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Briefing Note on HealthWatch - Report Stage

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1) HealthWatch England must be independent

HealthWatch England (HWE) must be independent of government and the CQC, and accountable to the public through Local HealthWatch (LHW). Elections from Local HealthWatch to HWE are essential to achieve genuine accountability to the community. The Government's proposed model for HWE will create a weak, obscure committee of the CQC that will have little power and influence and less credibility. A committee of the CQC which is internally accountable will not have the independence, power and authority to represent the public to the CQC, NHS Commissioning Board, Monitor and the Secretary of State. The DH Consultation on the accountability of HealthWatch England is welcome[1,2] but a commitment to independence and democratic accountability would be consistent with the values espoused by the Secretary of State, Andrew Lansley in his Bromley by Bow speech on the central role on the patient in decision making in the NHS[3]

Public confidence is critical if HW is to be a body of substance and influence. The public will expect that HWE will ensure that the chronic problems that affect health and social care services leading to the disasters at Mid Staffs[4] and many care homes will be substantially reduced. Creating a national body unable to freely, effectively and independently raise the banner for safe and effective services in health and social care would be a waste of public money. HWEs independence will only be valued and respected if the members of HWE are elected from LHW - evidence of effective, well regarded statutory committees is lacking except in the case of some parliamentary and local government committees whose members are elected. Most statutory committees remain obscure and unknown to the public.

2) Working with and monitoring the CQC

HWE will have a duty to raise issues of public concern with the CQC and ensure that the CQC takes action in a way consistent with the needs of the public. To do this, it must work closely with the CQC nationally and locally (through LHW) but it cannot

be a creature of the CQC. It must hold the CQC to account – but can it do this as a committee of the CQC? Establishing HWE as a body that is at best a mild irritant and at worst a public relations arm of the CQC, which sees LHW mainly as a source of information, and which boosts the CQC image without serving the public interest will be of no value and will fail to meet the demands for greater public accountability of health and social care that are certain to be a major demand of the Mid Staff Inquiry.[5]

Creating HWE as a fully independent body will not undermine the quality of the relationship between HWE and the CQC. HWE must be in a strong position to challenge and influence the regulators; Monitor and the CQC. As Baroness Cumberlege says; 'there are enormous advantages in having a very close relationship with the Care Quality Commission in terms of information sharing at a national and local level' and 'HWE could put enormous pressure on the Care Quality Commission'. Power and influence will be derived from the independence of HWE, back room functions can be provided through an agency agreement with the CQC or other appropriate bodies.

3) HWE supporting the development of Local HealthWatch

The public needs HWE not only to represent them to other statutory public bodies and to influence national policy on health and social care, but also to support and enable the effective transition and evolution of LINks into LHW.

Genuine public involvement in health and social care has been neglected by government for many years. HWE has the potential to perform a critical role in the creation and building of powerful local HealthWatch organisations and campaign on major issues of public concern. The government's plans for HWE and LHW will substantially weaken public involvement in health and social care by undermining their independence and will consequently be disempowering and poor value for money.

HWE must have a major role in the effective transition from LINks to LHW and in their continuing development, especially during their first two critical years, when monitoring and activities to achieve service improvements are likely to be at their most problematic. The experience of Patients Forum and LINks was that many did not become fully functional for their first two years, and because of the laissez-faire approach of the government toward public involvement, some LINks are still not functioning well almost four years after being established.

4) Setting standards for LHW

HWE must not only set standards but must be able to support development, measure progress against standards and provide training and learning resources for LHW members and staff.

5) HWE must carry out research

HWE needs to be able to carry out research with LHW and other bodies, to identify what is happening locally in the NHS and social care. Data needs to be collected from service users via LHW to assess the quality of care through comparative studies. Data will also be required from the NHS and local government to produce policy reports on ways in which health and social care and patient safety can be improved, to make formal recommendations to secure these improvements and to have sufficient high quality data from this research to inform commissioning through the NHS Commissioning Board and to influence the activities of Monitor.

6) HWE's duty to secure improvement in care

HWE must have a duty to secure improvements in services on behalf of the public. We must avoid a repeat of the Commission for Patient and Public Involvement in Health (CPPIH), which merely watched and created frustration, whilst Patient Forums struggled to become effective local advocates for the public. CPPIH failed because it did not have the confidence of Patients Forums, the public or the government. Such a situation can only be prevented by ensuring that HWE is accountable to LHW, by ensuring that LHW and HWE are seen as being part of the same organisation, that information and reports are shared in both directions and that LHWs are consulted by the Secretary of State if major problems are identified with HWE. We all want LHW and HWE to succeed.

7) Local HealthWatch (LHW)

Local HealthWatch is intended to carry out five main "activities": influencing commissioning, monitoring services, involving the public, signposting people to services and providing the independent advocacy service (ICAS). It is essential that LHWs do not pick and choose which of these "activities" they wish to carry out; the "activities" should be designated as functions to ensure that LHW carry out each of the five areas of work.

8) LHW and advocacy

It is essential that the advocacy (ICAS) work includes social care in addition to healthcare. People with complaints should not be expected to go to one advocate for their social care complaint and a second advocate for health care complaints. That would be absurd. Advocacy must be provided to meet the level of local need and to ensure that advocacy support during the investigation of a complaint, especially for complex complaints, is available throughout the process of investigation.

9) LHW and commissioning through CCGs

It is essential that CCGs have a duty to consult LHW about their commissioning plans. It does not make sense for LHW to have a duty to influence commissioning, if the commissioners do not have a reciprocal duty to consult LHW. The views of local people, patients and users of social care services are the resources and evidence that LHW brings to the commissioning table. As Lord Whitty put it: **'**local HealthWatch should hold the clinical commissioning group to account for incorporating the evidence that the local HealthWatch has produced at the very start of the commissioning period'. The proposal for LHW to formally advise the NHSCB of adequacy of local CCG consultation on commissioning plans is very appropriate.

10) Independence for LHW

Independence for LHW will not be secured by co-locating them with the local authority they are intended to monitor and influence. Unless we have strong, independent LHW, they will be no more than window dressing or part of the local public relations machinery.

> "the fact that the local authority holds the purse strings remains a risk to the independence of local HealthWatch. There is therefore a strong case for local HealthWatch organisations not to be funded by the local authority. The argument that the importance of localism requires accountability is not as strong as the need to have effective, independent local services". Lord Low

11) The statutory framework for LHW

The current plans by Ministers to remove the statutory status from LHW; leaving them only with statutory activities will weaken LHW still further. It is irrational to spend 60 million on a new system of statutory public involvement and then to cut out its teeth so that it becomes ineffective.

12) Funding of LHW

There is a simple solution to the problem of independence and funding for LHW. The funding of LHW can be located with the NHS Commissioning Board (NHSCB) as a 'commissioning function'. HWE can ensure, through its powers in relation to the NHSCB, that the commissioning function is carried out appropriately and adequately, money would go direct to the LHW whose activities in relation to finances would be subject to regular audit. This would enable LHW effectively to monitor local authority social care services, influence local authority commissioning, participate in the HWBB and carry out all of its duties in relation to the NHS without any hint of conflicts of interest. Community Health Councils were statutory bodies, the model was stable, conflict rare and the reason was that 'pay and rations' were handled by a distant regional health body to reduce any possible conflicts of interest.

13) Ring Fencing

The location of funding for LINks with local authorities has been a disaster for many LINks whose budgets have been massively cut.[6] Many LINks have also been subject to a confusing contracting process, which has been the cause of considerable conflict. The location of the LHW commissioning function with the NHSCB would resolves for the government the problem of attempting to find some means of ring-fencing funding – they would just need to transfer the budget to the NHSCB. It is clear that without either locating the funding with the NHSCB or ring-fencing of LHW budgets, that many LHW will be doomed to failure, and in many parts of the country will be little more that a shadow of a LHW – all website, no action.

14) Elections to LHW

LINks and Patients' Forum suffered from sometimes having a fairly random membership and from being unrepresentative of some parts of the community. It would be easy to solve the problem of membership for LHW by requiring them to have an elected local membership. The process is simple, cheap and effective. Representative from user and carer groups, parent and toddler groups, people with long-term conditions, from schools and colleges, voluntary and community sectors and other relevant bodies could easily be elected to sit on the statutory LHW. This also provides an opportunity to ensure that LHW is reflective of local communities in terms of for example; gender, disability and ethnicity.

15) Monitoring services for children

The legislation for LINks excludes from their purview the monitoring of social care services provided for children. This is irrational and means that LINks' members can monitor care provided by the NHS to children, but cannot monitor the quality of care provided in social care settings. LHW must be able to monitor the whole spectrum of care and HWE must be able to raise major issues about child care with national bodies that have responsibility for policy and strategy in relation to the care of children. As *Baroness Massey put it:*

> **"**To ensure that HealthWatch England's functions are clear and explicit in relation to children as well as to others and that its functions in providing advice to the Secretary of State, the NHS Commissioning Board and monitoring authorities on the views of patients and members of the public refer to the views of children, who are patients and members of the public".

16) An authorization process for LINks and LHW?

It is good news that Ministers have agreed to provide money for LHW Pathfinders and that Action Learning Sets should soon be active. When HWE opens its doors it should be able to provide immediate support for LINks to go through a process that secures an effective transition into a statutory body corporate. An authorization process similar to the one provided for CCGs would be appropriate to enable a successful transition for the majority of LINks.

17) Indemnity for members of LHW

The issue of indemnity for those running the ICAS service is dealt with in the Bill, but not the needs of active members of LHW. Governments have failed to deal with this issue since the abolition of CHCs (whose members were indemnified by the government). There are two principle risks; a) suffering or causing harm during a monitoring visit to a care provider, and b) legal action taken by a provider, as a result of an adverse report on the care provider. Reports on private providers of care are most likely to result in threats of legal action. A LHW may wish to highlight in the local press its findings following a visit to a care provider, if there is a risk of harm to patients or users. It may wish to state that repeated reports and recommendations have been ignored by the care provider or commissioner, or in the case of recalcitrant provider (e.g. Mid Staffs). The LHW may wish to run a campaign to improve care locally (remember the success of Casualty Watch[7]). In all of these case members of the LHW require indemnity against legal action that might be taken against them and legal resources to enable them to take action if they have been harmed. Currently, such cover is not provided by the government to LINks and where cover exists it is through a local insurance policy at a level that can be afforded by the local host. The current situation is not consistent with the needs of members of

statutory bodies monitoring health and social care services consequent upon an Act of Parliament.

REFERENCES

[1], Consultation on the regulations for HealthWatch England Membership http://www.dh.gov.uk/health/2012/01/HealthWatch-member/

[2] HealthWatch England Narrative http://www.dh.gov.uk/health/2012/01/HealthWatch-member/

[3] Andrew Lansley, 8 June 2010: Secretary of State for Health's speech - 'My ambition for patient-centered care' http://www.dh.gov.uk/en/MediaCentre/Speeches/DH_116643

[4] Cure the NHS - http://www.curethenhs.co.uk/site/content_home.php

[5] The Mid Staffordshire NHS Foundation Trust Public Inquiry – Witness Statement of Kay Sheldon. http://www.midstaffspublicinquiry.com/sites/default/files/evidence/Kay_Sheldon_-_witness_statement_and_exhibits.pdf

[6] Evolution or Abolition – a NALM Report. http://www.nalm2010.org.uk/uploads/6/6/0/6/6606397/evolution_or_abolition.pdf

[7] ACHCEW: Casualty Watch. http://tinyurl.com/7wf8jm5