EXPLANATORY MEMORANDUM

The National Health Service, Wales, The Community Health Councils (Establishment, Transfer of Functions and Abolition) (Wales) Order 2010

and

The National Health Service, Wales, The Community Health Councils (Constitution, Membership and Procedures) (Wales) Regulations 2010

This Explanatory Memorandum has been prepared by the Health and Social Services Directorate General and is laid before the National Assembly for Wales in conjunction with the above subordinate legislation and in accordance with Standing Order 24.1.

Minister's Declaration

In my view, this Explanatory Memorandum gives a fair and reasonable view of the expected impact of the National Health Service, Wales, The Community Health Councils (Establishment, Transfer of Functions and Abolition) (Wales) Order 2010 ("the Order") and the National Health Service, Wales, The Community Health Councils (Constitution, Membership and Procedures) (Wales) Regulations 2010 ("the Regulations"). I am satisfied that the benefits outweigh any costs.

Edwina Hart AM OStJ MBE
Minister for Health and Social Services
9 February 2010

1. Description

The Order provides for the dissolution of 17 of the existing 19 Community Health Councils (CHCs) in Wales, and the establishment of six new CHCs from 1 April. The two CHCs in Powys are retained.

The Regulations make provision for the membership, proceedings and functions of CHCs and the Board of Community Health Councils in Wales.

The Regulations revoke the Community Health Councils Regulations 2004 and the Community Health Councils (Amendment) Regulations 2005, save that regulation 32 continues in existence the CHC Board established under regulation 23 of the 2004 Regulations to the extent that regulation 23 of those regulations establishes the CHC Board.

2. Matters of special interest to the Subordinate Legislation Committee

There are no matters of special interest.

3. Legislative background

The relevant legal powers are:

- Section 182 of the National Health Service (Wales) Act 2006 ("the 2006 Act") provides for the continuation of Community Health Councils in Wales (CHCs) including powers of the Welsh Ministers to abolish and establish CHCs by Order, and for further provision to be made about CHCs in Wales under Schedule 10 to the 2006 Act.

- Schedule 10 to the 2006 Act provides for the Welsh Ministers to have regulation making powers in relation to CHCs including: the membership, staff, premises and expenses of CHCs and the performance of CHC functions including the provision by CHCs of the independent advocacy services required to be provided under s187 of the 2006 Act. Provision may also be made for the discharge of any function of a Council by a committee, and for the inspection of health service premises by CHC members. The Schedule also provides the Welsh Ministers with the power to establish a body to advise and assist CHCs with the performance of their functions.

- Section 187 of the of the 2006 Act places a duty on the Welsh Ministers to arrange, to such extent as they consider necessary to meet all reasonable requirements, for the provision of independent advocacy services.

- Section 203 (9) and (10)(a) of the 2006 Act provides that powers under the Act to make regulations or orders may be exercised in relation to all cases to which the power extends or in relation to any specified cases or classes of cases; may be exercised fully or partially and may, in

particular, make different provision for different areas. The regulation or order making power includes a power to make such incidental or supplementary provision as the person exercising the power considers expedient.

- Sections 12 and 19 of the 2006 Act give the Welsh Ministers the power to direct Local Health Boards and NHS Trusts. Paragraph 7(3) of Schedule 2 to the 2006 Act and paragraph 25(3) of Schedule 3 to the 2006 Act give Welsh Ministers the power to issue directions to Local Health Boards and NHS Trusts in respect of matters connected with the employment of staff.

The powers are powers of Welsh Ministers.

Both the Order and the Regulations will be subject to the negative resolution procedure.

4. Purpose and intended effect of the legislation

In statements to the National Assembly for Wales in plenary on 16 July and 30 September 2008 the Minister for Health and Social Services indicated her intention to strengthen the role of CHCs in Wales and to ensure that, in the context of the wider proposals for changes to the structure of the NHS in Wales, the CHCs' role as the voice of the patient was made more effective.

The Minister confirmed in a statement to plenary on 11 November 2008, that it was her intention to establish seven new Local Health Boards (LHBs) in Wales to plan, design, develop and secure the delivery of NHS services for the citizens of their respective areas. At the same time the Minister announced that there would be a further consultation early in 2009 to deal specifically with the role and functions of Community Health Councils within this new NHS in Wales.

The new NHS structure, consisting of seven LHBs (and three NHS Trusts), became operational on 1 October 2009. The current CHC structure, consisting of 19 Councils, does not match that of its NHS partners and requires change in order to provide the CHCs with the regional strength and cohesion which they will need to be able to exercise in representing the public's interests in the new look NHS. At the same time, it is necessary to protect and provide for CHCs' access to local opinion so as to ensure that communities' views are reflected.

The Order gives effect to a reduction in the number of CHCs to 8 in total. There will be 6 new CHCs, (excluding the two Powys CHCs), which will be made up of a number of local committees, formed of 12 members each.

The Regulations provide for a number of other changes designed to strengthen those CHCs' ability to make the patient and public voice heard in the new NHS structure, including an executive committee at each CHC drawn from the local committees, which will set the strategic direction for the CHC, and the setting

up of service planning committees to foster direct dialogue with the LHBs on matters relating to service changes.

As stated above, the Order establishes 6 new CHCs: Aneurin Bevan Community Health Council; Abertawe Bro Morgannwg Community Health Council; Betsi Cadwaladr Community Health Council; Cardiff and Vale of Glamorgan Community Health Council, Cwm Taf Community Health Council and Hywel Dda Community Health Council. The Order also continues in existence two Community Health Councils: Brecknock and Radnor Community Health Council and Montgomeryshire Community Health Council. The new structure is intended to provide the new CHCs with regional strength and cohesion in their dealings with the NHS.

The Regulations provide for one half of the CHC membership to be appointed by Welsh Ministers, one quarter to be appointed by local authorities and the remaining quarter to be appointed by voluntary organisations. (These are the same proportions as were set out in the Community Health Councils Regulations 2004).

The Regulations also provide that new Councils (ie those Councils established by the Order) will have the following committees: Local Committees; a services planning committee and an executive committee.

In respect of Local Committees, regulation 17 provides that the Councils listed at numbers 1 to 6 inclusive in column 1 of Schedule 2 (ie new Councils) must appoint committees to be known as local committees of the Council for each of the relevant local authority areas, or parts, thereof, specified in column 2 of that Schedule. Regulation 17(1)(b) sets out the areas for which local committees must be given responsibility. Regulation 17(1)(c) sets out whom the Council must appoint as members of each local committee. In practice, each local committee has 12 members and the membership of the Community Health Council is the sum total of the membership of each of its local committees. Local Committees are intended to provide CHCs with strong links to their local communities and community groups.

Regulation 18 provides that a new Council must appoint a committee to be known as a services planning committee to liaise with the relevant Local Health Board regarding the planning and development of or proposals for changes to, the delivery of health services within the Council's district. Regulation 18(1) (b) provides that a Council may give such a committee responsibility for carrying out such other of the Council's functions as the Council may determine. Regulation 18(1)(c) sets out the minimum requirements for membership of the committee. It is intended that the services planning committee will provide CHCs with a key mechanism by which to ensure effective representation of the public's interest in the planning and development of services.

Regulation 19 requires new Councils to establish a committee to be known as an executive committee to oversee the conduct and performance of all relevant local committees and to ensure the effective delivery of the Council's statutory

duties and core functions throughout the district of the Council. Regulation 19(1) (b) sets out the responsibilities that a Council must give to its executive committee and regulation 19(1)(c) provides that a Council may give the executive committee responsibility for performing such other functions of the Council as the Council thinks fit. Regulation 19(1)(d) specifies the membership of the executive committee. A key role of the executive committee will be to provide the CHC with strategic direction.

As stated above, the requirement to establish local committees, a services planning committee and an executive committee is only placed on new Councils. However, the Councils which were continued in existence by the Order, namely Brecknock and Radnor Community Health Council and Montgomeryshire Community Health Council, may still appoint committees under the provisions in regulation 20 and may establish joint committees with one or more other Community Health Councils in accordance with the provisions contained in regulation 21. Incidentally, regulations 20 and 21 also apply to new Councils.

5. Consultation

There has been a significant amount of engagement with stakeholders undertaken in the development of the policy and the draft legislation. The details of consultation are included in the RIA below.

6. Regulatory Impact Assessment (RIA)

Please see part 2 of this document.

PART 2 – REGULATORY IMPACT ASSESSMENT

7. Options

The following options are available:

Option 1: Do nothing and leave the current legislation in place.

Option 2: Introduce a variation on the proposed arrangements through Regulations as suggested by some CHCs.

Option 3: Introduce the proposed arrangements by way of Order and Regulations.

The Assembly Government, after substantial and comprehensive consultation on this matter is of the view that Option 3 is the preferred way forward.

Option 1 – Do nothing

The NHS in Wales has now been restructured and seven large, integrated LHBs are in place. The current CHC structure does not match that of its NHS counterparts and is much more fragmented, being based on local community patterns. Whilst there is certainly a need to retain and strengthen a local focus, leaving the current structure as it is will place CHCs in a significantly weaker position in relation to their LHBs. By simply leaving the current arrangements and legislation in place, CHCs will not be afforded the opportunity to realise the potential for regional strength and cohesion offered by a structure in which the CHC will be speaking with one voice for the public and patients across the whole region.

Doing nothing will also make it more difficult for NHS bodies to involve and engage with CHCs in the planning and development of services. For example, if the current arrangements are left in place, the Betsi Cadwaladr University LHB will need to consult with six separate CHCs before making any significant changes to its services. The potential difficulties for reaching consensus and the likely negative impacts on service development and improvement are clear. In the past it has sometimes been difficult for multiple CHCs operating across an NHS area to reach agreement on their response to NHS proposals. There would continue to be a public and patient voice in the planning, delivery and development of NHS services, but it would be far less effective than would otherwise be the case.

The Assembly Government has no powers of Direction in relation to CHCs, so any changes to their structure, functions and membership have to be made by way of secondary legislation ie by way of Order and Regulations.

Option 2 – Introduce a variation on the proposed arrangements through Regulations as suggested by some CHCs

The Minister for Health and Social Services has held three separate public consultations on these issues over the course of the past year and has also invited CHCs to submit their own proposals for future working arrangements. Responses have suggested a number of variations to the proposals. The key differences have been around the number of CHCs in the new structure and the number of members in each CHC Local Committee.

On the question of the overall structure, there have been a number of suggestions that we put in place arrangements which are somewhere between the existing situation and the proposals for six new CHCs, for example, by having more than one CHC in some of the geographically larger areas. For reasons described above, we have been keen to ensure that CHCs are placed on an even footing with their NHS partners by providing them with a structure which matches that of the NHS. We have concluded that to establish a greater number of CHCs than is being proposed, would be both to re-introduce a number of the difficulties which have been evident in the current arrangements, and represent a failure to realise the opportunity to strengthen the CHC and public voice.

We have also given the issue of member numbers a great deal of thought and have been keen to strike the most effective balance between having sufficient people to perform the CHCs' statutory functions and enabling Councils to take timely decisions. Having considered a number of options we have concluded that 12 members in each Local Committee represents the optimum number for engagement with local communities and the NHS and also for the effective operation of the CHCs and their own decision making processes. A number of existing CHCs and their Area Committees (i.e. the current Gwent and Clwyd CHCs) already operate successfully on this model, with each Area Committee consisting of 12 members and the CHC consisting of the sum of those parts.

The Minister has agreed to keep the membership number under review.

Option 3 – Introduce the proposed arrangements by way of Order and Regulations

The Assembly Government wishes to ensure that CHCs will be placed in the best possible position to represent public and patient interests in the NHS and that we make the best possible use of available resources. The Minister's view is that the structure and arrangements proposed in the Order and Regulations will give CHCs the necessary local focus and regional power to enable them to perform effectively on behalf of local patients and the public.

The Regulations take account of comments received following a number of consultations undertaken on this subject. The original idea of having Area Associations made up of local people, with a smaller central CHC membership was not taken forward as a result of comments received. Instead, the Minister

agreed that local committees would be put in place made up of full CHC members.

8. Costs and benefits

Option 1 – Do nothing

Benefits: Maintaining the status quo is the option which will require the least administrative effort.

Costs: these are related to the missed opportunities outlined in Options 2 and 3. There would be no additional financial costs attached to this option.

Option 2 – Introduce a variation on the proposed arrangements through regulations as suggested by some CHCs

Benefits: It is certain that to vary the proposals in some of the ways suggested would result in more complex arrangements than either exists now or as set out in the Minister's preferred approach. We are also of the view that varied arrangements would be more costly and would not deliver any more discernable benefit that the preferred option.

Costs: The introduction of a CHC structure which does not match that of its NHS partners will not deliver the benefits outlined in Option 3 below. A set of arrangements somewhere between the status quo and the proposed structure will also incur at least some of the additional financial costs identified below (depending upon the actual number of CHCs which would be established under any "variable" set of arrangements).

Option 3 – Introduce the proposed arrangements by way of Order and Regulations

Benefits: As already described, the key benefit will be the strengthening of the citizen's engagement and voice in the NHS in Wales.

In the medium to longer term there will also be opportunities to realise savings through the rationalisation of the CHC estate. The Board of CHCs is working with Assembly Government officials to develop a medium to long term plan for the future arrangements for CHC premises. However, it is acknowledged that there will be a need to retain more than one physical presence in some of the larger and more dispersed CHC areas. Future plans will seek innovative and cost-effective ways of achieving that aim.

Costs: These proposals will involve additional staff costs notably around the appointment of Chief Officers to support the new CHCs. The exact costs will depend upon the level at which these staff are appointed, but are estimated to be £73k in 2010-11. The larger geographical areas covered by the new CHCs are likely to lead to an increase in travel and subsistence costs, calculated to be £19k in 2010-11. Any changes to the number and location of CHC premises is likely to result in excess travel payments to staff, estimated to be £83k per year

from the date of the change for the period of entitlement. We are of the view that these costs are manageable within existing resources and can be mitigated by savings to be made through more streamlined working practices.

Impact on other sectors

Small business: We do not consider that the Order and Regulations will have an impact on small business.

Local government/voluntary sector: We do not anticipate that the Order and Regulations will impact significantly on local government or the voluntary sector. The proportion of CHC members drawn from each of the appointing bodies remains the same in the proposed arrangements as in the existing arrangements: a half appointed by the Welsh Assembly Government, a quarter by local authorities, and a quarter by the voluntary sector. Local Committees will exist in each of the local authority areas affected. The only change is that those sectors will be required overall to identify fewer people for CHC membership than they do now. A protocol will be agreed with both the local authority and voluntary sectors to ensure that members with the essential skills and attributes for CHC membership are identified and supported to make the maximum contribution it terms of health scrutiny.

Duties

Equality. The appointment of members to the new CHCs will have regard to the need to draw members from across all sectors of the community. This is addressed in the advertisements and application pack. In addition, the Minister will expect new CHCs to demonstrate how they have reached out, through the local committee structure, and gathered the views of members of the community across the equality strands.

Rurality. The representation of patients and the public in rural areas is a challenge and a number of comments have been made to the Minister on this subject. This will be addressed to an extent as part of the strategy for CHC premises to ensure that CHCs have a physical presence in the most rural of areas. However, we are of the view that the local committee structure, together with better and more innovative ways of working across CHCs should deliver strong representation for people in the rural parts of Wales. Assembly Government officials will be working with the CHC Board to address these issues.

9. Consultation

The Minister for Health and Social Services has held three public consultations on these issues since January 2009 and has separately invited CHCs to submit their own proposals for future arrangements.

The first of the consultations took place between 30 January and 24 April 2009 The consultation paper set-out proposals for the:

- Dissolution of the existing nineteen (19) Community Health Councils (CHCs) in Wales;
- Establishment of seven (7) new CHCs with twenty three (23) underpinning Area Associations;

There were 319 responses the majority of which did not support a change in the structure, particularly the proposals for Area Associations and that their members would be 'associate' rather than full members of their parent CHCs.

Having considered those responses, the Minister for Health and Social Services invited CHCs to submit their own proposals for future working arrangements, but also announced her intention to introduce those changes on which a broad consensus had emerged. The Minister launched a second public consultation on those changes on 15 June 2009.

The paper outlined 4 specific areas for changes in the Regulations:

- Community Health Council (CHC) terms of membership
- Advocacy function
- CHC Board composition and terms of membership
- Employing body for the staff of CHCs and the CHC Board.

The consultation closed on 26 July 2009 and received 15 responses broadly supportive of the proposals.

By the separate deadline of 31 July, the Minister had received responses from all of the CHCs from whom she had invited proposals. The CHCs were unable to reach consensus on the way forward.

Having considered all of the responses to these consultations and the ideas put forward by the CHCs, the Minister launched a third public consultation on her preferred model on 7 December 2009. The consultation set out the changes proposed in the Order and Regulations. The proposals for Area Associations and Associate Members had been replaced by those for Local Committees whose members would be full members of the CHC.

The consultation closed on 15 January and received 65 responses. Those responses were largely supportive of the proposals, but there were concerns about: CHC member numbers; the proposed timetable for making the changes; the names of the new CHCs; the retention of CHC offices.

In response to the concerns about the CHCs' names, the Minister decided to allow those that so wished, if it would be helpful to their local communities, to add the geographical area which they cover to their names, for example, Hywel Dda, The West Wales CHC. However, the legal names will be as set out in the Order and Regulations. The issue of member numbers has been discussed above, as has that of the retention of CHC offices. Work is well-developed to give effect to the remainder of the proposals, in particular the recruitment of a new membership and the employment arrangements for the CHC staff group.

Details of the consultation, the proposals, copies of the responses received, and the consultation report are available on the Welsh Assembly Government's website at:

http://wales.gov.uk/consultations/healthsocialcare/reformofchcs/?lang=en&status=closed

Conclusion

Following consultation, there have been no amendments to the Order and two amendments to the Regulations following legal advice.

10. Competition Assessment

We do not consider it necessary to undertake a competition assessment for these Regulations since they will not affect the business sector in any significant way. The filter questions are shown at Annex 1.

11. Post implementation review

The Minister for Health and Social Services has announced her intention to review these arrangements after two years of operation. Additionally, CHCs and the Board of CHCs will be required to submit annual reports to the Assembly Government.

ANNEX 1

The competition filter test	
Question	**Answer yes or no**
Q1: In the market(s) affected by the new regulation, does any firm have more than 10% market share?	No
Q2: In the market(s) affected by the new regulation, does any firm have more than 20% market share?	No
Q3: In the market(s) affected by the new regulation, do the largest three firms together have at least 50% market share?	No
Q4: Would the costs of the regulation affect some firms substantially more than others?	No
Q5: Is the regulation likely to affect the market structure, changing the number or size of businesses/organisation?	No
Q6: Would the regulation lead to higher set-up costs for new or potential suppliers that existing suppliers do not have to meet?	No
Q7: Would the regulation lead to higher ongoing costs for new or potential suppliers that existing suppliers do not have to meet?	No
Q8: Is the sector characterised by rapid technological change?	No
Q9: Would the regulation restrict the ability of suppliers to choose the price, quality, range or location of their products?	No