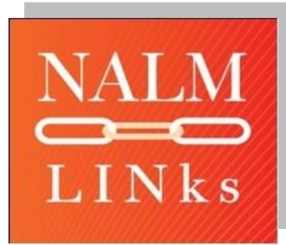

National Association of LINk Members

The national voice for LINks' members

DRAFT

Consultation on the regulations for HealthWatch England Membership

Gateway reference 17159
Publication date 26 January 2012
Responses by 2 March 2012
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NALM welcomes the opportunity to respond to this consultation and to influence the development of HWE and the membership of the board of HealthWatch England.

- Direct elections from Local HealthWatch to the Board of HealthWatch England are essential.

- HealthWatch England must be fully independent.

- The Board of HealthWatch England must have a diverse and inclusive membership.

- HealthWatch England must strengthen and give real power to the collective voice of patients and the public in social care and health

- HealthWatch England must have the power and ability to influence and shape the content and

direction of policy in the CQC, Monitor, NHS Commissioning Board and with the Secretary of State.

1) HWE must actively represent the public and be pro-active with the CQC, Monitor, NHSCB and the Secretary of State.

HealthWatch England should seek views and information about the experiences of people who use health or social care services and ensure that these views and experiences influence and improve the quality of services and access to those services. Creating services that meet the needs of people is fundamental. This must be an active function not a passive one. 'Being heard' is not enough.

2) The Chair of HWE must have a set on the Board of CQC, Monitor, NHS Commissioning Board and the DH Department Board

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We agree that it will be useful for the Chair of HWE to be a member of the Board of the CQC. The Chair of HWE should also have a seat on the Board of Monitor, the NHS Commissioning Board and Department of Health's Departmental Board members. This will ensure that HWE has real influence in every key decision making policy body.

3) HWE must be completely independent of the CQC

Although it may be the intention for HWE to have it own identity, it is unlikely that this will happen in reality because the HWE committee will be rapidly absorbed into and overwhelmed by the infrastructure of CQC.

4) The Regulations must state that HWE will be an independent body.

The document does not state that it is the intention to create HWE as an independent body. We believe that independence is fundamental to the success and influence of HWE.

5) Accessing technical expertise through an agency agreement with the CQC

We agree that HWE should have access to CQC's expertise and infrastructure including data management, gathering and use of intelligence, analysis, and an evidence base of information about services across the country. This can be provided through an agency agreement. Being buried within the CQC is not necessary to achieve this shared objective.

6) Prioritise the creation of a cadre of expert staff to support the development of LHW

We support the creation of independent HWE in advance of LHW and believe it should have the resources and infrastructure to support the development of LHW and the sharing of good and best practice.

7) When HWE makes formal recommendations there must be action - a polite reply is not enough!

It is essential that HWE will be able to make formal recommendations to the CQC, Monitor, NHS Commissioning Board, local authorities and the Secretary of State. There must be a duty of each of these bodies to respond to and take action in response to recommendations made by HWE.

8) Formulating independent policies to create better health and social care nationally and locally

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HWE must be able to formulate independent national policies based on need identified in communities across England. These policies may not be consistent with policies of the CQC, Monitor, the NHSCB, the Secretary of State and local authorities. These policies may be aimed at improving the performance of any or all of these bodies.

9) HWE must share all of its reports with LHW and local people

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All reports produced by HWE must be made available as hard copy to all LHW organisations and libraries in England.

10) LHW will be led locally - HWE must support, facilitate and enable the success and empowerment of LHW

The CQC has unrealistic ambitions about accessing data from LHW. The LINk-LHW transition chaos which the government is enabling, will mean, in many parts of the country, that any systematic data production will take years to achieve, at least 2 years from establishment of LHW. In addition LHW may not find it appropriate to provide the types of data that the CQC may want and the CQC should not be attempting to steer/prompt the direction of work of LHW. HWE and the CQC might collaborate to carry out national surveys using data collected from LHW (see example: http://www.achcew.org/achcew-publications.html). We hope that LHW will help to address failings in the quality and safety of care by enriching the evidence used to regulate services and informing the CQC's risk management systems locally and nationally, but the CQC should not assume nor expect that they will be able to access the data they want - LHW will have it own priorities. It is not the handmaid of the CQC.

11) HWE staff must be accountable to the HWE not to the CQC

Regarding core functions being provided by the CQC we hope that this will not mean that HWE staff become accountable to the CQC rather than senior staff in HWE. HWE staff must be HW-facing.

12) Monitoring of health and social care services must be rationalised - it absurd having three bodies carrying out the same monitoring tasks.

We would expect the "experts by experience" programme to be integrated with LHW and 'patient-led inspections'. It makes no sense to have three groups of people carrying out the same monitoring activities in health and social care. Duplication is dilution.

13) LHW must be consulted before any major changes are made to HWE

If as a result of criticisms of the CQC and the Secretary of State attempts were made to terminate HWE, under the current proposals LHW would not have any locus in the decision-making process. Local HealthWatch must be consulted before any attempts are made to substantially to vary, or terminate the operation of HWE.

14) HWE is being established to service the public - not the CQC or Department of Health

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The Department of Health and CQC see the HWE as a strategic organisation, defined within their own architecture, whereas we believe most patients and the public will look to HWE to be a body with enabling and improvement levers and functions to be operated on behalf of LHW. Nevertheless, to achieve its practical functions and objectives it must take a strategic approach.

15) Having a small unrepresentative Board for HWE will damage its credibility

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We do not see the value of a small unrepresentative HWE board. Both Monitor and the CQC have Boards which are too small to be appropriately inclusive. We believe a Board of 12 people would be appropriate, consisting of at least 8 elected members and four appointed members to ensure inclusiveness and diversity. Additional, co-opted members, if necessary, would increase the diversity and influence of the HWE board. We strongly believe that the Board of HWE must represent a diverse communities, diverse views and experiences, and ensure that members possess the expertise needed to influence and engage other organisations. Compliance with the public sector equality duty (under the Equality Act 2010), and to act according to the Nolan principles is both fundamental and essential.

16) HWE Board members must understand the levers of community empowerment and influence

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We agree that HWE Board members must have sufficient skills and experience to allow HealthWatch England to deliver its work programme. Board members must also give the Board a reputation that places it at the centre of public empowerment in health and social care. Board members must be credible people in the eyes of LHW and the wider community.

17) The Chair of HWE cannot be accountable to the Chair of the CQC

We do not believe that it is appropriate for the Chair of HWE to be accountable to the Chair of the CQC. There are considerable risks in relation to the influence that the CQC might have over HWE. The credibility of HWE would be forfeit, there are reputational risks - if the CQC were to be seen as a failing organisational this would impact heavily on the reputation of HWE.

18) Local LINks and the Chair of HWE should agree criteria for appointment of Members to the HWE Board

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We strongly believe that the Chair of HealthWatch England in collaboration with LINks provide the most appropriate source of expertise to determine the criteria; required skills and expertise, for potential members of the HealthWatch England Board.

19) There needs to be more reflection of those excluded from membership of the HWE Board

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We agree the exclusions from membership of the HWE Board suggested by the Department are reasonable - however there may be good reasons to allow appeals. For example a person who has had an appointment terminated. The candidate may have attempted to expose corruption or incompetence in a public body and was later vindicated.

20) Key strengths for members of the HWE Board

We agree that it is important to appoint members with the specific skills and expertise, who will be able to ensure that HealthWatch England can influence health and social care policy through using its influence with the Secretary of State, CQC, Monitor and the NHS Commissioning Board and ensure HWE can fulfil its functions of:

- enabling the development of LHW;
- providing support, advice and assistance to local HealthWatch organisations;
- using the information from local HealthWatch on the views of patients and service users, to influence the national agenda.

We agree that members of the HWE Board should be appointed on the basis of a strong background in public and patient involvement in health and/or social care.

21) Most Board members of HWE must be elected from LHW

We strongly believe that as LHW is funded by government to influence local health and social care services and is intended to have a diverse membership, that it is appropriate that the majority of HWE Board membership should be elected from LHW. We agree that this should encompass patients, service users, carers and the public, and voluntary and community-based groups, including those organisations that work with hard-to-reach groups.

22) Direct elections to the Board of HWE - not to a 'pool'.

We strongly believe that the majority of members of the HWE Board must be elected from LHW - not to a pool of potential candidates, but directly to the Board. We would think it bizarre and absurd if local Councillors or MPs were elected to a pool and then selected by unelected people to sit in the local Council or in parliament - so why should this apply to HWE?. If the CQC is anxious 'rogue' people being elected to the Board of HWE, a common standard should be agreed for candidates across the country prior to election. We acknowledge and accept that in the first year elections to the Board would not be possible as local HealthWatch will not be established until April 2013.

23) The length of appointment should be a maximum of two terms of 3 years.

We agree that a maximum tenure is appropriate. We would recommend that no member of the Board should be in post for longer than two terms of three years. This is to enable to the termination of appointments after 3 years if a Board member has not performed well, and renewal/extension of appointments for people who are reflecting the needs of local communities successfully, and functioning well as a leader of a national body, which is having a significant impact on the effectiveness of health and social care services.

Malcolm Alexander, Chair
Ruth Marsden, Vice Chair

End

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