National Association of Patients' Forums – Steering Group

Local Government and Public Involvement in Health Bill

Weaknesses of the Bill in Terms of Influence and 'Holding to Account'

The key difficulties with the Bill concern the way that it is likely to limit the capacity of patients and the public to exercise any real influence with local health and social care services. A critical problem is the failure of the Bill to create for LINks any identity as an 'independent' body and the absence of powers to hold local health and social care commissioners to account. This is because the duties and powers are mostly vested in providers and commissioners rather than with the LINks organisations. That the legislation should have evolved in this way is surprising given that the catalyst for recent legislation on PPI (e.g. Patients Forum and Section 11 of the Health and Social Care Act) derives from the findings and recommendations of the Bristol Royal Infirmary Enquiry (*Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 -1995* Command Paper: CM 5207). Two of the key recommendations from this report (which were accepted by the Government) follow:

The planning and development of services

13 The aim of a patient-centred service is that it be designed and planned to address the needs of the particular sectors of the public it exists to serve. Thus strategic planning at national level, including the priorities set by government, must have input from the public. Equally, at local level, the particular needs of the communities served by the NHS must also be acknowledged through involvement of these communities. This means involvement in the initial development of options for change as well as consultation on those options. Too often in the past, when major changes in service are needed, local communities have been excluded from the process of developing ideas and options. As a result, consultation has often been perceived by the public as a gesture or a sham. There are genuine and difficult problems involved in the re-organisation of local services, and the only way to gain public acceptance is to let in the public much earlier in the process.
http://www.bristol-inquiry.org.uk/final_report/report/sec2chap28_8.htm#950855

The operation and delivery of services

14 As regards public involvement in the *operation* of the NHS, two concerns are central: safety in the care of patients and high quality in the delivery of the service. What we contemplate here is effective involvement of the public, at national and local levels, both in setting and reviewing the standards to be met regarding the safety and quality of care,

and in monitoring the observance of those standards. In the past, these have been seen as matters solely for healthcare professionals on which, given the technical nature of the issues, the `lay' public were thought to have little to offer. The issues are not only technical. Indeed, if the quality of the care given to patients is to be taken seriously, there are some matters on which only patients are qualified to speak, for example, the extent to which any particular service accords with the needs of the patient. It was the NHS's current weakness in this regard, its unresponsiveness to the interests and needs of the public, which contributed towards the NHS being ranked below a number of European countries in the World Health Organisation's recent analysis of national healthcare services. The views of patients and the public are relevant not only to the standards to be observed by healthcare professionals; but also to the standards and performance of hospitals. We have already proposed, in Chapter 27, a system of validation of trusts. Clearly, as elsewhere, the public must be involved in this process.
http://www.bristol-inquiry.org.uk/final_report/report/sec2chap28_9.htm#949177

Retreat from the concept of a Patient-Led service

The wording of the Bill does not suggest that the Government is committed to ensuring that the NHS develops as a patient-centred service. This would require a system in which patients and the public have the opportunity to participate and be involved at national and local levels, both in setting and reviewing the standards and in monitoring the observance of those standards. It would appear that the intentions of the Government are the very opposite to those intended by the Bristol Inquiry. This is also evidenced by the recent DH proposal that LINks members should be held at arms length from patients in services where care is provided to vulnerable people and children. The intention of the Government that LINks members wishing to visit NHS facilities should gain consent first from the Healthcare Commission (and presumably the Commission for Social Care Inspection in the case of social care) undermines the rights of LINks members to carry out monitoring, which they think is useful in terms of their local intelligence, knowledge and local reports. The opportunity for 'spot visits' and visits at short notice would be made impossible by this proposal. The proposal to restrict access would also undermine the confidence of the community in LINks and would create a 'wall' between local people and the services they pay for. Developing effective relationships between LINks and local providers would be almost impossible if the HCC or CSCI mediated the relationships between the community and their health and social care facilities.

Visits to premises are important both to raise public confidence in the NHS and for public safety. The paucity of resources in the hand of official inspectorates HCC/CSCI leaves many areas unvisited and unchecked for long periods. These organisations may do two visits a year. The oversight of the inspectorates may be adequate in terms of governance, but not in terms of service monitoring.

The overall effect of the imposition of such limitations on the operation of LINks would be to undermine their independence and reduce public confidence and safety. The model presented for LINks is unlikely to appeal to many members of the general public or patients, who are unlikely to get involved except in the most token and transient way.

Duties of services-providers to allow entry by local involvement networks – clause 225

Although clause 222(2) places a duty on local authorities to enable *people* to monitor, and review, the commissioning and provision of local care services, clause 225 only places a duty on service providers to 'allow authorised representative to enter and view, and observe the carrying-on of activities on, premises owned or controlled by the services-provider.' Clause 225 (3) places numerous potential restrictions on the activities of LINks members.

In practice, the duty on providers to allow LINks members to 'enter and view and observe the health and social care' would not enable them to gather any useful information for monitoring purposes. To do this it is necessary to talk to patient and staff and have the freedom to enter as a right. The numerous examples of negligent care that occur in health and social institutions can rarely be identified by watching what happens in these institutions. Where they are discovered by PPI Forums, it is because of disclosure by a patient, relative or member of staff to a Forum member.

The duty to monitor the process and delivery of health and social care should be placed with the LINks organisation in order to ensure that they are independent, rather than LINks being beholden to care providers for the right of access.

LINks should have a duty to raise issues of concern with any appropriate body (not only those referred to in 222(2)d(ii). Such other bodies might include the Strategic Health Authority, Healthcare Commission and the Commission for Social Care Inspection.

Access to primary care services

It is not clear from clause 225 (7) whether the duty to provide access for LINks to premises is intended to include access to the premises of GPs and other primary care providers (including the premises controlled by commercial providers of primary care services). The right of access to GPs surgeries is included in the current legislation covering Patient's Forums. Clause 225(7) might allow for those who control primary care premises to be required to allow access for LINks but this will need to be clarified and stated explicitly in the Regulations.

Access to the premises of private providers of health care

Similarly, many services are now run by private providers either in a contractual relationship with a PCT or an NHS Trust. Access to information about these services is very limited because private contractors do not abide by the same public service duties as NHS providers. Experience of Patient Transport Service providers in London, has shown that most are unwilling to collaborate with Patients' Forums to improve the quality of patient care. Clause 225(7) might provide an opportunity to include private contractors within the purview of LINks.

In our view it is essential for the Bill to state explicitly that private/independent providers of health and social care, will be subject to the same levels of monitoring and scrutiny as NHS and Local Authority providers of health and social care.

Membership of LINks

LINks organisations are not intended to have an appointed membership and there is no evidence in the Bill of any intention to provide governance arrangements to ensure that the LINks meet any particular needs of the community. LINks members would appear not to be accountable, except informally to other LINks members. The accountability arrangement apparently fall on the local authority to make the activities listed in 222(2) happen and it appears that the membership of LINks is intended to be completely flexible; thus the use of the term 'enabling people' rather than enabling LINks members. LINks support organisation will be accountable to the local authority for the provision of services to LINks, not accountable to LINks members.

However there is a duty in clause 227 for an annual report to be produced on behalf of the LINks and in 227(3)(a) for the report to address 'in particular, such matters as the Secretary of State may direct'. This clause appears to undermine the independence of LINks. It is unclear from clause 227(2) whether the LINks would have any control over the contents of the report, except that it is a requirement that the report records activities in relation to clause 222(2).

Overall, the emphasis emerging on the structure and functions of LINks, suggests that these organisations will be a 'resource' for commissioners, providers and local authorities rather than the public. The model presented in the Bill would enable these bodies to use LINks to demonstrate that they have consulted with the public and relieve the NHS and local authorities from having to initiate and conduct their own genuine consultations. The public seems poorly served by the model described in the Bill.

Conflicts of Interest

Although clause 223 deals with some of the conflicts of interest that could arise from the LINks model, it does not deal with two key potential conflicts of interest:

1) Were a social care provider to become the 'host' (223(3)), there could be a conflict of interests if the 'host' were to provide local services, which the LINks wished to monitor. As the 'host' is responsible for most of the arrangements on behalf of LINks including writing their reports, it would be inappropriate and could seriously undermine the work of LINks if the 'host' had both roles in the same geographical area.

2) As the membership of LINks is informal, any group of people with a commercial (including voluntary organisations) or personal interest, could attempt to influence commissioning through LINks in their own interests. Representatives of such organisations could produce (as LINks members) damaging reports on services provided by the current service provider in an area, in order to gain contractual advantage in competition with the current service provider.

Resources to Fund LINks

Currently little information is available about the funding of LINks. The key concerns are:

1) The resources should be adequate to meet the needs of a LINks organisation in relation to its size. As there is no fixed membership the body could be very large and would require substantial funds to pay for their publications, advertising, public meetings, reports etc. in relation to the size of their membership.

2) LINks will need shop front premises to create a real identity in the community and to provide a location for LINks members to become known in the local community. If they are to succeed a return to the concept of the 'one-stop shop' for LINks would create a powerful image in the community of an identifiable body that intended to serve the interests of the whole community.

3) The level of funding must be adequate to ensure that the LINks can carry functions described in clause 222(2).

4) Funds going to the LA for the purpose of funding LINks must be secured for that purpose and not available to meet other areas of LA expenditure.

Commissioning of Services

The Bill provides in 222(2)(a) for LINks to be involved in activities relating to 'promoting, and supporting, the involvement of people in the commissioning...of local care services. Clause 222(b) provides for: 'enabling people to monitor, and review, the commissioning and provision of local care services. In clause 233 the PCT may be required to prepare a report on the consultations it has carried out and the way it has been influenced as a result of these consultations. However, the clause does not say 'public' consultations. Thus consultations might be with Trusts or GPs or local authorities.

The Bill does not give LINks any power to influence commissioning of services in their area. Indeed the weakening of powers currently under Section 11 of the HSC Act substantially reduces the power of communities to influence the commissioning of services (clause 232(1B)) by adding the word 'significant' to the Bill.

Duty to consult users of health services

Clause 232(1B), by adding the word 'significant' to the Bill reduces substantially the opportunities for individuals and communities to influence service provision and the commissioning of services. Although there is no evidence that the current wording of Section 11 of the HSC Act has led to anything other than higher levels of public involvement in health services, the Altrincham General Hospital and North East Derbyshire judicial reviews appear to have persuaded the Government to weaken the legislation, in order to reduce the opportunities to influence commissioning decisions. We strongly oppose this damaging amendment to the legislation.

Transition Timetable

Given the complexity of the new arrangement, the need to advertise for Hosts in the European Journal and pressure on the local authorities, it is inconceivable that LINks will be established before 2009. This would mean a substantial gap between the abolition of Patient' Forums (intended for March 31st 2008) and the formation of LINks. During this period the NHS would not be monitored by the community, there would be no community organisations to review the 'annual health checks' carried out by the Healthcare Commission on PCT and NHS Trusts, and there would be no capacity to influence commissioning decisions of PCTs.

The value of the trust, confidence and understanding which has evolved out of the relationships between members of PPI Forums and specific NHS institutions and services cannot be overstated. Without an adequate and effective transition this will be lost, members will give up and LINks will flounder for many years until they find a way of working.

We strongly urge that the Government puts back the abolition of Forums by one year to allow a smooth transition to the LINks system.

Conclusion

There is little tangible evidence in the Bill as it stands that LINks would have any real influence on health or social care institutions. The function described for LINks by the Department of Health, e.g. surveys, collecting views, gathering evidence, talking to the communities and reporting to commissioners would in practice be carried out by the Host. The Bill appears to create LINks which will have few powers, little potential for raising standards of health and social care and would be unattractive to members of the community who wanted to develop better and more effective local services.

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