Lessons learned independent review into NHS Service Change Engagement and Consultation Exercises by Health Boards in Wales.

By Ann Lloyd CBE

10/1/2014
## Contents

Chapter One: Introduction ........................................... p3
Recommendations ...................................................... p6
Chapter Two: Roles and Responsibilities ........................ p8
The Three Consultation Exercises ................................... p10
Betsi Cadwaladr University Health Board ......................... p10
Hywel Dda University Health Board ............................... p11
The South Wales Programme ....................................... p12
Initial Conclusions Arising from the Consultations ............. p14
Community Health Councils ....................................... p19
Chapter Three: Consultation and Engagement ................... p23
Best Practice ......................................................... p25
Chapter Four: Considering the Evidence ........................ p28
Chapter Five: Reform for the Future ............................... p32
Final Words .......................................................... p39
Attachment 1a: People interviewed ............................... p40
Attachment 1b: Organisations ...................................... p44
Attachment 2a: Questions to health boards ........................ p46
Attachment 2b: Questions to community health councils ....... p49
Attachment 3a: Evaluation of the evidence ....................... p52
Attachment 3b: Additional evidence - health boards and CHCs p66
Attachment 4: References ......................................... p100
Chapter One: INTRODUCTION

Evolution in health services is essential to the improvement of the health and wellbeing of communities and should be welcomed. The quality, range and effectiveness of care and treatment has improved exponentially over the past 50 years – and the public’s knowledge and expectations of the range and quality of services available has increased accordingly.

However, much of the knowledge of the public (rather than their own personal experience) is influenced by the media – who often report failure – or by word of mouth. Little air time is given to innovation – except in the specialist press or about the availability of a new super drug or treatment. Efforts to engage communities in the design and delivery of their care has been variable; their interest in such engagement can also be limited until they believe their services are being changed by a third party who might not know their wishes and desires. The public reaction to change on occasion has inhibited change being affected because of a real concern from the communities that they were going to lose what they had and the NHS had not explained well enough the service provision that would be available. Many communities inevitably suspect that their current services will be taken away from them and that will have no say in what replaces them – if anything – and that in an emergency they will have to travel miles at risk. They believe they will lose their knowledge about the ways in which they can access care when needed and that their health and wellbeing will be placed at risk. Communities need to be given the opportunity and help to be able to access issues concerning their health and wellbeing as they wish.

The NHS also has a difficult message to impart, which encompasses a narrative of consolidating more specialist services while, at the same time, bringing care closer
to home. The language used by the NHS is also difficult to understand and the information provided can lead to confusion and suspicion.

Organisations making service change for reasons of safety have often been faced with significant resistance which has sometimes meant that necessary change has not happened quickly enough or the changes required have been modified.

The NHS has traditionally found it difficult to engage effectively; the approach of design, consult and then change on the whole has not been productive.

Patients/citizens say they want continuity of care, particularly from “their” GP or a secondary care clinician. Many also have an emotional attachment to hospital buildings – many of which their ancestors helped pay for. They are reluctant to let go of what is familiar to them.

There are exceptions, but despite considerable efforts many health organisations have struggled to effect service change peacefully and with the full acceptance of the majority voices within the communities, especially when considering the removal of or redesign of emergency or specialist hospital services. The NHS is littered with tales of coffins being dragged through the streets by protestors; sit ins and the receipt of a general barrage of challenge from those amongst the general public who feel strongly about the proposals from the NHS.

Such reactions have made the NHS nervous about consulting on service change and much time, resource and effort has been devoted to better engaging patients and the public in the rationale for changes. However, the concept of continuous engagement with communities about all aspects of their health and wellbeing has been very variable – but good examples of community engagement do exist in Wales.

Much of the basis for the public’s suspicion of service change surrounds their belief about the adequacy of the amount of money to run their health services – they suspect that services are being changed or surreptitiously removed to save money; the safety and adequacy of the services they receive has, in the past, almost been a secondary issue. The quality of information - including benchmarking information – has not been good enough to spell out the case for them. Has the service been honest or open enough to describe what good quality, safe care might look like and how this compares with the one available to them currently?

The NHS in Wales has had many strategies for the development of health care for its citizens. All strategies place improving the quality and safety of care for the public at the forefront of the redesign of services – balanced by sustainability and an improvement in equity and access.

As a result of the latest round of consultations about service change in Wales, some fundamental messages have been delivered about the sustainability of the services for the future – and there has been the welcome development of NHS organisations
planning care pathways together across boundaries. However, despite valiant efforts on the part of many organisations, there has been considerable opposition expressed by the public about the changes proposed.

So, what can be done to engage the communities more effectively and consistently so that they really contribute to the design of safe, sustainable and cost effective services for their future? Could the balance of power – and with it responsibility – really move from a domination by the NHS towards a rebalance in which communities themselves begin to share influence, power, control and responsibility for the design and quality of the services they receive?

Should there be a “citizens’ NHS” in which the NHS has effective and continuous systems for involving the community in the design of the services for the future, enabling citizens to contribute to the debate about whether or not services are well run, of good quality and sustainable and in which people are involved in determining patterns for their own care and treatment and are assisted to protect and improve their own health?

As part of the Wales health reconfiguration service change projects conducted during 2013 and 2014, the Minister for Health and Social Services gave a commitment to a lessons learned review of the reconfiguration process in respect of the engagement and consultation exercises conducted by health boards and to consider whether or not any changes would be required through legislation and guidance to improve the processes.

The purpose of the review would be to clarify the nature of effective and acceptable engagement and consultation prior to and during service change and to clarify grounds for community health council (CHC) referral and judicial review on the grounds of impaired consultation.

The review would capture evidence of good practice and provide recommendations to improve the Welsh Government’s current Guide on Engagement and Consultation on Service Change, which was issued November 2011 and includes guidance on the referral of service change proposals by CHCs - March 2013.

The review would also assess the role of CHCs in the whole process and provide advice on both the part that they play in the consultation and referral processes and their ability to discharge those responsibilities effectively.

The review has been undertaken in four phases:

1. Initial scoping exercise and research into best practice;
2. An engagement exercise capturing experience and views of key stakeholders;
3. Assessment of the information gathered and a critical examination of the guidance against the best practice evidence and issues arising from the field;
During the course of this investigation I have met a wide range of stakeholders who have provided me with evidence of their experience of service change engagement and consultation processes in Wales frankly and honestly. I have listened carefully to their thoughts and opinions and have been grateful for the considerable volume of literature and other evidence they have provided.

It has been a disappointment to me that due to the timescales involved I have been unable to meet everyone who might have valid experience and advice to give me – particularly the WCVA co-production team - but I have tried to elicit their responses through written evidence, an offer which has been taken up by many. A list of all those interviewed and who responded to my request for their comments is found as attachments 1a and 1b.

The outcome of my investigation reflects on the engagement and consultation experience across Wales; the effectiveness of current service change guidelines; the role of CHCs in the process and their ability to discharge their responsibilities effectively.

The report contains a number of examples of honest endeavour and good practice together with suggestions for the future. These suggestions are my own views underpinned by the evidence provided and the outcome of additional research that I have undertaken.

I am grateful for the time and effort given by those who responded to this investigation and I have been enthused and encouraged by their passion for improving the quality and safety of care available to the citizens of Wales. I am very grateful to all of those who took time to respond to me and their patience in answering my questions and in providing me with such helpful views and advice.

I am also really grateful to Caroline Hopkins and Lorna Roberts from the Welsh Government for arranging my meetings and taking many of the notes.

I am particularly grateful to Maggie Robinson BSc (Econ) for the incredibly helpful research that she has undertaken on my behalf and to the unerringly wise judgement I have received from my small review team of Peter Molyneux, Marie Gabriel, Vijay Sharma and Ros Hakesley Brown CBE.

Ann Lloyd CBE
RECOMMENDATIONS

These are the main areas where I have made recommendations for reform of the current engagement and consultation system, including guidance. These are set out in more detail in chapter five.

Health Boards

Health boards should continuously engage with their local communities to help them plan and develop healthcare and services, not only when undertaking major service change. Health boards should be formally held to account for the quality of that engagement.

Effective and continuous engagement should become the main vehicle for local service changes. The guidance about when consultation is used should be revised to reserve it for fundamental service change, which affects large numbers of people or if the removal of an asset is proposed.

From the beginning of continuous engagement on any specific area of service delivery or service change, health boards must make clear the process through which decisions will be made.

Consideration should be given to the constitution and governance of health boards in respect of their capacity to plan strategically for the future and make strategic decisions.

Health boards should be held to account by the Minister for their ability to manage their reputation.

The rules and governance surrounding collective responsibility for decision making between health boards need clarification and review.

Community Health Councils

Should CHCs retain their current responsibilities, those roles, responsibilities and the membership of CHCs together with their governance should be overhauled – much of the work and recommendations undertaken by Marcus Longley in his review remain relevant to this recommendation.
There is a need to reform the way in which CHCs undertake their responsibilities in respect of service change and public engagement. They are currently ill equipped to propose alternatives to suggested service change models.

There must be a well-understood and effective mechanism in place for holding CHCs and their individual members to account for the discharge of their responsibilities.

The ways in which they assemble and manage their community networks requires thorough review to ensure that it is truly representative.

The Board of CHCs will need to be reformed in order to achieve its potential. It will need to work with the reformed CHCs to promote improvements in the quality and extent of patient focus and public engagement in the NHS in Wales. It will need to work with CHCs to support and monitor the ways in which engagement is undertaken.

**Guidance**

The guidance and statutes should be reformed to emphasise the necessity for continuous engagement and the quality standards that will be associated with it.

Advice should be available on best practice in service planning and design.

The guidance should include the requirement of health boards to build in an evaluation of the consultation and engagement experience from the beginning of the plan to reform the delivery of care and the impact that engagement and consultation has had on the final decision reached.

The appeals mechanism and the processes for and powers of referral should be overhauled. It should not remain the sole prerogative of the CHC to refer a proposal to the Minister. Instead the CHC, together with a formal body such as reformed local service boards, which represent the collective publically accountable bodies, would be charged with making any referral.

If a referral to the Minister is made, a third party check should be introduced into the process to act as adjudicator on behalf of the Minister on areas of dispute between the health boards and the communities. The adjudicator would consist of an expert panel or standing committee with an independent, non-clinical chair.
Chapter Two: ROLES AND RESPONSIBILITIES
AND WHAT HAPPENED DURING ENGAGEMENT
AND CONSULTATION

GUIDANCE AND RESPONSIBILITIES

In publishing its guidance the Welsh Government was clear in its expectation that all organisations in the NHS should be responsive to the needs and views of their citizens. The Welsh Government urged health boards and community health councils (CHCs) to work together to develop methods for continuous engagement which would promote and deliver service transformations for their populations.

This guidance replaced the interim guidance on consultation issued under Ministerial letter EH/ML/016/08 – the emphasis within the interim guidance had been placed on the need for a new approach to change based on continuous engagement to ensure that the NHS organisations were more responsive to the needs and views of their citizens.

The 2013 guidance reflected a further rebalancing between continuous engagement and formal consultation with NHS bodies and reformed CHCs working together to develop methods of continuous engagement which would promote and deliver service transformation for their populations.

It is difficult to disagree with the sentiments contained within the guidance or the principles it espouses but it needs a reality check and needs to be written more tautly. The guidance has been written to allow for some local variations but its use has been interpreted more widely by organisations concerned.

In cases where substantial change or an issue requiring consultation was identified, a two-stage process was to be adopted - extensive discussion with citizens, staff, staff representatives and professional bodies, stakeholders and the third sector and partner organisations was followed by a focused formal consultation on any fully evaluated proposals emerging from the discussion phase.
The guidance highlights the principle that the health boards have strategic responsibility for ensuring safe and sustainable services and stresses that “it is vital that LHBs and CHCs work together to achieve this across the whole of their area ... within the resources available”.

It states the “primary task of CHCs is to assess the impact of the proposed changes on health services, not to take a partisan role” and that “CHCs must recognise that maintaining the status quo is not an acceptable response if safe and sustained services cannot be maintained within available resources”.

The guidance also makes clear that the power of CHCs to refer an issue to the Minister for decision relates only to engagement and consultation between CHCs and the NHS, not between the NHS and other stakeholders.

The regulations issued in 2010 allocate a particular role in NHS planning to CHCs, comprising of the right to:

"Be involved by the relevant LHB in the planning of services, the development and consideration of proposals for service changes and decisions affecting the operation of services, and be consulted at the inception of and throughout any planning, development, consideration or decision making process in accordance with government guidance.

"Be consulted at inception and throughout the process on any proposal for a substantial development of the health service or a substantial variation in service.

"Comment on any proposal consulted on.

"Report to Welsh Ministers if dissatisfied about the content or time allowed in a consultation, about not being consulted at inception, about the frequency of involvement throughout the proposal and decision making process or about the adequacy of the explanation for not being involved.

"Refer a proposal it believes not to be in the interests of the health service in its area to Welsh Ministers for a final decision.

"Receive information on planning matters from NHS bodies.”
THE THREE CONSULTATION EXERCISES

The three most recent major exercises in engagement and consultation in Wales were conducted in different ways. The details of the methodologies used are found as part of the references at attachment 4.

**Betsi Cadwaladr University Health Board**

The preparatory work for the consultation process on *Healthcare in North Wales is Changing* involved a series of clinically-led work streams which undertook reviews of the specific service areas involved. These built on an approach used in previous work and the methodology was independently evaluated. Specific work streams also undertook additional engagement exercises.

In preparation for the formal consultation, the health board commissioned training and support sessions on best practice from the Consultation Institute. The stakeholder data base was developed using the health board’s contact lists and previous engagement work and included the details of people who had previously contacted the health board to express an interest in receiving information.

The health board worked hard “to ensure that there was meaningful opportunity to engage for all and that the approach was proportionate and aligned with best practice”.

Opinion Research Services (ORS) assessed the action and stated that the approach was extensive and conscientious and the Older People’s Commissioner for Wales (OPC) indicated in feedback that the health board “had made genuine efforts to ensure the meaningful involvement of older people”.

Betsi Cadwaladr Community Health Council distributed posters, flyers and information sheets about the consultation proposals as well as meeting with many people and using a short questionnaire to gather views. The CHC gave a detailed response to the health board’s proposals, setting out areas where there were concerns and a need for assurance. Finally, although some areas of concern remained, the CHC was able to confirm on balance that it believed: “That several of the proposals will be in the interests of people who use health services, subject to the technical documents supporting the paper providing the necessary assurances the CHC has asked for.”
Hywel Dda University Health Board

The clinical services strategy for the health board was launched in August 2012 to run for 11 weeks. However, the development of that strategy had started in May 2010 with the establishment of 10 clinically-led workshops; the work from these culminated in a series of clinical engagement events in May 2011 from which emerged a vision and option appraisal criteria used to develop the high-level options. Between December 2011 and April 2012 citizens were invited to provide feedback on the health board's vision. Opinion Research Services (ORS) was commissioned to collate and analyse all the feedback and publish the findings. Between June and April 2012 a pre-consultation public engagement programme was undertaken, with extensive engagement with key internal and external stakeholders. This culminated in the completion of a technical annex and consultation document.

The consultation closed in October 2012 but extended. The resultant information was collated and reviewed and examined and presented to the board for decision in January 2013. Hywel Dda Community Health Council subsequently formally objected to the ways in which the consultation had been undertaken and also to the proposals themselves and referred the matter to the Minister in February 2013. The Minister rejected the assertions of the CHC and asked that it resume its discussions with the health board for a final agreement to be reached by March 31, 2013.

The CHC asked for an extension to April 30, 2013, which was granted but, unable to make headway, re-referred the matter to the Minister on April 19. Running in parallel to these discussions was the submission of an application for judicial review from a member of a pressure group in Llanelli.

The Minister asked an independent scrutiny panel, led by Dr David Salter, former deputy Chief Medical Officer for Wales, to review the proposals and on January 21, 2014 informed the CHC of his decision.

Subsequently, the Court heard the judicial review and found in favour of the health board. An appeal against that decision was rejected on August 21, 2014.

The changes proposed by Hywel Dda University Health Board to maternity and neonatal services at Glangwili and Withybush hospitals, in Carmarthen and Haverfordwest respectively, came into effect in August 2014. Further changes will be made to paediatric inpatient care at Withybush Hospital in October 2014.
The South Wales Programme

This programme was undertaken as a collaborative involving five health boards - Abertawe Bro Morgannwg, Aneurin Bevan, Cardiff and Vale, Cwm Taf and Powys - working with the Welsh Ambulance Services NHS Trust. It focused on four specialist hospital services - consultant-led maternity care; inpatient paediatric services; neonatal services and emergency medicine for the sickest and most seriously injured patients.

The programme followed a five-stage process:

1. Review of advice, guidance and evidence about how services should be best provided to produce safe care;
2. Testing the advice with the professional staff that currently provide this care;
3. Summarise the emerging findings for public discussion;
4. Reflect on the themes emerging from public discussion;
5. Produce proposals for public consultation.

Underpinning these considerations each health board needed to have a plan for all the services it provided for people living in its area to include:

- Plans for developing and extending local primary and community health services;
- Plans for community and general hospital services;
- Plans to ensure close working with other public services such as social services.

Such proposals would form part of the three-year plans for approval by the Minister.

The South Wales Programme was chaired by an independent chair and had an independent programme director.

The South Wales Programme called for a new approach to working with the professional staff providing healthcare for patients across South Wales. The five health boards organised a series of conferences and summits to bring staff and clinicians together to discuss how the evidence for safe sustainable services matched their current direct experience.

With the advice from the clinical conferences and leaders, the health boards conducted engagement discussions with communities over the following three months – making no assumptions about the outcome of the discussions - and detailed work was undertaken to develop options that could be evaluated to see how they measured up against the sustainability criteria developed by the programme.

The programme also followed an equality impact assessment process against which all options were reviewed and changes were made.
An extensive consultation process was started in May 2013 with meetings chaired by each of the five community health councils in 79 locations across South Wales. Opinion Research Services (ORS) were again asked to collate and interpret the feedback from consultation and the results of the consultation exercise were submitted to the individual health boards for decision.

Complete agreement was not at first reached and further time had to be given for discussions with one of the partners following which a final collective conclusion was reached.
INITIAL CONCLUSIONS ARISING FROM THE THREE CONSULTATIONS

Huge amounts of time and effort have been devoted to the engagement and consultation processes across Wales by many very committed NHS staff and community representatives. There is evidence within the references of the considerable thought given to reaching out to as many in their communities as possible. The consultations differed from each other in methodology and had varying challenges to overcome – some of which remain today.

In reviewing the evidence, a number of common themes emerge:

- The Welsh Government guidance was loosely worded in places and was open to interpretation.

- There was concern expressed by people charged with implementing the guidance about the differentiation between engagement and consultation, with confusion arising in the minds of the communities about why, on occasions, they were being asked the same question twice.

- The comprehensive engagement of clinicians was a great step forward and invaluable to the results. Meaningful clinical engagement is crucial to future success. Care has to be taken that the whole clinical body providing care should be engaged and involved - there should be no selectivity in the use of clinicians. The Academy of Royal Colleges in Wales might add value by playing a greater part in providing independent advice on the standards required to provide care. Additionally staff employed by the organisations represent a substantial community resource and every effort should be made to engage them effectively in the discussion from the beginning of the process.

- Although there was considerable stakeholder involvement, this was generally at a later stage in the process and after the engagement of the clinicians. Citizens, patients and carers should be effectively engaged in discussion on major changes to the care they might receive from the beginning of the discussion – at the point at which the problems and concerns are emerging and best practice evidence from clinicians, including independent clinicians, is
Because of concerns about the acceptability of the changes mooted – not unreasonably so given the strength of feeling in some responses – the organisations put real effort into considering the design of the engagement/consultation exercise to ensure that it was appropriate for the target audiences. They tried hard to cover all bases in the face of having to drive through change that was inevitable; early and continuous, active dialogue with their community in which the communities were equal partners with other key influencers might have been more effective in hindsight. The perception by communities about the domination of the NHS in such exercises must alter – from assertion to discussion. Most of the organisations in Wales undertake engagement exercises only when faced with inevitable change – some mental health service redesign being an exception.

Among the health boards only Cwm Taf University Health Board has traditionally engaged its communities in a constant dialogue about its services, their delivery, design and development.

There is a real need to have effective public engagement that represents an ongoing relationship rather than an engagement activity when challenging the status quo.

- There was some good practice used; it was appropriate that the practice should vary according to organisation and community structure. However there needs to be a systematic review and analysis across the country to ensure that the methodology used is effective and represents good value for money.

- Good use was made of the equality impact assessments - although there were detractors (see attachment three). Real evidence has to be provided throughout any consultation and engagement process to show that the process has been dynamic and that strategy and plans have been reviewed and adjusted accordingly.

- External validators were used within the process; this was sensible – particularly the use of an independent reviewer of the outcome of consultation and in managing deliberative fora.
The scrutiny undertaken by local authorities varied throughout Wales – some considered that they had been fully engaged, others not. The responsibilities of local authorities in respect of the scrutiny of issues of the quality and safety of healthcare and the health and wellbeing of their communities needs to be clarified. The role and responsibilities of local service boards (LSBs) in assisting with the development of proposals for the delivery of safe and sustainable care also requires clarification. The councillors at local level might be better used and a concerted effort needs to be made to ensure that they are engaged effectively.

Where were the expert patients in the debate about change? Expert patient groups used to be used extensively in Wales in helping form policy but they seem to have declined in influence nationally. Their powerful impact should be revitalised.

The use of the third sector networks to link with hard to reach groups was effective where used and should be more formalised for the future. They will be particularly useful in establishing continuous engagement fora.

The Older People’s Commissioner issued helpful and sensible advice on engagement to the NHS prior to consultation. She had some concerns about the use of her guidance about which she advised the health boards concerned and displayed evidence of an independent voice working across the themes rather than engaging with the silos of discussion.

A large amount of information in varying formats was distributed to the communities and throughout the organisations but unfortunately in some instances it was very technical. Concerns were expressed that information changed or was not comparable to information previously received. Some information was described as being woefully inadequate. It is perfectly reasonable that information should be changed over time, however, communities need assurance that the evidence they are asked to consider is accurate and timely and in a format that make sense to them. Consultation documents must be clear to the general body of the interested parties and present issues fairly and in a way that facilitates an effective response.

Although clinicians were encouraged to be a positive part of the process, concerns were expressed that primary care believed that it was not fully engaged – particularly where changes in community hospital services were proposed. It is really important that primary and community care are fully
engaged in the processes and that their needs in terms of recruitment, training and development are taken fully into consideration in planning and designing care for the future.

- Some suspicions were expressed that although consultation and engagement was ongoing, the organisations had already made up their minds about the future shape of the service. As stated by Mr Justice Hickinbottom in his judgement in Flatley August 2014: “A decision maker cannot have a predetermined option such that consultation is a sham; he may have a preferred option but he must disclose that to potential consultees so as to better focus their responses.” Any such suspicions should be overcome by producing an audit trail that clearly shows how comments and concerns have been fed back into the organisation's decisions makers and have influenced the outcome.

This challenge is aimed specifically at the first of the Gunning principles – “that consultation must take place when the proposal is still at a formative stage”. However, this principle does not mean that the decision maker has to consult on all possible options to achieve a particular objective – the decision maker can consult on a preferred option so long as its mind is genuinely ajar. “To have an open mind does not mean an empty mind.” (Neil Garnham QC. – reference attachment 4). It is also disingenuous to consult on options that can never be delivered.

- All organisations undertook stakeholder mapping and tried to ensure they reached the “hard to reach and protected” groups. Further consideration should be given to the effectiveness, efficiency and comprehensiveness of the subsequent engagement, particularly from among the age groups whose services would be most affected.

- Health boards used the Consultation Institute to accredit their consultation processes and also to train and develop their staff in engagement and consultation. This was helpful in providing added assurance to their processes.

- The fundamental rationale behind the proposals was not always understood by the communities; the Welsh NHS Confederation survey (December 2013) indicates that “although the financial pressure on the NHS is widely understood …there is a much lower awareness of the quality and safety reasons that are driving the need for radical, transformational change.”
Additionally as pointed out by Opinion Research Services in its report about the Betsi Cadwaladr University Health Board consultation exercise:

“Analysis showed that if (as a result of all the proposals) respondents would no longer be able to use their local hospital, then their disagreement increased in direct proportion to their additional distance of travel to the nearest hub.”

It is really important the expectations and understanding of the local communities about the service is ascertained and evaluated and that good quality, accessible information is available to help them frame their expectations.

Considerable effort was expended by large numbers of people in producing, engaging and consulting on the three sets of proposals. But in the scale of the change that is needed to produce a sustainable solution to the provision of safe care in Wales, the percentage of services on which consultation took place was small – 6.7% in the case of the South Wales Programme.

Additionally the general public was asked to place great faith in the fulfilment of promises for the future – for example, the building of the new hospital in Cwmbran. There was a strong indication from the results of consultation elsewhere that existing facilities should not be removed until alternative community based services were successfully in place (comments received in respect of the Betsi Cadwaladr University Health Board consultation).

A number of protest groups emerged - or were regenerated – during the design and consultation phases. It is clear that in some instances people who are protesting genuinely will never be convinced.

However some of the protest groups could have been more positively and actively engaged in designing the solution.

The decision making processes need to be made very clear to the communities involved – and they need to be adhered to – and there needs to be increased clarity and governance around inter-organisational decision making.

Finally, the ways in which decisions will be implemented must be made clear - confidence in public body decision-makers will be destroyed if there is sloppiness in implementation and plans have to be changed because of the unexpected consequences of the decisions made.
THE ROLE OF COMMUNITY HEALTH COUNCILS AND THE BOARD OF COMMUNITY HEALTH COUNCILS

The Board of Community Health Councils in Wales maintains:

"The strength of community health councils (CHCs) lies in their ability and position to draw together disparate views and develop a cohesive and measured group to discuss proposals that does not allow special interest to cloud their judgement.

"In particular the role and function of the CHCs is to work with the NHS to represent the interests of the patients and public in the NHS by scrutinising the planning of local health services, recommending changes and improvements to local health services, encouraging the engagement of local people in the planning and delivery of health services and by eliciting the patient and publics views of services."

Their code of conduct clearly identifies they are statutory bodies independent of the health service whose duty is to represent the interests of the public in healthcare. Their effectiveness depends on their ability to speak with authority on the basis of direct knowledge and experience of the views and experiences of patients and their local communities.

The values underpinning their work are accountability, integrity and openness – CHCs need to demonstrate that they operate effectively and professionally. Their members are expected to be courteous and have consideration for others and be constructively critical. CHC members have a corporate responsibility to represent the interests of the whole of the population covered by the CHC; they need to actively seek out the views of minority and disadvantaged groups. They have to act impartially and are not allowed to pursue causes or problems of particular individuals or groups.

The geographic area they cover is largely vast and their membership is correspondingly large. “Local” CHCs have been retained in some areas following the amalgamation of health boards in 2009. They conduct their role in very different ways. Some use community networks while others use their membership as their “representative voice”. However, they admit it is really difficult to impose the requirement for unpaid volunteers - however committed they are - to be truly representative of the varying communities within the CHC area.
As pointed out by Professor Marcus Longley in his report of 2012 *Moving Towards First Class? A Review of CHCs in Wales*, their membership is largely non-diverse, so a reliance on members is not going to enable the CHC to form a balanced perspective from a wider community.

There is a danger of any organisation acting as a “proxy” for the voice of the people – such models suit the deference model of engagement and their authenticity will always be challenged.

The public must be engaged as genuinely interested stakeholders – can CHCs at the end of the day act as a resource for the local community through which to manage their health and wellbeing?

The CHCs gain an important perspective from the visits they undertake to NHS premises and from their complaints advocacy work, however they need to better share the information they obtain with the relevant health board rather than regarding it as “their” information as some CHCs do.

When it comes to a disagreement with the health board about service change proposals, under regulations the CHCs are supposed to propose an alternative solution. Given little professional input – for example independent clinical, financial and strategic advice - this responsibility is outside their collective capability, which they well recognise. Instead they have to resort to negotiating amendments to the proposals with health boards, or to a formal objection to proposals via a referral to the Minister who too frequently must either grant more time or intervene to ask a group of independent experts to provide him with the necessary advice to make a decision. Even then, individuals are able to make a referral for judicial review, either on the competence of the engagement/consultation process or on the solution proposed. This leads to delay, where implementation might be critical, diversion of effort away from engagement and implementation and a considerable use of public funds.

The judicial process has been tested recently in the Hywel Dda University Health Board area where the judge rejected the objections of the claimants. This judgement was subsequently appealed against and was again rejected. This process consumes much time, energy and resources and an alternative should be available to seek a reasoned solution. It is not just the health board and the Minister who are subject to challenge in this way; a decision by a CHC in Wales has also been referred for judicial review after, having given all the objections to the proposals for service change due consideration, it decided not to make a referral to the Minister.

The CHCs in Wales have existed for many years, have been reviewed frequently and changes made. The Marcus Longley review in 2012 made a variety of recommendations about the role and membership of CHCs; their governance; the ways they work with health boards and other bodies and their advocacy services. Although progress has been made on a few of his recommendations too few have
been actioned. This omission should not be overlooked. If they had been actioned earlier it is possible that the CHCs would have been in a stronger position to put forward a more comprehensive view derived from their communities and work better in partnership with the health boards.

The Williams Commission on Public Services (2014) concluded that CHCs played a vital role in ensuring the voice of the patient was at the heart of the delivery and governance of health services but recommended, in paragraph 2.59, that their role should be refocused.

In the light of their representation and the varying ways in which their patient and community networks are constructed and operate (attachment 3b) and the resources available to them, have they truly been enabled to act in the way required of them? The CHCs have interested and committed members who take their role seriously. Can they be reformed to enable them to undertake their responsibilities more effectively?

The Board of CHCs was established in April 2010. Its vision is:

“The Board of Community Health Councils in Wales together with the individual community health councils, will work collaboratively with the NHS, public bodies and third sector organisations to provide opportunities for patients and the public to influence NHS service improvements, development and delivery.”

To support it in this, it has the following functions:

1. Advising councils with respect to the performance of their functions;
2. Assisting councils in the performance of their functions;
3. Representing the collective views and interests of councils to Welsh Ministers;
4. Monitoring the performance of councils with a view to developing and ensuring consistency of standards by all councils;
5. Monitoring the conduct of members with a view to ensuring appropriate standards of conduct;
6. Monitoring the conduct and performance of officers with a view to ensuring appropriate standards of conduct;
7. Operating a complaints procedure.

It is also responsible for the provision of training and development for officers and members and the standards through which the CHCs conduct their functions.

This description of the role of the board, however, is not universally accepted by CHCs, and the board has been unable to make progress in achieving its objectives. It has commissioned work to more closely bind the output from CHCs, in terms of patient visits and advocacy and complaints into the work conducted by
Healthcare Inspectorate for Wales (HIW), but the protocol remains to be fully developed and implemented.
Chapter Three: CONSULTATION AND ENGAGEMENT

A great deal of thought and effort was expended in the drafting of proposals; in engagement and in consultation about major service change, not least by the members of the public who were involved. Some good practice was developed, which will be helpful for the future and in some areas there was much constructive discussion between the NHS and the communities they serve. However, evaluation of the effectiveness of the methodologies used was not built in from the beginning of the process and it is very difficult to ascertain the cost-effectiveness of the methodologies used.

The definition of consultation and engagement used by the Welsh Government in its guidance is a little opaque. It places an emphasis on “the need for a new approach to change based on continuous engagement rather than perfunctory involvement around specific proposals.

“The Welsh Government expects organisations to pay considerably more attention to continuous engagement to ensure that all organisations are responsive to the needs and views of their citizens. NHS bodies and CHCs are required to work together to develop methods of continuous engagement which promote and deliver service transformation for their populations.

“Where substantial change or an issue requiring consultation is identified the NHS is asked to use a two-stage process where extensive discussion with citizens, staff, staff representatives, professional bodies, stakeholders, third sector and partner organisations is followed by a focused formal consultation on any fully evaluated proposals emerging from the extensive discussion stage.”

The Welsh Government consultation guidance for its own staff notes that “it is important to distinguish between engagement and consultation. Engaging with organisations should be an integral part of our awareness and delivery roles. Consultation is a more formal process. Stakeholders have told us that consultation can sometimes appear superficial. Consultation is an opportunity to listen to what people think”.

The Consultation Institute defines consultation as being “a dynamic process of dialogue between individuals and groups based on a genuine exchange of views with the objective of influencing programmes of action – when there is something to influence”. Engagement represents continuous dialogue.
Opinion Research Services maintains that “influencing public policy is not simply a numbers game or a popularity contest in which the loudest voices or the greatest numbers automatically win the argument. Instead, consultation is to inform authorities of issues or arguments they might have overlooked or to contribute to the re-evaluation of matters already known or to re-assess priorities and principles critically.

"The Board consults the public and stakeholders because it is accountable. In this context accountability means giving an account of its ideas and then taking into account public and stakeholder views. It does not mean that the opinions of the largest majority should automatically decide public policy. Consultations are not referenda – they should inform but not displace professional and political judgements which above all should assess the cogency of the views expressed."

The Scottish Executive in its document Consultation Good Practice Guidance (updated 2008) defines consultation as: "A time-limited exercise when we provide specific opportunities for all those who wish to express their opinions on a proposed area of our work (such as identifying issues, developing or changing policies, testing proposals or evaluating provision) to do so in ways which will inform and enhance that work."

There is a comprehensive discussion on the difference between engagement and consultation contained in the Hickinbottom judgement between The Queen on the application of Anthony John Flatley and Hywel Dda University Health Board and Welsh Ministers August 2014 (Attachment 4).

To try to clarify the difference, the National Principles for Public Engagement in Wales (Participation Cymru, 2011) are useful, together with its guidance notes.

What organisations should hope to achieve through continuous engagement should be a fundamental improvement in the understanding of communities about the quality, safety, affordability and sustainability of their care and for those communities to be competently engaged and informed to enable them to have confidence in change and the prioritisation of resources, and believe that they have exercised their choice and have effectively helped influence and built the final outcome.

Service users have to help drive change supported by specialist and professional advice so that there can be clarity in the outcome of change and its effects on their ability to access care. The NHS has to move from its traditional sequence of design-consult-change to engage-design-consult-change.

The difficulty experienced by the NHS in Wales in effectively convincing communities about the changes they proposed is not unique. Many areas throughout the UK have faced the same challenges and have responded in differing ways. The Independent Reconfiguration Panel for England was established in 2003 and was set up as an independent body to advise the Secretary of State for Health on
contested NHS reconfigurations in England and specifically to give advice about proposals referred to the Secretary of State for decision. As well as providing formal advice to the Secretary of State on referral proposals, the IRP also provides informal advice to health bodies, local authorities, health overview and scrutiny committees and other stakeholders where reconfigurations are being planned or debated. The IRP, on an annual basis, provides an overview of learning from reviews; it has found year-on-year that reconfiguration proposals have been referred for the following reasons:

- Inadequate community and stakeholder engagement in the early stages of planning change;
- The clinical case has not been convincingly described or promoted;
- Mixed messages about clinical issues – if doctors in an area publicly disagree, their patients are entitled to be sceptical about proposed changes;
- Important content is missing from reconfiguration plans;
- Health agencies are caught on the back foot about the three issues most likely to excite local opinion – money, transport and emergency care;
- Important content is missing from reconfiguration plans, local communities want to know exactly what services will be provided and how to access them;
- Proposals emphasise what cannot be done and underplay the benefits of change and plans for additional services.

The IRP has concluded that publishing documents in whatever elaborate way was no substitute for continued personal engagement with stakeholders. The intervention of this third party in England has been very useful in seeking resolution, but as it admits: "We have not yet found a way of dealing with the politicisation of healthcare services planning." Its methodology is to be commended.

**BEST PRACTICE**

Concerning the best practice in constructing engagement and consultation with local communities, there is a lot of evidence – of which only a very small suite of examples is mentioned here – which demonstrates how different areas of the UK have approached the resolution of this issue. (Attachment 4).

The Scottish Government in 2008 produced guidance outlining practical advice and information on all aspects of carrying out a consultation exercise. Not intended to be prescriptive, it was designed to prompt staff to consider a full range of issues and options when deciding how to consult and contains much very helpful advice which is also to be commended. This guidance is underpinned by the establishment of the Scottish Community Development Centre and the publication of the *National*
Standards for Community Engagement. The Community Health Partnerships have established Public Partnership which provide for the routine involvement of local people in the design and delivery of the health services they use. Anyone who lives or works in an area can be a member. The Scottish Development Centre was developed to meet the government's vision of an active, inclusive, just Scotland. It has three priorities – to influence politicians, to work with agencies and partners to achieve effective community engagement and participation, and to build strong, healthy communities.

There are many very good examples of creative ways in which the public has been better engaged, for example:

- NHS North West in partnership with People’s Voice Media – Connecting Communities and the Patients’ Association, to develop community voices in commissioning care;
- NHS East Midlands and East of England – work relating to the development of patient and community “experts”, who worked alongside their expert clinical advisors and the communities to design care;
- NHS South of England’s Partners in Care scheme set up in partnership with local NHS trusts to help improve patient experience by engaging them more effectively with the clinical teams and the communities to design the delivery of care;
- The principles developed by the Patients Association in respect of patient and public involvement generally and its recommendations for patient engagement in GP-led commissioning contains useful guidelines.

More local schemes, for example the Newham Primary Care Trust community ownership project, which with the local authority, developed a distinct definition for patient and public engagement centred on the belief that citizens were equal partners in the design, delivery and review of both commissioned and provided services. The definition went beyond the idea of co-production as it included not only a sharing of power but also of accountability.

The WCVA work on co-production in Wales is well worth further exploration given the emphasis on requiring a new relationship between people and their public services. It advocates strongly that people, services and organisations begin to share power, control and responsibility for meeting people’s needs. This is a powerful message and should be endorsed and acted upon.

Additionally, NHS England working with Inhealth Associates and the Centre for Patient Leadership has developed “the Engagement Cycle” which helps organisations work with patients, carers and the public to transform and improve services so that patients receive integrated services, high quality health care and a better experience. The philosophy underpinning the cycle is the belief that PPI is
about partnership and effective relationships. This model is currently being used by Clinical Commissioning Groups (CCGs) in England.

There has also been the recent establishment of Healthwatch in England, which is described as the national consumer champion in health and social care. It has significant statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate care. These are independent bodies commissioned directly by the local authority; members are elected. They act as participating observers at NHS board meetings and hold both NHS organisations and the local authority to account for their performance against the key priorities determined by Healthwatch. It will be interesting to track their progress and effectiveness in their role as the services change in England over the next few years.

Attention also needs to be paid to the good practice that has been clearly documented in Wales (attachment 4) and to the good practice from other sectors and other areas of the NHS in the UK and elsewhere to ensure that engagement is based in the future on the best evidence available.
Chapter Four: CONSIDERING THE EVIDENCE

I have considered at length the wealth of information and evidence obtained through interviews, documentation and through written submissions before reaching any conclusions. Key (anonymised) quotes from the evidence are found as attachment 3a; responses to supplementary questions are found as attachment 3b and a full list of evidence submitted is found in attachment 4 as part of the references.

It is very clear that considerable improvements in stakeholder engagement have taken place in Wales and that a huge effort has been made to plan services by engaging clinicians, other staff and the communities more comprehensively.

Improvements have also been made in the following areas:

- Organisations have used good practice from elsewhere;
- Clinicians have been more effectively involved in the design of future services;
- Organisations have worked effectively across traditional boundaries to reach a common goal;
- External assurance has been used – the Consultation Institute and Opinion Research Services;
- Stakeholder mapping has been more effectively undertaken and used;
- There has been increasing honesty about the quality of the services currently provided;
- There is evidence that feedback from stakeholders is used honestly to influence the final outcome;
- There has been transparency exhibited by the health organisations in describing what did and did not work during the engagement and consultation process;
- As a consequences of all these efforts, the general public is much more aware of the need for changes to be made to their services to ensure their future quality, safety and sustainability.

However, a number of concerns have been raised on which I have had to reflect:

- The cost-effectiveness and sustainability of a programme of involvement such as that undertaken by the South Wales Programme – this was very time-consuming and labour intensive.

- Continuous engagement by health boards with their communities is patchy and needs to be undertaken as a regular feature rather than only when
change is mooted.

- Although there is much evidence of creative and innovative community care in Wales, much planning time and attention is devoted to secondary care, which makes communities suspicious about the style and shape of the basic services to which they will have access after changes are made – in other words service planning is being undertaken the wrong way around.

Far more attention should be paid to planning the future shape of primary and secondary care and to effectively engage their communities in developing those services.

- Public confidence in the future shape of their services still remains to be consolidated.

- Some organisations are struggling to find the capability and capacity to fulfil their respective roles in service change. The governance and capacity of health boards to make wide-ranging strategic decisions for the future needs to be determined.

- Governance and decision making processes between organisations needs clarification and more effective guidance.

- The guidance from the Welsh Government needs reviewing as organisations are unclear whether or not it is guidance or mandatory and it has been open to interpretation in the way in which it is applied.

- The role of the regulator in assessing the capability of health boards to consult and engage effectively is not currently being undertaken.

- There is confusion about the role and responsibility of the Board of CHCs; the reaction to and relationship with the more local CHCs is very variable in terms of effectiveness.

- Engagement with the media is very variable and needs to be managed proactively. Engagement with AMs and MPs is also variable and should be undertaken early and with an open mind.

- The scrutiny role of local authorities is variably applied and local service boards remain underdeveloped in their capability to plan and design jointly delivered services.
- Measurement of the quality of engagement with their communities is not embedded into the health boards' performance as a measurable quality indicator.

- Communities or their representatives have not traditionally helped shape the design and delivery of services as equal partners at an early enough stage.

- Organisations that have a fundamental effect on the shape and delivery of services stand apart from the processes of engagement and consultation, for example, the Wales Deanery and the Royal Colleges.

- There is uncertainty about when consultation rather than engagement is necessary – what is the definition of substantial change?

- The use of the power of referral is very variable and can be used as a threat and a blunt instrument. Judicial review has been described as “the weapon of choice for protestors.”

- What role does primary care play in discussions about service change?

- The actions and activities of the CHCs are variable and there needs to be a shared understanding about the difference between independence and neutrality in their actions.

- The Minister is being put into a position of taking decisions that should have been made by NHS service leaders.

- Where does co-production feature in the planning regimes of the NHS and has any NHS organisation - with the exception of mental health services - achieved success through this methodology?

- How can the NHS better transmit the message that service change is not solely about the necessity of saving money?

- Why is the profile of CHCs so small whereas protest groups are able to attract a considerable public profile?

- Why does good practice travel so slowly?

- Formal evaluation of the process of engagement and consultation has not universally been built into the consultation process.
The NHS in Wales will, over the next three years, in response to three-year plans, need to undertake the planning and implementation of considerable service change; it has to therefore focus on developing very sound relationships with both its communities and staff and their representatives to effect these changes. It has to build on the good practice that is evident in the evidence I have received and those engaged in determining the shape of future services have to be equipped with the competence and capability to play their respective parts in the discussion.

However well this is done, protestors will remain. The NHS needs to reframe its relationship with communities so that it becomes a more inclusive, engaged, informed and knowledgeable experience for those concerned and enables them to make the formal decisions on design and delivery more effectively.

The next chapter sets out some ideas about the way forward and suggestions for future reform of the system used currently.
In the light of the evidence received, it is clear some reform is required to the way in which the NHS in Wales and the general public engage in discussion around changes to the way services are delivered for the future. It is really important however to ensure that the good practice that has been developed is not lost and that real efforts are made to ensure that such good practice is embedded within organisations throughout Wales.

The good practice I have reviewed and the concerns I have expressed in the previous chapters need to be reflected on and given serious consideration in describing any future system - and be accepted or rejected as seen fit. However, I have a number of critical concerns on which I would wish to make some recommendations. I have grouped the recommendations into three categories – firstly (1), do it; secondly (2), think about it and thirdly (3), more work needed.

**Health Boards**

**Continuous engagement**

Public confidence in health boards can be either be enhanced or damaged by the way in which local people are involved in the processes leading to major changes in local health services.

Involving local people appropriately throughout the process is just as important as ensuring that the right clinical and financial information is available and that a robust business case is prepared.

There are many methodologies available to effect good continuous engagement, some of which already exist in Wales. It is the responsibility of health boards to engage effectively with their local communities, interest groups and other stakeholders to enable them to respond to their observations to help them to plan and develop care for the future. They should be formally held to account for the quality of that engagement. (1)

A suitable quality standard could be adapted from Participation Cymru’s engagement guidance. (2)

If they consider that this function would be most appropriately delegated to an independent third party on their behalf they will be able to account for the use of that
resource for the purpose intended and hold the third party to account for the quality of the engagement undertaken. (1) The health boards however must remain part of that engagement. (1)

The purpose of continuous engagement based on an accurate assessment of need for each community must be to involve patients, their families and carers and the general public in discussions about their accessibility to services, to enable them to influence changes in care; to involve them in the evaluation of the effectiveness of services and from time to time to be engaged in the re-design of services.

When to consult

The current system where engagement is conducted by both the health board and the CHC can confuse the public considerably. The distinction between engagement and consultation phases also causes confusion. The current system must be reformed to overcome this confusion. There has to be a much clearer distinction between continuous engagement, through which most service reform should take place, and consultation under statute. (1)

To do this, the rationale for consultation will require redrafting and the definition of substantial should be clarified – possibly being restricted to issues where fundamental service reform is being suggested in terms of the number of people affected by the proposals or the removal of an asset. (2)

Continuous engagement should not be conflated with the set process of consultation under statute. (1)

Reputation management

Health boards have a fundamental responsibility to manage their reputation, both from the view of the external image and their internal performance. Performance reviews should incorporate an indicator to measure reputational management so that the Minister can hold the board to account for the execution of this critical responsibility. (1)

Strategic planning

Consideration should also be given to the constitution and governance of health boards in respect of their capacity to plan strategically for the future and make strategic decisions. (2)

Collective decision making

Collective decision making is also a challenge to health boards. The South Wales Programme was successful in bringing about discussion on service change between organisations but its leaders remain concerned about the rules around collective decision making for the future. This needs to be resolved without delay. (1)
Guidance does exist about governance between organisations and this should be reviewed and implemented before the next stage of collective planning starts – to include the powers of health boards to delegate decision making to a third party. (2)

There has to be absolute clarity about how decisions might be made; this has to be adhered to by all parties. (1)

The role of external organisations

Organisations that have a real influence over the ways in which care can be delivered, for example the Wales Deanery and the Royal Colleges should play a much greater role in informing the communities about the standards required in today’s NHS and should work in co-operation with the health boards to convey these important messages. (1)

Evaluation

Health boards must review and evaluate the engagement and consultation experience as part of their consultation processes to enable them to reflect on how well it was handled and the impact that consultation and engagement had on the final decision. (1) Evaluation must be built into the process from the beginning. (1)

Community Health Councils (CHCs)

Roles and responsibilities

The roles and responsibilities of CHCs together with their governance should be overhauled – much of the work and recommendations undertaken by Marcus Longley in his review remain relevant. There is also much merit in the recommendations contained in the Williams Commission Report in respect of CHCs. (2)

The accountability of CHCs needs clarification – they need to be accountable to both the Minister, the health board in respect of the quality of their engagement processes and to the community itself. (1)

The terms of reference of this lessons learned review do not incorporate a fundamental review of the role and responsibilities of CHCs in Wales, only their responsibilities in respect of service change and development. However their four primary functions are inextricably bound together and, given the current level of their resources, affect their capacity to perform consistently.

I have therefore included my observations on all four primary functions, given the concerns I have encountered.
Advocacy and Complaints Management

This function is well regarded but should be reviewed and revitalised in terms of capacity, capability and effectiveness. (1) The information gathered from the complaints and concerns reviewed by the CHCs should form part of the evidence base of Healthcare Inspectorate Wales (1) and should be fed back to health boards on a regular basis. (1) Thought could also be given to their role in arbitration between complainants and the health board, given additional professional training. (2)

Training and development must be provided regularly by those administering the scheme (1) and their capability and competence should be assessed regularly. (1)

Consideration might be given to implementing some of the methodology recommended in the Health Foundation review of the Management of Complaints and Concerns at Mid-Staffordshire Hospital, particularly in improving understanding of the quality of outcomes for patients through the use of complaints received by health boards, and its review by an independent expert clinical panel on an all-Wales basis. (2)

The development of a helpline might be considered, given the geographic spread in Wales so emerging themes might be collated and shared. (2)

Visits

The rationale behind visiting and not the number of visits undertaken should be key. National and local themes for review should ensure that visits are allied to these themes and are used to inform action by health boards and regulators. (1) Good-quality training of lay members in patient environment reviews and confidentiality is essential to ensure consistency and to protect the rights of individuals. (1) The common methodology used should be reviewed to ensure that it can be compared as applied to the results from other organisations. (1)

There has to be a better tie-up between the outcome and methodology used from these visits and the visits undertaken by HIW (1); the recent work undertaken by HIW and the CHCs should be reviewed with a view to establishing how it might be implemented, if thought to be sound. (2)

Information Services

The information service should be reviewed to ensure it is up to date and effective. (1) There has to be increased clarity and understanding in the communities about the role and responsibilities of CHCs. (1)

Service Redevelopment and Community Engagement

The role of CHCs currently is to work with the NHS to represent the interests of patients and the public in service change and development. This role is undertaken
in varying ways throughout Wales and with varying effectiveness. There is evidence of some good practice, which should not be lost. However, given the difficulties that CHCs have encountered in engagement and consultation, in meeting the timescales required of them and in assembling alternative solutions to changes proposed in healthcare, there is a need to review and reform the way in which they undertake these responsibilities. (1)

The aim of the Board of CHCs in Wales is that the CHCs should become the measured voice of the public in Wales. However the CHCs themselves currently describe their organisations as being “the voice of the people” or, to use the HIW definition, to be “an independent consumer council”.

Their role, or that of any successor organisation, should be to amplify the voice of local people and hard-to-reach groups but not to be the voice of the people. They need to operate within a mature system which allows them to pay attention to dissonance and to mediate between views. They must at all times exercise absolute neutrality and independence. This maturity relies on a clear differentiation of the responsibilities between the CHC and the health board but also a mutually supportive relationship where the citizen and their needs remain centre stage. (2)

Currently their members act as representatives – and there are many of them. Their community networks are constructed very differently – see the evidence gathered (attachment 3b) – but the infrastructure does not exist to support their representatives or to ensure that the representatives are truly representative of the community they are appointed to serve.

Thought should be given to the best ways in which the health boards can affect their responsibilities for continuous engagement in service design and development. (3) There could be value for the health boards in commissioning an independent body to carry out the responsibilities for continuous engagement and for this body to be seen by the community as primarily acting in their interests. The health boards themselves must set the tone for such engagement. This independent body might be the CHC but they will need to be reformed to ensure that instead of its members acting as “representatives” they are trained and developed to become “experts” in community engagement to ensure that their advice and guidance to the health board really can withstand the test of ensuring that they effectively and fairly ensure the views and needs of the communities influence the policies and service plans of health providers. (2/3)

If it is decided that reformed CHCs should not undertake these responsibilities then there are many other models that can be used – such as the establishment of a charity, a social enterprise or a community interest vehicle. (2) Whichever solution is favoured, care must be taken in ensuring that the governance of the body, including the CHC, if this is the vehicle of choice, is fit for purpose and that any member is
recruited using best practice guidelines, monitored and assessed regularly and trained effectively. (1)

They will need to work closely with Public Health Wales to ensure that they have a sound and current understanding of the health needs of the communities they support and seek to represent (2). There must be a well-understood mechanism in place for holding them to account for the discharge of their responsibilities. (1)

Should the CHCs remain, the Board of CHCs will need to be reformed in order to achieve its potential. (2) It will need to work with the reformed CHCs to promote improvements in the quality and extent of patient focus and public engagement in the NHS in Wales. It would support and monitor the ways in which the CHCs undertake their responsibilities. It would work to promote improvements in the quality and extent of patient focus and public involvement in the NHS in Wales. It would collect systematic, comparable information on how the CHCs engage with patients and the public. (1)

GUIDANCE

The guidance and statutes should be reformed to emphasise the necessity for continuous engagement and the quality standards that will be associated with it. (1)

Consultation shall be restricted to issues of major change (to be defined either by the number of staff affected or the numbers of population whose access will be affected or the removal of an asset. (2)

There should be some clarity about whether the guidance represents a requirement placed on the NHS or is used as a code of good practice for the service. (2)

The guidance should include the requirement of health boards to build in an evaluation of the consultation and engagement experience from the beginning of the plan to reform the delivery of care and the impact that engagement and consultation has had on the final decision reached. (1)

The current guidance contains much helpful advice and information, but it needs to be more sharply written and should not conflate engagement and consultation together in the stages now described. (2) Advice on best practice in service planning should be available. (1)

Referrals

The appeals mechanism and the processes for and powers of referral should be overhauled. (1) It should not remain the sole prerogative of the CHC to refer a proposal to the Minister. Instead the CHC, together with a formal body such as
reformed local service boards, which represent the collective publically accountable bodies, would be charged with making any referral.

However if a referral is used, I would recommend that a third party check should be inserted into the process to act as adjudicator on behalf of the Minister on areas of dispute between the health boards and the communities. (1) The adjudicator would consist of an expert panel/standing committee, with an independent, non-clinical chair, and would contain clinical experts in the field (possibly drawn from the Academy of Royal Colleges in Wales), experts in the field of community engagement and lay representatives. (2)

Finally, the role of local authority scrutiny in the process of service change should be examined and clarified, with a view to their scrutinising more fully the health board’s response to the eradication of inequalities in respect of NHS care and access (2) and in joint service provision and planning. However, local authority scrutiny should not be used as the vehicle for approval of change in health service design and delivery (2).
Changes to and in health services in Wales are inevitable and the NHS has to pursue those changes with vigour to ensure the best quality and most cost-effective care is available.

The principle espoused by the Health and Social Services Minister in respect of prudent healthcare needs to be understood better by the general public and those principles need translating into reality quickly.

The public needs to be better engaged in continuous discussions on the future shape of their health services and must become genuine partners in the design and delivery of that care.

The system in Wales needs to be reformed to ensure that such engagement can take place on a more comprehensive basis so the need for a proxy voice becomes unnecessary and the communities themselves consider they have had an influence on the future design of their care.

Ann Lloyd CBE, BSc, MSc (Econ)

October 2014
Attachment 1a: PEOPLE INTERVIEWED

Interviews held with:

Paul Hollard, programme director, South Wales Programme
Peter Higson, chairman, Betsi Cadwaladr University Health Board
Judith Paget, interim chief executive, Aneurin Bevan University Health Board
David Jenkins, chair, Aneurin Bevan University Health Board
Eithne Hunter, head of strategic and operational planning, Aneurin Bevan University Health Board
Paul Worthington, chief officer, Cwm Taf Community Health Council (CHC)
David Salter, chair of Mid Wales Scrutiny Panel
Trevor Purt, chief executive, Betsi Cadwaladr University Health Board (formerly chief executive of Hywel Dda University Health Board)
Kirsty Williams AM, Leader of the Welsh Liberal Democrats
Lesley Jones, chair of Cardiff and Vale CHC
Steve Allen, chief officer, Cardiff and Vale CHC
Des Kitto, deputy chief officer, Cardiff and Vale CHC
Simon Dean, deputy chief executive NHS Wales, Department of Health and Social Services, Welsh Government
Dr Andrew Goodall, chief executive of NHS Wales and Director General Health and Social Services, Welsh Government
Ashley Warlow, chief officer, Hywel Dda CHC
Paul Hinge, chair, Hywel Dda CHC
Tony Wales, vice chair, Hywel Dda CHC
Dr Gabrielle Heathcote, chair Ceredigion locality and former vice chair Hywel Dda CHC
Philip Williams, chief officer, Abertawe Bro Morgannwg CHC
Kevin Dee, deputy chief officer, Abertawe Bro Morgannwg CHC
Roger Smith, chair, Abertawe Bro Morgannwg CHC
Emrys Davies, former chair, Abertawe Bro Morgannwg CHC
Allison Williams, chief executive, Cwm Taf University Health Board
Dr Chris Jones, chair, Cwm Taf University Health Board
Nicola Davies, planning, Cwm Taf University Health Board
Cathy O’Sullivan, chief officer, Aneurin Bevan CHC and former interim chair Board of CHCs
Sioned Rees, deputy director, local government partnerships, Welsh Government
Peter Donnelly, deputy Postgraduate Dean, Welsh Deanery
Professor Marcus Longley, Professor of Applied Health Policy and director of the Welsh Institute for Health and Social Care at the University of South Wales
Adam Cairns, chief executive, Cardiff and Vale University Health Board
Maria Battle, chair, Cardiff and Vale University Health Board
Abigail Harris, director of planning, Cardiff and Vale University Health Board
Dr Chris Jones, deputy Chief Medical Officer for Wales, Welsh Government
Dale Hall, chair, Opinion Research Services
Elwyn Price-Morris, former chief executive, Welsh Ambulance Services NHS Trust
Jean White, Chief Nursing Officer for Wales, Welsh Government
Steve Thomas, chief executive, Welsh Local Government Association
Naomi Alleyne, director of social services and housing, Welsh Local Government Association
Darren Millar AM, Shadow Health Minister, Welsh Conservatives
Helen Birtwhistle, director, Welsh NHS Confederation
Paul Roberts, chief executive, Abertawe Bro Morgannwg University Health Board
Andrew Davies, chair, Abertawe Bro Morgannwg University Health Board
Brecon and Radnor CHC
Montgomery CHC
Mike Evans, Flint Hospital Action Group
Gerald Kitley, Flint Hospital Action Group
Kathy Kitley, Flint Hospital Action Group
Kay Evans, Flint Hospital Action Group
Sandra Williams, Flint Hospital Action Group
Lynn Knight, Flint Hospital Action Group
Carol Price, Flint Hospital Action Group
Geoff Ryall-Harvey, chief officer Betsi Cadwaladr CHC
Carol Williams, deputy chief officer, Betsi Cadwaladr CHC
Jackie Allen, Betsi Cadwaladr CHC
Andy Birchin, Betsi Cadwaladr CHC
Sue Owen, Betsi Cadwaladr CHC
Pearl Roberts, Betsi Cadwaladr CHC
Geoff Lang, former acting chief executive, Betsi Cadwaladr University Health Board
Ruth Marks, who is undertaking an independent review of Healthcare Inspectorate Wales
Paula Walters, director, NHS Centre for Equality and Human Rights
Richard Self, equality practice officer, Public Health Wales
Simon Emery, Academy of Medical Royal Colleges in Wales
Paul Myres, Academy of Medical Royal Colleges in Wales
Susan Hill, Academy of Medical Royal Colleges in Wales
Sir Paul Williams, author Commission on Public Service Governance and Delivery
Mary Williams, chair Cwm Taf CHC
Rhion Jones, institute director and associate, Consultation Institute
Peter Finch, joint chair, Partnership Forum
Sarah Rochira, Older People’s Commissioner for Wales
Karen Howell, interim chief executive, Hywel Dda University Health Board
Sian Marie James, vice chair, Hywel Dda University Health Board
Chris Wright, director of corporate services, Hywel Dda University Health Board
Mike Usher, sector lead for health and central government, Welsh Audit Office
Peter Meredith-Smith, chair, Board of CHCs
Kate Chamberlain, chief executive, Healthcare Inspectorate Wales
Bob Hudson, chief executive, Powys Teaching Health Board
Mel Evans, former chair, Powys Teaching Health Board

Written questions sent to:
SWAT (Save Withybush Action Team)
The Welsh Health Specialised Services Committee
Wales Alliance for Citizen-Centred Support
Participation Cymru
One Voice Wales
SoSPPAN
North Wales Health Alliance
Elin Jones AM, Plaid Cymru health spokeswoman
Royal College of Nursing
Local authority chief executives
Local medical committees
British Medical Association
Attachment 1b: ORGANISATIONS

Meetings were held with the following organisations:

Abertawe Bro Morgannwg Community Health Council (CHC)
Abertawe Bro Morgannwg University Health Board
Academy of Medical Royal Colleges in Wales
Aneurin Bevan CHC
Aneurin Bevan University Health Board
Betsi Cadwaladr CHC
Betsi Cadwaladr University Health Board
Board of CHCs
Brecon and Radnor CHC
Cardiff and Vale CHC
Cardiff and Vale University Health Board
Consultation Institute
Cwm Taf CHC
Cwm Taf University Health Board
Flint Hospital Action Group
Healthcare Inspectorate Wales
Hywel Dda CHC
Hywel Dda University Health Board
Mid Wales Scrutiny Panel
Montgomery CHC
NHS Centre for Equality and Human Rights
Older People’s Commissioner for Wales
Opinion Research Services
Partnership Forum
Powys Teaching Health Board
South Wales Programme
Welsh Ambulance Services NHS Trust
Welsh Audit Office
Welsh Local Government Association
Welsh NHS Confederation

Written questions were sent to:
British Medical Association
North Wales Health Alliance
One Voice Wales
Participation Cymru
Royal College of Nursing
Save Withybush Action Team
SoSPPAN
Wales Alliance for Citizen-Centred Support
Welsh Health Specialised Services Committee
Attachment 2a: QUESTIONS TO HEALTH BOARDS

About the consultation processes used by health boards:

1. What is your recent experience of engagement and consultation on service change?

2. Could you describe the methodology you use to engage patients and communities in the design and delivery of services.

3. At what time in the strategic planning cycle do you engage your stakeholders or the community?

4. What best practice guidelines did you use to inform the development of this process?

5. Given recent experiences in engagement and consultation have you modified your processes?

6. How have you evaluated the effectiveness of your process? Did you do a PEST analysis or a SWOT?

7. How useful do you think your equality impact assessment has been in making/guiding your decisions?

8. How did your processes measure up against the guidance given by the Consultation Institute – and why /how did you choose to use them and what alternatives did you consider?

9. Have you evaluated your processes against the Gunning principles and how did you rate?

10. How do you decide upon which changes to consult formally? How does your board define what is significant?

11. Who do you consider your key stakeholders to be?

12. What format do you use for your patient and community networks and how effective are they. Apart from the CHC which other groups do you use to design and deliver care solutions?

13. In using representatives how do you ensure that they manage the engagement with their group well and how do you measure this?

14. What is your clinical engagement methodology and how effective is it?
15. How do you use your engagement officers – what is his/her professional background and what good practice have they introduced?

16. The IRP views on why proposals are referred to them – do you think you are guilty of any of these?

Questions about CHCs:

1. Could you describe your working practice with the CHC, including the quality of dialogue and information.

2. Their role is in respect of representing the community and how do they discharge their responsibilities effectively. Could this be improved?

3. Do you know how they manage their effectiveness?

4. What do you think of their governance arrangements and the ways in which they recruit their members? How do they exercise their neutrality or independence?

5. What methodology do they use to champion the patient's perspective?

6. What is the quality of the relationship with you?

7. What innovative practice do they use?

8. How equipped are they to propose an alternative solution?

9. What value is added by the Board of CHCs in Wales?

General questions:

1. To what extent did the Welsh Government guidelines help your effective engagement?

2. What advice would you give on amendments to the process?

3. How did you manage/handle any specific criticisms of the engagement?

4. What feedback methodologies did you use and how effective were they?

5. How have you evaluated the competence of your decision making?

6. To what extent did you find the Older Person's Commissioner's guidelines to be helpful?

7. How would you describe the maturity of your board in respect of engagement processes and practice, strategic planning and implementation of service change?
8. Methods used in communicating with the media and AMs/MPs during service change discussions.

9. Should there be a third party reality check on the process and what/who should this be?

10. What should the role of the Minister be?

Anything else – what would you have wished me to ask you?
Attachment 2b: QUESTIONS TO CHCs

About the consultation process used:

1. What has been your most recent experience of engagement and consultation and how effective was it?

2. Could you describe the methods used by the health board to engage communities, patients and yourselves in the design and delivery of services?

3. At what time within the cycle of strategic planning does the health board engage with you?

4. What methodology do you use to evaluate any proposals received? Where do you obtain your advice from?

5. What is your evaluation of the health board processes against the Gunning principles?

6. Do you know how the health board decides what is significant?

7. What is your relationship with their engagement officers?

8. What is the quality of the health board's relationship with you? And the communication with you?

9. What is the quality of the information you receive?

10. How effectively has the health board dealt with criticisms and what is the quality of feedback?

11. IRP reasons why proposals have been referred to them – do you believe the health board in your consultation has been guilty of any of these?

Questions about CHC effectiveness:

1. Your role in the community as patients' champion – how do you undertake this?

2. If you are the voice of the community how do you undertake this responsibility and how have you measured its effectiveness?
3. How do you assemble your patient networks?

4. If using representatives how do you ensure that they manage engagement with their specific group and how do you measure that?

5. What best practice have you introduced?

6. How do you challenge proposals – what evidence and expertise do you use and what information is available to you?

7. How do you measure your performance against your objectives and the purpose for which you have been established?

8. Could you describe the governance of the CHC and the ways in which you recruit your members?

9. How do you ensure that you and your teams/members are seen to exercise your neutrality/independence?

10. Who are your stakeholders and with which patient groups/associations and community associations do you work?

11. How do you recruit train and manage your volunteers?

12. How have you effectively engaged with all communities?

13. How do you determine your annual programme?

Questions about guidance:

1. To what extent have the Welsh Government guidelines helped or hindered the process of effective engagement?

2. What would you wish to recommend they change?

3. In undertaking your engagement and consultation responsibilities do you think that you are well equipped to manage these?

4. If not what would help?

5. What other patient groups have you related to in terms of experience of consultation and engagement?
6. What is the competence of the health board's decision making in respect of service change?

7. Should there be a third party check in the process?

Is there anything else you wish to add and what would you have liked me to ask you?
Attachment 3a: EVALUATION OF EVIDENCE

Quotes from the interviews

Methods used by health boards to engage patients and communities in the design and delivery of services (format of their networks)

"Ensure members of the public, CHCs, GPs and clinicians are all involved from the earliest time possible."

"Contact members of particular pressure groups and different patient groups for different areas of change."

"Local authorities and town councils are critical for supporting engagement with the community, they often already have an established network of stakeholders."

"Ask the public what they want to talk about; don't just engage them at times of change."

"Get recommendations from the CHC about who best to engage with on different issues."

"If engagement is done well early on then the formal consultation is generally brief and straightforward."

"Important to remember that staff are your community."

"Local councilors are key to good engagement."

"Ensuring that either the chair or deputy chair attends public meetings - shows people that the community voice is important to the community."

"Ongoing dialogue with the public is essential, especially during periods of change."

"It is important to remember that staff are your community so you should let the clinicians do the thinking."

"Use standing groups as much as possible to help ensure that representatives manage engagement effectively."

"Social media is becoming the best way to communicate with people."

"Ask the CHC to provide a list of interested parties."

"Some health boards have clinical boards in place to help with engagement."
"The use of expert patient groups and clinicians is a good method of engagement without having to formally consult."

"Each health board has its own methodology for engagement, but little evaluation takes place."

"Engagement was good when the third sector was involved through the CVCS – they interpret well what minority groups are saying."

"The public used the open meetings to raise all kinds of issues about the care they receive – this reflected a lack of routine engagement."

"Primary care engagement was really difficult."

"There is lots of engagement with interest groups and stakeholders but we need to know the views of the people – and what is accepted politically."

"The local authorities are invaluable with their local fora."

"There was a genuine effort to seek views but the engagement phase started too late. They did not prepare the ground."

"Cwm Taf University Health Board engages effectively and continuously."

"There is to be a new approach for patient experience in Wales – this will inform change for the future."

"CHCs should give advice on how to design and support engagement."

"A key feature and success of the South Wales Programme has been the important areas of clinical leadership, CHC engagement and public engagement and consultation."

"A number of semi-independent, specialty-specific work streams were established in ... which narrowed the involvement of the clinicians; had no or little public representation and whose minutes were missing or disputed."

Methods/networks used by CHCs to engage the communities in discussions on service change and design.

"Some CHCs hold regular public forums and meet bi-monthly, if there is something significant going on the number of meetings will increase over that time period."

"Publicise meetings with plenty of notice where possible, good structured process for meetings with regular engagement."

"Ensure that you listen to people not just talk to them."

"Use patient stories groups."
"Go back to patient groups and steering groups to tell them how their views made a difference to the overall outcome."

"Health watch groups compiled through ex-complainants and through advertisements."

"CHC should chair most of the big community meetings. Members are encouraged to attend as many meetings as possible to ensure that they hear everyone’s point of view firsthand."

"It can still be a challenge to get the information out there, there needs to be a fresh approach to doing this."

"CHCs work the best when they take the lead on the engagement process rather than the health boards."

"CHCs should attend public forums and council workshops where possible."

"They have to show that their response is pro-active, vibrant and relevant – this is missing at present."

**The effect that equality impact assessment had on the outcome of the consultation.**

"The SWP equality impact assessment was a set programme of work that helped design the outcome of the consultation and was very effective. This should set the bench mark for how equality impact assessments should be done."

"Locally it is harder to see equality impact assessment issues and the overall effects to particular groups."

"The discipline is important but it often becomes a bit of a tick box exercise. It is important that the process is done at the start of any changes and not just an afterthought."

"On a number of occasions equality impact assessments have not been used and where they are done they are not done effectively because people don’t have the skills to do them properly."

"An effective equality impact assessment can help facilitate inclusive engagement."

"A good equality impact assessment should do the following:
1) Look at what the impact will be on the patient
2) Review the consultation and feed in
3) Write back to partners to explain how their input has helped change the outcome."
The extent to which the processes used by the health boards have been modified as a consequence of their experience.

"Different health boards have introduced methods of continuous engagement. Realise there is a need to consult earlier."

"Having learned lessons from previous experiences most health boards now contact the CHC at the earliest stage to discuss potential changes and options."

"Changing for the Better programme is being introduced."

"Now talk to patients and public at a much earlier stage."

"Have learned that we shouldn’t be afraid to tell the public the truth and give them some choice about the changes that are made."

"It is important that the public don’t feel like they are being patronised."

"Have thoroughly reviewed the process of engagement and consultation and have amended our processes in the light of experience."

"There has been a concern that some of the decision-making processes have not allowed sufficient time for proper involvement, engagement and consultation with clinicians, let alone the general public."

"Together the health boards and the CHCs have learned the benefit of collaboration and recognise that local solutions to the challenges facing the clinical services may not be sufficient."

The strategic planning cycle – when do patients and communities become involved.

"There have been recent occasions when the health boards have consulted the CHC too late and the CHC then feels pressured to make a decision or recommendation without time to fully evaluate the information."

"The health board should talk the CHCs at the same time as they consult with clinicians."

"CHC are being included in the three-year planning cycle."

"Where CHCs sit on the health board planning boards/committees it means that they get the information they need firsthand and at an early stage in the process."

"If something is controversial or private the CHC encourage the health boards to come and talk to them in the first instance."

"The public should be consulted on the potential options not contacted after the options have already been decided."
"AMs need to be managed proactively so that a good feedback loop is maintained. They want no surprises."

"It is the responsibility of AMs to engage as well and take the initiative."

A description of health board/CHC key stakeholders

"Map stakeholders nationally first then locally. Use other health board stakeholder lists where appropriate. Consider current stakeholder lists to see who is affected by the potential changes and contact them separately. It is important to contact youth groups where possible as their views are often very different."

"Local authorities help contact key people in the community."

"Social media is the best way of testing public opinion."

"Third sector organisations are very helpful."

"Talk to local groups about local issues."

"CHC meet with carers, family and patients during their visits to carry out inspections."

"Local ward councilors – to get advice."

"Rhondda Cynon Taf and Merthyr have a consultation hub called citizens digital panel which is made up of over 2,000 people."

The role and effectiveness of LA scrutiny regarding service change.

"Each local authority could have a dedicated health board person to provide them with the information to undertake their scrutiny role."

"Political legitimacy is important in undertaking robust scrutiny."

"The Williams Commission is very helpful in reviewing this area of capability and should be followed."

Best practice guidelines used to develop the engagement strategy (health board and CHC)/ examples of best practice used. (Refer to the examples given in attachment 4)

"The planning leads are often used to fulfill the role of engagement officer as the two roles are closely linked."

"Involvement of the CHC in producing the engagement plan was key."

"The clinical groups in the South Wales Programme were a real success."
"The draft engagement strategy for the South Wales Programme was signed off by the CHC and a third party."

"CHCs sharing examples of best practice for training."

"Cwm Taf CHC pilot with Healthcare Inspectorate Wales to carry out joint visiting and monitoring."

"During the South Wales Programme, health board, CHC and the third sector had a memorandum of understanding and met every six weeks to discuss who was being engaged."

"Cardiff and Vale CHC have worked up a good relationship with the Cardiff Chinese community through a series of small meetings targeted particularly for this community offering help where required. This means that they are now happy to provide input when needed."

"Recent mental health changes in Cwm Taf where a success because the dialogue with the public started at an early stage and engagement was done throughout the planning process this meant that when it was time to conduct the formal consultation it was able to be brief and straightforward."

"Changes to stroke services – Aneurin Bevan CHC are working with the health board to make sure that the correct level of consultation is carried out. Going to outpatient clinics as well wards to talk to people who have been recently discharged and their careers."

"The South Wales Programme encouraged collaborative working within the health board and the CHCs alongside the local authority and voluntary sectors."

"The health and wellbeing structures in England work well."

"Brecon stroke unit changes – spoke to both patients and careers at an early stage."

**The way in which “significance” is determined.**

"Health boards seek advice from the CHC through joint discussions."

"If service change then there are generally internal discussions first and then discuss thoughts with the CHC and public."

"Continuous engagement with the public."

"Something might not be considered very significant to the clinicians but the public might think it is very significant. That is why it is important to share thinking with a wider group."

"Consider how something would stand against public scrutiny."

"Anything that impacts on the patient can be seen as significant."
"Use the IMPT to flag up what the health board thinks they will need to consult on and share this with the CHC before submission."

"Ask stakeholder reference groups."

"Be productive and make sure that the public are part of the process."

"A good process has been established with the CHC – work on the number of people affected and the scale of change."

Evaluation of the process used by health boards against the Gunning principles and the guidance provided by the consultation institute.

"The Gunning principles are not always helpful from an operational point of view."

"The Consultation Institute has provided some CHCs with training regarding what is effective engagement."

"The principles are generally followed but not much formal evaluation is done."

Description of the working relationship between the health board and the CHC including the quality of dialogue and information.

"A lot of the health boards believe that the quality of engagement is excellent. Meet regularly with the CHC chair and chief exec and attend CHC planning meetings. Work best together when both parties are kept fully informed and aware of any issues/changes. Have a common aim in providing the best for the people."

"Information provided by health boards to CHCs is generally of a good standard and if anything extra is required it is normally provided promptly."

"CHCs play a vital role in engagement with the community, they are often the ones who arrange and chair the community events."

"There can be a balancing act between working with the health board while at the same time protecting the interests of the public."

"It is sometimes felt by CHCs that the health boards don’t think about things long term and only want to focus on the changes that are happening there and then and not the ongoing effects that these changes could have."

"Service planning committees have improved the relationship between health boards and CHCs and are a means of sharing information."

"Health boards believe that they have a very productive relationship, the CHC have the ability to challenge when we required but they are also a partnership when it comes to communicating with the public. CHC chair and chief officer are invited to board meetings."
"Links with the health board's communication team and the CHCs are important."

"Getting a senior person from the service that is changing to contact the CHC at an early stage can often help."

"The relationship is very variable between different areas, there is generally an openness but this is not always true."

"In some areas the clash of personalities between the CHC and the health board is very unhelpful and destructive."

"The relationship was toxic – there was no respect and not trust."

"We felt that we were used as a shield by the health board."

The CHC's role in representing the community's voice and their effectiveness.

"They need to be critical friends to the health boards."

"They are the patient voice but also have to consider what is best for the community and not just the individual. Have to consider opinions from clinicians, patients, minority groups and the wider community not just listen to the loudest voice."

"The CHCs have great potential but are often not operated effectively."

"CHC try to give the public all the information that is available and reserve a balanced view."

"Some CHCs believe that members should not be sent out on their own to chair meetings without support from the chair, chief officer or deputy chief officer as this could leave them in a vulnerable."

"People need to have a better understanding of the role of the CHCs, if the CHC don't know what their role is how can the public be expected to understand."

"The CHC have a duty to protect the community but it is also their duty to ensure that best process is followed and an improved service is given."

"The title of council in the name often confuses the public and gives a misleading impression about who they work to/for."

"Any conflict of interests are identified at the start of public meetings and then members are asked not to get involved in any specific questions/discussions relating to that conflict."

"The CHCs are not sure who they are accountable to."

"The CHC represent interests not views. Understanding the local community but also knowing how to look at everything as a whole is vital and this is missed."
"It is not the role of the CHC to create public opinion but to reflect on what the public are saying."

"The Minister should be able to contact the CHCs to get patient opinion about which they should be able to provide evidence."

"Because the role of the CHC is not widely known and understood there is no way that they can be representing the whole community as people still don’t know that they can raise their concerns with the councils."

"It is the CHC’s role to certify that engagement has been done well."

"CHCs don’t have the skills needed to evaluate the information they are given by the health board effectively which means they might not always be giving the correct message to the public."

"The CHC should provide a scrutiny role on behalf of the community."

The ways in which CHC members are recruited – competence framework used and training and development provided.

"Training is currently done locally and is different for each CHC. Most CHCs agreed that there should be an all Wales approach to training which should be led by the CHC board."

"Some CHCs hold visiting and monitoring workshops."

"The chief officer currently has no role in recruiting. Some chief officers believe that they should sit in the interview panel."

"Membership needs to be broader – membership is often white, middle class from the older generation."

"Four training development days are held a year to help train and support members."

"CHC members are expected to chair sometimes difficult meetings and not all members have the skills/training required to do this."

"It was suggested that councilors should not be on the CHC membership as it can create too much of a conflict of interest."

"There should be a formal interview process for all members."

"Is there a need for 25% elected members – this can be very restrictive."

"CHC sign up to code of conduct, CHCs are reminded of this conduct annually and when appropriate."

"What is the induction process? There needs to be more intense training and focus on some specific items."
"CHC members should govern themselves in relation to conduct."

"Local authority members are often just appointed and don't have any real interest in the role of the board, this means that overall membership is not always effective."

"Ideally everyone should have to go through a formal recruitment process meet set criteria and be interviewed."

"Induction should be done on a national level and code of conduct should be included."

"Members should all receive training in how to best chair a meeting."

"The CHC can be too close to the subject. There are often local councilors on the group who have too much of a vested interest."

"The membership of the CHCs is vast and unwieldy and they often carry a number of vacancies."

The ability of CHCs to propose alternative solutions.

"CHCs should have a group of advisers or independent experts that they can call upon to help them provide informed alternatives."

"Without expert advice the CHCs can find it difficult to provide an alternative."

"CHCs don't have the capacity or the capability to provide an alternative."

"It would be better if the health board considers the CHC concerns and then either resolved them or provided an alternative."

"The timescales are often too tight to give the CHC time to provide an alternative."

"CHCs should be able to give valid and justified reasons to why they disagree with an option but should not be expected to provide alternatives."

"Members of the CHCs are bright and clever people who are prepared to challenge things they don't agree with and can seek out the evidence and information they need to provide an alternative."

The role and value added by the Board of CHCs.

"The board should develop and provide training but does not currently do this."

"The board should support the CHCs and hold them to account."

"The current CHC board has been very poor. There are very different views about what the board should be doing."
"Board should provide a national leadership and focus on national priorities."

"Should provide expertise on all-Wales issues."

"Should look to standardisation and good practice and promote this across Wales."

"The board needs some governance over the CHCs and should possible have the right to put them into special measures."

"Should be responsible for governance and disciplinary procedures."

"CHCs should be accountable to the board."

"The current board does not have enough power to deal with inappropriate behaviour. – they need to have tighter performance management controls."

"All CHC referrals should be approved by the board prior to being submitted formally."

"The board should have a regulatory role."

"There is currently a lot of uncertainty about the role of the board and what people are aware of is not considered to have been done well in the past."

"The CHCs have resisted change – they like to act as independent fiefdoms."

The competence of the Welsh Government guidelines – changes that might be made.

"The guidance helps because it provides a base line, it is clear and concise but potentially a bit over the top in terms of detail and the restrictions that this can put on the health board."

"What is the difference between engagement and consultation? If engagement is done well there would be no need for formal consultation so there should be less restrictions around the consultation process."

"The procedure is designed to inhibit change and slow the process down, there is a lot of repetition between engagement and consultation. If consultation is done well there might not be a need to formally consult."

"The guidelines are very one size fits all – they should be more flexible."

"They say the right things but are silent on what happens when there is a disagreement amongst health boards."

"It can be restrictive, you don’t always need 12 weeks to consult."

"The guidance could be less specific and leave the health boards to have more choice and leave them to account for their actions."
"Guidance around what is significant needs to be more clearly defined. – however the “grey area” can sometimes be helpful otherwise boards might need to feel they have to consult formally when you don’t really need to."

"Needs to be an emphasis on continued engagement."

"If not doing a formal consultation then you should be able to justify this."

"Guidance only focuses on one health board and one CHC this wasn’t the case for the South Wales Programme so there was no guidance on this."

"Health boards sometimes think it is just guidance so they don’t have to follow it."

"There should be an obligation within the guidance that the health board set out the information in a clear way that the lay person can understand."

"Some confusion regarding what is engagement and what is consultation."

"The referral process needs to be made clearer – judicial review is becoming the weapon of choice for those who object to the proposals."

"The regulations create a number of restrictions for example the CHC chair had to leave in the middle of the South Wales Programme because of time limits in the role."

"Effective engagement is an organisational cultural issue – the guidance isn’t really what helps it’s the engagement."

"Consultation should be reserved for when it is really needed, there are some things that boards should be able to make decisions on."

"The role of the CHC is not set out very clearly in the guidance."

"There should be a lot more “must” rather than “should” in the guidance - as it is it is currently too flexible."

"Health boards should be placed under a duty to engage and be held to account if they are not doing it effectively."

"There needs to be a process in place to check that engagement and consultation is done correctly."

"The consultation process needs to be clearly defined."

"The guidance isn’t always helpful when trying to make local changes."

"The guidance is open to interpretation – it is too casual and informal."
"The guidance could be rewritten as a tauter, tighter document – there are weaknesses that need to be addressed including:

- More is needed on the definition of continuous engagement
- The idea of a “compact” between CHCs and health boards regarding what would or would not amount to substantial change has not really worked and needs to be reconsidered
- The supervision of the operation of the process by HIW has never worked; it has neither the interest nor the expertise."

The competence/helpfulness of the Older People’s Commissioner’s guidelines.

"The guidance is mostly common sense, however the older group are not the only group that need to be considered. We are planning for the future so we need to think about that the youth group as well."

"The commissioner wants evidence that all communities and groups are consulted but often people are not willing to put themselves into a specific category."

"The commissioner is able to give a much broader opinion across the board not just health this helps to highlight gaps in the system."

The management of criticisms and feedback by health boards and CHCs.

"CHC and health board generally inform each other if they are aware of any issues that might be raised."

"We did not effectively show how the feedback influenced the final plan."

"Health boards take a positive approach when they receive criticism."

"Health boards act on any criticism that they receive."

"Health board generally takes criticism on board if the public has a problem then they raise any concerns at meetings. If these are not dealt with effectively then a report is submitted to the health board and CHC."

"There needs to be increasing sensitivity to the wider environment – the economy, transport, deprivation."

"The system is dominated by organisational interests and therefore response to feedback reflects this."

"The increased involvement of clinicians has led to increased commitment to establish processes that are fit for purpose as well as an attempt to make changes that overcome parochial interests, secrecy and the lack of consistency in decision making."

"The failure to meaningfully engage primary care teams ….. meant that they had little idea of what the health board was planning until it was too late for them to intervene."
The advantage of a third-party reality check.

"A third party check in Wales might not work as the areas concerned would still want the Minister to have the overall decision. Wales is very political. However the weakness of the South Wales Programme was that there was no decision-making body."

"Some CHCs felt that a third-party check would take away the threat of referring something to the Minister."

"A third-party check would help to protect all of the interested parties and provide the public that a fair and open process has been conducted."

The role of the Minister.

"The Minister should set direction of travel but allow boards to work within that and not get involved in directorial or operational issues; how can the Minister consider referrals if he has been involved in the decision making."

"The Minister needs to maintain a professional distance otherwise things could be seen as a political decision - change should be driven by clinical and service needs."

"Minister needs to be impartial and independent."

"There has to be an ultimate decision maker but this can mean that a decision on a referral becomes political."

"The Minister should hold the health board to account."

"The Minister ultimately needs to be the person making the decisions – there is too much buck passing at present."

"Roles and expectations differ – the public expects the Minister to take responsibility at an early stage and too soon. He should talk about purpose and intent and not the detail."

"The Minister is being put into a position of making decisions that should have been made lower down."
Hywel Dda Community Health Council
Response to supplementary questions

1. Please describe the ways in which you pull together your community and patient networks, and the ways in which you communicate with them. How do you ensure that they are truly representative?

The primary engagement resource for all community health councils (CHCs) is their membership as the number of salaried support staff is small. Members are rooted in communities and within their role are expected to be one of the primary links between the public and the CHC.

As volunteer human resource it is difficult to impose and guarantee truly representative engagement, however most members have now received equality and diversity training and core concepts such as health equity and vulnerability are central to their work.

As currently mandated, within each of the three counties, from a total of 12, three members come from an active third sector background, three are county councillors and six are Welsh Government appointed. In addition, a small number of members can be co-opted. Each group is rooted within their communities and brings the outcome of their active engagement back to the CHC.

To assist and coordinate Public and Patient Engagement (PPE) the CHC employs a PPE officer. Planning for PPE activities happens in a joint visiting, scrutiny, monitoring and PPE committee. These two functions are discussed together as the statutory role of visiting healthcare settings often overlaps with public contact and gathering patient experiences. Often, a specific local issue or question arises which might centre on quality of care or patient experience within a specific health setting. In this case standard methods such as surveys or questionnaires are employed and the CHC has access to software which helps in the survey design and subsequent analysis.

The chair of the CHC produces a regular column for local print media and when relevant, specific press releases are produced. TV and radio media contact is infrequent but accommodated. Limited CHC officer capacity coupled with the sensitive and emotive nature of local NHS change has limited opportunities to use social media so far.
2. Please describe your key stakeholders and how you determine who they are.

As a general illustration, the diagram below describes the kinds of key stakeholders the CHC routinely works with. Identifying stakeholders for a project will depend on the specifics associated with that task. In such a situation, stakeholder analysis tends not to be a formal process but an information gathering exercise exploring contacts, individuals and groups through the partner organisations shown below.

Through its membership, dedicated stakeholder meetings, and specific projects, the CHC aims to maintain a continuous dialogue with both partners and the wider public.

The CHC’s committee structures are designed to assist this with locality meetings that are moved around a large geography and open to the public. These are supported by a formal services planning committee attended by the health board and regular informal meetings with county directors, allowing for two-way flows of information.

The CHC has also embarked on joint projects which seek to link stakeholders who have a particular health interest with the CHC and its statutory relationship with the health board. This has culminated in useful joint-report documents which have subsequently been forwarded to health board management. Such partners have included Carmarthenshire Council and a learning disability advocacy organisation.

3. Please advise me of the best practice guidelines you used to develop the engagement strategy for your CHC/health board, and how you evaluated the effectiveness of that engagement strategy.

Hywel Dda does not produce a formal engagement strategy document but PPE priorities are identified and plans are made at the start of each year, agreed amongst officers and members before being approved by the Council’s Executive. Progress
against plans is monitored using performance indicators. It is important to note that a proportion of PPE activity has to be reactive and unplanned as local issues arise from intelligence gathered and are approached on a measured but *ad hoc* basis.

Accepting that the CHC operates a mixture of planned and unplanned PPE work it maintains engagement expertise via the Board of CHCs. Relevant officers have attended training and board-led meetings promoting Participation Cymru’s *National Principles of Engagement in Wales*, which are applied to planning and prioritisation.

In general, PPE performance and effectiveness across the organisation is discussed by members at the end of the year and this informs onward planning. Outcomes from specific projects are discussed in the VSM/PPE committee and consequent actions or work streams are identified.

The CHC receives various requests to carry out presentations within local community groups and organisations. These are accommodated by staff using agreed resources. Increasingly the CHC aims to evaluate such presentations to ensure they were useful and met expectations. Contact details and leaflets are left so that the relevant community groups and organisations can liaise with the CHC in the future or spread the word with other groups in their network. Awareness raising and marketing the CHC’s role remains a challenge given limited resources available. Clearly, the CHC struggles to compete in an environment where commercial marketing is so pervasive, but staff deal with a steady stream of correspondence and contact from the public.
Aneurin Bevan University Health Board

In your letter, you asked for additional information on the following:

Please describe the ways in which you pull together your community and patient networks, and the ways in which you communicate with them. How do you ensure that they are truly representative?

The health board has a communications and engagement framework and this is currently being reviewed and a specific engagement strategy is currently in development. The chair, chief executive and the board are clear about the importance of continuous engagement and arrangements that are open and transparent and engage as wide a cross section of our communities as possible. Therefore, the health board has a range of ways through which it seeks to continually engage with our communities. This happens through:

- Engagement through our planning networks for major services changes and developments, for example, the recently completed South Wales Programme and our local work on the Clinical Futures strategy through developments such as the Specialist and Critical Care Centre. There are also a range of new service models which are being developed in which patient and public voices are crucially important. This work is led by our planning directorate.

- The organisation also has a range of work also underway in our communities through existing partnerships with our local authorities and other partners through the engagement frameworks agreed as part of local service board and health, social care and wellbeing partnerships. The health board is also taking forward further engagement through our developing neighbourhood care networks with a particular focus on primary care and community service developments led by our lead clinicians. This work is being taken forward through our primary care and networks division. As part of this work and that of the local service board engagement framework a range of community groups and community based events are used to engage community views about services and the quality of care.

- The health board also has a patient experience framework, which works predominantly with patients in our hospitals through a range of approaches and mechanisms to obtain patient views. Key mechanisms for this are the Fundamentals of Care surveys and patient satisfaction surveys. The health board also has a patient information service and has in place a patients’ panel. This work is overseen by a patient experience board and is led through the director of nursing’s department. The health board through this mechanism engages directly with up to 150 patient groups.

- The health board has also established a stakeholder reference group (SRG), which each health board is required to establish. Aneurin Bevan UHB has sought to ensure its SRG is reflective of local networks and that representatives can bring views of their wider networks, but also report information back out to their respective networks and act a key channel for engagement and communication on key issues for the networks and for the health board. Key to the SRG is the engagement of the Gwent Association of Voluntary Organisations and the Torfaen Voluntary Alliance. This engagement with the third sector is a very important element of the work of
the SRG and provides a link to a much wider network of community interests. The SRG and these community groups also work on specific projects and advise of patient and public reader friendly documentation for the health board.

For instance, the SRG this year has worked closely with the lead officers for the development of our Annual Quality Statement to seek to make it as accessible as possible and covering subjects that patient and public would like to read about and again assurance about.

- The Health Board in its engagement and communication also has a very productive relationship with the Aneurin Bevan CHC. The health board meets regularly with the CHC to discuss key issues and officer of the health board regularly attend a joint planning committee. The CHC feeds back key issues to every public meeting of the health board through a report and discussion. The health board also seeks advice from the CHC on engagement and consultation activities and how to effectively to engage with patients. The members of the health board undertake a range of visits to services and facilities across the health board and engage with patients and staff and have over recent months have also been shadowing CHC members as they undertake their unannounced visits to health board services and sites.

- In terms of the ways in which we communicate with patients and the public, the health board does this through a range of media. These include:
  - Face-to-face meetings and discussions groups
  - Consultation and engagement events and community based events – the principle of going to community groups and the public rather than expecting them to come to us.
  - Communication through the media
  - Corporate publications
  - Increasing use of social media and online videos.
  - Health board website
  - Information leaflets and terminals
  - Obtaining a health presence in partner publications
  - Routine publication of information through our publication scheme and arrangements via Freedom of Information
  - A range of campaigns. The health board had particular success through our Winter Wise campaign and the Dr Olivia video.

It is very difficult to ensure that representatives that engage with us are truly representative or representing their respective constituencies of interest or geographical area. However, using representatives of established and recognised networks helps the organisation to be clear that individuals that do engage are engaging from a wider network perspective. Nonetheless, this does not diminish the valuable input that individuals can make, even if they are not part of wider interest or community groups.

Please describe your key stakeholders and how you determine who they are:

The health board seeks to engage with all community interests and the population of the health board area. The health board does, however, on some occasions identify target audiences depending upon the matter at hand. Therefore, on some occasions particular targeted communications take place with specifically tailored approaches,
documentation and messages. Therefore, the health board seeks to develop a range of communication and engagement methods and communication channels to ensure that our engagement is consistent, targeted and relevant. The health board also recognises that communication is not only about language and literacy and we seek to develop a supportive and inclusive environment, which supports and promotes openness and accessibility for all.

**Please advise me of the best practice guidelines you used to develop the engagement strategy for your CHC/health board, and how you evaluated the effectiveness of that engagement strategy.**

The work of the health board has been advised by a range of good practice guidelines including the:

- Welsh Government document *Guidance for Engagement and Consultation on Changes to Health Services in Wales*
- Consultation Institute guidance
- Participation Cymru *National Principles for Public Engagement*

The health board uses a range of measures of success and monitoring tools to assess the effectiveness of our engagement. Some examples of measurement of success included:

- Staff and patient surveys and feedback mechanisms
- Number of hits to Aneurin Bevan University Health Board intranet and internet site, including 1000 Lives Plus and campaign sections
- Enquiries/feedback via intranet and internet site
- Performance management programme
- Identification of barriers to communications, such as:
  - Inadequate information in messages
  - Lack of opportunities for feedback
  - Staff not taking responsibility themselves for finding out information
- Participation rates in specific campaigns
- Media tracking, including number of media releases on patient safety activity
- Level and trends of complaints and concerns from patients, AMs and MPs and the CHC
- Feedback from patient surveys such as the Fundamentals of Care and feedback from CHC monitoring visits.
North Wales Community Health Council

1. Please describe the ways in which you pull together your community and patient networks, and the ways in which you communicate with them. How do you ensure that they are truly representative?

Following the reconfiguration of CHCs in April 2010, the North Wales CHC recognised that communication is key to all of its work. With that in mind a communications group was formed with the aim of giving leadership relating to communications with patients, members of the public and organisations which work with us (appendix 1a provides the Terms of Reference for the CHCs communications group – these have been regularly revised since the creation of this group).

Work on our communications plan began in the summer of 2010. Members of the CHC identified stakeholders, messages, media and intended outcomes for the plan at development sessions in July and September; and members of the communications group worked on the detail of the plan at meetings through to December 2010.

The communications group recognised that the communications plan needed to be developed alongside the general business plan for the North Wales CHC as a whole. In recent years the forward plan for the CHC (appendices 1b and 1c) meant that the scale and intent of the communications plan, is in keeping with the emerging work programme for the CHC. Appendix 1d provides sample agendas from CHC local committee meeting and executive committee meetings. It can be seen from these that the key areas of:

- Actively seeking out people’s views and experiences of health care and;
- Representing the views and experiences of local people to those who make decisions about health care for North Wales

are regularly reviewed, discussed and developed. The structure of our local committee agendas makes possible for discussions between all members (including local government nominee members on local issues).

Appendix 1e provides a copy of the CHC’s communications plan. This sets out simple, overarching aims and objectives. The communications plan also refers to target groups for its communications. The following criteria being used to define target groups for CHC communications:

- Groups with a particular interest in current or planned discussions or consultations;
- Groups representing widely drawn parts of the community;
- Groups representing service users who were less frequently involved in discussions about services;
- Groups organised on a geographical basis, so as to give North Wales-wide coverage;
- Groups which would help the CHC test ‘seasonal’ experience of healthcare (eg older people).

Appendix 1f provides an example of a target audience list developed by the CHC.
The communications plan refers to building a supporting framework for the CHCs communications work and also to actions in order to establish regular communications with communities and decision makers by:

- **Written media** – news media and websites (examples included in appendix 1g. In the year 2013-14 over 10 news releases were published; contribution of features for publication in community and other publications about the work of the CHC are provided. Regular contact has been maintained with local, national and community media. Appendix 1h is an example of a spreadsheet which identifies opportunities for us to contribute to local health-related publications). This also includes radio and television appearances.

- **Speakers** (Appendix 1i is an example of a speakers timetable – which includes members attending to give presentations to external organisations, as well as inviting other organisations to attend CHC meetings. Appendix 1j is an extract from our speakers team pack – designed to enable members to give effective presentations about the work of the CHC to external organisations.) Local committees also invite speakers from organisations concerned with healthcare in their locality. During the period 1st April to 31st March 2014, members and officers of the CHC provided presentations to organisations with an interest in health issues, these included the following groups and organisations: town and community councils; Breathe Easy groups; Over-50s groups; Dementia Carers Support Groups; secondary schools; Alzheimer’s Society (including various memory cafes); medical students; Rotary Clubs; stroke carers cafes; access to advocacy; Bangor University; various health action groups.

We also invited people to come to talk to us about health services in North Wales, these included presentations to us from NEWCIS Carers; Diabetes Cymru; Betsi Cadwaladr University Health Board; Welsh Ambulance Services NHS Trust; Carers Outreach; Mantell Gwynedd; British Red Cross; Crossroads; Cruse and MIND.

- **Schools and College initiative** (Appendix 1k is an example of a letter sent to all North Wales secondary schools and colleges, offering students the opportunity to volunteer with the CHC as part of their Welsh Baccalaureate qualification. On the 4th September the North Wales CHC was present at a Welsh Baccalaureate fair – promoting this opportunity.)

- **Poster initiative** (we encourage our members and staff to distribute CHC literature at all health care establishments, we have targeted in particular local authority premises, GP practices, libraries and supermarkets – appendix 1l provides some examples of our correspondence in this respect).

- **Electronic communication/ social media** We have extensively developed the use of our website, providing regular updates and access to our work. Our website attracted 17,025 hits during the last reporting period year. We have established a presence on social media through Twitter with a following of over 500 – many of whom have re-tweeted our key messages - others sharing their experiences of health services with us.

- **Stands and events** (Appendix 1m is an example of our stands and events timetable enabling us to identify opportunities for the CHC to have presence, stands and literature at events with a health theme aimed at attracting large numbers of local people. During the 2013-14 reporting period these have
included: Carers Week – NEWCIS (Rhyl); Good Health Event (Dolgellau); Access 2 Advocacy event (Llangollen); Big Health Day – AVOW (Wrexham)

- **Welsh Language** Compliance with our Welsh language scheme has demonstrated that we have enabled everyone who received or used the CHC’s services to do so through the medium of Welsh or English, according to personal choice. We continued to encourage others to use and promote the Welsh language in the health sector. Our commitment that everyone who comes into contact with us should be treated with dignity and respect and receives a responsive service that is accessible in their language of choice, is clearly demonstrated in our annual monitoring report to the Welsh Language Commissioner submitted in January 2014.

Progress against the communications plan has been regularly monitored over the last four years (appendices 1n and 1o are examples of some of the reports presented to our executive committee).

1a. How do you we ensure that our community and patient networks are truly representative?

Our Membership and Staff:

One of the main ways in enabling us to ensure that our networks are truly representative is through the local knowledge of our staff and members. Members of the CHC are drawn from across the six counties of North Wales in the following ways:

- The membership of the North Wales CHC is 72 full members with each local committee having a maximum of 12 full, voting members. There are three categories of full members - public appointed members, 36 members appointed by the Welsh Ministers; local authority members, 18 members appointed by local authorities, (three from each of the respective local authorities in North Wales); and 18 third sector members, appointed by voluntary councils (three from each of the respective voluntary councils in North Wales). The CHC is able to appoint up to three co-opted members per local committee for a period of 12 months; appointments are endorsed by the executive committee.

- In respect of public appointed members, advertisements are placed in national and local press by the public appointments branch. (There is no agreed schedule to recruit public appointed members as and when vacancies arise). Interested parties are able to register their interest with either the North Wales CHC and/or the public appointments branch. Application packs are sent out by both the CHC and the public appointments branch but must be returned to the public appointments branch for sifting and interview scheduling. Interviews are undertaken by the CHC policy lead from Welsh Government and a chief officer.

- In respect of local authority members, the CHC has no involvement whatsoever in the selection of the appointed members.
In respect of the third sector members, CHC involvement varies. Applications have to be submitted to the respective voluntary organisation for sifting and interview scheduling. In some cases the CHC is invited to be a member of the interview panel.

With regards to co-opted members, the CHC provides application packs and receives applications from members of the general public. Interviews are undertaken by the chair and vice chair; deputy chief officers can be invited to be a member of the interview panel. Having interviewed the prospective co-opted member, the chair will request the approval of the respective local committee before making a recommendation to the executive committee that the co-option be endorsed.

The CHC cannot say that its membership is truly representative as specific groups are not targeted as and when vacancies are advertised. Applications are welcomed and encouraged from all groups and we ensure that no eligible candidate for public office receives less favourable treatment on the grounds of age, disability, gender, marital status, sexual orientation, gender reassignment, race, colour, nationality, ethnic or national origins, religion or religious affiliation. The CHC has little involvement in the recruitment of its full members at this stage nor is it able to influence the appointments; it may be prudent to look at broadening the role of the CHC in the recruitment process in the future.

We are aware that our members have additional interests other than the CHC and in many cases act as a conduit between the CHC and these other interests. We encourage our members to share information about their particular interests and networks with us. Appendix 1p is an example of how we gather this information from our membership. Appendix 1q provides details of some of the groups our members are involved with.

We regularly encourage our members to review how we communicate and engage with our stakeholders. Appendices 1r and 1s are examples of our workshops which have taken place to fulfil this aim.

**Some examples of our work: Actively seeking out people’s views and experiences of health care**

We continue to work to fulfil our aim to make sure that the CHC develops and sustains a detailed understanding of the needs and views of all sections of the communities we serve in North Wales.

During the last year we made contact with local people, both as individuals and members of community and other groups – enabling people to talk to the CHC about their experiences of North Wales’ health services.

We went about our work in several ways, including:

**Surveys and Questionnaires:**

Some of the surveys and questionnaires we conducted during this year are described below.

*Your Local Experiences of the NHS Questionnaire*
The CHC developed a new style of questionnaire during this year. The Your Local Experiences of the NHS Services Questionnaire was designed to allow people to give feedback about any aspect of the NHS and to give their views freely and in confidence to the CHC if they so wished. This questionnaire has been used by CHC members and staff when attending events and presentations and has enabled the CHC to identify areas of concern to the NHS service providers in North Wales.

In February 2014, members of the CHC undertook a pilot survey of patient experiences, approaching people at Ysbyty Gwynedd and inviting them to complete the questionnaire. A total of 424 of questionnaires were completed and returned to the CHC.

Many people told us a number of things about their experience of the NHS in North Wales and many people referred to a number of NHS services when completing the questionnaire. Most people told us about their experiences of hospitals, including district general hospitals and other smaller hospitals. Others told us about the services they receive from their GPs and some about services such as their dentists and pharmacists. Work is ongoing in identifying particular themes and the outcome of this survey will be developed in the coming year.

**Enhanced Care Service**

The Betsi Cadwaladr University Health Board's enhanced care service aims to provide an increased level of care to patients in their own homes, who otherwise would have to be admitted to a community hospital or to an acute hospital. For patients who are already in hospital, enhanced care can also support some of them to be discharged home sooner than they might have been.

The CHC has throughout the year worked with the health board to ensure that the implementation of this service across North Wales is developed taking into account feedback from patients and their carers who have used the service. A total of 394 questionnaires were issued to patients and carers during this period. Analysis of feedback received is ongoing, however the majority of comments showed a high level of satisfaction amongst those who had used this service.

**District Nursing Service**

In partnership with the health board, the CHC also undertook a survey of the district nursing service in North Wales. Patients who had used the service were selected at random and were invited to comment on their experiences of the service. Some 1,400 questionnaires were distributed to patients and carers, with locality matrons inviting comments from other patients and carers from across the region. All feedback received was analysed by the CHC and presented to the health board with suggested improvements in the form of an action plan. The CHC continues to work with the health board in monitoring the implementation of areas identified for improvement,

**Planned and ongoing surveys**

Questionnaires relating to the use of the Welsh language in health services; review of the CHC’s website and Your Local Experiences of the NHS all appear on our website on a continuous basis. CHC members and staff distribute the Your Local Experiences questionnaire as part of the CHCs publicity materials at all events and
presentations attended. During this year, plans were also put in place to conduct a pan North Wales GP out of hours service survey during the Easter 2014 period.

**Representing the views and experiences of local people to those who make decisions about health care for North Wales**

The CHC helps to improve health care by making sure that people who make decisions about health care at local and national level take into account the views and experiences of people who live in and visit North Wales.

Throughout the year we took every opportunity to represent people’s views to those who make decisions about healthcare.

We went about our work in several ways, including:

**Patient Stories**

In October 2013, the CHC embarked on a new initiative – Patient Stories. This allows patients to tell a story in their own words about their experiences (both good and bad) of the health service in North Wales. The initiative developed with good progress during the year with a number of patients sharing their stories with us. These in turn were relayed to the health board, in order that lessons could be learnt to improve the services provided in the future and to ensure that both good and bad experiences are shared with the appropriate staff.

**Consultations**

During the year the North Wales CHC responded to the following national consultations. This enabled the CHC to communicate directly on a formal basis with other statutory organisations.

<table>
<thead>
<tr>
<th>Consulting Body</th>
<th>Title</th>
<th>Consultation Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welsh Government</td>
<td>Welsh Declaration of the Rights of Older People</td>
<td>13.12.13 – 15.03.14</td>
</tr>
<tr>
<td>Welsh Government</td>
<td>Amendment of the Welsh Health Specialised Services Committee (Wales) Directions 2009</td>
<td>19.02.13 – 13.02.14</td>
</tr>
<tr>
<td>Welsh Government</td>
<td>Neurological Conditions Delivery Plan</td>
<td>30.10.13 – 31.01.14</td>
</tr>
<tr>
<td>Welsh Government</td>
<td>Respiratory Health Delivery Plan</td>
<td>21.10.13 – 09.01.14</td>
</tr>
<tr>
<td>Welsh Government</td>
<td>Future Regulation and Inspection of Care and Support in Wales White Paper</td>
<td>30.09.13 – 06.01.14</td>
</tr>
</tbody>
</table>
Copies of all the CHC's responses to the above consultations are available on request.

**Engaging with Communities about Primary Care**

Throughout the year we have liaised with GP practices across the region about the importance of public and patient engagement concerning any proposed changes to the services offered by a GP practice. We have continued to focus on encouraging patients to take part in such matters. The CHC’s involvement has ensured that patients are aware of what their GP practice is planning to do; patients are allowed to give their views on plans to change GP services and that patients can talk to the CHC as an independent organisation about their views and concerns.

The following table shows our involvement during the year concerning proposed changes to service provision at a number of GP practices.

| Denbighshire | The Health Centre, Green Lane, Corwen – practice vacancy |
| Flintshire | Hawarden Health Centre, changes to practice boundary (Saltney) |
| Wrexham | • Beechley Medical Centre, changes to manage practice  
• Hightown Branch Surgery, changes to service provision  
• Strathmore Medical Practice, changes to practice boundary |
| Conwy | Dolwyddelan branch surgery, changes to service provision |
| Gwynedd | • Llan Ffestiniog branch surgery, changes to service provision  
• Corwen House surgery, Penygroes, changes to management of practice |

**Other**

During the year we have continued to develop and maintain partnerships with many organisations which have similar objectives to ours. Representatives of the CHC attend an extensive number of meetings and events demonstrating a consistent involvement of the CHC being in discussion with the health board and other bodies to ensure that health services take account of local people’s views and experiences.
2. Please describe your key stakeholders and how you determine who they are.

In broad terms, our key stakeholders could be defined as the population of North Wales, some 676,000 residents – as health is relevant to all. However, when describing our key stakeholders it would be right to say that these are those who can have a positive or negative effect on an effort, or who are important within or to an organisation, agency, or institution engaged in an effort. In determining our key stakeholders, we recognise that our approach needs to shift and adapt to local circumstances. As mentioned above, the CHC keeps its key stakeholders under regular review, however at the outset of our work, we identify our key stakeholders in line with the following three categories:

**Government officials and policy makers:**

These are the people who can devise, pass and enforce laws and regulations that may either fulfill the goals of our efforts or directly cancel them out.

- Legislators. Welsh Government representatives, National Assembly Members (AMs), Members of Parliament (MPs);
- Local representatives. county councils; town and community councils; local medical committees;
- Health boards and NHS trusts (including Welsh Ambulance Services NHS Trust; Velindre NHS Trust, Powys Teaching Health Board); English NHS trusts; GPs;
- Government agencies, Healthcare Inspectorate Wales;
- Policy makers – Public Health Wales.

**II. Those who can influence others:**

- The media
- People who are in positions that convey influence; GMC, BMA, North Wales Universities, North Wales NHS staff groups; LMC
- Community leaders – people that others listen to: The six North Wales voluntary services councils; Citizens Advice Bureaux; Communities First

**III. Those with an interest in the outcome of an effort:**

- Patient groups; campaign groups; community activists
- People with an academic interest relating to a targeted issue or population (eg universities; Royal Colleges)
- Community at large.

As described above, the communications group went about identifying target audiences at an early stage (Appendix 1f). This task identified the CHC’s permanent partners.

In preparation for the 2012 consultation *Healthcare in North Wales is Changing* the CHC developed a targeted communications plan, which included reviewing the key stakeholders in that respect (appendix 2a). A governance paper published by the CHC following this consultation demonstrates how the CHC went about its work in this respect.
3. Please advise me of the best practice guidelines you used to develop the engagement strategy for your CHC, and how you evaluated the effectiveness of that engagement strategy?

The CHC produced *Public and Patient Engagement Strategic Framework* in 2010 (appendix 3a). This was produced following best practice guidelines within *Signposts 1 and 2 (A Practical Guide to Public and Patient Involvement in Wales)* (National Assembly for Wales/NHS Wales/Office for Public Management). At that time, little direction had been given by the Board of CHCs in Wales as to how to develop this strategy, however the strategy was shared with colleagues in other CHCs and was presented also to the Welsh Government National Advisory Board in 2010.

The strategy includes a PPI planning and evaluation toolkit, based on a toolkit developed by the Welsh Ambulance Services NHS Trust. As has been described above, our main focus has been on our communications work (being evaluated and monitored through our action plan and reports to the CHC’s executive committee). However, more recently, the CHC has taken a more focused approach to the aspects of engagement and involvement being the other main aims of our strategy. *Prepared to Engage* (appendix 3b) is a paper that was ratified in July 2014. This has now led to the development of CHC NHS Service Changes Task and Finish Group and an engagement and involvement group, which will take forward the aims and objectives of the strategy in a more meaningful and focussed way.

The CHC endorsed the *National Principles for Public Engagement in Wales* on 29th June 2011. Members and officers of the CHC have undertaken various training programmes and events organised by Participation Cymru and continue to be updated on national initiatives. CHC officers are also members of the Consultation Institute, having undertaken extensive training in relation to effective engagement and consultation. This has enabled the North Wales CHC to share lessons learnt on a national basis with other CHC colleagues.

Officers of the North Wales CHC have attended the PPE Forum (Board of CHCs) which allows colleagues form the CHCs to share good practice and develop further areas of work. We continue to strengthen our links with Health Watch in England and have worked together in training events with particular regards to cross-border issues.

The CHC reports to the Board of CHCs in Wales on its performance which includes public and patient engagement activity. Appendix 3c is an extract from a recent key performance indicator report. It is understood that this is also shared with colleagues in other CHCs.

We receive numerous mailings and articles relating to engagement activities and guidance. We regularly research methods of good practice. More recently we are cognisant of the *Code of Good Practice for Consultation of Stakeholders* and we will endeavour to use this in practice as part of our the work of our new engagement and involvement group (see Appendix 3d)
Betsi Cadwaladr University Health Board

Thank you for your letter of 26 August, requesting evidence to support the above review, which has been passed to me for a response.

I have provided a response to each of the queries you have raised below, although I have taken questions one and two together as there is significant overlap.

1. Please describe the ways in which you pull together your community and patient networks, and the ways in which you communicate with them. How do you ensure that they are truly representative?

2. Please describe your key stakeholders and how you determine who they are.

The preparatory work for our consultation process *Healthcare in North Wales is Changing* involved a series of clinically led work streams undertaking reviews of the specific service areas involved:

- Locality and community services
- Maternity and child health services
- Older people’s mental health
- Non-elective general surgery
- Vascular surgery
- Orthopaedics

These work streams built on an approach used in previous work on the North Wales clinical strategy (to 2010) which adapted the three cycle review process used by the Institute of Healthcare Improvement. The methodology was independently evaluated (see section on evaluation below.)

For each work stream, a reference group comprising of representatives of different sectors was established and the findings of the work streams were tested with the reference groups to take soundings from the different perspectives at key points in the review process. These reference groups varied according to the stakeholders associated with the service areas, but typically involved representatives of staff (clinical and non-clinical); CHC; local authorities; third sector; primary care; and key patient and community groups. Nominations were sought through co-ordinating bodies where feasible (such as the voluntary sector councils, the local medical committee) to ensure that sectors had an opportunity to nominate appropriate representatives rather than targeting known individuals.

Specific work streams also undertook additional engagement exercises: for example, the maternity and child health work stream used a simple online questionnaire to ask specific questions to inform the review; the non-elective general surgery work stream held a series of open drop-ins across North Wales for interested parties and members of the public.

In preparation for the formal consultation, the health board commissioned training and support sessions on best practice from the Consultation Institute, the not-for-
profit organisation whose mission is to promote the highest standards of public, stakeholder and employee consultation. This included training on stakeholder mapping. The stakeholder groups for each service area were mapped using this approach and this informed the development of the stakeholder database which was used for distribution of consultation materials.

The stakeholder database was developed using the health board’s contact lists from the previous engagement work undertaken in the service reviews. This was built upon using contact lists from the voluntary sector councils; the CHC’s contact lists; and the equality stakeholder contact lists held by the board’s equality team. The database also included details of individuals who had contacted the board to express an interest in receiving information.

The stakeholder database included 1,879 contacts to whom information on the consultation was sent individually and materials were also sent to key stakeholders and partner organisations. In addition to this a distribution plan was drawn up which ensured consultation materials were available in all hospitals and health clinics; GP surgeries and other primary care outlets, local authority premises, libraries, leisure centres, care and nursing homes. We cannot provide the database because of the inclusion of personal contact details of individuals; however the attached list gives the categories of groups who were recipients of information.

Consultation information was available in written form – bilingual, large print, audio and easy read, with other formats being offered on request. Media sessions were undertaken including live radio forums. Meetings were held with local authorities including attendance at scrutiny committees or full council as agreed; third sector and town and community council forums. We worked with a group of stakeholders with specific experience on equality matters together with an independent expert commissioned to advise and assess the health board’s approach. The assessment of the consultation document was that it scored well on a readability assessment (using the Fleisch score.) The equality impact assessment for North Denbighshire community services project was also identified as an example of good practice, the lessons from which were then used to inform impact assessment on the other areas under review.

A series of more formal public meetings were held at a range of venues across North Wales, at different times of day to enable people with different commitments to attend. There were 48 separate sessions held in all. In addition to the open questionnaire distributed with the consultation document, a household survey was used to target a random sample of 5,000 households across North Wales.

A series of focus groups was undertaken, facilitated independently by Opinion Research Services, and using a random selection of participants representing different age, gender, social groups and disability or limiting long-term illness.

During and after the consultation it became clear that there was a need for greater input by certain community groups with equality protected characteristics. Further engagement work was carried out with groups representing, in particular, some older people’s groups; people with a learning difficulty; homeless and vulnerable groups;
black and ethnic community representatives; and representative of the traveller community.

It is extremely difficult to ensure that participants in any engagement or consultation process are truly representative of the whole community we serve. North Wales covers a large and diverse geographical area and includes diverse community groups. The health board strove to ensure that there was meaningful opportunity to engage for all, and that the approach was proportionate and aligned with best practice.

The assessment of the consultation feedback in the full report by Opinion Research Services highlights the extent to which consultation responses can be taken to be representative of the population. The report assessed that the health board's approach was extensive and conscientious. This was reinforced in recent feedback from the Older People's Commissioner, which found that the health board had made genuine efforts to ensure meaningful involvement of older people.

The ORS report and Older People’s Commissioner letter are attached for completeness, together with the summary report on the consultation outcome submitted to the health board which sets out some of the issues found in the consultation process.

3. Please advise me of the best practice guidelines you used to develop the engagement strategy for your CHC / LHB, and how you evaluated the effectiveness of that engagement strategy.

The engagement and consultation strategy used by the health board was based on the health board's engagement framework, and drew upon a number of sources of best practice including:
- The National Principles for Public Engagement in Wales
- Guidance from the CEHR on decision-making by boards and on the specific duties under the Equality Act 2010
- Formal guidance on involvement of older people in service reconfiguration issued by the Older People’s Commissioner for Wales under s.12 of the Commissioner for Older People (Wales) Act 2006
- Best practice guidance on engagement and consultation issued by the Consultation Institute
- Principles from case law on consultation

And the Welsh Government’s Guidance For Engagement and Consultation on Changes to Health Services.

The three-cycle methodology used in the North Wales clinical strategy and on which the preparatory work streams leading to Healthcare in North Wales is Changing were based was independently evaluated by Finnamore, on behalf of NLIAH. This evaluation made comprehensive findings on the process and some recommendations for improvement, but confirmed the view that the process fulfilled the requirement of the NHS engagement and consultation guidance for continuous engagement.
The consultation process for Healthcare in North Wales is Changing was subject to an independent compliance assessment by the Consultation Institute. This is a four-stage assessment of the consultation scope and mandate; the consultation plan; a mid-term compliance review and an end-of-consultation review. This offers the opportunity to address any issues arising during the course of the consultation, check on involvement and take any remedial action necessary.

For example, at the start of the consultation the health board had commissioned a leaflet delivery to every household in North Wales by the Post Office to inform our whole population that the consultation was underway. During the consultation it was alleged by some that the leaflet was not received. This was checked with the Post Office and there were a couple of postcodes, in Colwyn Bay, where the Post Office could not confirm that delivery had been achieved. The health board commissioned a further leaflet delivery to all households in this area and put on an additional drop-in session in Colwyn Bay.

In Flint, there were concerns raised by the local community that there was not enough opportunity for individuals to express their views. In order to gain more assurance for the board that representative views were being heard, the health board commissioned further additional focus groups in Flint which were independently facilitated and involved randomly selected invitees.

The health board was awarded a certificate of best practice for the consultation following the assessment process.

These independent evaluations of process must also however be balanced with other feedback from consultees giving their view of the process. There were difficult issues being discussed and strong feelings in a number of communities. This was evidenced by petitions received by the health board and communication received, as well as media coverage. These concerns tended to be focused around local communities where there were significant changes proposed, although there were many concerns raised regarding neonatal services also.

The health board reviewed the process with the CHC and discussed this openly in public at the joint CHC and health board meeting.

The contention around the proposals and process was also referenced in the independent analysis undertaken by ORS, which summarised as follows:

“3. As a research practice with wide-ranging experience of controversial statutory consultations across the UK, ORS is able to certify that the formal consultation processes undertaken by BCUHB has been both intensive and extensive. Overall, there is no doubt that the exercise has been conscientious, competent and comprehensive in eliciting the opinions of stakeholders and many members of the public.

4. In the submissions and elsewhere, there has been some understandable criticism of the way in which the 48 public meeting sessions were organised; but BCUHB took independent advice on the conduct of these meetings from the Consultation Institute and the decision to hold 48 separate sessions with a team of senior managers.
present at each was certainly scrupulous – so those who believe there were shortcomings should take heart from the conscientiousness and scale of the consultation programme taken as a whole.”

I hope that this summary information is of help. If you require any further information or evidence, please do not hesitate to contact me.
<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
</table>
| 1 Please describe the ways in which you pull together your community and patient networks, and the ways in which you communicate with them. How do you ensure they are truly representative? | The health board links with community and patient networks in many different ways, depending on the groups and their preferred methods of communication. We seek to extend communication into engagement whereby our patients and communities can influence and shape how services are delivered. Examples include:  

**Siarad Iechyd / Talking Health**  
The health board was the first NHS organisation in Wales to establish an involvement and engagement scheme. Siarad Iechyd/Talking Health provides members with up to date information about the health board (through a regular newsletter) and offers opportunities for members to influence and shape health services through participating in responding to surveys / questionnaires, commenting on documents, sharing views on consultations and taking part in focus groups or meetings. Anyone with an interest in health can sign up to become a member.

Equality monitoring information is collected and where areas of under representation exist, we endeavour to target recruitment for these areas.
Siarad Iechyd/Talking Health membership includes a:  
- high number of carers, approximately 30% of members identifying themselves as carers.  
- high number of female members  
- high number of members aged 50-plus

We have effective links to seldom heard groups and utilise these existing mechanisms where people feel comfortable to gather the views from people with learning disabilities, gypsy traveller communities, Polish community etc  

**Sensory Loss Standards Implementation Group** |
The health board has established a sensory loss standards implementation group, which engages and works collaboratively with a wide range of national and local representative organisations and service users, including, amongst others, Deaf/Blind Cymru, Vision in Wales, Action on Hearing Loss, British Deaf Association, Wales Council for Deaf People, Carmarthenshire Coalition for Action on Disability, RNIB Cymru and Guide Dogs Cymru.

**Partnership working**

Public and patient engagement is promoted and enabled through various partnership working arrangements:

- Meeting regularly with health, social care and wellbeing facilitators to promote and support closer working with the third sector including CAVO (Ceredigion Association of Voluntary Organisations), CAVS (Carmarthenshire Association of Voluntary Services) and PAVS (Pembrokeshire Association of Voluntary Services).
- Third sector networks across each county for the dissemination of information such as regular stakeholder briefings, job opportunities etc.
- Health board representation at and links with county community equality confidence groups within Carmarthenshire, Pembrokeshire and Ceredigion, which include members from other public sector organisations and third sector organisations and individuals representing a range of protected groups, including older people, people with disabilities, multicultural groups and LGBT. Work is ongoing to increase the diversity of groups, including representation for children and young people.
- Close working with representative groups or organisations including
  - Gypsy Traveller community – Unity Project, links with learning disabilities via People First, Carers via Carers Networks, 50-plus forums and county-based equality groups.
- Cardigan Project – structure includes a stakeholder board with representatives from a wide range of organisations and interests in the local community including community councils, CHC, local authorities, voluntary organisations, league of friends etc.
- Cylch Caron – structure includes a stakeholder board with representatives from a wide range of organisations and interests in the local community including community councils, CHC, local authorities, voluntary organisations, league of
Withybush Hospital Signage Group – this project to improve directions and signs for patients in Withybush Hospital won the Citizens at the Centre of Service Re-Design and Delivery aware at the NHS Wales Awards 2013. The hospital was praised for working closely with adults with learning disabilities, staff, the local community health council, patients and Siarad Iechyd/Talking Health members to come up with a new approach to help people find their way around the hospital. By using colour zones and easily recognisable symbols, all patients have been able to work out more easily which department they need and how to get there. This is being rolled out to the other main hospitals across the health board.

Stakeholder Reference Group

The stakeholder reference group (SRG) aims to provide:

- Early engagement and involvement in the planning of health board overall strategic direction
- Advice to the health board on specific service proposals before formal consultation
- Feedback on the impact of the health board operations on the communities it serves

The health board is in the process of reviewing the structures supporting the function of the SRG. We are developing a locality model where there are regular meetings within each of the seven localities to ensure there is ongoing dialogue on local issues and vision and direction. Through regular meetings, engagement with communities would be normalised as opposed to simply when change is required.

Population Health Programme

The Population Health Programme (PHP) was launched in 2013 to achieve our ambitions to:

- exceeding the population’s expectations
- improving the health and wellbeing of the people we serve
- provide world class health care when it is required
- make the best use of resources
- work with staff, public and partners to design services that we are proud to
The programme is delivered through eight population health groups (PHGs) led by clinical leaders concentrating on the needs of a defined population segment. The groups have a wide membership of representatives - clinicians, primary care, acute care, mental health, community, acute care, managers, therapists, nurses, patient representatives, local authority, voluntary groups, carers, service users, and the third sector - to ensure a wide perspective is brought to the discussion.

**Capital Projects**
All major capital projects have user involvement at their core. An example of this would be the recent renal unit at Withybush General Hospital where service users were involved in the design and planning of the facility to ensure that it met their needs and they felt a level of ownership of the building.

| 2 | Please describe your key stakeholders and how you determine who they are | The health board holds an extensive database of key stakeholders, with around 3,000 contacts on our database in addition to our SI/TH members. It incorporates and reflects a wide range of stakeholders - from local authorities, CHCs and other public sector organisations to the media, politicians, community and third sector based groups including special interest groups.

We recognise our staff as key stakeholders (and residents) and seek to engage and inform through our Partnership Forum and Health Professional Forum in addition to a wide range of internal communication channels to enable them to act as ambassadors on behalf of the organisation and keep them informed of the health board’s direction.

When communicating/engaging/consulting on an issue/service change, detailed stakeholder mapping and analysis takes place in line with best practice to identify the most appropriate stakeholders and the best methods to engage and communicate with the target audiences for the issue and each activity has a detailed communications and engagement / consultation plan associated with it.

Examples of this operating in practice include: |
The CHC has an equal role to play in terms of communicating the challenges facing the NHS and promoting appropriate solutions. Every effort is therefore made to ensure that we work with the CHC on continuous dialogue through seeking their representation on the relevant programme groups or communications and engagement project groups.

<table>
<thead>
<tr>
<th>3</th>
<th>Please advise me of the best practice guidelines you used to develop your engagement strategy, how you evaluated the effectiveness of that strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Our engagement strategy was informed by the following policy context:</td>
</tr>
<tr>
<td></td>
<td>- CHC (Constitution, Membership and Procedures) (Wales) Regulations 2012</td>
</tr>
<tr>
<td></td>
<td>- <em>Designed for Life</em></td>
</tr>
<tr>
<td></td>
<td>- The Equality Act 2010</td>
</tr>
<tr>
<td></td>
<td>- <em>Guidance for Engagement and Consultation on Changes to Health Services</em></td>
</tr>
<tr>
<td></td>
<td>- One Wales</td>
</tr>
<tr>
<td></td>
<td>- <em>Putting Things Right</em></td>
</tr>
<tr>
<td></td>
<td>- Rural Health Plan</td>
</tr>
<tr>
<td></td>
<td>- Standards for Health Services in Wales</td>
</tr>
<tr>
<td></td>
<td>- Strategic Workforce and Financial Framework (SWaFF)</td>
</tr>
<tr>
<td></td>
<td>- Welsh Language Act (1993) and Welsh Language Measure 2011</td>
</tr>
<tr>
<td></td>
<td>Our engagement strategy reflected the following best practice guidelines:</td>
</tr>
<tr>
<td></td>
<td>- Signposts</td>
</tr>
<tr>
<td></td>
<td>- Signposts 2</td>
</tr>
<tr>
<td></td>
<td>- <em>National Principles for Public Engagement in Wales</em></td>
</tr>
<tr>
<td></td>
<td>We continue to work closely with the Consultation Institute – recognised best practice practitioners – on our engagement and consultation activities. This allows us to continually</td>
</tr>
</tbody>
</table>
review best practice and ensures our activities reflect modern engagement practice.

The engagement strategy includes key objectives and indicators to help us measure our performance, including:

- Raising the profile of the five-year plan with staff, stakeholders, patients and citizens
- Development of an involvement and engagement scheme
- Further development of e-participation opportunities
- Development of a patient advisory service
- Raised profile of Hywel Dda in the community
- Continued improvement of mechanisms for staff engagement
- Engaging and communicating with diverse groups of service users
- Ensure feedback from patient experience and engagement is embedded in the governance structures
- Improve feedback mechanisms for staff, patients and stakeholders to demonstrate the organisation is listening to and acting upon the views received
- Establishment of a process for evaluating the effectiveness of engagement and communication processes
- Ensure feedback from complaints, concerns and compliments is embedded into the governance structure so lessons are learned and quality improvement takes places
- Provide patient information that is appropriate to the individual patient’s needs
- Foster positive relationships with the media

Many have been achieved, and the strategy is now being refreshed in light of the three year planning cycle and the need to maintain and further develop continuous dialogue with our population and stakeholders.

The Your Health Your Future consultation process was independently scrutinised by the Consultation Institute and achieved the compliance assessment accreditation.

The engagement and consultation process was subject to a judicial review and confirmed the process undertaken by the health board fully satisfied the legal requirements.
We are currently in the process of reviewing and updating our engagement strategy, we are looking to incorporate what we have learned from undertaking a major service change engagement exercise followed by formal consultation and subsequent judicial review and it its likely to further reflect:

- Gunning Principles
- National Principles for Public Engagement in Wales
- Consultation Institute - Compliance Assessment
- Equality – engagement for people with protected characteristics NHS Centre for Equality and Human Rights, Commission for Equality and Human Rights reflected throughout the strategy and subsequent engagement, communications and consultation activities

The work we undertake around engagement and consultation and its effectiveness is reflected as part of our self assessment for Healthcare Standards for Wales. We have a number of case studies that highlight our best practice methodology both in terms of continuous dialogue and direct engagement on single issues (and our communications study on the *Your Health; Your Future* engagement and consultation process has been shared separately).
Cardiff and Vale University Health Board

Many thanks for your letter of August 26, 2014, outlining a number of questions on our approach to communication and engagement.

For ease of reference, my responses are detailed below in the order in which your questions are posed. It should be noted that the executive director of planning, Abigail Harris, is the executive lead for communications and engagement. These responses have also been informed by the health board’s strategic partnership and planning manager, who plays a key role in our stakeholder engagement programme.

Please describe the ways in which you pull together your community and patient networks, and the ways in which you communicate with them. How do you ensure that they are truly representative?

We work closely with colleagues in the Cardiff and Vale of Glamorgan CHC, County Voluntary Councils and local authority/local service board partnership and citizen focus teams to share intelligence about the constantly evolving pattern of networks in the Cardiff and Vale area, and to utilise each other’s communication and engagement mechanisms.

A range of teams across the health board have relationships with different communities of interest and geography; we draw on these dependent on the issue being engaged upon. Examples include: patient experience team’s well developed mechanisms for working with carers and oversight of patient groups across the health board; Cardiff Neighbourhood Partnerships’ relationships with community groups in different areas, including Communities First.

The health board has a number of different mechanisms for communicating and sharing information with community and patient networks including: traditional and social media; electronic communication via websites and newsletters (health board and partner) and targeted emails (including to locally elected members and town and community councils); using existing meetings, piggy-backing on to other events or organising specific events. For many communities, working with trusted intermediaries is the most successful way of communicating where there may be barriers to engagement.

Engagement work should go hand in hand with equality impact assessment activity and should help to ensure that those we are communicating with are representative.

We are also committed to listening to those voices which can be seldom heard by the statutory sector. This is particularly important given the increasing diversity of the communities we serve. As a result, we work closely with those in community leadership and faith roles, who serve as trusted intermediaries in their communities and provide an effective bridge for the health board to establish relationships with sections of our population who are traditionally more difficult to reach.
Our mental health and paediatric teams have been particularly successful in engaging with their service users, patients, carers and families, especially in respect of service user involvement in significant infrastructure developments - Phase Two of the Noah’s Ark Children’s Hospital for Wales and our new adult mental health unit at University Hospital Llandough, which is due to be commissioned in 2016.

**Please describe your key stakeholders and how you determine who they are.**

We are developing our own practical guide to engagement for internal use, which includes a starter for 10 list of stakeholders broken down into different categories. I am attaching the draft for your information.

This has been developed with input from a range of health board teams including planning, communications, patient experience and equalities, and also tested with the health and social care facilitators in the county voluntary councils. We have also shared with our colleagues at Cardiff and the Vale of Glamorgan CHC, whose input we value.

While knowing your main stakeholders, and having a constructive relationship with them, is essential, the nature of stakeholders varies dependent on the specific work being undertaken. The stakeholder mapping exercise undertaken at the start of an engagement process encourages consideration of all aspects and stages of the programme or project lifecycle when determining key stakeholders. Similar work elsewhere or previous work undertaken in the health board would also be reviewed. It is about identifying key individuals and organisations who have a potential interest in the outcome of the work and therefore need to be involved in some way. This can be achieved only by adopting a bespoke approach to discrete pieces of work.

At Cardiff and Vale, we are committed to improving the way we engage with both stakeholders and the public more generally, so that we are genuinely involved in ongoing dialogue with them, rather than engaging on a specific project-by-project basis.

In the last six months, we have begun to improve the way we approach this, for example, through regular AM/MP briefings, a direct programme of public engagement led by the health board chair and the first in a series of public meetings focused on patient experience and quality of care. We are also currently sharing a platform with colleagues at Cardiff Council as part of the Cardiff Debate, which seeks to engage local people in a dialogue about the challenges facing public services in the capital.

Equality impact assessment work will help inform stakeholder mapping. Working with our equality manager and the county voluntary council health and social care facilitators, we are developing a starter for 10 list of groups/organisations/projects which support people with protected characteristics.
Please advise me of the best practice guidelines you used to develop the engagement strategy for your CHC / LHB, and how you evaluated the effectiveness of that engagement strategy.

In terms of service change, the South Wales Programme communications framework references the host of things we took into account e.g. Welsh Government guidance, Equality Act, *National Principles for Public Engagement in Wales* (see Governance section 3). In advance of this, the health board’s own engagement plan for the South Wales Programme, approved by the board in September 2012, also referenced the relevant guidance and is attached to this letter for reference.

In terms of evaluating the effectiveness of engagement, the appropriate benchmark would be the extent to which the engagement objectives (SWP aims section 5) have been delivered. In addition, the South Wales Programme team worked closely with the independent Consultation Institute to ensure third party assurance of its consultation approach.

As outlined above, the health board is developing its own practical guide to engagement for internal use, which will include a standard template engagement plan which draws from the *NHS Connecting for Health* stakeholder engagement strategy template.

I trust this information is helpful. However, should you require any further clarification, please do not hesitate to contact me or Abigail Harris, executive director of planning, as I will be taking up a new role at the Welsh Ambulances Services NHS Trust for a period of one year from October 1.
ABERTAWE BRO MORGANWGW UNIVERSITY HEALTH BOARD

Changing for the Better and South Wales Programme
Summary of engagement activities, September to December 2012

Following the engagement exercise in May 2012 for Why Your Local NHS Needs to Change and feedback from the Consultation Institute, the following is a summary for health board members of the organisations / groups who have been identified as key stakeholders with whom the health board has engaged from 26th September to 19th December 2012:

Staff
Abertawe Bro Morgannwg University Health Board staff have been updated regularly with briefings organised through a series of open forums, utilising the team briefing sessions and an information cascade system through line managers (28 sessions held). A series of roads shows in main hospital canteens and for community staff were held across the health board (eight held), giving staff the chance to find out further information and ask questions. Regular bulletins were also be provided on the staff intranet and rumour line. In addition briefings have been provided for junior and senior medical staff (16 held).

Leaflets were distributed to staff and a note was also included in staff payslips, encouraging them to put forward their views. Copies of the booklet were distributed to staff rooms, wards and departments. All staff were encouraged to discuss the ideas in their regular departmental meetings.

Community Health Council (CHC)
Regular update briefings have been provided to the CHC through the regular meetings already held with the health board. The CHC have attended, observed and participated in all the public drop in sessions outlined below, the outpatient sessions and other key existing forums.

Independent contractors (GPs, chemists, opticians and dentists)
Copies of the signposting leaflet and engagement document were sent to every GP practice, dental practice, opticians and chemist asking for their responses to the ideas in the document. Copies of both documents were also provided for these premises so that the general public could pick them up or read while there. Posters were displayed in all primary care premises advertising the public drop in sessions.

Briefing sessions were also provided for independent contractors through existing mechanisms such as Protected Time for Learning (PT4L) and they were invited to the information drop-in days in their areas. Presentations were made to the local medical committee.

Health board advisory groups: Stakeholder Reference Group/Health Professionals Forum/Partnership Forum/local negotiating committee (BMA)
The engagement booklet was circulated to these groups and discussed formally at their meetings.
Civil community interest groups
There are approximately 3,500 civil community interest groups established across the Abertawe Bro Morgannwg area, many of which do not have a specific interest in health, but were recommended by the Consultation Institute as a way of gauging the view of our citizens. A copy of the engagement document was sent to each of these groups by the councils of voluntary services in each area, inviting them to participate in the process and submit their views on our ideas.

Voluntary Sector groups (with specific interest in health and social care)
The health board attends the quarterly Regional Voluntary Sector Health and Social Care Network and one of their meetings was used as a workshop session with a presentation from the health board and small group working to consider and debate the engagement document. In addition a range of other existing groups have had presentations in relation to the engagement document, for example the Disability Reference Group, Carers Groups and Deaf Clubs.

Local authorities
A briefing session has been held with each of the three local authorities shortly after the release of the engagement documents and further presentations and briefings with councillors in each local authority area have also been held. Presentations have also been made at each of the local service boards. The engagement documents were also distributed to all libraries in each area, in order for the public to access them.

AMs/MPs
A briefing session was held across South Wales on the ideas raised in the South Wales Programme at the start of the engagement process. In addition the health board has offered and held a range of briefings for AM's and MP's from its area through the engagement process.

Care homes
All nursing and residential care homes in the Abertawe Bro Morgannwg area were sent a copy of the engagement document and some leaflets to encourage residents to complete the questionnaires.

General public
Eleven community drop-in sessions were originally organised around the community network areas in Bridgend, Neath Port Talbot and Swansea. These sessions in the main ran from 11am until 7pm and were manned by a combination of clinicians, the C4B team, executives and other partner organisations such as the councils of voluntary services, voluntary organisations and patient groups. Following discussion at the September health board and various requests for additional venues, an additional eight sessions were added, making a total of 19 sessions.
In addition, at the suggestion of the CHC the outpatients department of each of our major hospitals was manned for a session and engagement documents distributed to patients attending appointments.

**Children and young people**
Because of the importance of these ideas for the future pattern of services, the health board worked with Funky Dragon and the three youth councils across the Abertawe Bro Morgannwg area to organise an engagement event with interactive workshops just for young people to get their views on the engagement ideas.

**Publicity for events**
A mixture of methods were used from distributing posters in the areas around the venues to paid advertisements in the Gem, Glamorgan Gazette, South Wales Evening Post, Neath Port Talbot Courier, Seaside News and Bay News. In addition local radio was used to encourage people to attend the drop in sessions and leaflets handed out in and around the venues. Banner posters were put up across health board premises and Swansea University. Details of the drop in sessions were also sent out with more than 60,000 outpatient letters and widely distributed in outpatient and other hospital and community settings. Subscribers to You Tell Us™ received updates. Social media were also used to promote awareness.

The subtitled film has been shown regularly during the engagement period on all the information screens within the outpatients departments / canteens etc. within the health board.
Attachment 4: REFERENCES

References and written material reviewed

Good practice - Wales

Betsi Cadwaladr University Health Board – presentation about Betsi Cadwaladr University Health Board consultation and evaluation, September 2013.

South Wales Programme – legacy statement, June 2014

Aneurin Bevan University Health Board – SRET planning tool kit, 2012-13

Cardiff and Vale University Health Board – How to write an engagement/consultation document, work in progress September 2014, including template for feedback and draft engagement plan

South Wales Programme – stage two equality impact assessment post-consultation analysis, 2013

Welsh Local Government Association – Review of the Use of EIAs in the Public Sector, 2013

South Wales Programme - EqIA Guide for Board Members, 2014

North Wales CHC – 37 appendices relating to best practice in communications and engagement for members, 2013-14

Hywel Dda University Health Board – engagement strategy, 2011-13

Abertawe Bro Morgannwg University Health Board and CHC – Gellinudd consultation check list, March 2013

Betsi Cadwaladr University Health Board and CHC – protocol for managing substantial change, June 2012

South Wales Programme – consultation framework (undated)

Participation Cymru – Principles for Engagement

Older People’s Commissioner for Wales – Best Practice Guidelines for Engaging and Consulting with Older People on Changes to Community Services in Wales, July 2014
Older People's Commissioner for Wales – guidance issued under section 12 of the Commissioner for Older People (Wales) Act 2006 relating to the standards expected for engaging and consulting older people, February 2013

North Wales CHC – Assessment criteria, technical aspects of the health board's proposals, undated.

**Good practice – elsewhere.**

Clive Sheldon QC – Consultation and legitimate expectations (which includes the Gunning Principles), January 2012

Scottish Development Centre guidelines, July 2009

Scottish Health Council – National Standards for Community Engagement, undated

Northern Ireland Health Board – Guidance on Strengthening Personal and Public Involvement in Health and Social Care, 2007

Patients' Association – Patient and Public Involvement, August 2012

Patients' Association – Partners in Care with the South of England NHS, August 2012

NHS North West – Community Voices in Commissioning, March 2012


Newham PCT and subsequently East London Mental Health Foundation Trust – Community Engagement, March 2013


Inhealth – The Engagement Cycle

**Information received from health boards**

Cwm Taf University Health Board – List of community stakeholders, 2014

Abertawe Bro Morgannwg University Health Board – Summary of engagement activities, South Wales Programme, December 2012
Hywel Dda University Health Board and Betsi Cadwaladr University Health Board – Briefing for the Health and Social Care Committee, National Assembly, October 2012

Hywel Dda University Health Board – Summary of engagement and consultation with Hywel Dda CHC, June 2013

Hywel Dda University Health Board – consultation: health board and CHC interface, June 2013

Hywel Dda University Health Board – Your Health Your Future consultation and communications, August 2012

Hywel Dda University Health Board – Communication and engagement activity report, undated

North Wales CHC - Note on 12 issues from the 2012-13 Betsi Cadwaladr University Health Board consultation by G. Donaldson, chair of North Wales CHC, June 2014

**Information received from CHCs**

Board of CHCs in Wales – continuous engagement strategy for CHCs, October 2013

Board of CHCs in Wales – schedule of suggested changes to its regulations, undated

Hywel Dda CHC – Outstanding issues, opinions and concerns regarding Hywel Dda University Health Board Your Health Your Future consultation on health services in West Wales, April 2013

Cwm Taf CHC – Terms of reference, monitoring and performance committee, February 2013

Cwm Taf CHC – Terms of reference, PPI committee, February 2012

Cwm Taf CHC – Terms of reference, service planning committee, March 2011

Cwm Taf CHC – KPIs, March 2014

Abertawe Bro Morgannwg CHC – Governance framework and structure, undated

Abertawe Bro Morgannwg CHC – Styles and approaches of CHCs in Wales, July 2011

Board of CHCs in Wales – Regulations progress, September 2013

Powys CHCs – Continuous engagement committee terms of reference, April 2014
Board of CHCs – Review of the progress of the recommendations made in the report  
Moving Towards World Class? by Marcus Longley

Board of CHCs - The role of CHCs and members, June 2013

Welsh Government - Code of conduct for CHC members, undated

Cardiff and Vale CHC - Guidance on engagement and consultation on changes to health services, January 2012

Abertawe Bro Morgannwg CHC – letter to chief executive of Abertawe Bro Morgannwg University Health Board about the South Wales Programme outcome, March 2014

**Information received and reviewed from other interested parties**

Submission from Flint local authority

Submission from Merthyr Tydfil local authority

Submission from BMA Cymru Wales

*Working Prudently* – AHPs and health scientists strategic framework 2014-17

Mid Wales Healthcare study engagement phase report, WIHSC, February 2014

Minister for Health and Social Services – speech to the Welsh NHS Confederation about prudent healthcare, January 2014

Approved Judgement – The Queen on the Application of Anthony John Flatley and Hywel Dda University Health Board and Welsh Ministers and The Queen on the application of Keyleigh Donohoe and Welsh Ministers and Hywel Dda University Health Board, August 2014 and the Judgement on the subsequent appeal, August 2014

*Moving Towards World Class? A review of CHCs in Wales* by Professor Marcus Longley, WIHSC, 2012

*From Rhetoric to Reality*, Welsh NHS Confederation report, January 2014

Guidance for engagement and consultation on changes to health services, Welsh Government, undated

Governance between organisations – maturity matrix J. Bullivant and A. Corbett-Nolan, 2009

Welsh Government – consultation guidance for staff, undated
Commission on Public Services Governance and Delivery – the Williams report, January 2014

Submissions received from the Flint Community Hospital action group.

Learning from reviews.

ORS – Balancing opinions – executive summary Hywel Dda University Health Board. January 2013

Consultation institute and charter

Cabinet Office – Consultation principles, undated

Operational protocol between Healthcare Inspectorate Wales and the Community Health Councils in Wales, October 2013