# NALM's Response to the HWE Consultation

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**National Association of LINks Members**

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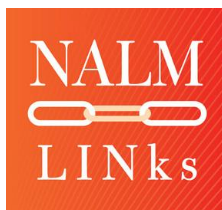


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# Consultation on the Regulations for HealthWatch England Membership

NALM welcomes the opportunity to respond to this consultation and to influence the development of Healthwatch England (HWE) and the membership of its Board. In the wake of recent events such as Mid Staffordshire Hospital and Winterbourne View, there can be little doubt that if we are to avoid similar situations, and ensure patients, residents, carers can quickly alert the NHS and councils of their concerns, a strong and effective network of local Healthwatch supported by a strong national body is essential.

## 1. Number of Members for HealthWatch England

***The Department's recommendation is to have a <u>minimum</u> membership of 6 and a <u>maximum</u> membership of 12***

**Having a small unrepresentative HWE Board will damage its credibility.**

NALM does 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. NALM believes a Board of 12 people would be appropriate, consisting of at least 8 elected members and 4 appointed members, to ensure inclusivity and diversity.

However, there are powerful arguments for a larger Board which includes 1 elected LHW representative from each of the former NHS regions. This would make the Board more genuinely representative of the country.

We believe strongly that the Board of HWE must represent diverse and hard-to-reach communities, in relation to ethnicity, disabilities, young and older people and the other groups identified by the Equalities Act. People with diverse views and experiences are essential to ensure that Board members possess the expertise needed to influence and engage other organisations. Compliance with the public sector equality duty (under the Equality Act 2010), and acting according to the Nolan principles is both fundamental and essential. Additional, co-opted members, if necessary, would increase the diversity and influence of the HWE Board.

MONITOR, the CQC and NICE have very specific functions within an overall system and do not, have the same need for the broad focus which is essential for HealthWatch England. Credibility and public confidence will only come if HWE is powerful, influential and effective and is seen as having a wide and geographically representative membership.

Our recommendation for the size of the HWE Board is considerably above what the consultation document suggests as a possible 'maximum' number. The key issue is, however, that if HealthWatch England is to be seen as a credible organisation, working on behalf of the whole population, it must be seen to have a broad and inclusive membership.

## 2. Suitability for Membership of the HealthWatch England Board

***The Department's position is that the setting of any criteria on the skills and expertise that are required for a person to be a member of HealthWatch England, should be a matter for the Chair of HealthWatch England, working collaboratively with CQC (and other stakeholders).***

**Key strengths for members of the HWE Board**

NALM agrees that it is important to elect/appoint members with the specific skills and expertise, who will be able to ensure that HWE influences health and social care policy through its influence with the Secretary of State, CQC, Monitor and the NHS Commissioning Board, and ensure HWE fulfils its functions, i.e.:

* Enabling and leading the development of effective LHW in every part of England.
* Setting standards for LHW and providing support, advice, assistance to LHW organisations.
* Using information from LHW on the views and experiences of patients and service users to influence the national agenda.

NALM agrees that members of the HWE Board should be elected/appointed on the basis of a strong background in public and patient involvement in health and/or social care. It is essential that the skills and expertise sought include, but are not dominated by 'national vision'. HWE will be looked to by 152 LHWs as an organisation that understands, and has experience of local problems and issues, including the special needs of rural areas, as well as having a national perspective.

## 3. Who might be disqualified from Membership

***The Department's recommendation is that some individuals may be automatically disqualified for reasons such as:***

- ***People who have received a prison sentence or suspended sentence of 3 months or more in the last 5 years.***
- ***People who are the subject of a bankruptcy restrictions order, or interim order.***
- ***Any who has been dismissed by an NHS body or local authority within the past five years other than by reason of redundancy.***
- ***In certain circumstances, those who have had an earlier term of appointment terminated.***
- ***Anyone who is under a disqualification order under the Company Directors Disqualification Act 1986.***
- ***Any who has been removed from trusteeship of a charity.***
- ***Anyone who fails to comply with the HealthWatch England Code of Conduct and Conflicts of Interest.***

**Caution must be exercised if exclusions from HWE Board membership are being considered**

There needs to be more reflection on those who might be excluded from membership of the HWE Board. NALM agrees that the exclusions from membership of the HWE Board suggested by the DH are reasonable – however, there might be good reasons to allow appeals. For example, a person might have had an appointment terminated because he or she had attempted to exposed corruption or incompetence in a public body, but was later vindicated when it was found that their allegations were substantiated.

NALM would not wish to see inclusion of criteria that reduced the diversity of the Board, or become tools for unreasonable 'control' over who sits on the Board.

## 4. Process for Appointing Members

***The Department's position is that members will be appointed to HealthWatch England according to transparent appointment criteria.***

The Chair of HWE, together with local LINks, should agree criteria for election/appointment of members to the HWE Board. NALM strongly believes that the Chair of HealthWatch England, in collaboration with LINks, provide the most appropriate source of expertise and insight to determine the criteria, required skills and expertise, for potential members of the HWE Board.

***An alternative may be for nominees for HealthWatch England to be elected at local level, potentially led by local HealthWatch, a certain number of whom would be appointed according to transparent appointment criteria.***

Most Board members of HWE should 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 influence national policy through HWE, and must have a diverse membership - that it is appropriate for the majority of HWE Board members to be directly elected from LHW.

NALM agrees that this should include patients, service users, carers and the public, and voluntary and community-based groups, including those organisations that work with hard-to-reach groups.

The regional representatives should be elected by their constituent LHWs. The remaining members may need to be appointed, either through a nomination procedure to the Chair of HWE, or through suitably framed national recruitment mechanisms.

It is further stressed that there should be no more than 1 member of the HWE Board representing the CQC and no more than 1 representing local authorities.

## *5.* Tenure of Board Members

***The Department's position is that the maximum tenure of a member should be 4 years.***

### Term of Office for HWE Board members

We accept that there is an immediate issue in that LHWs will not be established until April 2013, whereas it is intended that HWE will be in place by October 2012. It is recommended that, for the period up until 31st March 2013, a shadow board be convened using the principles outlined above.

Beyond that, it is recommended that the term of office be 3 years. Thereafter, a third of the members retiring – or eligible for re-election or re-appointment - for a further term on an annual basis.

Only in exceptional circumstances should anyone be a member for more than 2 successive terms of office. This is to enable 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 exceptionally well, and functioning as a notable leader of a national body and having a significant impact on the effectiveness, development and safety of health and social care services.

# 6. Recommendations to Health Ministers

### 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.**