WWW.NALM.org.uk

National Association of LINks Members

Patient and Public Involvement in Health and Social Care

Short Briefing Note for Andrew Lansley MP May 18th

NALM the National Association of LINks members was formed on April 1st 2008 and formally launched on April 2nd by Sir Cyril Chantler, Chair of the King's Fund. It was attended by 150 LINks members from across the country. The Secretary of Health was invited to attend but neither he nor other Ministers nor civil servants from the DH attended the launch.

The Chair of NALM Malcolm Alexander chaired a recent meeting in Stafford called by 'Cure the NHS' and attended by 200 local people.

NALM has 700 individual members nationally and is actively recruiting LINks

Effectiveness

- *Effectiveness of patient and public involvement in the NHS* - The Government's policy of closing PPI bodies if they are effective, is a major factor in weakening the ability of patient and the public to monitor the NHS (CHCs closed in 2003, Patients' Forums 2008)

Continuity

- Patients and the public need assurances that the DH and C&LG are committed to 10 fully funded years to develop, monitor, inspect and create powerful LINks. They must be independent local organisations of citizens able to perform and 'blow the whistle'

when patients complain and systems in the NHS and social care are going wrong.

Attempt by government to control LINk

- The DH has used part of the £28m LINks budget to fund civil servants to work with each Regional Government office to organise LINks. The policy of funding civil servants to organise LINks on behalf of DH, could fundamentally undermine their independence. The resource should be used to enable LINks to set up their own regional and national structures through NALM

Weaknesses at Stafford

- There was a large group of Foundation Trust governors who appeared to be out of touch with what was happening at grass roots level in the hospital. Governors had no real power and were unable to prevent the disasters at Stafford. The FT members appeared to have no influence on the FT board and were largely cosmetic. The LINk members, with a few notable exceptions, according to the Cure the NHS, failed to raise critical issues about the developing crisis. LINks, which were set up precisely for the purpose of monitoring, had not yet set up effective systems to identify problems and advise on finding solutions. The Cure the NHS feels let down by their local LINk.

Models of effective public involvement

- Effective patient led involvement requires continuity, regular visiting, getting to know patients and staff, having an ear for local people's concerns, getting in contact with local information, being able to call for answers and investigations when things are apparently going wrong and being able to publicly challenge the Chief Executive, Chair and Board members. Most particularly LINks need to be able to operate independently with and on behalf of patients and carers, and must have the courage to 'blow the whistle' when things have gone wrong. The model needs to be powerful, effective and include occasionally being able to veto decisions of Trust Boards.

  We should establish well trained 'Public Inspection Teams' (NHS PITS) made up of patients and carers and operated through re-launched LINks

Effective training

- Effective training and coaching of members of the public is required for them to participate in monitoring and inspections of hospitals and the proposed NHS PITS

Reporting-back

- Trust boards should regularly report back at public meetings on the effectiveness of the hospital and community services. This should include details of patient safety information, e.g. MRSA and C.difficile incidence, accidents in wards, theatres and in the community, mistakes with the use of drugs etc. This information needs to be in the public arena if Trusts are to be accountable.

Public Inquiries/Terms of Reference: http://tinyurl.com/prpyek

- We need to ensure that Cure the NHS is involved in the determination the Terms of Reference for a public inquiry.

FT members – Mid-Staffs – barring from office

- Members of the FT Board who were members during the development of the crisis should be barred from future public office as hospital managers, directors or members of Trust Boards.

Board Membership at Mid Staffs FT

- **Current Board Members**

Non-executive directors:
-David Stone OBE – interim chair
-Dennis Heywood,
-Sir Stephen Moss,
-Roger Carder,
-Eric Morton
-Mike Gill - Director of Finance and Planning
-Karen Morrey (was on previous Board) - Chief Operating Officer
-Helen Moss (was on previous Board) - Director of Nursing and Governance
-Mike Court - Director of Strategy, Planning and Performance
-Manjit Obhrai - Medical Director

- **Previous Board Membership**

Electronic sign off - details of individual(s)

	Title	Full name	Job title
1.	Mr	Martin Yeates	Chief Executive
2.	Mr	Toni Brisby	Chair of Trust
3.	Mr	John Newsham	Director of Finance & Deputy Chief Executive
4.	Dr	Helen Moss	Director of Nursing and Governance
5.	Dr	Val Suarez	Medical Director
6.	Ms	Karen Morrey	Chief Operating Officer
7.	Mr	David Denny	Non-Executive Director
8.	Mr	Peter Bell	Non-Executive Director
9.	Dr	Mike Wall	Non-Executive Director
10.	Mr	Gerry Hindley	Non-Executive Director

Annual Health Check

Annual Health Check 2006-7 http://www.midstaffs.nhs.uk/aboutUs/corporate/publications/AnnualAuditLetter2006-07.pdf. It was signed off by 10 Directors above.

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Appendix One

Cure the NHS Survival Guide

http://tinyurl.com/pjy97j

We have put together the following points to help to ensure everyone receives the treatment and care they should expect regardless of age or vulnerability as a patient.

1. **Everyone has a right to be tested for MRSA and C-diff on admission to the hospital.** Ask to be tested on admission to ensure you are not taking the infection into the hospital- some hospitals will offer the tests as they do not want someone bringing infections into the hospital.

2. **Everyone should have a care plan.** This sets out the plan for you or your relatives care. Ask to see it, inform staff you want to be involved with

your relatives care provide as much information as you can. Ensure you have regular communication with the doctors and nurses. Ask when the ward round takes place. Inform staff you want to be present. Ask questions, you have a right to be kept informed of test results and any changes to the plan of care i.e. medication. Ensure you know who your relatives 'named nurse' is and that they know who you are.

3. **Try to spend as much time with your relative as possible.** Try to get there other than at visiting times, especially meal times. You have a right to stay, ask to be shown the relatives facilities i.e. bathroom.

4. **Ensure your relative is receiving the right nutrition and fluids.** Ensure you have access the nutrition and fluid charts. If you have concerns and one is not in place ask for one. If they are not being filled in by the staff, ask why. You may find 'refused' has been put on the chart. If so question it. If your relative is unable to feed themselves ask what system is in place to ensure your relative is given food and fluids.

5. **You have a right to an assessment from social services.** This is for anyone who is classed as a vulnerable adult. Ask for one.

6. **If you are not happy with any treatment or service you or your relative is receiving, ask to see the ward manager.** You have a right to ask questions and make a complaint. This should be done in writing and addressed to the Chief Executive. Send copies to your MP and Cure the NHS. Include any evidence - times, dates, witness contact details.

Cure the NHS members hope this guide will help you or your relatives during their hospital stay. If you have any other advice that we could add please let us know and we can include them. If we all help each other we can help to ensure a safer stay for others.

Appendix Two

Cabinet Office UK Resilience

CabinetOffice

Public Inquiries

also be some subject areas, such as financial services, where it is appropriate to keep a specialised framework in place.

Inquiries do not determine civil or criminal liability. They are not a substitute for court proceedings, and they don't punish people or award compensation. They are a tool for establishing facts and preventing a problem from recurring.

On the face of the 2005 Act, there is a new requirement on an inquiry chairman to have regard to the need to control costs. Sections on payment of inquiry and witness expenses provide the Minister with a degree of budgetary control, while ensuring that the inquiry has adequate funds. Proposed procedure rules should strengthen a chairman's hand in controlling costs.

Under the 2005 Act, inquiries will be able to compel any information that could be compelled by a court in normal civil proceedings. Failure to co-operate will be a summary offence, and inquiry chairmen will also have the option of asking the High Court to enforce any orders that they make. During the last few years, there have been a number of inquiries set up to investigate the circumstances surrounding disasters:

- 2000 Shipman Inquiry set up under the 1921 Act by Department of Health and chaired by Dame Janet Smith.

No inquiries into a disaster have been set up under the 2005 Act, which came into force on 7 June 2005 throughout the UK. Earlier inquiries have been converted to inquiries under the 2005 Act in respect of the deaths of Billy Wright and Robert Hamill in Northern Ireland although these have been the subject of judicial review proceedings, challenging the decision to so convert.

Section 19 of the 2005 Act gives the minister power to make a restriction order prohibiting disclosure of evidence in the public interest. The restriction order might apply indefinitely and would not be restricted to matters of national security.

UK Policy and Guidance

Public inquiries are governed by the **Inquiries Act 2005** and a wide variety of other legislation, including the Health and Safety at Work etc Act 1974, Merchant Shipping Act 1995, Railways Act 2005 [External

website], and the **National Health Service Act 1977**. But public inquiries may also be established on a non-statutory basis. This was the case with the BSE Inquiry and the **Stephen Lawrence Inquiry**. An information sheet on the Inquiries Act 2005 was issued by the then Department for Constitutional Affairs (DCA) on 7 June 2005.

No guidance has been issued to local authorities on the handling of public inquiries. It is expected that all persons called to give evidence to a public inquiry will fully co-operate with that inquiry. The inquiry team may of course offer advice to those appearing as witnesses or otherwise involved and ensure that such persons are aware of the terms of reference and what may be expected of them. In cases of doubt, the persons concerned should clarify their position. Under no circumstances should a person be expected to incriminate themselves when answering a question. Public inquiries do not determine questions of criminal or civil liability.

Roles and Responsibilities

England

A decision on the form of an Inquiry is taken by ministers at the time depending on the nature and circumstances of the event, except where this has been devolved to an independent body such as the Health and Safety Commission. The default position is to establish an inquiry under the Inquiries Act 2005 - however, the minister may decide for whatever reason to use other legislation or perhaps proceed on a non-statutory basis. **The terms of reference will normally be determined wholly by the minister in discussion with officials and, as necessary with the benefit of the knowledge of technical experts. Other legislation which might be considered is:**

- In cases where there has been fatalities in England and Wales under **section 17A of the Coroners Act 1988** exceptional reason to the contrary", and may discharge any jury. He must then sign and send to the registrar of deaths a certificate stating the registration particulars, so far as by then ascertained. Once the findings of the public inquiry are published, the Lord Chancellor must send the coroner a copy. The coroner may only resume the inquest after 28 days from publication of the findings or (if the Lord Chancellor directs) from the end of the inquiry, and then only if, in his opinion, there is exceptional reason to do so. This

procedure was followed in the Ladbroke Grove Rail disaster, as well as the Shipman Inquiry (twice), the Gaul inquiry (twice) and the Hutton Inquiry. There are separate arrangements in Scotland and Northern Ireland (see below).

- **The Health and Safety at Work etc Act 1974** where under section 14 of this Act, the Health and Safety Commission has powers to direct investigations and inquiries into ..."any accident, occurrence, situation or other whatsoever which the Commission thinks it necessary or expedient to investigate..."
- The Secretary of State for Health may cause a local inquiry to be held under section 318 of **The Public Health Act 1936** in any case where he deems it advisable that one should be held in relation to any matter concerning the public health in any place.
- The Secretary of State for Environment or for Wales can cause a local Inquiry to be held under section 96 of the **Control of Pollution Act 1974 with a view to preventing or dealing with pollution or under section 70 of the Public Health (Control of Disease) Act 1984** in relation to any matter concerning the public health.

Many inquiries will be held close to the events which have occasioned its establishment. For example, the Shipman Inquiry was held at Manchester Town Hall; the Bristol Royal Infirmary Inquiry took place in Bristol. In such circumstances, local authorities are expected to co-operate fully with the inquiry team in finding suitable facilities if requested to do so. In particular, the local authority should be willing to find suitable accommodation and second administration staff as required.

The Inquiry's own responsibility in this area will be to ensure that its needs are fully understood by those it has requested to provide or facilitate the provision of resources.

Funding

The costs of the inquiry will be met by the relevant government department or from the budget of the independent body unless, although this seems highly unlikely, an inquiry into a disaster has been established by local or regional government, rather than central government.

Links to other Topic Sheets

- Coroners' inquests