Government Response to the Health Committee's Report on Patient and Public Involvement in the NHS.

Recommendation 17 – LINks' rights of entry.

Ensuring that the public have complete confidence in the services provided by health and social care providers, both public and private is of paramount importance and not necessarily contrary to the Government's overall policy 'to reduce the burden of inspection'.

Whilst inspection always imposes an added burden on a provider it is not unwelcome to a responsible provider and is in fact welcomed as an independent check or confirmation that things are alright or that other innocently overlooked matters need correcting.

What is unnecessarily burdensome are overlapping inspections by different bodies that occur within too small a period of time. These can be avoided by liaison between the various bodies or, if effective liaison cannot be organized by the inspecting body giving advance notice to the provider that they will be visiting within, say a specific period of time. The provider being invited to say if they have been notified of another inspection within that time.

There is nothing wrong with LINks replicating the work of other bodies, indeed as a principle it is desirable that LINks, as a body representing the public etc. should be able to provide independent assurance of the quality and quantity of services.

It is unlikely that in the normal course of events LINks inspections would be burdensome since given the limited resources that LINks are likely have they will never be able to inspect more than a tiny proportion of the many (100s or even 1,000s) of facilities within their area.

Children's services are a special case and inspections of them require special skills. A solution to the particular problems would be for LINks to participate in inspections done by other 'expert' bodies rather than to do their own independent inspections.

Not allowing LINks to enter those facilities where there is a tenancy or licence agreement between the individual and the landlord and would therefore be classed as someone's home is an unnecessary restriction. Respect for an individual's rights and privacy can be achieved without excluding attendance and by not entering without permission or invitation.

If the public, patients, users etc are to have justifiable confidence in LINks then restrictions on powers of inspection need to be minimal and only imposed where absolutely essential. I would hope that the Government would see matters in the same light.

JohnAmos.
14.06.2007

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COMMENTS ON THE GOVERNMENT'S RESPONSE TO THE HEALTH SELECT COMMITTEE'S CONCLUSIONS AND RECOMMENDATIONS ON PATIENT AND PUBLIC INVOLVEMENT IN THE NHS.

Recommendation 1. In moving away from a 'one size fits all' PPI the Government is creating a degree of uncertainty not only amongst those who will be part of LINks but amongst patients and the public. Hitherto the 'public watchdog', PPIF or the predecessor organizations, CHCs could act as the public's voice in all or in any matter concerning the NHS. This will not be the case with LINKs, since although they will be free to make their own decisions as to what matters to cover they will have very limited resources which means that work will have to be prioritized and only planned work will be undertaken. At present much of the work done by PPIFs is not known about sufficiently well in advance to include it in the work programme.

Recommendation 2. It is questionable whether "Patients, carers and users of services are experts in the care they both need and want…" that is not to deny that their input is essential.
It is a glib and rather meaningless statement to say, "…patients and the public should be able to directly influence the services provided for them." - since comment does not guarantee action

Recommendation 3. There can be no guarantee that a stronger local voice will be developed in all areas, it is more likely that there will continue to be differences between areas for obvious reasons. Having weak and ill-defined structures makes this more likely rather than less so.

Recommendation 4. Expression of one's desires is one thing actually acting on those desires is something else. There is no evidence that when most people are asked for their opinion on anything that they are willing put time and effort into expressing their views. Only if something they perceive as being adverse is proposed do they come forward in other than insignificant numbers. Flexibility will not ensure involvement.

Recommendation 5. The trouble with all pilot schemes is that everyone is always committed 110% to making them work, so they do. In a real situation there are various levels of commitment and the ideal conditions of pilots do not exist and consequently outcomes are not nearly so good.

Recommendation 6. It is far from clear how it is going to be ensured that a host organization delivers that which is expected of it. The experience of contracting-out for services shows that it is impossible to hold a contractor to his/her promises if they are unwilling. Non renewal of a contract or a termination are the ultimate sanctions but these can create a worse situation so often an unsatisfactory situation is allowed to continue as the lesser of the evils.

Recommendation 7. It is understood that the 'early adopters' are not pilots. However, if they were and were given the same budgets as LINks will receive then it highly likely that they would fail.

Recommendation 8. 'Engaging' is a fine concept but how can it be ensured that it occurs. One can only 'invite' individuals or organizations to participate and I'm afraid that as soon as it is realized that there will be a commitment of time and effort then most run for cover.

Recommendation 9. Avoidance of duplication may be desirable but it does not sit comfortably with LINks being independent bodies that will 'set their own agendas'. How will the public and patients know what the circumscribed activities of a LINk are, especially when each LINk can be different?

Recommendation 10. Comments about lack of clarity about LINks role and structure are made elsewhere.

Recommendation 11. Not knowing how much each LINk will receive it is difficult to know whether enough money will be made available to ensure that LINks succeed. What is clear now is PPIFs have less than half the amount of money needed to enable them to do their work properly and that this situation is likely to continue under LINks.

5 or 50 members

Recommendation 12 and 13. See comments on recommendation 11. There is no suggestion that the Government or DoH will give guidance as to what work it expects LINks to do as their core task and then what other work they might do funds permitting.

Recommendation 14. The Government is again indulging in wishful thinking and ignoring the evidence of the Select Committee, which clearly stated that volunteers would opt to concentrate on the quality of services, rather than making commissioning a priority.

Recommendation 15. 'Reaching out' has a resource implication and a considerable one at that; will this be factored into a LINks budget and earmarked?

Recommendation 16. The response here deals with flexible involvement – I am not aware of any working examples that parallel what is hoped for with LINks.

Recommendation 17. I have made comments on 'Rights of Entry' in a separate document.

Recommendation 18. It would only be appropriate to try to raise the profile of LINks in the minds of the public and patients if it could be made clear what the functions of LINks were – at present this clarification does not seem to be forthcoming. The cost implications have not been addressed.

Recommendation 19. The training by the NCI would seem to be essentially for employees and irrelevant to volunteers.

Recommendation 20. It is beyond belief that host organizations would not do their utmost to prevent LINks from acting in ways that could jeopardise their interests and relationships with partner organizations.

Recommendation 21. There seem to be no sanctions or measures that could be imposed if a LINk fails to meet its obligations.

Recommendation 22. As discussions are taking place it is difficult to comment other that to support the Select Committee's recommendation.

Recommendation 23. The question should be asked what happens if LINks do not adapt to changing circumstances?

Recommendation 24. It is not much use issuing strictures if there are no sanctions to impose if a NHS body fails to consult. If there any why aren't they spelt out here?

Recommendation 25. See comments under recommendation 24. Sharing good practice does not seem to be enough.

Recommendation 26. The first requirement is for OSCs and LINks to work together and not in isolation. If the SoS can evaluate thoroughly then why have the IRP? "all options for local resolution have been fully explored" seems a bit of a red herring.

Recommendation 27. A report is awaited at the end of June 2007. It is clear that there are concerns that are 'National' and these are voiced best by a national body.

John Amos.
19.06.2007.