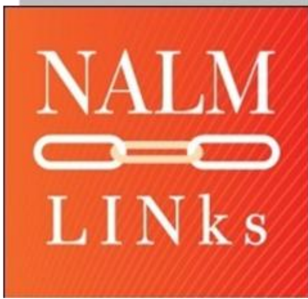

HEALTHWATCH CONSULTATION

The National Voice for LINks and LINk Members

The National Association of LINks Members

Public and Patient Involvement in Health and Social Care

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RESPONSE TO CONSULTATION ON ALLOCATION OPTIONS FOR DISTRIBUTION OF ADDITIONAL FUNDING TO LOCAL AUTHORITIES FOR LOCAL HEALTHWATCH, NHS COMPLAINTS ADVOCACY, PCT DEPRIVATION OF LIBERTY SAFEGUARDS

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THE AIMS OF NALM

The aims of NALM are to:

1. Provide a national voice for LINKs' members and to give LINks greater influence

2. Promote public involvement that leads to real change and the ability to influence key decisions about how care services are planned and run

3. Promote the capacity and effectiveness of LINks' members to monitor and influence services at a local, regional and national level and to give people a genuine voice in their health and social care services

4. Support the capacity of communities to be involved and engage in consultations about changes to services, influence key decisions about health and social care services and hold those services to account

5. Promote diversity and inclusion and support the involvement of people whose voices are not currently being heard

6. Promote open and transparent communication between communities across the country and the health service

7. Promote accountability in the NHS and social care to patients and the public

RESPONSE TO CONSULTATION ON ALLOCATION OPTIONS FOR DISTRIBUTION OF ADDITIONAL FUNDING TO LOCAL AUTHORITIES FOR LOCAL HEALTHWATCH, NHS COMPLAINTS ADVOCACY, PCT DEPRIVATION OF LIBERTY SAFEGUARDS

INTRODUCTION

Proposed levels of funding for HealthWatch will not allow them much capacity to carry out the wide range of tasks laid out in the Health and Social Care Bill. In particular with current proposed funding levels there will be limited capacity to carry out the essential ground work in terms of engaging with all the community, voluntary organisations and groups that the NICE guidance recommends to achieve effective community engagement.

The current LINk budget of 27 millions has not been adjusted for inflation since 2002, so in practice LINks are experiencing significant year on year cuts. The HealthWatch budget should be topped up with savings from accidents or incidents avoided as a result of complaints acting as catalysts for improving health services.

HealthWatch must come out onto the high street where it can be seen by the public not hidden away in backroom offices. To be successful HealthWatch advice, signposting, advocacy and monitoring services, must be widely advertised to the public, social care users, health service users and carers. The funding formula will need to be adjusted year on year in light of the success of HealthWatch in making its services widely available and used. Cuts to health and social care services are likely to substantially increase the use of HealthWatch services.

1. We welcome the opportunity to respond to the consultation document and note the reasons given for the slightly shorter consultation period than would normally be given (para 7).

2. We regret the apparent restriction of responses to e-mails only and would suggest that all responses received in whatever form should be considered. Further, we would request that DH consultation exercises do not restrict responses to e-mail alone on the basis that restrictions could well mean that people with some sensory disabilities or those who do not have access to the internet are excluded, this would not appear to be in line with the Equalities Act.

Additionally, we question the way the overall level of funding proposed has been determined. We believe the document is flawed in its overall approach in that it does not focus on the *level* of additional funding needed in relation to the new duties and responsibilities; it concentrates on the *method* of allocation of what appears to be an already agreed level of funding.

We believe the document seriously underestimates the level of new funding that should be made available because:

a) The new function of signposting covers <u>social care</u> as well as health. The PALS money does not cover community based health services and it does not cover social care – so we think it badly underestimates the money needed to provide advice and signposting to the full range of health and care services.

b) The estimated increase for advice and signposting of 5% per year is a seriously low estimate. We would expect this new and accessible service to increase its activities dramatically in the first few years. The increase could well be 100% each year as the service becomes increasingly a well-known part of every local community. Taking into account the above we think the increase in funding for the first 3 year should be:

2012/13	2013/4	2014/5
£50m	£70m	£90m

3. We acknowledge the reference to the signposting, advice and information giving role (para 15) which will pass to local HealthWatch under the current provisions of the Health and Social Care Bill. We will say more at a later stage on the overall range of duties (paras 20-23) which will fall to local HealthWatch.

4. We particularly note that the consultation is not about the overall level of funding of local HealthWatch and is limited only to those areas identified in the title and in the allocation of additional amounts in relation to those functions (para 25). We understand that some confusion has been caused in relation to this, an error which was also apparent in the Bill debate in the House of Lords on 12th October 2011. We wish to make the point that 'allocation of additional amounts' presupposes that there are 'amounts' to which these allocations will be 'additional'. Feedback from current LINks evidences that there are some LINks which have received little of their allocation for this financial year and some have received budget cuts of up to 75%. There is no commitment from the Government to ringfence funding, so HealthWatch in many areas will be severely underesouced and unable to carry out some of its functions.

5. We welcome recognition of the need for start up funding, which will be allocated in 2012-13 in relation to demand from patients for help to make choices (para 26) and strongly support this providing the information available to HealthWatch is of a high enough quality and detail to assist patient, and if the choices are genuine. In the current system patient choice is often a sham, because critical information that would help patient choose an appropriate service or practitioner is not available and when the patient makes a choice they may be told that the service is not available or the waiting list too long. Increasingly commissioners are reducing the choice of services to meet demands for cuts in budgets.

6. PALS costs (paras 27-28) The PALS spend is based on 2011/12 *figures.* However, some PCT's have already made huge cuts to PALS budgets, e.g. in North West London, there has been a reduction of around 66% in PALS staff and costs in the current financial year. The impact of this is demonstrated through the failure of

PALS to respond to queries and complaints in a way that is consistent with last year's standards. Yet the consultation document is using 10/11 volumes to assess need and determine budgets.

7. A typical NHS Trust organisation may receive complaints in excess of 50 a month (HSJ August, 2011) The **Government Response to the House of Commons Health Select Committee Sixth Report of Session 2010-11: Complaints and Litigation** states:

"The revised plans we set out will put patients firmly at the heart of our health service; patients will have a stronger voice and the NHS will be more accountable for the quality and experience of care it provides for patients. Under these plans, we propose to create a new committee within the Care Quality Commission, to be called HealthWatch England. This will operate as the national champion for patients and members of the public by presenting their collective consumer voice and using their powers to influence the Secretary of State and relevant bodies to improve the quality and safety of health and social care services. Where a Local HealthWatch becomes aware of poor complaints handling within an organisation, such as a provider or commissioner of local care services, it would be able to submit views, reports and recommendations."…"Whilst not being directly involved in the handling of individual complaints, Local HealthWatch will provide support, either by explaining where the complainant is able to access those advocacy services, or through the provision of advocacy services to help the complainant pursue the complaint if the LA has contracted with the LHW to do so."

The **Response** clearly states "a patient's experience of an organisation's handling of their complaint will fall within this [Local HealthWatch] remit."

Additionally, FTs are not required to submit information on written complaints although the DH announced in September 2011 a policy change, saying that "something needs to be done" about voluntary reporting for FTs after figures released revealed FTs are increasingly failing to report patients' complaints, restricting the government's ability to gauge overall satisfaction with NHS performance. This caused the Patients' Association to state, "You can have local management, local involvement, local anything you want. But if local people do not have access to data to enable them to make comparisons then it is a waste of time." There is no reassurance on this matter in the response of Foundation Trust Network Chief Executive Sue Slipman, who said: "As FTs are independent organisations they are not under any obligation to report to the Department of Health on this matter [complaints]"

8. Also, we have major concerns over the current exercise being undertaken to identify the existing level of resources used by PCTs in performing PALS signposting and information giving functions. There has been a wide range of approaches to providing this service by PCTs including, in some instances, the virtual transfer of PALS staff to community services. Consequently, available data will show a significant under-estimation of the real cost of providing these services which, if not properly addressed, will be replicated in calculating the additional funding to local HealthWatch.

9. We strongly disagree with the assumption that the majority of signposting services will be required by younger adults (para 34). Our collective experience shows that information requests are received from all sections of the community including people with mental illness and/or their carers, people with a learning or physical disability or their carers, people with dementias and/or their carers. In that the highest users of health and social care services are older people, it is from this group and their carers and relatives that we would expect to see the highest level of demand for information, advice and signposting. This demand will be the most costly to the system in terms of 'reach'. We again refer to the policy on equality and diversity and the requirements of the Equalities Act 2010. Respect for and valuing equality and diversity requires realistic sums to convert the rhetoric into reality. Clearly, there is an urgent need for an Equalities Impact Assessment on the proposals in the consultation document.

We dispute the claim that the increase in demand will be about 5%. In addition to population growth, the needs of migrants, the needs of those who travel long distances to work, the proposed ending of GP practice boundaries and huge changes and upheaval to the NHS lead us to propose that at least a 30% increase in funding is needed.

10. Question LHW1 and LHW2 –

Underestimates of population cohorts (adult working age) will disadvantage certain Boroughs, e.g. in areas with transient populations there is often an underestimating of population size.

Neither option takes into account health inequalities in any meaningful way. LHW2 looks at social care but it is not made clear what is this an indication of - an ageing population (state supported care tends to be concentrated on specific high need groups). This may disadvantage areas with e.g. a high proportion of children.

Faced with the limitations of the Consultation, we support the option set out in LHW2 using the adult social care Relative Needs Formulae in that, in the absence of other measures, this is likely to more accurately determine the level of demand than that of LHW1

We are concerned that the numbering of questions could be confused with the numbering of the options (i.e. LHW 1 refers to a question and an option as does LHW2!) and hope that care will be taken to ensure that respondents are not confused by this.

11 Question LHW2 – we strongly support the principal there should be a minimum allocation and given the information available, £20,000 would appear to be not unreasonable; but would provide for a very minimal service. Minimum Grant Allocation: Page 12, Allocation.....43 is tacit acknowledgement of the need for protected funding for Local HealthWatch work. It is absurd to suggest that only one facet of the work of Local HealthWatch merits finding protection.

Further, the DH treats its own services differently from those provided to the public; the SHAs for example, are in receipt of dedicated amounts for specific workstreams.

12. Question LHW3 – our views concerning the population likely to be seeking signposting, advice and information assistance are covered in our paragraph 7 above.

13. We acknowledge and support the issues raised in relation to economies of scale (para 55) in relation to NHS Complaints Advocacy services. We particularly support the recognition of the likely training needs and would propose that finance to support this is made available during 2012-13 if the responsibility is to be passed over from 1st April 2013. Failure to do this would be likely to lead to an absence of an acceptable service level and quality for the period until training has been completed. Current ICAS providers are stressing the need for continuing, competent ownership of cases ongoing.

14. We regret the absence of data sought (para 61) on the use of ICAS. We acknowledge the difficulty of identifying caseload by local authority area but evidence to the NALM Transformation Board of November 2010 clearly showed that 45,000 ‘contacts’ were made that year to only one of the three big national providers of ICAS services and in addition 7,000 to 8,000 ‘self-help’ packs were sent and self-downloaded.

15. We support the principle of not recommending a minimum allocation in that it is likely that there will be a substantial level of joint commissioning of a vital service that, of necessity, must be fully professional and easily accessible.

16. Question NHSCA1 – we support the option set out as NHSCA2 – i.e. using the Adult Social Care Relative Needs Formulae and again express concern over the similarity of numbering of funding options and questions.

17. Question NHSCA2 – again we take this view based on the views set out in our paragraph 7 above.

18. We support the proposal not to use option DOLS 3 for allocating PCT Deprivation of Liberty Safeguards finance for the reasons set out (para 80).

19. We strongly support the proposal for a minimum level of funding to ensure trained workers are available – we are not in a position to assess whether the £20,000 pounds proposed for each local authority para (83) is adequate and would simply say that the DH needs to ensure that the sum allocated is *allocated*.

20. Question DOLS1 - We would prefer the transfer of funding, and therefore responsibility, to take place in April 2013 but would propose that training support money (para 83) is available during 2012-13 to ensure that the service is properly available from 1st April 2013. Again we note the confusion of numbering between options and questions.

21. Question DOLS2 – we support funding option DOLS2.

22. Question DOLS3 – a minimum allocation, yes but see our paragraph 17 above.

23. Question DOLS4 – for the reasons previously given.

24. Further comments – We are extremely concerned over the issue of resources which will be available to set up and operate local HealthWatch. Firstly, under the current proposals within the Health and Social Care Bill the final decision will be taken by individual local authorities, each of which will have its own cost pressures and local policies and priorities. Evidence to the NALM Transformation Board of Nov 2010 from CQC stated that it was clear that "ADASS are really feeling the funding squeeze. They are not anti-HW but they have no money".

25. In September 2011, the European Union Act 2011 (Amendment) Bill made HealthWatch subject to the Freedom of Information Act. We welcome that development. However, the Consultation makes no provision for the costs of such accountabilities. The SHAs returns in their Annual Reports indicated that even a small annual volume of such requests can be costly in time and money

26. The massive underfunding of LINk/Healthwatch and the failure to ringfence funding will result in a network of local Health organisations across the country unable to demonstrate comparable and satisfactory services for their local populations. Equality of service provision in relation to access and quality are fundamental and are likely to be sabotaged by the underfunding and the failure to ringfence.

There are increasing expectations over what local HealthWatch will deliver. In a statement by the Secretary of State for Health in response to the report of the Care Quality Commission (October 13th 2011) on the failure of a significant minority of acute hospitals to treat older patients with dignity and respect and to meet their basic needs he said: 'local HealthWatch would be established with powers to enter unannounced to ensure that local hospitals fulfilled their duties in this respect'.

27. The candid findings of the CQC internal review (Sept 2011) highlighted its own lack of cash and capacity to undertake this vital and essential inspection work. 'An internal review of the CQC led by board member Martin Marshall found the CQC faces a "fundamental challenge" and that its stretched resources and capacity will not be eased in the near or medium future. The CQC has asked for an extra £15m of resources'. Local HealthWatch, according to the expectations of the SoS and because of the shortcomings of the CQC, will increasingly be the 'default' guardian of the vulnerable and must have an adequate and secure budget to discharge this function.

28. The functions of local HealthWatch will include:- signposting, advice and information giving, assisting with complaints, community networking, intelligence work on national and local statistics in order to inform the commissioning overview functions and assist patients in their choices, enter and view, and possibly advocacy. Local HealthWatch will need the resources to support all of these functions and to support the training of volunteer members carrying out monitoring visits, inspections, enter and view and participating in Health and Wellbeing Board and a wide range of influencing activities in relation to commissioning.

29.The **Government Response to the House of Commons Health Select Committee Sixth Report of Session 2010-11: Complaints and Litigation** clearly states, "To retain their independence, Local HealthWatch will sit outside the NHS" yet the funding proposals assume the funding is passported to the local authorities, unringfenced, leaving Local HealthWatch without genuine "independence". This is the greatest risk to the success of HealthWatch.

30. In its recent Board paper on HealthWatch England, the Care Quality Commission states that neither HealthWatch England nor local HealthWatch will be able to carry out their responsibilities if they are not properly resourced. This issue has been placed DH HealthWatch Programme Board risk register.

31.The RIA for the Health and Social Care Bill similarly flags up the risk of the funding allocations passported to the local authorities for Local HealthWatch not being passed on (Key Risk 1: local authorities may choose not to fully fund local HealthWatch.)

32. We take this opportunity of strongly supporting these concerns over these risks – a view we will not hesitate to return to should it prove necessary.

Based on the submission from: LINk members of the HealthWatch Advisory Board, 'Transition' and 'Local HealthWatch' workstreams.