance issues may not be addressed assertively by senior staff. This is a matter for on-going staff development and appraisal.
- **Welsh Government** – links between the Government and CHCs are generally satisfactory, but two issues cause concern. First, Welsh Government appears to be involved in various matters (such as the signing of leases on premises, or the determination of members' expense allowance rates) which are perhaps more operational than policy matters, and could therefore be more appropriately delegated. Second, there is some concern that the accountability of the Director to the Chief Nursing Officer is perceived to undermine the independence of CHCs themselves. We have found no direct evidence that this line of accountability does *in fact* compromise the Director's ability to act appropriately, but the impression persists.

11.4.3 Director of the Board

The CHC Board – as discussed above – has key internal and external roles, and the Director – as the most senior member of staff across all CHCs – has a significant leadership role. Part of the latter includes the line management of CHC Chief Officers.

In most cases, this has been an unproblematic relationship, but there have been some instances where it has been complicated by the Chief Officer's dual accountabilities to the Director and his/her CHC, and the perceived conflict between them. Regulation (32(2)) describes the role of the Board as being 'advising' and 'assisting Councils in the performance of their functions', and 'monitoring' the conduct and performance of members and staff – language consistent with the desire that individual CHCs should be independent, but not autonomous. Ministers' expectation of how this would be interpreted in practice was made clear in the 2009 consultation document: 'collective decisions taken by the Board are accepted and acted upon by all CHCs – whilst this cannot be enforced in regulations, CHCs would be expected to abide by collective decisions unless there were clear and reasonable grounds for not doing so'.

However, where these arrangements have been put to the test in controversial circumstances, there has been a reluctance to make and abide by collective decisions. In fact, the Board has not formally discussed the issues. This appears to be in part a result of the ambiguities of the language of the Regulations, in part a result of the particular composition of the Board and the way it has operated, and in part because of the managerial style which has been adopted. The result has contributed to a continuing, unsatisfactory working relationship between the Board and the individual CHCs concerned, and between the CHC and its LHB, which none of the parties involved seek to condone.

11.4.4 Membership and appointments

Issues associated with the Membership continue to cause considerable concern within CHCs. The most frequently voiced issues were:

- **Lack of diversity in membership** – the extent and impact of this issue is discussed above, and it has been one which has plagued CHCs in Wales (and similar organisations elsewhere) for many years. CHCs have tried various means of encouraging a wider range of applicants, but with limited success. There has been no recent rigorous and comprehensive review of this issue by CHCs to identify the obstacles to greater diversity, but the onerous nature of the Welsh Government appointments process (see below), the

nature of the contribution required, and the prevailing culture within some CHCs may offer a partial explanation. Where some progress has been made, and a more diverse Membership achieved, a number of individuals have resigned before their term of office expired, because for a variety of reasons they found the experience of being a CHC Member unsatisfactory. In addition, very little publicity is given to the provision to reimburse Members of loss of earnings (currently only three CHC Members across Wales are making such claims), and doing so might further help to increase diversity.

- **Delays in appointing Welsh Government Members** – there was general concern at the length of time taken to appoint Members in the most recent recruitment round, for which selection interviews were held in January 2012. Letters of appointment were not sent out until May 2012. This left CHCs depleted of Members for weeks, and applicants feeling that their volunteered contribution was not valued. It would seem that the onerous requirements of the Commissioner for Public Appointments' Code of Practice for Ministerial Appointments to Public Bodies necessitated an unduly protracted process for the appointment of quite large numbers of voluntary CHC Members. These arrangements have now been simplified, and we were informed that appointments will be completed in future within a total of two months of interview.
- **Onerous nature of the Welsh Government appointments process** – apart from the delays discussed above, the most recent recruitment round was generally regarded as being more appropriate to the nature of the position than the previous round of recruitment, and the contribution of CHC Chief Officers to the process was appreciated. However, concerns still remain that the process – from initial advertising, to application and interview - is geared to recruit from only a narrow section of Welsh society, primarily people with sufficient self-confidence, education and a desire to apply in the particular way required. This may be a further obstacle to greater diversity of Membership.
- **Inadequate overall number of Members** – given the persistent vacancies, most CHCs reported that they had insufficient Members to carry out their core functions. They filled the gaps by asking Members to work for more than the notional 3-5 days per month which the role is supposed to require, and by the repeated co-option of other Members. For some CHCs, the problem was compounded by an unfavourable ratio of Members to population served, and for others by the time burden of serving a rural area. It was difficult to calculate an optimal number of Members, given the difference of opinion over the relative merits of CHCs' different roles, and over how such roles should best be discharged. The problem will be exacerbated if CHCs start to work with nursing homes in the future.
- **Eight-year maximum service rule** – Regulation 10 imposes a life-time limit of 8 years on CHC Membership. This has led to the loss of some valued and experienced Members, but nevertheless probably strikes a pragmatic balance between a reasonable length of service and the need for new Members.
- **Use of co-opted Members** – CHCs make extensive use of co-opted Members whose role is limited in Regulation 5 to 'a period [not] exceeding one year and must not be re-appointed at the expiry of their term unless the Council decides that such re-appointment is necessary for the performance by the Council of its functions'. Many Councils interpret this flexibly, to enlist the contribution of people who may not wish to subject themselves to the rigours of the more formal selection process, but who nevertheless have proved their worth. This flexibility is very helpful.

Membership of the national Board is determined in the Regulations, and ensures that CHC Chairs constitute a majority of the membership. The Chair and Vice Chair are additionally elected by all CHC Members, but contests are rare, often because so few Members understand the role of the Board.

11.4.5 Third sector and Local Authority Membership

The three Members of each local committee nominated from the voluntary sector often provide a very valuable contribution to the work of the CHC. This category of Membership – with its local accountability and flexible appointment process – could prove a useful way of increasing diversity – and indeed has done so in some cases. However, it would appear that this flexibility is not always used to maximum effect, partly because of a lack of alignment in some cases between the expectation of the CHC and the local County Voluntary Council, and partly because of the nature of the Member's role. The potential is therefore not being fully exploited

In theory, the presence of elected Councillors on the CHC should help it discharge its functions by providing links to a key local service provider and stakeholder, and through access to the sources of intelligence available to such community leaders. Sometimes this works well; in many cases it doesn't, with Local Authority Members either not appointed, or filled by Councillors with very limited availability because of other responsibilities. It is difficult to see what else can be done with this issue, unless the nature of their contribution is changed, or the inclusion criteria relaxed – perhaps to fewer than three, or by including people nominated by the authority but not necessarily serving Councillors.

11.5 'PROFESSIONAL' ORGANISATIONS

Constitutionally and philosophically, CHCs are Member-led organisations, deliberately valuing the lay perspective and contribution to what is otherwise a complex, clinically- and managerially-led set of organisations. There is no widespread desire that CHC Members should be paid. It is important, though, that they are effective and efficient, and therefore 'professional' in that sense. The following brief description of their key roles, taken from the 2009 consultation document,⁴¹ illustrates the need for high levels of competence:

- 'Systematically' gathering local people's views on health service matters... and feeding these proactively to the LHBs and to the Assembly Government;
- The ability to inspect premises where NHS services are provided, with a view to improving service quality – whilst it will not be set out in the legislation, the proposal is that there would be a formal Memorandum of Understanding with the existing inspectorates on visits to ensure best use of resources and no duplication;
- Engaging with the health service on plans and responding to formal consultations;
- Effectively scrutinising plans and the performance of services provided for patients.'

Such professionalism will only be achieved by Members and staff working together and complementing each other. Again, many CHCs achieve this. The training programme for Members plays an important part. The development of a national approach to assessing the quality of the Hospital Patient Environment survey, and its associated training, has improved the usefulness of the exercise, as has the authority which comes with a Ministerial mandate to do such work. CHCs are increasingly improving their ability to gather evidence robustly, and are working with other agencies (including the LHBs) to harness CHCs' independence to others' specialist expertise and greater resources. CHCs are getting better at using their different sources of intelligence – including from complaints – to target their work, and are becoming more proactive in choosing the most important areas on which to focus. Staff are also working with Members to identify the optimal balance between different sort of evidence, ranging from anecdotes to a review of the research literature, and training of lay researchers is being considered.

All of these initiatives are valuable, and more are needed. It is also important that CHCs achieve *consistently* high standards in these areas (see below).

⁴¹ Welsh Assembly Government (2009) *Proposals on the Future of Community Health Councils in Wales*, Ministerial foreword, p6-7 Cardiff: Welsh Assembly Government

11.6 CHC AND HEALTH BOARD RELATIONSHIPS

In most parts of Wales, effective and respectful relationships exist between the LHB and CHC, with an appropriate level of robust scrutiny. LHBs are universally appreciative of the potential contribution of CHCs to their own work. In a small number of places, such good relationships do not always exist, and approaches to tackling this disparity have been discussed above.

Relationships can continue to improve along the lines discussed earlier, including greater shared understanding of the respective roles of the CHC and LHB and how they should complement each other; improved coordination of the work of CHCs and HIW (see below); work better targeted on issues of prime concern; better use of available intelligence and evidence; and more insightful scrutiny.

11.7 VALUE FOR MONEY

CHCs have a combined budget for all their activities of approximately £3.8m, or approximately £1.27 for each person in Wales. The use of volunteer input significantly increases the impact of this expenditure – volunteer Members work more hours each month than all the CHC staff combined.

As a result of the amalgamation of CHCs into eight in 2010, each CHC now has a complement of staff sufficient to deploy effectively as needs require. There are still some apparent anomalies in the distribution of some of these resources which merit further consideration. There is also further scope for using the resources of individual CHCs to provide all-Wales leads on particular issues. The universal adoption of good practice is considered below.

There is considerable reason for suspecting that budgets within the CHC envelope are not allocated on rational grounds. We have seen no persuasive evidence that decisions are taken on the basis of need or priority, and are in many ways a reflection of historical decisions without any critical thinking about where and how the allocated resources might be most effectively used.

Underpinning any approach to maximising value for money must lie a robust and appropriate system of performance management, as the 2009 consultation document observed: *'The development of a standard and consistent approach to the collection and dissemination of information is essential so that the work and performance of CHCs across Wales can be compared'*.⁴² At present, the system in use focuses almost exclusively on process measures, and gives little attention to outputs or outcomes. The targets are not always explicit or sufficiently demanding, and the process for ensuring compliance is somewhat unclear. In short, it is impossible at the moment to form a judgement on the absolute or relative performance of individual CHCs (or CHCs as a whole) in meaningful terms, and it is therefore difficult to see how the performance management information can drive up performance.

11.8 GOOD PRACTICE

It is clear that many CHCs are developing innovative ways of performing their roles, and several examples of good practice are cited throughout this report. But it is also clear that staff and Members' knowledge of what is going on elsewhere – in other CHCs, and elsewhere in the UK - is limited and not sufficient. This somewhat parochial approach, combined with the lack of robust performance management information discussed above, is ill-designed to encourage the adoption of good practice. The national Board has a key role to play here, not only to facilitate innovation and publicise it, but also to require CHCs to adopt it.

⁴² Welsh Assembly Government (2009) *Proposals on the Future of Community Health Councils in Wales*, Ministerial foreword, p12 Cardiff: Welsh Assembly Government

11.9 'CRITICAL FRIENDS'

As discussed above there is still some work to be done, in some parts of Wales, to ensure that Members and staff of CHCs have a shared view of their role and how it should be most appropriately discharged. This needs to be developed jointly with LHBs and Trusts, and to go beyond the statement of high level principle to the application of those principles in challenging real-world situations. For example, how should members of one public body refer to the work of another in public? How should CHC Members reconcile their passionate commitment to local services with their need to be objective and impartial? How should CHCs deal with issues of major disagreement with their LHB? These have all proved to be issues of contention in some parts of Wales. Once agreed, these norms need to be enforced, locally and nationally.

More specifically, CHCs' work on the healthcare environment, and visits to premises, needs some further refinement. A proportion of this work is still focused on relatively mundane matters, with limited attempt to prioritise, and therefore too often is accordingly not taken seriously by LHBs. This in turn can lead to frustration amongst CHC Members, who find that they are repeatedly raising the same issues when they are not addressed, and indeed on the part of health organisations who can find the input of CHCs very helpful when it is focused on more salient and pressing issues.

The national Board, through its Chair, has an important role as the 'critical friend' of the Minister, but this has not been discharged particularly effectively. It is important that CHCs use the opportunity afforded by their national presence to speak up for patients and the public whenever there are major issues which are not being resolved through local action. They should be a well-informed, objective and supportive source of information and advice for the Minister in some of the most important aspects of the health portfolio.

11.10 RELATIONSHIPS WITH OTHER BODIES

Helpful understandings have now been developed between CHCs and most of the other health-related bodies with whom they need to cooperate. Some of these are working well in practice, including links with the postgraduate medical Deanery, and with several of the healthcare professional regulatory bodies.

There is still some work required to make a reality of perhaps the most important of these, the link with Healthcare Inspectorate Wales (HIW). The formal Memorandum of Understanding is a helpful document, but the extent of cooperation and coordination between CHCs and HIW is still rather limited. Whilst some intelligence is shared, there is as yet little evidence that the approaches of either body are significantly shaped by the work of the other, in order to avoid overlaps and gaps. HIW takes quite a different approach to its work than do CHCs, emphasising far more the development of high levels of specialised expertise, rigorous quality assurance, far greater examination of deliberately chosen issues in depth, and a focus on the key determinants of safety and quality of outcome. They have much greater perceived authority. If CHCs and HIW are fully to coordinate their efforts, it may be helpful for the two bodies to jointly examine what are the priorities in monitoring the healthcare environment and care, and to buttress this with some shared training and developmental activity. This would sit well with CHCs' own need to appraise the respective value of their different sorts of activity.

Currently, Powys teaching LHB provides financial and other technical support to the CHCs. While this arrangement has generally worked quite well, there may now be merit in transferring this function to another NHS body (e.g. Velindre NHS Trust) which is developing an expertise in supporting miscellaneous functions within NHS Wales. The 2010 Regulations were deliberately worded to allow such a transfer to take place without the need for new Regulations.

11.11 COMPLAINTS ADVOCACY

The Complaints Advocacy service is now well-established in each CHC, providing a timely, appropriate, empathetic and effective service for about one in nine of the people who complain about NHS services in Wales. There are areas for further development, including greater standardisation of some operational procedures, better publicity and awareness, the introduction of an element of external accreditation of both process and outcome, and a common approach to staff training and development. There are worthwhile synergies between the work of the advocates and the other work of the CHC, which are gradually being exploited. There is little reason to believe that the service could be more efficiently or effectively provided by an external organisation, and some reason to be concerned that breaking the link between complaints advocacy and the CHC would hinder the work of both.

12 RECOMMENDATIONS

The recommendations which follow are a combination of short-, medium- and longer-term measures:

1. **Immediate improvements** (Recommendations 1-9) - measures designed to make the current arrangements work better. They are generally fairly straightforward, and do not require changes to the current Regulations. Implementation timescale: 6-12 months
2. **Substantial improvements** (Recommendations 10-16) - slightly more complex measures to get the best from current arrangements, and to bring all CHCs up to the level of the best. These may require changes to Regulations, and may be more complex to implement Implementation timescale: 12-18 months
3. **Re-design** (Recommendation 17) - to make a step change towards 'world class' patient and public engagement, more fundamental and ambitious measures are required than those in the previous categories. These are deliberately not constrained by current structures and mechanisms, and are an ambitious attempt to move Wales towards being comparable with the best anywhere, starting from a 'blank sheet of paper'. Implementation timescale: 2-3 years

12.1 IMMEDIATE IMPROVEMENTS

RECOMMENDATION 1 · The Role of the CHC Board should be re-affirmed and endorsed by CHCs

It is clear that the powers of the CHC Board were crafted in 2010 to ensure that the performance of each CHC in Wales was maintained at an acceptable level, and that good governance was assured within the CHC movement, without the Minister needing to intervene. The Regulations required the Board to 'assist' and 'advise' CHCs in discharge of these functions, and the Minister was clear at the time that she expected CHCs to accept that assistance and follow the advice, unless there were overwhelming reasons not to do so. The governance structure was one intended to allow CHCs a measure of independence under their national Board, which they were to use to assure their high performance and good governance, and similarly CHC Chief Officers were to be line managed by the Director. In the subsequent period, the Board has not adequately exercised this leadership function and should now do so, with clear support from Welsh Government. Similarly, CHCs should accept that leadership. Establishing this relationship between national and local is fundamental to many of the recommendations which follow in this section.

We believe that the Regulations provide sufficient and proportionate governance arrangements to implement this recommendation, provided that all involved work in the way which was clearly intended. If that leadership and cooperation are not achieved, the Regulations should be re-written to establish an unambiguous line of accountability from national Board to local CHC.

This matter is now urgent, and progress against this recommendation should be reviewed in six months.

RECOMMENDATION 2 · Clarify the role of CHCs

We found several different conceptions of the proper role of CHCs, and what they mean in practice. This is compounded by the fact that both CHCs and LHBs/NHS Trusts both have responsibilities to engage with their patients and the public. Where such issues and respective roles have not been clarified and agreed, there has been some confusion and potential duplication of activity, which is inconsistent with transparent and efficient engagement processes. Accordingly, the national Board should lead the following work programmes:

- a. **Clarify the role and function of CHCs** · Develop a clear statement of the purpose of CHCs, taking into account the perspectives of key stakeholders, which is explicit about how roles should be discharged, and includes some worked examples to illustrate difficult areas in practice;
- b. **Make links to the Code of Conduct** · Members should be actively engaged in this process of defining roles, and supported in translating such statements into a clear understanding of what it means in for their roles practice, based on the Nolan and other accepted principles of conduct in public life; and
- c. **Explore range of options for joint working with LHBs** · The Board should work with the Welsh NHS Confederation to identify the range of appropriate ways in which CHCs can collaborate with their LHB, to preserve independence, avoid duplication, and maximise impact. A range of approaches has been described in this report, and should form the basis for the discussion.

RECOMMENDATION 3 · The CHC Board should adopt a more transparent and outcome-focused approach to the performance management of individual CHCs, using SMART metrics and an effective process to ensure that performance is acceptable.

The current performance management measures and processes are not adequate. There is currently no effective and transparent process for ensuring that CHCs are delivering an acceptable and value for money service to the citizens they serve. The current metrics focus too much on process measures and not on the CHC's impact, are not always SMART (specific, measurable, attainable, relevant and timely), and the connections between performance assessment and improvement are also weak. These faults must be rectified by the Board.

The appraisal processes of staff and Members should then be aligned. Each member of staff and each CHC Member should take part in an annual process, adapted to their respective roles, to ensure that everyone has an opportunity to make a full contribution, against a common set of objectives and expectations.

Accountability to the Board should be matched with more significant accountability to local communities. Each CHC should develop an appropriate and effective means of reporting their work to local communities on a regular basis, accounting for their impact and providing people with an opportunity to comment meaningfully on the CHC's work.

RECOMMENDATION 4 · The CHC Board should be more proactive in identifying and sharing good practice between CHCs, and in facilitating learning amongst staff and Members

Senior CHC staff and members are not sufficiently aware of successful approaches to common issues across Wales, and there is considerable scope for bringing the performance of all CHCs up to that of the best through such sharing. These learning opportunities and needs should be systematically identified and evaluated through the improved performance management recommended above. More use could also be made of the allocation of 'leading roles' to individual CHC senior staff, encouraging them to develop expertise on behalf of all CHCs, developing common approaches and resources, and then ensuring that all CHCs then followed the new approach. The Board should also explore with NLIAH or similar body the opportunities for developing a national learning programme/set for CHC Chief Officers and their senior staff, to meet the needs for the corporate development of staff, and further build the shared sense of common effort across CHCs.

RECOMMENDATION 5 · The CHC Board should ensure that CHCs use their business planning processes to identify and prioritise themes and issues to be explored proactively, on both a local and national basis, so that a higher proportion of their total workload is determined in such a fashion

Most CHCs currently only devote a small amount of their resources to proactively identified themes or issues, spending more of their time reactively or routinely (i.e. with no robust assessment of relative priorities). Such themes might be service based (e.g. stroke services) or client group (e.g. learning disabilities), or indeed any issue relevant to health and health services which requires significant attention. The advantages of working more proactively include the ability to marshal sufficient resources to do the job thoroughly, to help set the agenda locally and nationally, and to link up the work of several CHCs who have such issues in common. The improved performance management and learning described above will facilitate this process of coordinated efforts.

RECOMMENDATION 6 · The Complaints Advocacy function within CHCs should be further strengthened and developed

The CHC Complaints Advocacy function has developed well over the past few years, and is making a professional and valued contribution to the way in which complaints are now addressed in NHS Wales. As part of the further consolidation of the service, consideration should now be given to instituting a system for the independent accreditation of the quality of the process and outcomes of the service, and to adopting good practice in raising the public profile of the service so that it is more visible to those whom might benefit from it. The allocation of a lead role for the service to one Chief Officer has worked, and this should now be strengthened to ensure the adoption of standard approaches across all CHCs' complaints advocacy services, wherever practicable. The division of budgets for the service between the different CHCs should also be reviewed, to ensure resources are allocated according to need.

RECOMMENDATION 7 · The Board of CHCs should resolve the position regarding visiting Nursing Homes, and CHCs start such visits as a matter of urgency

It was clear in 2010 that CHCs should extend their oversight to include nursing homes providing care for the NHS. This has not happened, apparently because of somewhat unclear and conflicting legal advice, which has not been resolved. It is unacceptable that the Minister's intention should not have been fulfilled in this respect, and that potentially vulnerable nursing home patients still do not have the benefit of the oversight of their local CHC. The Board, with assistance from the Welsh Government, should resolve this matter without further delay, and support the development of an appropriate protocol for visiting nursing homes.

RECOMMENDATION 8 · The agency arrangement for financial, HR and other support, and the division of administrative responsibilities for CHC, should be reviewed

The Powys teaching LHB currently provides financial, HR and other support for CHCs, including the employment of CHC staff. The Board should review this arrangement, including the specification for the service required and which body is best placed to provide it, in order to ensure that it meets CHCs' needs, represents value for money, and offers a good strategic fit in the future. Such a review was anticipated in 2010, and changes can be made without the need to change the Regulations.

In addition, the respective administrative responsibilities of the different bodies with a national role in the CHC movement appear somewhat arbitrary and sub-optimal. For example, Welsh Government is required to enter into some, but not all legal contracts on behalf of CHCs; there is confusion over who has

responsibility for relatively minor matters such as changes to Members' travel rates. All of these issues should now be reviewed, and responsibility delegated to the lowest possible level, leaving Welsh Government unencumbered with CHC administrative issues.

RECOMMENDATION 9 · CHCs should make much greater use of electronic communications technology

Some CHCs have embraced simple technologies such as PC-based video conferencing, and electronic communication with members of the public, but in others, progress has been slow, thereby perpetuating inefficiencies and excluding people from their work. All CHCs should review their use of technologies and the new social media, proposing how they might reach a range of communities with whom they typically struggle to engage, and present for the approval of the Board a plan for their wider adoption.

12.2 SUBSTANTIAL IMPROVEMENTS

RECOMMENDATION 10 · Appoint the Chair and non-executive members of the Board of CHCs

The Board of CHCs has a vital role to play in ensuring that individual CHCs are effective and efficient, in ensuring that patient and public issues with a national dimension are identified and appropriately addressed, and that the NHS in Wales continues to put the interests of its patients and the public at the forefront of its work. This is a leadership task of considerable magnitude, requiring a demanding set of skills, experience and aptitude, ensuring good leadership for the CHC movement, and a credible and influential voice to external stakeholders. At present, most of the Board posts are filled by election, for which there has been little or no competition, and very little awareness amongst the electorate (CHC Members). It is no reflection on the current incumbents to observe that such a process is not sufficiently robust to ensure adequate governance arrangements for such an important public service.

It is also important, however, for the model of self-government created in 2010, that the CHC Membership regards the Board as credible proponents of the views of the CHC movement as a whole.

In order, therefore, to ensure the elements of both effective leadership and democratic accountability, it is recommended that the Chair of the national Board should, at the end of the current term of office, be appointed through the Public Appointments Process for a four year term, together with two non-executive members of that Board. In order to make the role more easily understood, the Chair should be given a title which more easily conveys their responsibilities, such as 'Patients Commissioner'. This will place them alongside other key figures in Welsh public life whose role it is to 'speak truth to power' on behalf of important sections of the community whose interests might otherwise be neglected. Drawing on the unique intelligence network of CHCs, with more than 270 members across Wales and the current annual budget of £3.8m, the Patients Commissioner would ensure that health policy and practice really kept the patient and the public at the centre. In order to reflect the importance of voluntary work within the CHC movement, no members of the Board (with the exception of the Director) should carry a salary.

The rest of the Board should be comprised as follows:

- Chair, appointed through the public appointments process
- 7 Chairs of CHCs, who would elect one of their number to serve as Vice Chair
- Two non-executive members, appointed through the public appointments process
- Director of the Board of CHCs
- Staff member

RECOMMENDATION 11 · Improve the diversity of CHC Membership

The current lack of diversity in the Membership of CHCs across Wales is a significant weakness. CHCs are reliant on their Members to ensure that they do indeed reflect the needs and circumstances of their local populations. If they are not themselves reasonably diverse, they will not be able to do this adequately, and will not command the confidence of the communities they are supposed to represent.

Some more radical approaches to achieve this goal are discussed in Recommendation 17 below, but more can be done now, within current Regulations, to improve this situation. Four immediate steps are recommended:

1. **Welsh Government should make increased diversity of CHC Membership an immediate priority**, both in the recruitment process they administer, and also for their partners in the voluntary sector and local government. Welsh Government should implement any suggestions arising from the review recommended below;
2. **The Board of CHCs should immediately review the reasons for lack of diversity in applications and retention of CHC Members**, drawing on available expertise in Welsh Government and the third sector;
3. In the light of the above, **each CHC should discuss with local partners in the voluntary sector and local government how to increase and retain greater diversity of Membership; and the rules on local authority members should be changed**. Good practice should be identified and widely adopted. In order to maximise the contribution from the local authority members, the requirement that they all be serving Councillors should be dropped, allowing authorities to nominate others that they deem suitable against the key requirements of all Members.
4. CHCs should develop **different ways of allowing people to become involved in their work**, without requiring them to assume the corporate responsibilities of full Members. In this way, the enthusiasm of volunteers, who care passionately about aspects of their health service, could be harnessed to the work of CHCs. A variety of different avenues for engagement should be offered, including electronic (surveys, comments on documents etc), scrutiny of particular services in which people have an interest, and others. In short, CHCs should adapt their ways of working to suit people's circumstances, and not make people conform to their ways of working. Good practice should be developed and widely adopted.

Progress in this area should be reviewed and reported annually to the Minister.

RECOMMENDATION 12 · The CHC Board should review the overall balance of CHC activity

CHC Members are a crucial resource for CHCs, but there is little systematic evaluation of the most appropriate mix of their activities in relation to improved outcomes for patients and the public. Work programmes tend to be reflective of previous programmes, with little objective evaluation of the relative merits of, for example, environmental 'inspections' compared with service scrutiny or engagement with diverse communities. As a result, it is difficult to be assured that CHCs are spending their time to greatest effect.

The CHC Board should now lead a rigorous evaluation of the relative priority of different types of activity, taking account of the views of stakeholders and the evidence on impact, and each CHC and Local

Committee should use the results to shape their own work programmes. The Board should use CHCs' performance management processes to ensure that work is balanced appropriately.

RECOMMENDATION 13 · Establish Powys as a unified CHC

The principle of co-terminosity between CHCs and LHBs was established in 2010, and has served well. Only in Powys was this principle not followed, with separate CHCs serving Montgomery and Brecknock and Radnor. During the last two years, the potential gains from unifying these two CHCs have become clear – particularly the improved efficiencies from sharing staff and other resources and reduced bureaucracy, and the opportunities for members in both parts of the county to support each other. One CHC for Powys should now be formed.

If the new Powys CHC were to have only one Local Committee – as might be expected to be the case, given that it would serve only one local authority area – it would be faced with considerable geographical challenges, having only 12 members to serve the largest such area in Wales. Given the reliance upon the work of members, this would impact on the efficiency of the CHC. It is therefore recommended that the new Powys CHC should have two Local Committees, serving Montgomery and Brecknock and Radnor, respectively. However, the Committees should be encouraged to work cooperatively wherever possible (see Recommendation 14 below)

RECOMMENDATION 14 · Minimise the bureaucratic burdens of separate Local Committees

Local Committees were established in 2010 to ensure that the new, larger CHCs retained a strong link with the local authority areas in Wales. In many parts of Wales this arrangement has worked well. But in some parts of the country, Local Committees have become somewhat superfluous, particularly where the geographical areas covered are small and there is considerable community of interest between the Local Committee areas. The existence of the Local Committees – and the associated meetings and other activity – has also in some places diverted Members' time to relatively unproductive activity, and has not strengthened the sense of cohesion of the CHC as a whole.

In order to reflect the different needs across Wales, it is now recommended that the Committees continue to exist, but that CHCs are encouraged by the Board to explore every opportunity to reduce their potential isolation, and to reduce the administrative burden they might otherwise generate.

RECOMMENDATION 15 · Review CHC financial allocations and budgetary management arrangements

The Board, through its Director, has responsibility for the national allocation to CHCs as a whole. It should develop a more robust financial management framework, capable of planning for future budgetary constraints, and which will ensure that in-year financial variations are managed to ensure maximum value for money across the entire CHC allocation.

The current distribution of budgets between CHCs is a mix of historical accident and marginal adjustment to reflect different need. It is not a rational - nor defensible - formula, and should therefore be reviewed by the Board from a zero-base.

RECOMMENDATION 16 · Consider changing CHCs' names

If, after 38 years of promoting themselves, CHCs can still be described as 'Wales' best kept secret', there is a strong case for a new public image. In addition to the substantive changes recommended above, the name itself should also now be reconsidered. There are two aspects to this:

- ‘Community Health Council’ is a poorly recognised brand, and often misleads people, with its associations with ‘Councils’ and ‘Community Councils’. Consideration should be given to a new name which more closely reflects CHCs’ functions, and might usefully be associated with the Patients Commissioner, or with an identity such as ‘Patients Voice’
- The use of the Local Health Board’s nomenclature is also confusing, especially in parts of Wales (such as Betsi Cadwaladr) where the dominance of the LHB’s brand leads members of the public to assume that the CHC is in fact part of the LHB. A more generic term, such as North Wales, would serve to emphasise the CHC’s independence (whence, for example, ‘Patients Voice North Wales’). The ability to break the link with the health board name was granted by the previous Minister after the second round of consultation in 2010.

12.3 RE-DESIGN: TOWARDS ‘WORLD CLASS’

The recommendations above are intended to make the most of the current arrangement of CHCs, bringing all up to the level of the best, and establishing a more effective national Board. However, there are several fundamental issues which have been identified in this report which are unlikely to be completely resolved by these relatively modest changes.

This third section of recommendations, therefore, is bolder. It addresses the more challenging question: how could Wales move towards ‘world class’ patient and public engagement, ensuring the best influence for patients over the care they receive, and services which are truly designed for the needs and wishes of all our communities? We make one recommendation here:

RECOMMENDATION 17 · Undertake an inclusive process of deliberation to define what would constitute ‘world class’ in this context (our ‘aspiration’), and then to bring forward specific organisational recommendations to help bring it about.

This would start with a blank sheet of paper, with no presumption in favour of any one solution. CHCs have served Wales now for almost 40 years, with minor changes, and now is the time to think through this crucial aspect of healthcare without any preconceptions about how it is best delivered. In order to scope the task, we present below some initial thoughts, drawn from the evidence considered in this review, and the very helpful discussions we have had with CHC Members and staff and others right across Wales. These form the seed corn for the process we are now recommending.

What might ‘world class’ mean?

There are many possible definitions, and it will be valuable to engage all stakeholders in their development. But as a ‘starter for six’, these have already emerged as strong contenders:

1. **Effective voice for all patients at the national level**, drawing on the local intelligence of CHCs to shape the national agenda, ‘speaking truth to power’, and ensuring that all NHS bodies perform better than they would otherwise. This is much more than just offering responses on issues raised by others – it is about establishing the case for change in areas which others have not yet accepted but which are vital for patients and the public; about gathering evidence; setting challenging aims for the NHS; and holding to account for improvement;
2. **Focus locally on the issues which matter most**, often including complex issues of quality and safety, and not just the physical environment of care – this requires a closely coordinated

relationship with Inspectorates, working symbiotically and recognising each others' areas of respective expertise;

3. **Robust and credible scrutiny** for the key decisions of LHBs and Trusts, challenging assumptions and evidence on the basis of robust analysis;
4. **Healthcare organisations that fulfil their own engagement responsibilities** to the highest standards, ensuring that all communities have a voice, and use the evidence they collect genuinely to shape their decisions;
5. **Patients with concerns are dealt with promptly, professionally and humanely, and that services learn** from individual failings; and
6. **Health services would be scrutinised in the wider context of all public services** to recognise the inter-dependency of such services and to minimise the 'consultation burden'.

How might it be achieved?

The achievement of aspirations such as these requires the whole system – planners, providers, policy makers, as well as patients and the public – to be engaged in these activities, with clear mechanisms to ensure that they fulfil their responsibilities.

We recommend that various organisational options to deliver such 'world class' arrangements now be developed, drawing on experience elsewhere and all the ideas explored in this review, and set in the context of the current direction of travel within Welsh health policy, and of policy on citizen centred Welsh public services as a whole. The options, with an appraisal of their strengths and weaknesses, would then inform a debate amongst all interested parties on what form and function the 'Future CHC' model should adopt.

The following are all possible approaches - alone, or in combination - worthy of further consideration. The first three assume the continuation of CHCs in some form, the last five moving to a different model:

1. **Modified *status quo*** – leaving existing responsibilities and structures largely intact, but maximising the benefits from implementing the earlier recommendations in this report. This would reduce organisational turmoil and would be simple to implement;
2. **One national CHC** – establishing one CHC for the whole of Wales, with local committees serving the areas currently served by the separate CHCs. This might maximise the benefits of coordinated working and reduce bureaucratic costs;
3. **Confederation of CHCs** – give a stronger voice to local CHCs, with the national body acting as their agent. This would give primacy to each existing CHCs, with the national body supporting rather than directing their work;
4. **Oversight of LHB delivery** – this would involve being clear that LHBs have prime responsibility for patient and public engagement and improving the quality of the patient experience, but establishing a mechanism to hold them effectively to account. This might involve creating clear national standards and performance measures, enforced through an independent scrutiny function;

5. **Expand the inspectorate function** – this would build on HIW’s lead responsibility and provide a complementary (and co-located) lay ‘inspection’ function to support the current approach. This could incorporate 4 above;
6. **Local government scrutiny** – establishing a mechanism whereby local authorities scrutinised the work of LHBs and Trusts, and had formal powers to do so. This might capitalise on the democratic legitimacy and resources of local authorities;
7. **Creation of third sector oversight** – establish a body in the third sector (a social enterprise of some sort) to hold LHBs and Trusts to account. This could be a membership body, drawing on volunteers and interested stakeholder groups in the community, with formal powers to scrutinise the NHS; and
8. **Creation of mechanisms spanning all or most of Wales’ public services**, to ensure lay and service user perspectives are influential.

This is not intended as a definitive list, but merely an indication of the range of possible alternative approaches which might approximate better to ‘world class’.

12.4 NEXT STEPS

Implementing these recommendations will be a significant challenge to the Board, CHC staff and Members in the next few months, and they may require short-term managerial and other support to enable them to succeed. Clear and decisive leadership will also be a major factor, as will be a determination to act with pace.

The need for effective and credible scrutiny, coordinated patient and public involvement, and professional advocacy has never been greater. If the Welsh Government’s aspiration to reach for ‘world class’ in our healthcare is to succeed, the functions currently performed by CHCs must also be truly world class. The scale of the challenge will not be lost on those involved.

Written Statement - Review of Community Health Councils

Lesley Griffiths, Minister for Health and Social Services

Community Health Councils fulfil an important role in providing a voice for patients and in monitoring the NHS throughout Wales. On their inception in April 2010, the previous Minister for Health and Social Services announced a review of Community Health Councils should be undertaken two years after their inception. I have decided this review will commence in April 2012 and be undertaken by Professor Marcus Longley of the Welsh Institute for Health and Social Care.

The terms of reference of the Review are:

Working with stakeholders, including Community Health Councils, Local Health Boards and Trusts, Local Authorities, the Third Sector, NHS Confederation, Health Bodies such as PHW, Healthcare Inspectorate Wales, the Care and Social Services Inspectorate for Wales, the Children's Commissioner and the Older People's Commissioner, the review will:

- undertake a root and branch review of the governance of Community Health Councils and, in particular, to make recommendations on
 -
 - the operational structure
 - lines of accountability including links to the Welsh Government
 - the role and responsibilities of the Director of the Board of Community Health Councils
 - the membership structure and the appointment processes
 - making effective use of Third Sector and Local Authorities membership
- recommend where and how we need to develop Community Health Councils, including the members, into 'professional' organisations which fit the strategic needs of 'Together for Health'
- review how Community Health Councils and Health Boards are working together for the benefit of people in Wales including how they fulfil their statutory obligations
- review what we are getting for our money and where Community Health Councils can be more efficient
- identify good practice examples within the Community Health Councils which need to be more widely adopted and how this can be done
- review and make recommendations on any future developments on their "critical friend" role in relation to Health Boards, including acting as the 'patients' voice
- consider their relationship with the Welsh Government and other bodies including Healthcare Inspectorate Wales, the Care and Social Services Inspectorate for Wales, the Children's Commissioner and the Older People's Commissioner
- consider how the Advocacy Service should be provided in the future.

I anticipate the review will report to me in June. This will be followed by formal consultations on its recommendations over the summer. I will report the findings of the review to the Assembly in the Autumn.

Source:

<http://wales.gov.uk/about/cabinet/cabinetstatements/2012/chcreview/;jsessionid=5Qk3P9hCQ6yJQwRMRDF3Qf8snhM1McyH4y7t3N9Zry4J06LjdyZ!-1508250504?lang=en>

APPENDIX 2 – CALL FOR INFORMATION

Review of Community Health Councils – Initial collection of information

The Welsh Government has commissioned the Welsh Institute for Health and Social Care, University of Glamorgan, to carry out a Review of Community Health Councils. The terms of Reference are set out in an Appendix, together with an outline of the approach to the review.

The latter may be subject to minor revision, but the intention is to begin by reviewing a wide variety of written material, and then to follow this up with an extensive series of discussions with key stakeholders.

It would therefore be most helpful if you could provide us with the information set out below, and any other written material you think may help with our terms of reference. Feel free to provide us with whatever documentation you think will shed light on these items. We rely on your assessment of the potential material to determine what may be most germane to our work; other issues can be explored when we meet you in May.

It would be helpful to have the information as soon as is practical – we don't mind if you send it in batches - and in any event by **Friday 27 April 2012**. It should be sent to Amy Simpson at WIHSC, University of Glamorgan, Pontypridd CF37 1DL or by email: asimpson@glam.ac.uk

We will be contacting you soon to arrange to come and talk to you further, but in the meantime, many thanks for your cooperation in this. Please feel free to contact Amy or any member of the team for clarification or further information: Professor Marcus Longley mlongley@glam.ac.uk or Dr Mark Llewellyn mrllewel@glam.ac.uk, all on 01443 483070.

We are also happy to receive any other submissions from people with relevant experience or views, and these should be sent to Amy Simpson in the same way.

Individual CHCs

1. Statement of purpose and description of activities
2. Description of structures and accountability arrangements
3. Copy of all policies relating to governance issues, including code of conduct of members
4. List of current members, including brief demographic characteristics, date of appointment, and attendance record; description of approach to improving diversity
5. Job descriptions and personal specifications for staff
6. Copy of past, current, and any future work plans
7. Engagement strategies, including feedback to local communities
8. Details of joint work carried out with any other body including LHBS
9. Marketing plans, including analysis of reasons for not using CHC services
10. Performance indicators in use, and assessment of performance against them
11. Copies of CHC Council agendas and minutes for the last year
12. Budget details - including information on main areas of expenditure
13. Advocacy service – activity since the service was established (including number of cases per month, taxonomy, referral source, CHC input per case, nature of the issue), outcomes of cases, and response/waiting times.
14. Examples of good practice – short descriptions of work you have done which you think is particularly noteworthy
15. Analysis of media coverage of CHC

APPENDIX 2 – CALL FOR INFORMATION

National Board of CHCs

1. Statement of purpose and description of activities
2. Description of structures and accountability arrangements
3. Copy of all policies relating to governance issues, including code of conduct of members
4. Job descriptions and personal specifications for staff
5. Copy of current and any future work plans
6. Details of joint work carried out with other bodies
7. Performance indicators in use, and assessment of performance against them
8. Copies of Board and Management Team agendas and minutes for the last year
9. Budget details - including information on main areas of expenditure
10. Examples of good practice – short descriptions of work you have done which you think is particularly noteworthy
11. Analysis of media coverage of National Board

LHBs and Trusts

1. Agrees approaches to joint working with your CHC(s)
2. Description of any joint activities with your CHC(s)

HIW

1. Details of joint working with CHCs, including any written protocols etc and their implementation

APPENDIX 3 – SURVEY

The eight Community Health Councils in Wales were established in April 2010. The then Minister for Health and Social Services announced her intention to review the arrangements after two years of operation. That review is currently being undertaken by the Welsh Institute for Health & Social Care (WIHSC). As part of the review process WIHSC would welcome your comments on the following questions, which are based on the terms of reference for the review. Please feel free to comment on any or all of these questions.

Please comment on the following areas:

- The operational structure of CHCs
- Lines of accountability including links to the Welsh Government
- The role and responsibilities of the Director of the Board of Community Health Councils
- The membership structure and the appointment processes
- Making effective use of Third Sector and Local Authorities membership

Where and how do we need to develop Community Health Councils, including the members, into 'professional' organisations which fit the strategic needs of 'Together for Health'?

How well are Community Health Councils and Health Boards working together for the benefit of people in Wales?

What are we getting for our money and where can Community Health Councils be more efficient?

APPENDIX 3 – SURVEY

Please identify good practice examples within the Community Health Councils which need to be more widely adopted. How can this be done?

How should CHC's develop their "critical friend" role in relation to Health Boards, including acting as the 'patients' voice?

How well do CHCs work with the Welsh Government and other bodies, including Healthcare Inspectorate Wales, the Care and Social Services Inspectorate for Wales, the Children's Commissioner and the Older People's Commissioner?

How should the CHC Advocacy Service be provided in the future?

Any other comments – *continue on a separate sheet if necessary*

You can submit this survey anonymously but if you would like to provide your details or tell us which category you believe you fall in, please do so below:

Name & contact details:

Community Health Councils - Local Health Boards/Trusts - Local Authority - Voluntary Sector -
- Member of the public - Other *please specify* - I'd rather not say

Thank you for completing this survey. Please return it by email to wihsc@glam.ac.uk or 'FREEPOST' (no stamp required) to:

Marcus Longley

Welsh Institute for Health & Social Care

University of Glamorgan

FREEPOST CF2486

Lower Glyntaf Campus

Treforest, Pontypridd, CF37 4BD

APPENDIX 3 – SURVEY

Sefydlwyd yr wyth Cyngor Iechyd Cymunedol yng Nghymru yn Ebrill 2010. Cyhoeddodd y Gweinidog yr Adeg honno dros Iechyd a Gwasanaethau Cymdeithasol ei bwriad o adolygu'r trefniadau ar ôl dwy flynedd o'u gweithredu. Mae'r adolygiad hwnnw ar waith ar hyn o bryd gan Sefydliad Iechyd a Gofal Cymdeithasol Cymru (WIHSC), Prifysgol Morgannwg. Fel rhan o'r broses adolygu, byddai WIHSC yn croesawu'ch sylwadau ar y cwestiynau canlynol sy'n seiliedig ar amodau gorchwyl yr arolwg. Croeso i chi rhoi'ch sylwadau ar unrhyw un o'r cwestiynau hyn neu ar y cwestiynau i gyd.

Rhowch eich sylwadau ar y meysydd canlynol:

- Strwythur Gweithredol y Cyngorau Iechyd Cymunedol
- Llinellau atebolrwydd gan gynnwys cysylltiadau â Llywodraeth Cymru
- Rôl a chyfrifoldebau Cyfarwyddwr Bwrdd y Cyngorau Iechyd Cymunedol
- Strwythur aelodaeth a'r prosesau penodi
- Gwneud defnydd effeithiol o aelodaeth y Trydydd Sector a'r Awdurdodau Lleol

Ble a sut mae angen i ni ddatblygu'r Cyngorau Iechyd Cymunedol, gan gynnwys yr aelodau, i fod yn sefydliadau 'proffesiynol sy'n addas ar gyfer anghenion strategol 'Law yn Law ag Iechyd'?

Pa mor dda mae Cyngorau Iechyd Cymunedol a Byrddau Iechyd yn cydweithio er lles pobl Cymru?

Beth ydyn ni'n ei gael am ein harian a lle gall Cyngorau Iechyd Cymunedol fod yn fwy effeithlon?

APPENDIX 3 – SURVEY

Nodwch enghreifftiau o arferion da o fewn y Cyngorau Iechyd Cymunedol y dylid eu mabwysiadu'n ehangach. Sut gellid gwneud hyn?

Sut dylai Cyngorau Iechyd Cymunedol ddatblygu eu rôl "cyfaill beirniadol" o ran y Byrddau Iechyd, gan gynnwys gweithredu fel 'llais y claf'?

Pa mor dda mae Cyngorau Iechyd Cymunedol yn cydweithio gyda Llywodraeth Cymru a chyrff eraill, gan gynnwys Arolygiaeth Gofal Iechyd Cymru, Arolygiaeth Gwasanaethau Gofal a Chymdeithasol Cymru, y Comisiynydd Plant a'r Comisiynydd Pobl Hŷn?

Sut dylid darparu Gwasanaeth Eiriolaeth Cyngorau Iechyd Cymunedol yn y dyfodol?

Unrhyw sylw arall – *defnyddiwch dudalen ar wahan os oes angen*

Gallwch gyflwyno'r arolwg hwn yn ddiennw ond os hoffech ddarparu'ch manylion neu ddweud i ba categori y credwch eich bod yn perthyn, gwnewch hynny isod:

Enw a Manylion cyswllt:

Cyngorau Iechyd Cymunedol - Byrddau/ Ymddiriedolaethau Iechyd Lleol - Awdurdod Lleol - Y Sector Gwirfoddol - Aelod o'r Cyhoedd - Arall *rhowch fanylion*
Mae'n well gen i beidio â dweud

Diolch am gwblhau'r arolwg hwn. Gallwch ei ddychwelyd drwy e-bost i wihsc@glam.ac.uk neu ddefnyddio 'RHADBOST' (does dim angen stamp):

Marcus Longley, Cyfarwyddwr, Sefydliad Iechyd a Gofal Cymdeithasol Cymru, Prifysgol Morgannwg
Prifysgol Morgannwg, **RHADBOST CF2486**
Campws Glyntâf Isaf
Trefforest, Pontypridd, CF37 4BD

APPENDIX 4 – OPEN CALL FOR EVIDENCE

A REVIEW OF COMMUNITY HEALTH COUNCILS IN WALES

The eight Community Health Councils in Wales were established in April 2010. The then Minister for Health and Social Services announced her intention to review the arrangements after two years of operation. That review is currently being undertaken by the Welsh Institute for Health & Social Care (WIHSC), University of Glamorgan. Subsequently the Minister will consult on any proposed change.

Further details on the review and its terms of reference can be found at:
<http://wales.gov.uk/about/cabinet/cabinetstatements/2012/chcreview/?lang=en>

HOW CAN YOU CONTRIBUTE TO THE REVIEW?

We would be delighted to hear your views on CHCs. Please contact us in any of the following ways.

- **ONLINE FORM:** at <https://www.survey.glam.ac.uk/chcsreviewwales>
- **QUESTIONNAIRE:** request a copy using the contact details below
- **MEET THE REVIEW TEAM:** WIHSC will be holding a series of meetings throughout Wales. To find out more and/or arrange to meet the team please call 01443 483070.
- **PHONE:** 01443 483070 to talk to the review team, **FAX:** comments to 01443 483079
- **EMAIL:** comments to wihsc@glam.ac.uk , or **POST** to

Professor Marcus Longley

Director, Welsh Institute for Health & Social Care, University of Glamorgan

FREEPOST CF2486, Lower Glyntaf Campus

Treforest, Pontypridd, CF37 4BD

The closing date for sharing your views with the review team is 1st June 2012

Please don't hesitate to contact WIHSC if you have any queries. We look forward to hearing from you.

wihsc



ADOLYGIAD O GYNGHORAU IECHYD CYMUNEDOL YNG NGHYMURU

Sefydlwyd yr wyth Cyngor Iechyd Cymunedol yng Nghymru yn Ebrill 2010. Cyhoeddodd y Gweinidog yr adeg honno dros Iechyd a Gwasanaethau Cymdeithasol ei bwriad i adolygu'r trefniadau ar ôl dwy flynedd o'u gweithredu. Mae'r adolygiad hwnnw ar waith ar hyn o bryd gan Sefydliad Iechyd a Gofal Cymdeithasol Cymru (WIHSC), Prifysgol Morgannwg. Wedi hynny bydd y gweinidog yn ymgynghori ar unrhyw ddarpar newid.

Cewch ragor o fanylion am yr adolygiad a'i amodau gorchwyl ar:

<http://wales.gov.uk/about/cabinet/cabinetstatements/2012/chcreview/?lang=en>

SUT GALLWCH GYFRANNAU AT YR ADOLYGIAD?

Bydden ni wrth ein bodd cael clywed eich barn ar y Cyngorau Iechyd Cymunedol. Defnyddiwch unrhyw un o'r dulliau isod i gysylltu â ni:

- **FFURFLEN AR-LEIN:** ar <https://www.survey.glam.ac.uk/cyngoriechydcymuned>
- **HOLIADUR:** gofyn am gopi gan ddefnyddio'r manylion cyswllt isod
- **CWRDD Â THIM YR ADOLYGIAD:** Bydd WIHSC yn cynnal cyfres o gyfarfodydd drwy Gymru. I gael gwybod rhagor a/neu drefu cyfarfod â'r tîm, ffoniwch 01443 483070.
- **FFONIO:** 01443 483070 neu siarad ag aelodau'r tîm adolygiad, **FFACSIO:** sylwadau i 01443 483079
- **E-BOST:** wihsc@glam.ac.uk, neu **BOSTIO'ch** sylwadau at

Yr Athro Marcus Longley

Cyfarwyddwr Sefydliad Iechyd a Gofal Cymdeithasol Cymru, Prifysgol Morgannwg

RHADBOST CF2486, Campws Glyntâf Isaf,

Trefforest, Pontypridd, CF37 4BD

Y dyddiad cau ar gyfer eich sylwadau ydy 1 Mehefin 2012

APPENDIX 4 – OPEN CALL FOR EVIDENCE

Croeso i chi gysylltu â WIHSC os oes gennych unrhywy ymholiadau. Edrychwn ymlaen at glywed gennych.



APPENDIX 5 – REVIEW ENGAGEMENT

Abertawe Bro Morgannwg Community Health Council

Abertawe Bro Morgannwg University Health Board

Action against Medical Accidents (AvMA)

Aneurin Bevan Community Health Council

Aneurin Bevan Health Board

Betsi Cadwaladr Community Health Council

Betsi Cadwaladr University Health Board

Brecknock & Radnor Community Health Council

Cardiff and Vale Community Health Council

Cardiff and Vale University Health Board

Care and Social Services Inspectorate Wales

Citizens Advice Cymru

Citizens Advice Scotland

Consumer Focus

Cwm Taf Community Health Council

Cwm Taf Health Board

Disability Can Do Organisation

Diverse Cymru

General Pharmaceutical Council

Happy Feet Project

Healthcare Inspectorate Wales

HSD Public Service Development

Hywel Dda Community Health Council

Hywel Dda Health Board

Montgomery Community Health Council

National Board of Community Health Councils

National Leadership and innovation Agency for Healthcare

Participation Cymru

Pensioners Forum Wales

Powys Teaching Health Board

Public Service Ombudsmen for Wales

RCT 50+ Forum

Royal Pharmaceutical Society Wales

Scottish Government

South Wales Cardiac Network

Spinal Injury Charity

Velindre NHS Trust

Wales Council for Voluntary Action

Wales Deanery

Welsh Ambulance Services NHS Trust

Welsh Government

Welsh Local Government Association

Welsh NHS Confederation

44 written or verbal responses from individuals

APPENDIX 6 – KEY DOCUMENTS

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