March 7th 2012

Please find below and attached NALM's comments in relation to HealthWatch

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Introduction

Public involvement in health and social care in England has been in a turbulent state since 2003 when the government abolished Community Health Councils. Despite the genuine aspiration of government to establish effective public involvement systems, these aspirations have failed people in many parts of the country leaving an unacceptable patchiness and putting users of health and social care services at greater risk of harm through failing services. In 2003 there were over 500 Patients' Forums set up around the country, many with a tiny membership. They had a national body that was independent, it was distant and isolated from local Patients' Forums and failed because it was not useful to local Forums and was not respected by them. The government quickly tired of having an independent national PPI body, especially one that was poorly led, unpopular with the people it was supposed to serve and of no relevance to the wider public.

Abolition of Patients' Forums led to Local Involvement Networks being established with no statutory national body. The name "LINks" made them invisible to the public and they were often isolated and struggled against the odds to develop successful systems to monitor services and influence commissioning. However, after 2-3 years, many LINks have done well and have established a good local reputation and have had an important impact on the effectiveness of local services. What they need is a national body to support them, enable them to develop successfully and to give a hand to those that are failing. Recognising the problems and weaknesses of some LINks the government decided to abolish them and replace them with HealthWatch (does abolition happen every five years?). The plan to have a national body – HWE - working closely in a supportive relationship with LHW is a very good one. The intention is to have HWE up and running by October 1st 2012 and LHW running by April 1st 2013. Ministers had a vision of a relationship between the local and the national that was going in the right direction, but needed some tuning to make it work for the benefit of the public. That plan has now been wrecked by the government that created the vision

Building national and local HealthWatch

What seemed to worry government was setting up another body like the CPPIH that would fail. The reasons CPPIH, Forums and some LINks failed is because they were designed in Whitehall, by people who have little idea of the needs of local communities, rather than by local people who have experience of the organisational form and support mechanisms required for success. Designing a successful and robust model was possible in 1974! To do it successfully needs the active support and advice of people with practical experience of how to build a successful national HWE working in tandem with LHW. A national governance framework is required from the centre to enable local people to get on with the job of organizing the monitoring of local services. Support with governance from the centre reduces local friction and speeds the process of local development. This was the plan, but it has now been abandoned by government.

The critical importance of HWE

HWE should provide a national vehicle to drive standards in health and social care and identify areas of poor practice. It has a very special mission, which is quite different to that of the regulator (the CQC). It should amplify the voice of the people so that it can be heard in the office of the Secretary of State and throughout the CQC, Monitor and the NHSCB. HWE is the voice of the abused patient, the forgotten person with dementia on the second floor of a nursing home, of the child with learning disabilities who is getting poor care in a children's ward, and of people waiting excessive periods waiting for emergency care in an A&E department. When LHW or a member of the public raises their voice because of persistent local problems, HWE must hear it immediately and it must respond immediately. To do this independence is critical.

Independence and the CQC

Embedding HWE in the CQC is a fundamental error because it diminishes the power and influence of HWE – it becomes a 'Committee of the CQC'. The only people who think a Committee is important are people who sit on Committees – most people think a Committee is a talking shop. HWE must not be thought of across the country as a talking shop.

The CQC has a huge and important job to do. However, it is not an easy organisation to contact or communicate with, it is highly bureaucratic and has exactly the wrong culture for HWE. Members of the public do not want to go through CQC call-centre to raise urgent issues – they want to speak to an expert in HWE who understands the problems and acts immediately. Combining a people facing body – HWE - with a regulator – the CQC - that is focused on data and regulation will quickly suffocate HWE.

It has been said that CPPIH failed because it did not have enough influence with government and it has been argued that locating HWE within the CQC puts it in the centre of regulation, where is can have real power and influence. The truth is that CPPIH failed because it was not understood by the public, had little information about what was going on locally and had nothing to say to government. HWE needs to be trusted by the public and be seen as a 'big hitter'. It must be seen to be able to hold the CQC, Monitor and the NHS CB to account and have influence with every local authority in England. It must be seen to be independent, able to move quickly when things are going wrong and demonstrate to the public that is can move fast. We don't want any more outrages like Mid Staffs or the disasters of Winterbourne View. But they won't be prevented by HWE being buried in the CQC. People knew about these disasters but each thought someone else would act. The family and carers had nowhere to go. HWE must remain separate form bureaucratic moderating influences that might persuade not to act because that would be interfering in someone else's locus of responsibilities.

HWE cannot have dual loyalties – it must be accountable to the public for all it does.

The methodologies used by the CQC, e.g. the Quality and Risk Profile might be a magnificent tool for the CQC, but for HWE this is only one means of gathering information. The main way that HWE will gather information will be through live communication with LHW, voluntary organisations and the public. People should be able to say – something terrible has happened in this care home, I must contact my local HealthWatch; and if they see this as a major problem they will contact HWE. Or if the name of HWE is well known the person might phone the number and get though to someone who knows what to do immediately – not to a call-centre that will immediately alienate the public. HWE will make a call to the nursing home or Trust. A HW visit might take place. An investigation. Contact made with the CQC and Monitor and the CCG. A course of action that will alert all who need to be alerted. This will never happen if the HWE is guarded within the bureaucratic arms of the CQC – a body it must monitor and hold to account.

HWE needs to be wholly free to carry out its own programme of work developed in liaison with LHW, the voluntary sector and the public. It needs to be informed by the CQC and many other national bodies. It must work with all of these bodies on a need to know basis – information is shared, trust built and interventions made. It cannot be an information milking machine on behalf of CQC. That appears to be the vision of the CQC – a vehicle to collect qualitative data to add the QRP.

http://www.cqc.org.uk/organisations-we-regulate/registered-services/quality-and-risk-profiles-qrps

HWE must operate as a separate independent organisation

Being independent and being seen to be independent requires HWE to be run by a Board that has the public trust and confidence, that meets in public, that speaks to the public. Not a Board like the CQCs that does not even allow questions to be put by the public. To be a statutory Committee of a Board that does not even recognise the need to be open and accountable to the public, would be absurd for England's leading public involvement body. HWE must have its own Board, it must meet in publicly accessible places, discuss issues of major national importance and be seen as a body that people will want to connect with, attend their meetings, raise issues with them, watch them live on the internet, engage with them. It must be a living organisation not an obscure committee of the CQC.

Elections to HWE

The CQC is very anxious about having members of the HWE Committee elected directly from LHW. But why are they so worried about a little democracy? The recent consultation on HWE regulations was silent on the issue of independence and elusive on the issues of elections. It did consider the possibility of elections to HWE but not directly to the HWE Committee – it would have to be through some intermediate mechanism just in case a 'rogue' representative was elected to the Committee. HWE can't creep in shadows of the CQC's fears about direct public involvement.

As a regulator, the CQC may have to keep its distance to ensure objectivity – as the people's voice HWE must invite the people in and be disappointed if they don't turn up, because if they do not show then HWE will have failed in its job. Direct elections from LHW to HWE will ensure that HealthWatch is a combined national and local organisation that is trusted by local people.

A committee of CQC appointees will ensure that HWE will be borne in obscurity and remain there.

Relationships with other national bodies

Strong relationships with the CQC, Monitor and the NHS CB are critical for HWE. Local relationships between CQC inspectors and LHW will be required – sharing of critical information. Sharing of data nationally will be essential and this would be easy to set up with an agency agreement, an agreement requiring reciprocity about key issues of patient safety, quality and access. The relationship with the NHSCB in relation to its patient safety arm (NPSA) will be just as important to HWE as the CQC arm. The anxieties of the government about HWE failing have driven them to overreact and create certain failure- locating HWE within the CQC will distort it relationships with the CQC, Monitor and the NHS CB and it will just be seen as the PPI arm of CQC and probably closed down in 2018 (the five year cycle of closing PPI organisations).

Establishing LHW as an independent body

Current Government plans for LHW will ensure its failure. Ministers intend that LHW should be a contractor working with subcontractors to provide the range of activities required of LHW. In some fortunate cases 'grant in aid' might be used to fund LHW. Having LHW as a body beholden to the local council and funding it through the local council creates a weak, confused, fragmented set of LHW contractors. It will be an abysmal mess and take years to establish.

The solution is for LHW to be established by HWE and funded by either HWE or by the NHS Commissioning Board. There are great advantages with this model. LHW in the current model is expected to monitor the services of the body that commissions it, which is also the body to which it is accountable. LHW will be accountable to the local authority, the subcontractor will be accountable to the LHW. It is an accountability nightmare, infested by contracts and lawyers. Money down the drain, and no way of knowing which drain.

Locating LHW with HWE will be simple and accountability clear. With an elected Board, accountability of HWE for the establishing and funding LHW will be in the public arena, rather concealed within hundreds of contacts, with hundreds of companies and charities. Problems with LHW will be identified quickly and a HWE team available to support LHW address any weaknesses. LHW will then be free to monitor local social care and health services and take its seat on the Health and Wellbeing Board, without the fear that criticism of the local authority will ensure that its contract will not be renewed or its budge cut.

Please find below our recommendations to the consultation on HWE and attached our full response.

6. Recommendations to Health Ministers from NALM

6.1 Independence – Independence – Independence

HealthWatch England must be fully independent. One of the lessons coming from the Mid Staffs Inquiry relates to the issue of independence. It is most likely that the report of the Inquiry will identify a systemic failure of organisations to focus on the primary needs of hospital patients. The inter-connectedness of the hospital with Monitor, the Deptartment of Health and its regional offices, the CQC and others meant that there was no truly independent perspective. This situation must not be repeated in the establishment of HealthWatch structures. The keys to the approach must be independence and transparency throughout the system – this is the only way to re-build public confidence in and credibility of the process.

6.2 Enhancing the Collective Voice of the Public

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

6.3 Influencing National Policy in Health and Social Care

HWE 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.

6.4 Proactive Leadership

HWE must actively represent the public and be pro-active incluencing the CQC, Monitor, NHSCB and the Secretary of State on behalf of the public.

6.5 Hearing the Public Voice and Acting Effectively

HealthWatch England should seek views and information about the experiences of people who use health or social care services. They must 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. Access without power influence is useless.

6.6 Access and Influence

The Chair of HWE must have a seat on the Board of CQC, Monitor, NHS Commissioning Board and the DH Department Board, to ensure that the public's influence is felt everywhere in the health and social care system. This will ensure that HWE has real influence in every relevant key decision-making policy body.

6.7 Influencing the CQC, MONITOR, NHSCB and The Secretary of State

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

6.8 Independence from the CQC

HWE must be completely independent of the CQC. This must be managed carefully, because although it may be the intention for HWE to have it own identity, it is unlikely that this will happen in reality, because a HWE committee will be rapidly absorbed into and overwhelmed by the infrastructure of CQC.

6.9 The Regulations must confirm Indepence

The Regulations must state that HWE will be an independent body. The consultation document does not state that it is the intention to create HWE as an independent body. We believe that independence is fundamental to the credibility, success and influence of HWE.

6.10 Agency Agreement for CQC resources

Technical expertise should be obtained 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 these shared objectives.

6.11 Developing a cadre of experts in public involvement

The creation of a cadre of expert staff to support the development of LHW essential. NALM supports the creation of independent HWE in advance of LHW and believe it should have the resources and infrastructure both to actively support the development of LHW especially in its earliest stages, and the sharing of good and best practice.

6.12 A duty to respond to HealthWatch England recommendations

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 on each of these bodies to respond to and take action in response to recommendations made by HWE.

6.13 HealthWatch England Report must be in the public arena

HWE must share all of its reports with LHW and local people. All reports produced by HWE must be made available as hard copy to all LHW organisations and libraries in England.

6.14 Accessing and Sharing Data about Services

LHW will be led locally, but HWE must support, facilitate and enable the success and empowerment of LHW. The CQC currently 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 examples: http://www.achcew.org

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 its own priorities. It is not the handmaiden of the CQC. HWE should not be viewed as a 'bolt-on' that will redress, through LHWs, the shortcomings of the CQC.

6.15 Accountability of HealthWatch staff

HWE staff must be accountable to the HWE - not to the CQC. Regarding core functions being provided by the CQC, HWE staff must not become accountable to the CQC rather than senior staff in HWE. HWE staff must be HW-facing.

6.16 Rationalising the Monitoring of Health and Social Care

Monitoring of health and social care services must be rationalised – having three bodies carrying out similar monitoring tasks is a poor use of resources and will require a great deal of coordination. 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.

6.17 Consultation with Local HealthWatch on any major changes to HealthWatch England

LHW must be consulted before any major changes are made to HWE. If as a result of criticisms of its performance, the Secretary of State attempts to terminate HWE, under the current proposals LHW would not have any locus in the decision-making process. LHW must be consulted before any attempts are made to substantially vary, or terminate the operation of HWE. LHW must be included in plans for it redevelopment.

6.18 Strategic and Accountable to the Public

HWE is being established as a service the public – not the CQC or Department of Health. 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 powers, levers and functions, to be operated on their behalf and in response to demands from LHW. Nevertheless, to achieve its functions and objectives it must take a strategic approach.

6.19 Board Members must be Credible National Leaders

HWE Board members must understand the levers of community empowerment and influence. NALM agrees that HWE Board members must have sufficient skills and experience to enable HWE to deliver its work programme. Board members must also ensure the Board has 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.

6.20 The Chair of HealthWatch England must not be accountable to the CQC

The Chair of HWE cannot be accountable to the Chair of the CQC. It is not appropriate. 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 - and if the CQC were to be seen as a failing organisational this would impact heavily on the reputation of HWE. The Chair of HWE cannot not be subservient to the Chair of the CQC.

The Minister's agreement to make HWE accountable to the Secretary of State is welcome. Any assessment of the performance of the CQC by the Secretary of State must include the views of LHW.

LORD PATEL
LORD HARRIS OF HARINGEY
BARONESS WHEELER

Leave out Clause 180 and insert the following new Clause—

"HealthWatch England

(1) There shall be a body corporate known as HealthWatch England.

(2) The primary duty of HealthWatch England shall be to represent the interests of patients and users of national health services and social care services (hereafter known as "patients and users") in relation to providers, regulators and the Secretary of State.

(3) HealthWatch England shall be independent of any provider of national health or social care services or of any regulator of health or social care or of any other body established by this Act or otherwise.

(4) HealthWatch England shall have the following functions—

(a) to establish a local HealthWatch organisation for each local authority area;

(b) to provide each local HealthWatch organisation with such resources as may be agreed by HealthWatch England;

(c) to provide local HealthWatch organisations with advice on, and assistance in relation to, their functions and on such other matters that HealthWatch England may determine; and

(d) to provide relevant persons with information and advice on—

(i) the views of people who use health and social care services and of other members of the public on their needs for, and experiences of, health and social care services; and

(ii) the views of local HealthWatch organisations and of other persons on the standard of provision of health and social care services and on whether or how the standard could or should be improved.

(5) Relevant persons referred to in subsection (4)(d) are—

(a) the Secretary of State;
(b) the National Health Service Commissioning Board;
(c) the Care Quality Commission;
(d) Monitor; and
(e) English local authorities.

(6) A person provided with advice under subsection (4)(d) must inform HealthWatch England in writing of his or her response or proposed response to the advice.

(7) HealthWatch England shall in addition have powers of investigation as prescribed in subsections (8) and (9) and powers to require disclosure of information as prescribed in subsection (6).

(8) HealthWatch England may investigate—

(a) a complaint made by or on behalf of a patient or user or a local HealthWatch organisation which appears to the Board to raise one or more issues of general relevance; or

(b) any matter which appears to the Board of HealthWatch UK to be or be related to a problem which affects or may affect patients or users generally or patients or users of a particular description.

(9) For the purpose of subsection (8) a complaint raises an issue of general relevance if it raises—

(a) a novel issue which affects or may affect patients or users in general or patients or users of a particular description, or

(b) any other issue which has or may have an important effect on patients or users generally or patients or users of a particular description.

(10) HealthWatch England may by notice require a person within subsection (11) to supply it with such information as is specified or described in the notice within a reasonable period as is so specified and the information so specified or described must be information that HealthWatch England requires for the purpose of exercising its function.

(11) The persons referred to in subsection (6) are—

(a) any provider of health or social care services licensed by the Care Quality Commission and Monitor under the provisions of this Act;
(b) the National Health Service Commissioning Board;
(c) Monitor;
(d) Care Quality Commission; and
(e) any other person specified or of a description specified by the Secretary of State.

(12) If a person within subsection (11) fails to comply with a notice under subsection (10) the person must, if so required, give notice to HealthWatch England of the reason for the failure and if that reason for failure is not acceptable to the Board of HealthWatch England then the Board of HealthWatch England may take steps to publish the notice and the reasons for failure provided or to seek enforcement of the said notice through the courts.

(13) HealthWatch England must publish details of arrangements it makes under this section, including details of payments of remuneration or other amounts.

(14) In performing functions under this section, HealthWatch England must have regard to such aspects of Government policy as the Secretary of State may direct.

(15) As soon as possible after the end of each financial year, HealthWatch England must publish a report on the way in which it has exercised its functions during the year.

(16) HealthWatch England must—

(a) lay before Parliament a copy of each report made under subsection (15); and
(b) send a copy of each such report to the Secretary of State.

(17) HealthWatch England may publish other reports at such times, and on such matters relating to health or social care, as it deems appropriate.

(18) Before publishing a report under subsection (15) or (17), HealthWatch England must, so far as practicable, exclude any matter which relates to the private affairs of an individual, the publication of which, in its opinion, would or might seriously and prejudicially affect that individual's interests.

(19) In this section "financial year" means—

(a) the period beginning with the date on which HealthWatch England is appointed and ending with the following 31 March, and

(b) each successive period of 12 months ending with 31 March."

BARONESS BAKEWELL

Insert the following new Clause—

"HealthWatch England's Commissioner for Older People

(1) The Health and Social Care Act 2008 is amended as follows.

(2) In Chapter 3 of Part 1 (quality of health and social care), before section 46 and the preceding cross-heading insert—

"HealthWatch England's Commissioner for Older People

HealthWatch England's Commissioner for Older People

(1) A member of HealthWatch England shall be designated as the Commissioner for Older People in England.

(2) The Commissioner shall exercise their functions independent of their role as a member of HealthWatch England.

(3) The general functions of the Commissioner shall be to consult with and garner the opinions of older people, and to represent those opinions in all arenas of public discourse including Parliament.

(4) The Commissioner shall be free to set its own parameters within the broad context of monitoring institutions.

(5) The Commissioner must encourage the involvement of older people in the work of the Commissioner.

(6) The Commissioner must, in a particular, take reasonable steps to listen to and consult with older people on the work to be undertaken by the Commissioner.""