Guest editorial Sunday 23 January 2011: A closer eye on HealthWatch

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Today's guest editorial comes from the author of the excellent Arbitary Constant blog, Rich Watts. It suggests that councils can continue to cream-skim scrutiny funding budgets; that HeathWatch won't be very independent either locally or nationally; and that the position of advocacy, especially in social care, is seriously unclear.

HealthWatch: Good in principle, worrying in practice

Criticisms of the reforms of the health system have focused primarily on shifting £80bn of public expenditure to GP commissioning consortia.

Much less attention has been paid to the issue of patient/user voice and representation in the reformed system, something this post aims to address (building on two posts at the time of the White Paper, here and here and one just before the Health & Social Care Bill was published).

The consumer champion

The White Paper contained proposals for the creation of both HealthWatch England and local HealthWatch - building on the work of existing Local Involvement Networks (LINks) - in each upper-tier local authority area.

Local HealthWatch will essentially be the local "consumer champion" for health and social care users, promoting choice and control, influencing the shape of services, and highlighting issues in service delivery, including through advocacy.

HealthWatch England will provide support to local HealthWatch and synthesise the issues they highlight at the national level, working with the NHS Commissioning Board and the Care Quality Commission.

In principle, the introduction of HealthWatch based on the work of LINks is a good idea (though there is a question over how effective LINks have been); what's more, there is "extra" money being made available for both local HealthWatch and HealthWatch England to carry out their roles.

In practice, however, there are 3 significant areas of worry about HealthWatch arising from the Next Steps consultation response and the Health & Social Care Bill and its associated Impact Assessment.

Financial matters

> 'Though there will be "extra" money for local HealthWatch, this is being taken from existing services ... the major issue is that this money won't be ringfenced. Councils can choose how to spend it'

The first is money. Though there will be "extra" money for local HealthWatch, this is being taken from existing services.

In 2009/10, £27m was allocated for LINks. For local HW, the funding that was used to fund the Independent Complaints Advocacy Service (£11.7m) and PALS (£19.3m) is being handed to local authorities to commission local HW, meaning there will be £59.1m in 2010/11.

HW England will also have £3.5m of its own funding (figures from Impact Assessment, para D42).

But the major issue - and the number one risk identified by the DH itself - is that this money won't be ringfenced. Instead, since the money will be allocated to local authorities under normal LA funding arrangements, Councils can choose how to spend it.

A nine per cent solution

> 'Councils ... effectively creamskimmed 9% off the LINks budget. There is no guarantee they won't do the same for local HealthWatch'

In 2009/10, although £27m was allocated for LINks, Councils only spent £24.3m of it on LINks - they effectively creamskimmed 9% off the budget. There is no guarantee they won't do the same for local HW.

The second issue is independence. Local HW will be "contracted by and accountable to Local Authorities" (Impact Assessment, para D34). This does not make them independent in principle; nor, potentially, in practice.

More worrying is that HW England will only be a statutory committee of the CQC. Despite the Next Steps consultation response suggesting this means HW England would be "independent" (para 2.59), the Impact Assessment formally recognises (para D24) that

"setting up HealthWatch as a statutory committee of CQC [means] it would not be formally independent of the NHS and social care system".

Not very independent

Furthermore, HW England's funding will need to "maximise synergies" with roles within CQC (para D28) to ensure its funding of £3.5m goes as far as possible. No "independent" committee should have to rely to this extent on staff within its host body.

Even more significantly, the Chair of the Committee will be appointed by the Secretary of State (Next Steps, para 2.59). The Health & Social Bill also stipulates that some members of the Committee will be appointed and others elected (Impact Assessment, para D27), but with no details about the blend of appointed and elected members or the process for elections (D26) - this is to follow in further regulations.

None of this sounds particularly independent, and there have to be worries about how this will operate in practice. Anyone who knows how the statutory disability committee within the EHRC has operated in practice - a very similar set up to that proposed for HW England within CQC - will rightly be concerned.

The final issue is advocacy, particularly complaints advocacy, in which confusion reigns. Next Steps suggests (para 2.43) that local HW should have a role in NHS complaints advocacy, but that Local Authorities will now be responsible for commissioning it and that this may or may not be through local HW.

Conversely, the policy summary signed by Andrew Lansley as part of the Impact Assessment says that HW *will* bring together patient voice and complaints advocacy. It won't - especially since advocacy in *social care* is not mentioned a *single time* anywhere in documents relating to the Health & Social Care Bill.

Unlike much of the rest of the proposed health reforms, the suggestions for HealthWatch were actually quite good in principle.

In practice, significant questions about money, independence and advocacy as one of the new, key functions of HW means the end position for HealthWatch is much the same as everything else associated with Lansley's reforms.