The national voice for LINks' members

Local Involvement Networks (LINks)

Independent and Accountable?

A NALM Report on Local Authority monitoring of LINks' Hosts

June 2010

The National Association of LINks' Members

Public and Patient Involvement in Health and Social Care

NATIONAL ASSOCIATION OF LINks' MEMBERS

Patient and Public Involvement in Health and Social Care

A NALM Report on
Local Authority monitoring of LINks' Hosts
June 2010

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THE AIMS OF NALM

The aims of NALM are to:

1. Provide a national voice for LINKs' members

2. Promote public involvement that leads to real change and the ability to influence key decisions about how care services are planned and run

3. Promote the capacity and effectiveness of LINks' members to monitor and influence services at a local, regional and national level and to give people a genuine voice in their health and social care services

4. Support the capacity of communities to be involved and engage in consultations about changes to services, influence key decisions about health and social services and hold those services to account

5. Promote diversity and inclusion and support the involvement of people whose voices are not currently being heard

6. Promote open and transparent communication between communities across the country and the health service

7. Promote accountability in the NHS and social care to patients and the public

CONTENTS

The statutory duty to ensure that local involvement network activities are carried on rests with Local Authorities [with social services responsibilities].

Ann Keen, Health Minister, Hansard, 28.1.09

ABSTRACT

A survey of 150 Local Authorities (LA) was conducted in December 2009 to establish the provision made for monitoring 79 Host organisations supporting Local Involvement Networks (LINks). Of the 141 (94%) respondents to a questionnaire, 29 (20.6%) LAs had a formal LA Monitoring Committee and 15 (10.6%) LAs had informal alternative arrangements. The majority of 79 (56%) LAs measured the Host performance without a Monitoring Committee, but 18 (12.8%) LAs did not monitor their LINks' Host at all. Monitoring Committees had a number of functions including advisory, liaison and partnership, direct contract monitoring or review functions.

LA officers constituted a relatively large proportion of Monitoring Committee Membership (50%), compared with LA councillors (8.8%) and LA representatives chaired the meetings. There was more Host staff (11.5%) than LINks' representatives (8.2%) on these committees. LINks' membership of the Host Monitoring Committees was mostly *ad hoc* and relied on goodwill and invitations rather than automatic representation. Primary Care Trusts (12.1%) had a larger representation than NHS Trusts (6.0%), and a small proportion of PCT members had the right to vote (4.4%). Other representatives constituted a small proportion of the Monitoring Committees (3.3%).

Assessment of contract compliance by the Host was measured by targets or key performance indicators (KPIs) by 123 (87.2%) of LAs and 56 (39.7%) replied that there were penalties for failure to achieve the targets set. The main penalty for non-compliance was termination of the contract, which had been effective in 2 (1.4%) of contracts with the Hosts appointed in 2008. Loss of income for the Host was also a penalty.

A small proportion of LAs (24, 17.0%) provided a copy of their Host Monitoring Form. Targets and key outcomes were set in each LA contract with the Host organisation. Analysis of the criteria used showed that there were 3 sets of performance indicators measured - public engagement activities, membership policy and governance, and procedures. Output was measured by the number of LINk activities performed using qualitative or quantitative methods. Criteria were generally well monitored, but notably monitoring Host performance on training of LINks' members was carried out in only 75.0% of Hosts, and monitoring of the Host performance in supporting LINks' independence was low (16.7%). Although data on monitoring of targets may have been available in reports on Hosts presented at monitoring meetings, these meetings tended to be infrequent: 48.9% of the monitoring meetings took place every 3 months, 9.9 % every 6 months and 8.5% were annual meetings. The remaining 32.6% did not have monitoring meetings.

The methods used to monitor key performance indicators were mainly qualitative (83.3%), and there was a low level of quantitative performance scoring (29.2%). Outputs - such as the number of LINks meetings and consultations attended - were not well recorded. The number of patients interviewed was very low (8.3%), and the number of 'enter and view' visits were also minimal (8.3%). LINks fed into the performance management of the Host in 95 (67.4%) of the LAs which replied to the questionnaire; 24.8% of LINks made a written report, 31.9% made a verbal report and 36.2% LINks' representatives attended Host Performance Monitoring Meetings.

Comment made by 9 (6.4%) LAs provided valuable information for discussion about the development of LA monitoring of Host organisation - and how LINks can be involved in that process.

INTRODUCTION

Legislation, passed in 2007, required Local Authorities to make arrangements for provision of Local Involvement Networks (LINks) to provide public and patient representation in health and social care [1-2]. LINks replaced Patient's Forums (sometimes known as Patient and Public Involvement Forums – PPIFs), which were dissolved in March 2008 after four years. Community Health Councils (CHC) preceded the Patients' Forums and were the established body for patient representation from 1974-2003 [3-5]. CHCs were usually based on health authority boundaries, whilst Patients' Forums were based on NHS hospitals or Primary Care Trusts. Both CHCs and Patients' Forums monitored health services at their designated NHS hospitals and Primary Care Trust services. LINks have a wider remit, which includes monitoring and involvement in social care.

The method of funding of LINks through non-ringfenced budgets via Local Authorities is a key factor in differentiating LINks from CHCs and Patients' Forums.

The CHCs were funded through a distant Regional Health Authority to ensure their full independence. CHC staff was employed on permanent contracts to run public services in premises owned or rented by the NHS. They had a statutory role in responding to complaints and other patient and public issues regarding NHS hospitals and primary care services. Their volunteers undertook their monitoring work on four year appointment, and 50% were elected through the local voluntary sector.

The Commission for Public and Patient Involvement in Health (CPPIH) either provided in-house support services for Patients' Forums, or allocated funding to charitable and voluntary service organisations, which were given contracts to provide administrative service for each Patients' Forum. Volunteers undertook the work of gathering views and representing the patient and the public view locally. They were able to exchange ideas with other Patients' Forums through a national website and regular regional and national meetings.

The Department of Communities and Local Government (DCLG) allocated funding for LINks through the Area Based Grant given to each Local Authority [6]. The funds are allocated to enable each Local Authority to commission a Host to support the involvement of local people in the commissioning and monitoring of health and social services.

The commissioning of a Host organisation by the LA, is intended to enable the Host to employ LINk Support Staff to assist the volunteers to engage with patients and the public in health and social services. The LINks remit is to monitor all publicly funded services in the Local Authority area - including services provided by hospital Trusts, Foundation Trusts, PCTs, GP, dentist, pharmacists and other independent providers. Funding has been allocated for three years from 2008-2011 but the funds are not ring-fenced. LINk's expenditure must be declared in the LINk Annual Review [7] and the LA Annual Accounts. Local Authorities have a statutory duty to monitor the contracts made with Host organisations.

The aims of this survey are to explore the accountability arrangement for LINks and the systems Local Authorities have developed and assess the effectiveness of Host organisations. The survey also explores how LINks have been incorporated into the monitoring process. By collating the views of Local Authority personnel, the aim is also to seek a consensus on best practice and find ways to develop the arrangements, at least up to 2011.

Local Authorities will need to ensure that the hosting arrangements they commission are fit for purpose.

Baroness Andrews, Minister, Dept of Communities and Local Government*. *11.11.08, Hansard

Many Local Authorities appear to believe that once a host is in place they have fulfilled their duties under the law — exactly the misconception that many of us fought so hard to avoid when we persuaded the Government to build transitional provisions into the Bill.

Earl Howe, response to Queen's Speech 11.2.09, Hansard

THE STATUTORY ROLE OF LINks

The statutory role of Local Involvement Networks (LINks) is described in s221 of Local Government and Public Involvement in Health Act and the accompanying statutory regulations. Each Local Authority in England with social service responsibilities must ensure that a LINk is operating in the area of the Local Authority and must contract with a Host to provide support for the LINk.

The statutory role of the LINk is to:

(a) Promote and support the involvement of people in the commissioning, provision and scrutiny of local health and social care services

(b) Enable people to monitor the commissioning, provision and scrutiny of local health and social care services

(c) Obtain the views of people about their needs for, and their experiences of, local health and social care services

(d) In relation to the above roles, the LINks must send reports about the quality of services, and recommendations about how local care services could or ought to be improved to Local Authorities, PCTs, NHS Trusts, Foundation Trusts and other relevant commissioners and providers of health and social care, as appropriate

PUBLIC INVOLVEMENT POLICY AND THE LEGAL FRAMEWORK

LINks are funded to monitor care services, promote involvement, improve access and quality, and to influence the commissioning of services. A key way of doing this is through the bundle of legislation and policies on PPI in health and social care. Well trained Hosts and LINk members are the key to ensuring that LINKs are able to influence local health and social care bodies effectively.

Health bodies are required to involve and consult with the public under s242 of the NHS Act 2006 (amended by the Local Government and Public Involvement in Health Act 2007).

Health and social care bodies must also comply with standards set by the Government and monitored by the Care Quality Commission – CQC (the regulators) and Strategic Health Authorities (as performance managers). The CQC will do this using 'Quality and Risk Profiles', which include all the information gathered about each care provider in relation to essential standards of quality and safety. These are expressed as outcomes related to the experiences of people receiving services; e.g. respecting and involving people who use services.

Real Involvement (Department of Health 2008) recommends health bodies to:

- Seek people's views and taken them into account when making a decision about the service
- Carry out any research, consultation or other discussions with patients, local organisations, the LINks and other local people

- Demonstrate proper consideration of evidence derived from users of the service or the clinicians running the service, when NHS managers make decisions to vary or change these services

- Provide information to show that any closure decision was properly made in accordance with duties under the Act or duties in relation to CQC standards

- Have representatives on committees and steering groups, co-designing services directly with people and delegating activities to users and community representatives where appropriate.

PCTs have additional duties under World Class Commissioning Competency 3, to engage with the public and patients, and to proactively seek and build continuous and meaningful engagement with them, in order to shape services and improve health. PCTs must ensure the public is involved in decisions about the allocation of public funds on behalf of patients and communities, so that services reflect the needs, priorities and aspirations of the local population. Proactively, engaging with LINKs is fundamental to the success of PCTs in seeking out the views and experiences of the public, patients, their carers and other stakeholders - especially those least able to act as advocates for themselves.

LINks also have a specific duty to raise issues of concern with the relevant Overview and Scrutiny Committee. Where local NHS bodies have under consideration any proposal for a substantial development of the health service in the area of a Local Authority, they must consult the Overview and Scrutiny Committee of that Authority.

If the Overview and Scrutiny Committee is not satisfied that consultation on a proposal to close or vary services has been adequate, it may report the matter to the Secretary of State in writing, who may require the PCT concerned to carry out further consultation, with the Overview and Scrutiny Committee.

Effective LINks

A LINk representative sitting with PCT Board members at public Board Meetings and actively participating in the business of the PCT, both actively represents the local community and exercises direct influence in commissioning and other major PCT decisions.

Effective PCTs

A successful and effective PCT will ensure that patients and the public can share their experiences of health and care services with the commissioning leads, and will invite patients and the public to respond to, and comment upon issues in order to influence its commissioning decisions and to ensure that services are safe, convenient and effective.

THE NHS CONSTITUTION

The NHS Constitution underlines the fact that public and user involvement should be part of the fabric of the NHS, by setting out a right for people to be involved. It says:

"You have the right to be involved, directly or through representatives, in the planning of healthcare services, in the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services."

METHODOLOGY

The National Association of LINks' Members (NALM) contacted all 150 Local Authority Lead officers in England in December 2009 by direct e-mail, with a questionnaire (Appendix 1). Two reminders were sent to each of those who failed to respond. Those who did not reply to the reminders were sent a Freedom of Information (FOI) request.

Questionnaire returns were eventually received from 141 (94%) Local Authorities. Six (4.0%) of Local Authorities responded to a FOI request without the questionnaire completed, and there was no reply at all from 3 (2.0%) of Local Authorities. The results were compiled on Excel files for analysis (Appendix 2, 3). Commentary was selected from the replies, to gain a better understanding of the issues regarding monitoring of LINks' Hosts by Local Authorities (Appendix 4).

Performance Monitoring Forms provided by Local Authorities, which assessed contract compliance of the Host, were analysed according to the criteria, and output performance indicators identified in the NHS National Centre for Involvement Guide 15, Checking Progress. Each form was scored according to the presence or absence of the criteria, and monitored output compared with the total performance indicators measured.

FINDINGS

1. Local Authorities and Host organisations for LINks

There are 150 Local Authorities (LAs) in England, monitoring 79 Hosts (Appendix 2). Although each LA monitored its contracted Host/s the number of LAs contracting services from Host organisations was complex (Table1).

Table 1. Comparison of the number of Local Authorities and Host organisations

Host organisations 2008 - 2009	LA / Host (n)	LA (n)	%	Host (n)	%
2 or 3 Hosts / LA	6 *	6	4.0	11	13.9
Single Host organisations	1	48	32.0	48	60.8
2 Local Authorities / Host	2	18	12.0	9	11.4
3 Local Authorities / Host	3	9	6.0	3	3.8
4 Local Authorities / Host	4	4	2.7	1	1.3
5 Local Authorities / Host	4 ŦŦ	5	3.3	1.5 Ŧ	1.3
8 Local Authorities / Host	7 Ŧ	8	5.3	1.5 Ŧ	1.3
10 Local Authorities / Host	10	10	6.7	1	1.3
12 Local Authorities / Host	12	12	8.0	1	1.3
13 Local Authorities / Host	13	13	8.7	1	1.3
17 Local Authorities / Host	17	17	11.3	1	1.3
Total	**79 ***	**150**	**100**	**79**	**100**

* = 6 Local Authorities monitor 11 Host organisations,
Ŧ = Host duties shared with other Hosts

The smallest group of 6 (4.0%) LAs monitored 11 (13.9%) Hosts. This group was unusual because it had arrangements with either 2 or 3 Hosts each.

There were 48 (32.0%) LAs, which monitored one Host each. The LAs with 2 - 4 Hosts each constituted a relatively small group (31, 20.7%) with 13 (16.5%) Hosts.

The largest group of 65 (43.3%) LAs made arrangements with 7 (8.9%) Hosts and in this group Hosts were shared between the LAs.

Hosts were widely distributed, except for one organisation with 4 x LAs which was located in the south east. The Host with 12 x LAs was mainly located in the Midlands and North and the Host with 13 x LAs was in the south of England.

Overall there was no bias towards any of the 6 categories of Local Authority, except that 4 Local Authorities with 1 Host are located in Outer and Inner London – (Appendix 2).

2. Membership of Local Authority formal Monitoring Committees

The findings show that out of the 141 (94%) Local Authorities that responded to the questionnaire, 29 (20.6%) had a formal monitoring LA Committee, 15 (10.6%) made informal arrangements, and the remaining 97 (68.8%) had no Monitoring Committee. Overall 123 (87.2%) LAs measured the Host performance (Figure 1) and 18 (12.8%) LAs had no Host monitoring (Appendix 3).

Monitoring Committee titles varied, but included the advisory, liaison, partnership, direct contract monitoring or review functions. LA Councillors or officers such as contract managers or service managers chaired Monitoring Committees - (Appendix 3).

Figure 1. The proportion of Local Authorities with formal committees to monitor Hosts

	Local Authorities with no Host monitoring arrangements
	Local Authorities with informal monitoring arrangements
	Local Authorities with formal Host Monitoring Committees
	Local Authorities with no Host Monitoring Committees

A minority of Local Authorities 29 (20.6%) had a formal committee to monitor the Host organisations (Figure 1). Nationally Local Authority officers predominated as representatives on the formal Monitoring Committees (91, 50%) and there were relatively few LA Councillors (16, 8.3%), but these members acted as the Chair of the Committees if they attended (Figure 2).

Figure 2. Group membership of formal committees monitoring LINks' Hosts

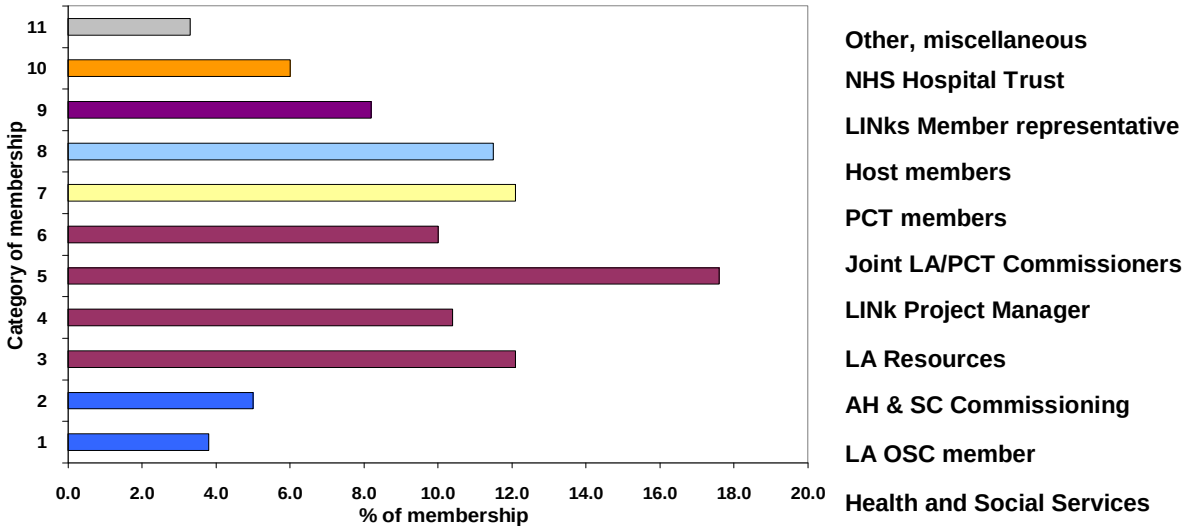
	LA Councillors		Host Members
	Other representatives		Primary Care Trusts
	NHS Trust members		LA Officers
	LINk Members' representatives		

3. Representation on Monitoring Committees

There were more Host members (21, 11.5%) than LINks' representatives (15, 8.2%) on Monitoring Committees. LINks' representatives had relatively little influence on the Host Monitoring Committee (Figure 3). Comment provided in the questionnaire returns shows that LINKs**'** membership of the Host Monitoring Committees was mainly *ad hoc* and relied on goodwill and invitations rather than automatic representation (Appendix 3).

The PCTs (22, 12.1%) had a larger membership of Host Monitoring Committees than NHS Trusts (11, 6.0%), but commissioners and service providers combined had a relatively large representation (33, 18.1%). A relatively small number of PCT members 8 (4.4%) had the right to vote. Monitoring Committee structure varied nationally, but the representation demonstrated, as would be expected strong LA control.

Figure 3. Detailed membership formal Host Monitoring Committees



Key: AH & SC = Adult Health and Social Care Commissioning
OSC = Overview and Scrutiny Committee

Host Monitoring Committees had a relatively large LA membership of LINk Project Managers (32, 17.6%), Adult Health & Social Care Commissioners (22, 12.1%), Resources Managers (19, 10.4%) and Joint LA /PCT Commissioners (18, 10.0 %).

The LA Councillors were either members of the Overview and Scrutiny Committees (9, 5.0%) or had responsibility for LA Health and Social Services (7, 3.8%).

Other representatives constituted a small proportion of the Host Monitoring Committees (6, 3.3%). Miscellaneous 'other' members included representatives of Children's Services and Senior Purchasing Officers.

In some cases, Host Monitoring Committees were in the process of evolution and development:

LA (14)

It is likely that a member of the LINk's stewardship group will be co-opted onto the Adults' Services Select Committee early in 2010. The Select Committee and the Stewardship Group have already exchanged their programmes of future activities.

4. Local Authority assessment of LINks' Host performance

4.1 Assessment of contract compliance by the Host organisation

Assessment of contract compliance by the Host was measured by targets or key outcomes by 123 (87.2%) of LAs. 56 (39.7%) replied that there were penalties for failure to achieve the targets set. Samples of Host Monitoring Forms were provided by 24 (17.0%) Las - from which an analysis was made. (Figure 4).

Penalties for failure were specified by 56 (39.7%) LAs and 7 (5.0%) stated that the main penalty for non-compliance was termination of the contract (Appendix 3). Two (1.4%) LAs declared that the contract with the Host appointed in 2008 had been terminated. Loss of income for the Host was also described as a penalty written into the contracts.

LA (40)

Please note there is not a standard form for measuring contract compliance. Key deliverables are agreed and Host performance is measured against these at quarterly contract monitoring meetings.

LA (106)

Given the developmental nature of LINks and the lack of formal guidance on performance indicators etc from DH we are discussing with LINks what appropriate outcomes measures would be. We see them as (a) organisational - having the right contacts to influence – and (b) contributing to change - making things happen.

4.2 Performance Monitoring

A small proportion of LAs (24, 17.0%), provided a copy of their Host Monitoring Form. Targets and key outcomes were derived from the LA contract with the Host organisation.

Analysis of the criteria used, showed that there were 3 sets of performance indicators measured - public engagement activities, membership policy and governance and procedures.

Output was measured according to the LINk activities accounted for and qualitative or quantitative methods were used to measure output.

a) Criteria monitored

Public engagement activities

Monitoring of intended public engagement activities was variable - (Figure 4). There were 3 criteria that were well monitored – (i) Development of a LINk work plan (22, 91.7%); (ii) A policy to ensure equal opportunities (22, 91.7%) - and (iii) Interaction with statutory bodies, such as the PCT (21, 87.5%). Communication with the public by circulation of LINks' newsletters, press and radio coverage of events (19, 79.2%), and an 'enter and view' policy (17, 70.8%), were monitored by fewer LAs. The production of the LINks Annual Report was monitored by 16 (66.7%) LAs.

LINk input into quarterly meetings of LAs (13, 54.2%) was hardly monitored. Only 4 (16.7%) LAs monitored the independence of LINks.

Membership policy

The policy to promote the diversity of LINks' membership (22, 91.7%) and increase membership (20, 83.3%), was monitored by the majority of LAs, but the policy to monitor the number of new LINks' members (16, 66.7%) was less well monitored. Relatively few LAs (18, 75.0%) monitored the training of LINks members (Figure 4).

Governance and procedures

The majority of LAs monitored whether the Host had ensured that the LINks had a communications strategy (22, 91.5%), a governing body (21, 87.5%), monitored the LINks budget (21, 87.5%) or that the LINks were accountable to their membership (21, 87.5%). Fewer LAs monitored approval of governance documents (19, 79.2%). (Figure 4).

b) Outputs monitored

Hosts' outputs were recorded in the Performance Monitoring Forms in less than 50% of cases. These records may be held elsewhere, such as in the Minutes of meetings held every 3-6 months or annual meetings. The number of LINks' Core Group meetings was recorded by 10 (41.7%) LAs, general members' meetings by 7 (29.2%), and executive meetings by 5 (20.8%) LAs. Involvement in Consultations on service development were not well recorded, or had not taken place since there were only 4 (16.7%) consultations reviewed and 2 (8.3%) consultation meetings attended. Records of the number of patients interviewed was very low (2, 8.3%), and the number of 'enter and view' visits recorded were also minimal (2, 8.3%).

The methods used to monitor outcomes of the performance indicators were mainly qualitative (20, 83.3%), and there was a low level of quantitative performance scoring (7, 29.2%).

LA (12)

What are needed are some clear guidelines from the DH on what measures they will use to assess the effectiveness of the LINks. Some clear guidelines on the formal relationship between the LINk, Host and the Council are needed from the DH.

5. LINk input into performance monitoring

LINks fed into the performance management of the Host in 95 (67.4%) of the LAs that replied to the questionnaire. There were 40 (28.4%) LINks that had supplied a written report, 45 (31.9%) had made a verbal report and 51 (36.2%) LINks' representatives attended Host Performance Monitoring Meetings.

Although the targets may have been monitored in the Host reports made at meetings, 69 (48.9%) of the Monitoring Meetings took place every 3 months, 14 (9.9%) every 6 months and 12 (8.5%) were only annual meetings.

The remaining 46 (32.7%) did not have Monitoring Meetings.

Sample comments from the LA replies to the questionnaire, reflect the informal nature of feedback and that processes are not yet established (Appendix 3).

LA (24)

The monitoring officer has informal conversations with the LINk Chair regarding host performance.

LA (39)

No specific regular meetings other than Steering Group meetings which are monthly.

LA (42)

The Council does receive views and comments from the LINk about the performance of the Host. The Council will follow up these issues as necessary and appropriate.

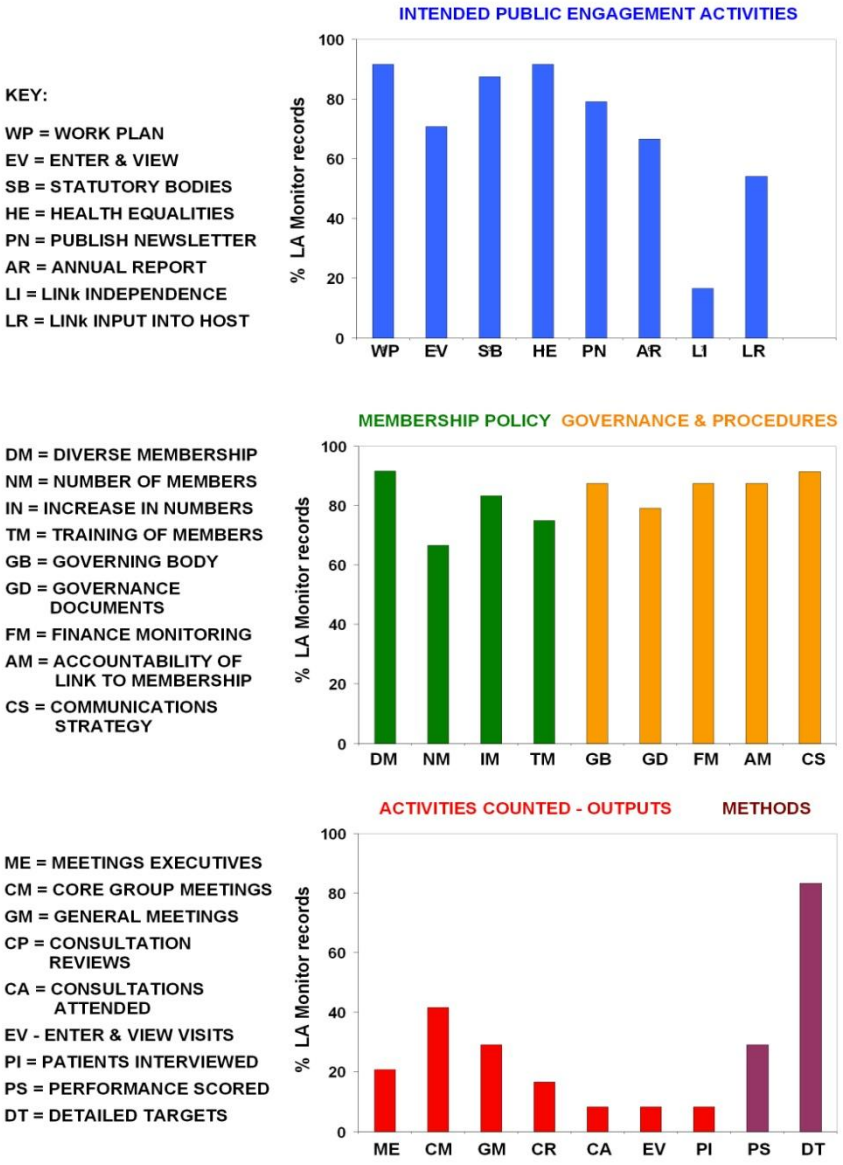
LA (33)

We meet the LINk to discuss performance of the Host when necessary.

LA (111)

The LINk Chair and Vice Chair attend the LINk Host quarterly meeting. We do not have regular separate meetings with LINk to discuss performance of the Host. However, we are available to meet with the LINk to discuss these issues whenever the need arises.

Figure 4. LINks Host performance indicators monitored by Local Authorities



6. Local Authority Comments

There were 9 (6.4%) LAs that made a comprehensive contribution to discussion about the present situation –and to the monitoring and developments in the future. The comments contributed are eloquent summaries of the challenges at present and identify future needs (Appendix 4).

CONCLUSION

In England, Local Authority officers and Councillors constituted more than half of formal Host Monitoring Committee membership, in contrast to just over a tenth of Host staff and the minimal LINks representation of less than a tenth. Comment from Local Authorities (LAs), demonstrated that LINks representation on the Host Monitoring Committees was mainly *ad hoc* and relied on goodwill and invitations, rather than automatic representation.

Although LINks were reported to have fed into the Performance Management of the Host in two thirds of the LAs that replied to the questionnaire, just over a quarter of LINks provided a written report, and just over a third of LINks' representatives attended Host Performance Monitoring Meetings.

The low level of LINks representation on Host Monitoring Committees appears to have had an impact on the selection of performance indicators and targets. The Host policy on training of LINks' members, and 'enter and view' was monitored by three-quarters of LAs. However, less than a tenth of the LAs recorded the number of patients interviewed, or the number of 'enter and view' visits. Although the targets may have been monitored in the Host reports made at meetings, these meetings were usually infrequent with half of the Performance Monitoring Meetings taking place every 3 months, and less than a tenth taking place every 6 months - a similar proportion to annual meetings. The remaining third of LAs did not have monitoring meetings at all. NALM believes this situation is unsatisfactory and needs urgent attention.

Primary Care Trusts constituted just over a tenth of the total membership of Host performance Monitoring Committees and half of those had the right to vote. In contrast, NHS Trusts had less than a tenth of the representation and no vote. However, the presence of commissioners and providers of services on performance Monitoring Committees raises the problem of conflict of interest.

The relatively large proportion of LA officers on the Monitoring Committees constituting half of total representation, is logical and appropriate, but where their responsibilities are for commissioning or management of care services, a conflict of interest may arise because one remit of LINks is to 'hold providers to account'. If the Monitoring Committee set performance indicators and targets which directly influence the LINks' work plan, this compromises the independence of LINks. It is a cause for concern that only a sixth of LAs monitored the Host's role in supporting the independence of LINks.

Independence, appropriate training, and CRB checks for LINks' volunteers are essential in identifying the early warning signs of failures of NHS services identified in the Francis Report. [8]

Highly complex Department of Health funding of LINks, via the Department of Communities and Local Government through the Area Based Grant, needs revisiting since it makes Hosts, and consequently LINks, dependent on Local Authorities. Inevitably, political considerations about policy on the commissioning of services have been brought into the provision of patient and public involvement. This situation is radically different from the way that Patients' Forums and CHCs were funded, which ensured they were apolitical and manifestly independent.

Only two Performance Monitoring Forms, provided by the Las, contained information about financial monitoring and declared the annual budget for LINks. Ann Keen MP [9] and John Healey MP [10] both stated that LINks must declare the amount spent from the Area Based Grant, so LAs need to monitor expenditure on the Hosts [7].

Transparency on expenditure is needed nationally since the total amount allocated for LINks in 2008-2009 was £27M, but the Department of Health grant for LINks was not ring-fenced. [6]

Just under half of LAs reported that there were penalties for the Hosts' failure to achieve the targets set which were derived from the contracts. Penalties for non-compliance included financial loss or termination of the contract, which served as an inducement to achieve the targets set, whether those targets were appropriate to the LINk or not. The contracts with two Hosts appointed in 2008 were terminated by mutual agreement.

Local interpretation of the duty to monitor Host activities produced a variety of monitoring strategies, but the majority of LAs did not have a Monitoring Committee to measure the Host's performance, and a few did not monitor the Host activity at all. Advantages of strong positive monitoring were that a consensus between the LA, Host and LINk about performance indicators and outcomes, could focus attention on the work that LINks need to do. A disadvantage of formal monitoring identified, was that over- managing by LAs was counter-productive. Input from the small number of 'other' representatives demonstrated the flexibility of the Monitoring Committees. and contributed to a balanced consensus at local level.

There was a marked contrast in the response of Local Authorities to the questionnaire. Responses ranged from enthusiastic, comprehensive contributions with discussion to no acknowledgement or reply, despite Freedom of Information requests. If any progress is to be made to establish and develop effective LINks, then the foundation of LA / Host relationships must be satisfactory and include LINks, since the contracts made are for the purpose of providing their support.

It is encouraging to have contributions from the dynamic group of LAs who made valuable comments, which can act as the base from which progress can be made by further discussion involving more LAs.

RECOMMENDATIONS

To LAs and LINks

- LAs should actively encourage LINks to be involved in the quarterly reports on Host performance. (*See Model Contract, D of H)*
- Both LAs and LINks need to be involved in setting the performance targets for the Host.

To LAs

- Commissioners and providers of services should not be members of the Host Monitoring Committee.
- LAs should not be involved in setting LINks' work plans.
  (See Local Government and Public Involvement in Health Act; LAs cannot be LINks)

To LINks

- Quarterly reports on the Host performance should be submitted to the LA, whether they are requested or not.
- 'Enter and view' visits need to be increased in order to comply with the Legislation to hold providers and commissioners to account, and to identify situations where there is a breakdown in services - as occurred at the Mid Staffordshire Foundation Trust.

To Department of Health

- Legislation should be reviewed to eliminate potential undue influence by service commissioners who can divert LINks' activities away from contentious changes in services, or from problems with existing services. Commissioners or providers of services are not permitted to act as LINks' Hosts or be members of LINks, but allowing them to monitor the Hosts is tantamount to placing them in control of LINks' activities by determination of performance targets, with attendant penalties of loss of contract, if the Host does not achieve the targets.
- Funding of LINks through Area Based Grants to Local Authorities, needs to be changed because it allows political influence in LINks' activities.

To NALM

- The survey of the LA monitoring of LINks' Hosts has revealed a variety of arrangements, which need to be evaluated and regularised.
- Discussion with LINks, LAs and Hosts needs to be undertaken soon to prepare for the changes which may take place in 2011, at the end of the Department of Health 3 year funding cycle for LINks.

REFERENCES

(1)	Local Government and Public Involvement in Health Act (2007), Ch 28, Part 14, s 221-242	www.opsi.gov.uk
(2)	Explanatory Memorandum to The Local Involvement Networks regulation (2008), No. 528	www.opsi.gov.uk
(3)	Do we really have a voice in the NHS ? A study in the effectiveness of public and patient involvement in NHS Wales	Allen, S. (2008). MSc Thesis University of Glamorgan. (Quoted with permission of the Author)
(4)	Citizens, Consumers & the NHS, capturing voices	Hogg, C. (2008), Palgrave Macmillan
(5)	Health and Health Care in Britain	Baggott, R. (2004), Palgrave Macmillan
(6)	Department of Health Bulletin, Issue 8, December 2007	Gateway Ref. 9200
(7)	Directions on Matters to be Addressed in Local Involvement, Network Annual Reports, (2008)	Gateway Ref. 9697.
(8)	Mid Staffordshire NHS Foundation Trust Inquiry	Robert Francis Report, 24.02.10 Gateway ref. 13743
(9)	Ann Keen, MP, 26.02.08	Hansard
(10)	John Healey MP, 20.01.09	Hansard
(11)	LINks National Directory	Alexander M., Marsden R. NALM, January 2010

SPECIAL THANKS TO:

All the Local Authorities that took part in the survey, in particular contributions made in their comments.

Maggie Andrews – Data collation and analysis ... andrews.maggie@ymail.com
Polly Healy – Design and proof reading ... ... callpolly@btinternet.com

Appendix 1 – Questionnaire

QUESTIONNAIRE

LOCAL AUTHORITY MONITORING
of
HOST contracted to support Local Involvement Networks, 2008-2009

(Local Government and Public Involvement in Health Act 2007)

Local Authority:

Host:

Please tick the appropriate box ✓ r enter information requested below:-

Question 1. Do you have a Local Authority committee to monitor contract compliance of the Host?				
YES		**NO**		
				If NO please go straight to Question 6

Question 1a. If you have a Host Monitoring Committee what is its title?

Question 1b. Who chairs the Host Monitoring Committee?	
Name:	**Title:**

Question 2. Are Councillors with the responsibilities shown below members of the Host Monitoring Committee?							
Health and Social Services				**Overview and Scrutiny Committee/s**			
YES		**NO**		**YES**		**NO**	

Question 3. Do officers of your Local Authority with the following responsibilities attend the Host Monitoring Committee?

	YES	NO
Integrated Adult Health & Social Care Commissioning		
Communities and / or Resources Management		
LINks Project Management / Contract Management		
Joint LA / PCT Services Commissioning		

Question 4. Do Primary Care Trust (PCT) officers / representatives attend the Host Monitoring Committee ?

YES ☐ NO ☐

Question 4a. If PCT officers / representatives attend the Host Monitoring Committee are they members with voting rights?

YES ☐ NO ☐

Question 4b. If PCT offices / representatives attend the Host Monitoring Committee what is their position in the PCT?

Question 5. Do members of the Host Monitoring Committee have any of the responsibilities shown below ?

	YES	NO
Host Representative		
LINks members Representative		
Provider Trust or Foundation Trust Representative		

OTHER ☐

If OTHER please specify:

Question 6.	**Does your Local Authority measure the Host's performance using assessment against 'targets' and / or 'key outcomes' derived from the Contract?**			
	YES		**NO**	
Question 6 a.	**If YES then are there any penalties for failure to achieve performance against target and outcomes?**			
	YES		**NO**	
Question 6 b.	**If YES can you provide a copy of the form used to assess contract compliance by your Host?**			

Question 7.	**Does your LINk feed into your performance management of the Host ?**				
	YES		**NO**		
Question 7 a.	**If YES is this by means of any of the following ?**				
	Written report		**Verbal report**		**Attendance at Performance Monitoring Meetings**
Question 7 b.	**How often do performance management meetings take place?**				
	3 monthly		**6 monthly**		**Yearly**

Thank you for completing the questionnaire.

If you have any queries about the questions please contact NALM

www.Nalm2008@aol.com

PLEASE REPLY TO THE QUESTIONS BY 31st DECEMBER 2009

PLEASE RETURN THE FORM TO

THE NATIONAL ASSOCIATION OF LINks MEMBERS (NALM)

30 Portland Rise, LONDON, N4 2PP,
or
www.Nalm2008@aol.com

Comments.	Do you have suggestions or advice that would improve the effectiveness of Local Involvement Networks?

Appendix 2 - Local Authorities and Hosts 2008-2009

PRINCIPAL METROPOLITAN CITIES		
LOCAL AUTHORITY	**HOST**	**Funding ***
BIRMINGHAM CITY COUNCIL	GATEWAY FAMILY SERVICES	558,000
LEEDS CITY COUNCIL	THE SHAW TRUST	308,000
LIVERPOOL CITY COUNCIL	LIVERPOOL CVS	291,000
MANCHESTER CITY COUNCIL	BLACK HEALTH AGENCY	288,000
NEWCASTLE-UPON-TYNE COUNCIL	NEWCASTLE COUNCIL FOR VOLUNTARY SERVICES & COMMUNITY ACTION HEALTH	171,000
SHEFFIELD CITY COUNCIL	VOLUNTARY ACTION SHEFFIELD	263,000
	Total	**1,879,000**

OTHER METROPOLITAN CITIES		
LOCAL AUTHORITY	**HOST**	**Funding ***
BARNSLEY MB COUNCIL	BARNSLEY ARENA V. A. B, BARNADOS	152,000
BOLTON MB COUNCIL	COMMUNITY CARE OPTIONS	166,000
CITY OF BRADFORD MD COUNCIL	KEIGHLEY VOLUNTARY SERVICES	259,000
BURY MB COUNCIL	COMMUNITY CARE OPTIONS	122,000
CALDERDALE MB COUNCIL	CLOVERLEAF ADVOCACY	130,000
COVENTRY CITY COUNCIL	VOLUNTRAY ACTION COVENTRY	178,000
DONCASTER MB COUNCIL	CARERS FEDERATION	172,000
DUDLEY MB COUNCIL	THE SHAW TRUST	173,000
GATESHEAD MB COUNCIL	GATESHEAD VOLUNTARY ORGANISATIONS COUNCIL	140,000
KIRKLEES COUNCIL	CLOVERLEAF ADVOCACY	202,000
KNOWSLEY MB COUNCIL	SEFTON CVS	140,000
NORTH TYNESIDE MB COUNCIL	NORTH TYNESIDE VOLUNATRY ORGANISATION DEVELOPMENT AGENCY & AGE CONCERN NT	134,000
OLDHAM MB COUNCIL	THE GADDUM CENTRE	151,000
ROCHDALE MB COUNCIL	THE GADDUM CENTRE	147,000

ROTHERHAM MB COUNCIL	VOLUNTARY ACTION ROTHERHAM	160,000
SALFORD CITY COUNCIL	UNLIMITED POTENTIAL	159,000
SANDWELL MB COUNCIL	BLACK COUNTRY HOUSING GROUP	202,000
SEFTON COUNCIL	SEFTON CVS	172,000
SOLIHULL MB COUNCIL	HAP UK LTD	119,000
SOUTH TYNESIDE MB COUNCIL	BLISS=ABILITY	127,000
St HELENS MB COUNCIL	St HELENS CVS	132,000
STOCKPORT MB COUNCIL	PEBBLE ENTERPRISES	149,000
SUNDERLAND CITY COUNCIL	AGE CONCERN SUNDERLAND	176,000
TAMESIDE MB COUNCIL	TAMESIDE THIRD SECTOR COALITION (T3SC)	146,000
TRAFFORD MB COUNCIL	VOLUNTARY AND COMMUNITY ACTION TRAFFORD	130,000
CITY OF WAKEFIELD MBD COUNCIL	THE SHAW TRUST	182,000
WALSALL MB COUNCIL	(CARERS FEDERATION) BLACK COUNTRY HOUSING GROUP	170,000
WIGAN MB COUNCIL	CARERS FEDERATION	175,000
WIRRAL MB COUNCIL	VOLUNTARY COMMUNITY ACTION WIRRAL (VCAW)	200,000
WOLVERHAMPTON CITY COUNCIL	WOLVERHAMPTON VOLUNTARY SECT0R COUNCIL	169,000
Total		**4,834,000**

INNER LONDON

LOCAL AUTHORITY	HOST	Funding *
CAMDEN	THE SHAW TRUST	176,000
GREENWICH COUNCIL	PARKWOOD HEALTHCARE	188,000
HACKNEY COUNCIL	SOCIAL CARE FOR HEALTH	207,000
HAMMERSMITH & FULHAM COUNCIL	HESTIA HOUSING & SUPPORT	143,000
ISLINGTON COUNCIL	(ISLINGTON VS ACTION COUNCIL) VOL. ACTION ISLINGTON	170,000
KENSINGTON & CHELSEA COUNCIL	HESTIA HOUSING & SUPPORT	140,000
LAMBETH COUNCIL	AGE CONCERN LAMBETH	207,000
LEWISHAM COUNCIL	PARKWOOD HEALTHCARE	197,000
SOUTHWARK C	CAMBRIDGE HOUSE	211,000
TOWER HAMLETS	URBAN INCLUSION COMMUNITY	208,000

WANDSWORTH COUNCIL	WANDSWORTH CARE ALLIANCE	169,000
WESTMINSTER CITY COUNCIL	VOLUNTARY ACTION WESTMINSTER	174,000
CITY OF LONDON	(see WESTMINSTER above)	63,000
Total		**2,253,000**

OUTER LONDON		
LOCAL AUTHORITY	**HOST**	**Funding ***
BARKING & DAGENHAM	CENTRE FOR INDEPENDENT, INTEGRATED INCLUSIVE LIVING CONSORTIUM	147,000
BARNET COUNCIL	COMMUNITY INVESTORS DEV. AGENCY	182,000
BEXLEY COUNCIL	THE SHAW TRUST	131,000
BRENT COUNCIL	HESTIA HOUSING & SUPPORT	185,000
BROMLEY COUNCIL	THE SHAW TRUST	151,000
CROYDON	CROYDON VOLUNTARY ACTION	188,000
EALING COUNCIL	HESTIA HOUSING & SUPPORT	183,000
ENFIELD COUNCIL	COMMUNITY INVESTORS DEVELOPMENT AGENCY	179,000
HARINGEY COUNCIL	THE SHAW TRUST	172,000
HARROW COUNCIL	PARKWOOD HEALTHCARE	138,000
HAVERING COUNCIL	THE SHAW TRUST	133,000
HILLINGDON COUNCIL	HAP UK LTD	147,000
HOUNSLOW COUNCIL	HAP UK LTD	142,000
KINGSTON UPON THAMES	KINGSTON VOLUNTARY ACTION	102,000
MERTON COUNCIL	MERTON VOLUNTARY SERVICE COUNCIL	123,000
NEWHAM COUNCIL	THE FORUM FOR HEALTH & WELLBEING	214,000
REDBRIDGE COUNCIL	REDBRIDGE COUNCIL FOR VOL. SERVICES	156,000
RICHMOND UPON THAMES COUNCIL	RICHMOND CVS	107,000
SUTTON COUNCIL	SUTTON CENTRE FOR THE VOL. SECTOR	118,000
WALTHAM FOREST COUNCIL	VOLUNTARY ACTION WALTHAM FOREST	164,000
	Total	**3,062,000**

SHIRE COUNTIES		
LOCAL AUTHORITY	**HOST**	**Funding ***
CENTRAL BEDFORDSHIRE	VOLUNTARY ACTION LUTON	171,000
BUCKINGHAMSHIRE COUNTY COUNCIL	HAP UK LTD	182,000
CAMBRIDGESHIRE COUNTY COUNCIL	CAMBRIDGESHIRE ACRE	219,000
CHESHIRE EAST COUNCIL	CARERS FEDERATION	257,000
CHESHIRE WEST /CHESTER COUNCIL	CARERS FEDERATION	
CORNWALL COUNCIL	CORNWALL RURAL CC + PENWITH COMMUNITY DEVELOPMENT TRUST & AGE CONCERN	252,000
CUMBRIA COUNTY COUNCIL	CUMBRIA CVS	232,000
DERBYSHIRE COUNTY COUNCIL	AMBER VALLEY CVS + N DERBY VOLUNTARY ACTION	314,000
DEVON COUNTY COUNCIL	EAST DEVON VOLUNTEER SUPPORT AGENCY	298,000
DORSET COUNTY COUNCIL	HELP & CARE	183,000
DURHAM COUNTY COUNCIL	PIONEERING CARE PARTNERSHIP	256,000
EAST SUSSEX COUNTY COUNCIL	EAST SUSSEX DISABILITY ASSOCIATION	236,000
ESSEX COUNTY COUNCIL	THE COUNCIL FOR ETHNIC MINORITIES VOL. ORG.	480,000
GLOUCESTERSHIRE COUNTY COUNCIL	GLOUCESTERSHIRE RURAL COMM. COUNCIL	231,000
HAMPSHIRE COUNTY COUNCIL	HAP LTD	378,000
HERTFORDSHIRE COUNTY COUNCIL	THE SHAW TRUST	361,000
KENT COUNTY COUNCIL	KENT & MEDWAY NETWORKS LTD	492,000
LANCASHIRE COUNTY COUNCIL	BLACK HEALTH AGENCY	454,000
LEICESTER COUNTY COUNCIL	CVS COMMUNITY PARTNERSHIP	219,000
LINCOLNSHIRE COUNTY COUNCIL	THE SHAW TRUST	285,000
NORFOLK COUNTY COUNCIL	VOLUNTARY NORFLOK	342,000
NORTH YORKSHIRE COUNTY COUNCIL	NORTH BANK FORUM	222,000
NORTHAMPTONSHIRE COUNTY COUNCIL	NORTHAMPTON VOLUNTEERING CENTRE	253,000
NORTHUMBERLAND COUNTY COUNCIL	ADAPT NE & NORTHUMBERLAND COMMUNITY DEVELOPMENT NETWORK	165,000
NOTTINGHAMSHIRE COUNTY COUNCIL	CARERS FEDERATION	304,000
OXFORDSHIRE COUNTY COUNCIL	HELP & CARE	222,000

SHROPSHIRE COUNCIL	CARERS FEDERATION	150,000
SOMERSET COUNTY COUNCIL	HELP & CARE	226,000
STAFFORDSHIRE COUNTY COUNCIL	STAFFORDSHIRE UNIVERSITY	301,000
SUFFOLK COUNTY COUNCIL	THE SHAW TRUST	280,000
SURREY COUNTY COUNCIL	HAP UK LTD	333,000
WARWICKSHIRE COUNTY COUNCIL	HAP UK LTD	212,000
WEST SUSSEX COUNTY COUNCIL	HELP & CARE	281,000
WILTSHIRE COUNCIL	HAP UK LTD	181,000
WORCESTER COUNTY COUNCIL	THE SHAW TRUST	222,000
	Total	**9,194,000**

SHIRE UNITARY AUTHORITIES		
LOCAL AUTHORITY	**HOST**	**Funding ***
BATH & N EAST SOMERSET COUNCIL	SCOUT ENTERPRISES	109,000
BLACKBURN +DARWEN BOROUGH COUNCIL	CARERS FEDERATION	123,000
BLACKPOOL BOROUGH COUNCIL	GROUNDWORK LANCASHIRE WEST & WIGAN	126,000
BOURNEMOUTH BOROUGH COUNCIL	HELP & CARE	119,000
BRACKNELL FOREST BOROUGH COUNCIL	HELP & CARE	86,000
BRIGHTON & HOVE CITY COUNCIL	COMMUNITY & VOLUNTRAY SECTOR FORUM	148,000
BRISTOL CITY COUNCIL	THE CARE FORUM	210,000
DARLINGTON BOROUGH COUNCIL	CARERS FEDERATION	96,000
DERBY CITY COUNCIL	(DERBY CVS) COMMUNITY ACTION DERBY	150,000
EAST RIDING YORKSHIRE COUNCIL	HUMBER AND WOLDS RURAL COMMUNITY COUNCIL	158,000
HALTON BOROUGH COUNCIL	HALTON VOLUNTARY ACTION	111,000
HARTLEPOOL BOROUGH COUNCIL	HARTLEPOOL VOLUNTARY DEV. AGENCY	99,000
HEREFORDSHIRE COUNCIL	CARERS FEDERATION	119,000
ISLE OF WIGHT COUNCIL	HELP & CARE IOW	115,000
COUNCIL OF THE ISLES OF SCILLY	SCOUT ENTERPRISES (WESTERN) LTD	61,000

KINGSTON UPON HULL COUNTY COUNCIL	HULL COMMUNITY AND VOLUNTARY SERVICES	173,000
LEICESTER CITY COUNCIL	CARERS FEDERATION	186,000
LUTON BOROUGH COUNCIL	THE SHAW TRUST	131,000
MEDWAY COUNCIL	KENT & MEDWAY NETWORKS LTD	136,000
MIDDLESBOROUGH COUNCIL	CARERS FEDERATION	122,000
MILTON KEYNES COUNCIL	AGE CONCERN	129,000
N EAST LINCOLNSHIRE COUNCIL	VANEL	120,000
NORTH LINCONSHIRE COUNCIL	VOLUNTARY ACTION NORTH LINCONSHIRE	114,000
NORTH SOMERSET DISTRICT COUNCIL	SCOUT ENTERPRISES (WESTERN) LTD	121,000
NOTTINGHAM COUNCIL	CARERS FEDERATION	184,000
PETERBOROUGH COUNTY COUNCIL	THE SHAW TRUST	122,000
PLYMOUTH COUNTY COUNCIL	COLEBROOK HOUSING SOCIETY LTD	151,000
BOROUGH OF POOLE	HELP & CARE	103,000
PORTSMOUTH COUNTY COUNCIL	HAP UK LTD	125,000
READING BOROUGH COUNCIL	READING VOLUNTARY ACTION	104,000
REDCAR & CLEAVLAND BC	THE SHAW TRUST	116,000
RUTLAND CC	THE SHAW TRUST	69,000
SLOUGH BC	HELP & CARE	104,000
S GLOUCESTERSHIRE COUNCIL	THE CARE FORUM	124,000
SOUTHAMPTON CITY COUNCIL	HAP UK LTD	141,000
SOUTHEND ON SEA	COUNCIL for ETHNIC VOL. ORG.	123,000
STOCKTON-ON-TEES BOROUGH COUNCIL	THE SHAW TRUST	126,000
STOKE-ON-TRENT COUNTY COUNCIL	AGE CONCERN	163,000
SWINDON BOROUGH COUNCIL	VOLUNTARY ACTION SWINDON	112,000
TELFORD AND WREKIN COUNCIL	STAFFORDSHIRE UNIVERSTY	119,000
THURROCK COUNCIL	COUNCIL OF ETHNIC MINORITY VSO	111,000
TORBAY COUNCIL	HELP & CARE	119,000
WARRINGTON BC	BLACK HEALTH AGENCY	117,000
WEST BERKSHIRE COUNCIL	HELP AND CARE	95,000
WOKINGHAM BOROUGH COUNCIL	HELP AND CARE	87,000

YORK CITY COUNCIL	NORTH BANK FORUM	108,000
	Total	**5,778,000**

* = Funding allocated by the Department of Health to LINks in Area Based Grants	**TOTAL**	**27,000,000**

HOST NAME	LA / HOST	LA (n)	%	HOST (n)	%
2 OR 3 HOSTS / LA	6 *	6	4.0	11	13.9
INDIVIDUAL CHARITIES	1	48	32.0	48	60.8
CLOVERLEAF ADVOCACY	2	18	12.0	9	11.4
COMMUNITY CARE OPTIONS	2				
COMMUNITY INVESTORS DEVELOPMENT AGENCY	2				
KENT & MEDWAY NETWORKS LTD	2				
NORTH BANK FORUM	2				
SEFTON CVS	2				
STAFFORDSHIRE UNIVERSITY	2				
THE CARE FORUM	2				
THE GADDUM CENTRE	2				
BLACK HEALTH AGENCY	3	9	6.0	3	3.8
PARKWOOD HEALTHCARE	3				
SCOUT ENTERPRISES	3				
HESTIA HOUSING & SUPPORT	4	4	2.7	1	1.3
AGE CONCERN (shared)	5	5	3.3		
VOLUNTARY ACTION (shared)	8	8	5.3	6+1[Ŧ]	8.9
HAP UK LTD	10	10	6.7		
CARERS FEDERATION (part shared)	12	12	8.0		
HELP & CARE	13	13	8.7		
THE SHAW TRUST	17	17	11.3		
TOTAL		**150**	**100**	**79**	**100**

* = 6 LOCAL AUTHORITIES MONITORING 11 HOSTS, [Ŧ] = SHARED HOSTS

Key: LOCAL AUTHORITIES (HOST NAME) = HOST APPOINTED IN 2008		
LB = LONDON BOROUGH	MB = METROPLITAN BOROUGH VA = VOLUNTRAY ACTION	C = COUNCIL *CC* = CITY COUNCIL
RB = ROYAL BOROUGH	MBD =METROPOLITAN BOROUGH DISTRICT	
CC = COUNTY COUNCIL	BC = BOROUGH COUNCIL	LA = LOCAL AUTHORITY

LOCAL AUTHORITY MONITORING OF TWO OR MORE HOST ORGANISATIONS								
	HOSTS	**TOTAL**	**LOCAL AUTHORITY CATEGORY**					
HOST NAME	**/ LA**	**LA (n)**	**PMC**	**OMC**	**IL**	**OL**	**SC**	**SUA**
CORWALL RURAL CC	**1**							
PENWITH COMMUNITY DT	**1**	**1**					1	
AGE CONCERN (below)								
BARNSLEY ARENA	**1**							
VOLUNTARY ACTION B (below)		**1**		1				
BARNARDOS	**1**							
NEWCASTLE CVS	**1**	**1**	1					
COMMUNITY ACTION HEALTH	**1**							
AMBER VALLEY CVS	**1**	**1**					1	
NORTH DERBEYSHIRE VS	**1**							
NORTH TYNESIDE VODA	**1**	**1**		1				
AGE CONCERN NT (below)								
ADAPT NE	**1**	**1**					1	
NORTHUMBERLAND CD	**1**							
TOTAL	**11**	**6**	1	2	0	0	3	0

CC = COMMUNITY COUNCIL	CVS = COUNCIL FOR VOLUNTARY SERVICES
DT DEVELOPMENT TRUST	VS = VOLUNTARY SERVICE
B = BARNSLEY	NT = NORTH TYNESIDE
VODA = VOLUNTARY ORGANISATION DEVELOPMENT AGENCY	
CD = COMMUNITY DEVELOPMENT	(see below) = HOST COUNTED IN MAIN GROUP
LA / HOST = LOCAL AUTHORITY per HOST ORGANISATION	
PMC = PRINCIPAL METROPOLITAN CITY	OMC = OTHER METROPOLITAN CITY
IL = INNER LONDON	OL = OUTER LONDON
SUA = SHIRE UNITARY AUTHORITIES	SC = SHIRE COUNTIES
DA = DEVELOPMENT AGENCY	VS = VOLUNTARY SERVICES

HOST ORGANISATIONS WITH ONE OR MORE LOCAL AUTHORITY								
	LA /	**TOTAL**	**LOCAL AUTHORITY CATEGORY**					
HOST NAME	**HOST**	**n** *(%)*	**PMC**	**OMC**	**IL**	**OL**	**SC**	**SUA**
2 OR MORE HOSTS / LA *	**6**	**6**	1	2	0	0	3	0
INDIVIDUAL CHARITIES	**1**	**48**	2	11	5	8	10	12
CLOVERLEAF ADVOCACY COMMUNITY CARE OPTIONS COMMUNITY INVESTORS DA KENT & MEDWAY NETWORKS NORTH BANK FORUM STAFFORDSHIRE UNIVERSITY THE CARE FORUM THE GADDUM CENTRE	**2**	**18**	0	8	0	2	3	5
BLACK HEALTH AGENCY PARKWOOD HEALTHCARE SCOUT ENTERPRISES	**3**	**9**	1	0	2	1	1	4
HESTIA HOUSING & SUPPORT	**4**	4	0	0	2	2	0	0
AGE CONCERN	**6**	**6**	0	2	1	0	1	2
VOLUNTARY ACTION	**8**	**8**	1	2	1	1	1	2
HAP UK LTD	**10**	**10**	0	1	0	2	5	2

CARERS FEDERATION	**12**	**12**	0	3	0	0	3	6
HELP & CARE	**13**	**13**	0	0	0	0	4	9
THE SHAW TRUST	**17**	**17**	1	2	1	4	4	5
TOTAL		***150***	6	30	13	20	34	47

LOCAL AUTHORITIES (LA)	**(n)**	**%**	**Funding ***	**%**
PRINCIPAL METROPOLITAN CITIES	6	4.0	1,879,000	7.0
OTHER METROPOLITAN CITIES	30	20.0	4,834,000	17.9
INNER LONDON	13	8.7	2,253,000	8.3
OUTER LONDON	20	13.3	3,062,000	11.3
SHIRE COUNTIES	34	22.7	9,194,000	34.1
SHIRE UNITARY AUTHORITIES	47	31.3	5,778,000	21.4
TOTAL	**150**	**100**	**27,000,000**	**100**

Appendix 3 – Local Authority Replies

LA No. *	Q 1 a. Host Monitoring Committee Title	Q 1 c. Host Monitoring Committee Chair
(01)	Liaison Group	Voluntary & Community Services Co-ordinator
(02)	LINk Contract Monitoring	Product portfolio manager
(04)	LINks contract review	Community Strategy Manager
(08)	Health & Wellbeing Scrutiny Committee + LINks Advisory Group	Chair of H&WS Cttee.
(09)	Contract Review meetings	Contract Managers on rotation
(14)	Adult's Services Select Committee	County Councillor
(16)	LINk liaison group	Assistant Dir. Joint Commissioning + NHS
(18)	Contract Management Reference Group	Head of Policy and Governance
(20)	LINk Contract Monitoring Committee	Head of Partnerships, Business & Community Development
(30)	LINks Management Group	Policy Officer
(37)	LINK Host Monitoring Group	Principal Officer (User Carer Issues)
(40)	LINks Partnership Group	Executive Member for Health Care and Safeguarding, Cllr.
(41)	Links Contract Monitoring Group	3 Contract Managers on rotation
(45)	Performance and Value for Money Select Committee	Councillor
(51)	LINK Advisory Group	Health OSC, Corporate Policy and Performance Manager
(54)	Community and Children's Service Committee	Chairman of Community and Children's Service Committee
(55)	Project Partnership Group	No position given
(62)	Local Authority LINks Meeting	No position given
(74)	Procurement Manager (not a committee)	Procurement Manager
(81)	LINks Group	Contracts Manager

(86)	Host Contract Monitoring Committee	Head of Policy, Research and Customer Relations
(87)	Contract Monitoring Steering Group	Community Engagement Manager
(89)	LINk Performance Group	Interim Director of Community Services
(90)	Corporate Procurement Social Care NHS	Head of Transformation
(96)	Advise and cross agency working	No position given
(107)	Senior Management Team, Adult Social Care	Director
(109)	LINk Steering Group	Head of Adult Services
(114)	LINk Contract Monitoring Meeting, not a Councillor-based committee.	LINk Contract Manager

Q 1. Alternative arrangements to a single designated performance Monitoring Committee	
LA No.*	**Alternative Arrangement**
(01)	The LINk Liaison Group does not carry out the quarterly performance monitoring of the Host and LINk. Quarterly performance monitoring is carried out by the *County Council* officer, Voluntary & Community Services Co-ordinator. The officer holds a quarterly face-to-face meeting, with the Host, LINk Manager, and Chair of LINk Core Group. The notes from this meeting and a quarterly performance summary are presented to and discussed with the LINk Liaison Group.
(07)	Contract compliance of the Host is monitored at quarterly monitoring meetings between the Host, the Local Authority LINk Lead Officer and an officer from Sustainable Communities. Representatives from the LINk and the PCT have been invited to be involved in this process but have not yet decided to take up this offer. Adults and Older People Overview and Scrutiny Committee receive monitoring reports every 6 months. These meetings are attended by the Local Authority LINk Lead Officer and the LINk Host. In future the meetings will also be attended by the LINk Chair.
(08)	Health and Well Being Scrutiny receive reports and officer has regular contract meetings to monitor performance. We also have an advisory group for the LINk made up of public body representatives and Chair of the LINk and Team Leader for host. The aim of this is to provide a route for unlocking barriers and providing general support and information.

(09)	*The Local Authority* does not have a committee, but has Contract Review meetings with the Contract Managers from the *County Council* plus various reps from Host.
(11)	Whilst the Local Authority does not have a formal Host Monitoring Committee there have been regular joint meetings of the PCT, council officers i.e. legal, scrutiny, community engagement and the hospital trusts. The original purpose of these meetings was to unpack the roles and responsibilities of the various officers in relation to *the* LINk and more recently to address issues of concern around performance and progress of the LINk. There are also regular briefings of the lead member with responsibility for Health & Social Care and Citizenship, Equalities and Communities and the Chair of the overview and scrutiny committee.
(24)	The Council considered a formal Monitoring Committee but decided to have a pool of experts to support the monitoring officer on specific issues as and when required. The monitoring officer can also seek host performance views of a stakeholder group that has representation from the LINk and is facilitated by the host.
(34)	Whilst we recognise the very clear fiduciary duty that arises from the use of public funds, we are equally clear that we can best discharge this through supporting the LINk in its relationship with the host, not over managing the process. We see the relationship between the LINk and the review panels/scrutiny committees as being the key to success, and the work we put in to make this relationship effective underpins much of the success of the LINk. We also have a Joint Health, Social Care and Voluntary Sector Strategic Forum (at Director/Head of Service level) which brings together the key players and to which the LINk will provide reports and briefings as necessary.
(35)	The decision to end the current contract has been by mutual agreement. We will be developing our methods of monitoring with the new provider once selected. The Local Authority is now involved in the selection of a new host and will be involved in the future.
(42)	Whilst we do not have a specific committee tasked with monitoring LINk, the LINk does give updates and progress reports to the Council Health Scrutiny panel. Any issues relating to LINk can also be conveyed to the Executive Member for Adult Social Care and Health at the discretion of officers. The Council has appointed a lead officer for the Host contract and a grants officer to oversee the Host funding and the requesting of performance information.
(75)	Although there is no Host Monitoring Committee an evaluation is scheduled for 2010/11. Additionally the Host reported to Scrutiny Committee in July 2009 with a further report back expected shortly. The contracting process went to Scrutiny before the tenders were advertised.
(84)	The Partnership Development Group is currently being developed. Many of the questions have yet to be decided upon.

(110)	We are currently re-tendering for a host therefore the questions asked cannot be answered until a re-tendering process and appointment of a host has been achieved. The contract with our previous host finished in December 2009. Once this is in place then we would have a monitoring group, but until complete we cannot say who this will be.
(112)	Although we do not have a Committee, the performance of the Host organisation is monitored through six monthly meetings. The executive of the Link attended the meetings.
(114)	The LINk Development Manager (employed by and part of the Host) has direct liaison with Social Care provider and commissioning groups within DCC, which act as de facto monitoring of the LINk Host. The LDM sits on a number of project groups (e.g,, Personalisation Agenda/Project, JSNA - Joint Strategic Needs Assessment, LAA - Local Area Agreement, ARM - Annual Review Meeting, Health & Wellbeing Partnership), whose participation with, and contribution to, the County Council LINk Contract Manager monitors.The Contract Manager also has a "direct line" to the Chair of the elected LINk Steering Group, and has regular conversations with that person, as an additional form of monitoring the Host.

Q 4 b.	**Position of PCT officers/ representatives on the Monitoring Committee**
(01)	Head of Engagement & Equalities
(02)	Two PCT representatives Mental Health Commissioner and PPI Lead
(08)	Patient & Public Involvement
(16)	Involvement and Engagement Officer
(30)	Manager of community engagement and communication
(37)	Head of Patient Experience
(40)	Director of Integrated Adult Health & Social Care Commissioning
(51)	LINk Advisory Group includes appropriate officers from LA and 3 PCTs
(55)	Head of Community Engagement
(81)	Assistant Director of Locality Commissioning
(87)	Head of Community Engagement and Public Health
(88)	Director of Corporate Affairs
(90)	Engagement Manager and Director of Communications
(96)	Advise and cross agency working
(107)	PALS Officers/Complaints Officers

Q 5 d. Monitoring Committee members who have responsibilities other than the examples given.	
LA No.*	
(14)	It is likely that a member of the LINk's stewardship group will be co-opted onto the Adults' Services Select Committee early in 2010. The select committee and the stewardship group have already exchanged their programmes of future activities.
(37)	On the LINk Host Contract Monitoring Group we also have representatives from Children's Services, the local hospital and a Mental Health Foundation Trust, to ensure that we are establishing as clear a picture as possible as to the impact of the Host and the LINk in health and social care services.
(40)	Acting Manager of Community Resources Unit
(114)	Chief Executives of the Host, LINk Development Manager (employed by Host), Service Manager for Community & Voluntary Sector Contracts, Quality Manager for the county's Children's and Younger Adults Dept (CAYA), Senior Purchasing Officer from Central Purchasing (where original contract was created and let).

Q 6 a. Penalties for failure to achieve performance against assessment targets	
LA No.*	
(24)	There are no penalties for failure to achieve performance against targets as such but the host contract contains variation and termination clauses.
(34)	The contract would be terminated if Host non-compliant. Close co-operation with LINk in setting up contract with Host.
(35)	Contract was used to assess Host compliance. The contract has been mutually terminated with the Host.
(40)	The Council reserves the right to terminate the contract in accordance with the terms and conditions set down in the contract and award the contract to the second place bidder within the first 6 months of the start of the contract. Should the Council be dissatisfied in any way with the governance arrangements, management arrangements or performance outcomes relating to the service put in place by the winning bidder.
(42)	If the performance of the Host falls below the standard required under the terms of the contract, then the Council will investigate, set actions for improvement and if there is no satisfactory improvement the Council can consider termination of the contract.
(61)	Whilst we have mechanisms within the contract to address breaches of the contract we have had no recourse to use these and therefore remain untested.

(79)	This is not a situation that has arisen and is preventable by frequent monitoring.
(85)	Not yet.
(106)	Given the developmental nature of LINks and the lack of formal guidance on performance indicators etc from DH we are discussing with LINks what appropriate outcomes measures would be. We see them as a) organisational (having the right contacts to influence) b) contributing to change (making things happen).
(110)	The contract with our previous host finished in December 2009.
(124)	During the period November 2008 to March 2009 performance measures (in addition to the performance of tasks required as a condition of the contract) had been drafted. No penalties for failure to achieve performance were agreed other than penalties outlined in the contract.

Q 6 b. Can you provide a copy of the form used to assess contract compliance by your Host ?	
(39)	No form used. Contract monitoring through monthly meetings.
(40)	Please note there is not a standard form for measuring contract compliance. Key deliverables are agreed and Host performance is measured against these at quarterly contract monitoring meetings.
(42)	The Council does not have a standard form to assess contract compliance specifically but does set out its requirements for the submission of performance information by the Host.
(84)	Still under development.
(108)	Outputs are agreed as part of an SLA against which the LINk submit evidence which we use to determine the release of funds.
(114)	There is no single form. The contract itself is used, as are a number of spreadsheets, activity reports, Reported Issues Summaries, Risk Assessments, and monthly reports from the LINk Development Manager.

Q 7.	Does the LINk actively influence your performance management of the Host ?
(24)	The monitoring officer has informal conversations with the LINk Chair regarding host performance.
(42)	Whilst the answer given as “no”, the Council does receive views and comments from LINk about the performance of the Host. The Council will follow up these issues as necessary and appropriate.
(45)	We have answered No as there is no direct communication between the LINk and the contract monitoring role. However, the LINk is in regular contact with a member of our Adult Social Care and Health staff who will raise any LINk concerns they hear to the performance management process.
(61)	Principally the LINk host is required to report against KPIs on a quarterly basis. These are monitored and any actions to remedy problems would be agreed.
(79)	The LINk chair attends monitoring meetings and LINk members complete a performance evaluation questionnaire.
(106)	The LINk is very well connected in *this Local Authority*. The chair of the LINk meets with Health and Overview and Scrutiny Chairs on a quarterly basis. He also meets PCT CEs and the Director of ACS on a quarterly basis.
(114)	The elected LINk Steering Group is in regular contact with the Host and has a good degree of contact with the LINk Development Manager, and with the Development Workers at events and consultations around the county. This is informal, substantive, grassroots monitoring of the Host activities by the Steering Group.

Q 7 a. & 7 b.	How does the LINk influence your performance management of the Host ?
(33)	We meet the LINk to discuss performance of the Host when necessary.
(39)	No specific regular meetings other than Steering Group meetings which are monthly
(42)	Quarterly meetings are held between the Council lead officer and the local Host manager. It is likely that there will be also additional contact with Host senior head office managers. Informal meetings are planned every two months or so between the lead officer and LINk Chair.
(61)	The Council has undertaken 360º Feedback which has included the LINk members.

(79)	This is in the form of a questionnaire completed by members.
(106)	In addition, both ACS and the PCT attend LINk Board meetings as non-voting advisers and therefore hear the debate and see what is going on. The chair of the LINk has easy access to me as contract manager.
(111)	The Link Chair and Vice Chair attend the LINk Host quarterly meeting. We do not have regular separate meetings with LINk to discuss performance of the Host. However, we are available to meet with the LINk to discuss these issues whenever the need arises.
(114)	The 4 LINk Development Workers meet regularly (at least quarterly) with the eight or so local PPI teams within the county, in their respective four territories. These meetings accomplish effective information sharing on emerging issues, and as a joint 360 degree monitoring function.

* = Random number given by NALM to the questionnaire returns from L A

Text in italics = Local Authority name replaced by general title.

Appendix 4 – Local Authority Comments

LA No.	General Comments
(11)	In relation to improving the performance of LINks there continues to be lack of clarity in relation to roles and responsibilities on the part of LINks members and a fundamental tension between LINk members and the Host. A toolkit for local involvement networks would be helpful (possibly) detailing job descriptions for Exec officers on steering groups and setting out clear distinction between the host and LINks members and key responsibilities for involvement.
(12)	1. Some clear guidelines from the DoH on what measures they will use to assess the effectiveness of the LINks. 2. Some clear guidelines on the formal relationship between the Link, the Host and the Council from the DoH. 3. Clarification from the DoH on the exact legal status of the LINk. On the face of it, the LINk has no legal status under English Law and there is no contractual relationship between the LINk and any other body.
(17)	One approach we have found helpful is that we developed Outcomes and Performance Indicators and agreed them jointly between LINk itself, the LINk Host and Local Authority so they are shared by all parties. These focus on impact of the LINk's work which is dependent on both Host and LINk working together rather than just the Host. Some focus particularly on work of the Host.
(34)	When the contracts are re let most Local Authorities would probably do things slightly differently, having learned from the first three years. However, we do see it as being focussed around the needs of the LINk rather than the Local Authority. Each Local Authority set up its contract in different ways. In our case this was in close co-operation with the LINk itself. The focus of support for the LINk is determined by the LINk, representing the individual and organisational members. Some LINks want the host to do most of the work for them others, like *our LINk*, see themselves as being in charge, with the host providing support services as required.
(40)	The LINks Partnership Group (Host Monitoring Committee) needs to have an input into the LINk work programmes to ensure that they are targeting areas where they can make an impact and are reviewing those issues that they have a right to consult about.
(42)	Suggestions to improve LINk effectiveness: • A national model constitution • Nationally agreed core KPIs • More support, information and guidance from regional government agencies

	to councils, LINKs and Host bodies to ensure that LINKs operate effectively • Training for LINk Board Members Adequate resources to support LINK operations - Boards are stretched in their capacity to take on issues and engage with other local networks, eg safeguarding boards and local strategic partnerships.
(107)	The LINK primarily relies of the goodwill of volunteers and hence its success depends on the commitment of people giving their own time. We are fortunate in this are that those volunteers are passionate about improving health care. Making the transition from PPI forums to having powers to scrutinise social care services is quite a challenge and one which our own LINk are rising to in the third year of their contract – Given the vast number of external social care providers it is important to ensure that LINks do not feel it is their job to replace statutory inspection services (such as CQC). Regular involvement with local training around safeguarding has proved to be an important part building a better understanding of some of the social care issues LINks can help to alert the Statutory services too.
(114)	The ethos of the County Council is strong on partnership working in all aspects of the various statutory agencies, local government levels, and voluntary/community groups, to seek to ensure the best outcomes for residents. The role of LINk Contract Manager was placed for payroll purposes within the Adult Care Dept., which has had the additional benefit of my being better able to inform the Dept. about the function and purposes of the LINk entity. However, the role is strictly ring-fenced as to be independent of any influence by social care provision or commissioning. The role could have been placed for administrative purposes in Central Purchasing or Corporate Resources, but was beneficially placed in Adult Care.
(123)	Clarity is needed on the 3 way relationship between the LA, host and the LINk, and the boundaries and expectations on each partner in the project. We would like information on the future plans for the LINK project at a national level, e.g. with the current uncertainly surrounding the continuation it is very difficult to consider the options for procuring for the next period from a LA perspective.

Local Authorities that made the most helpful contributions		
Bath & North East Somerset C	Isle of Wight Council	Northumberland County Council
City of Bradford Council	Kingston upon Hull C Council	North Lincolnshire Council
Brighton & Hove City Council	Kirklees Council	North Yorkshire Council
Bristol & North East Somerset Council	London Borough of Barnet	Reading Borough Council
Bournemouth Borough Council	London Borough of Enfield	Rochdale MB Council

Cheshire East & West Councils	London Borough of Harrow	Rotherham MB Council
Darlington Borough Council	London Borough of Hounslow	Sandwell MB Council
Derbyshire County Council	London Borough of Islington	Sefton Metropolitan Council
Doncaster MB Council	London Borough of Redbridge	Sheffield City Council
East Sussex County Council	London Borough of Richmond	Somerset County Council
Gateshead MB Council	London Borough of Southwark	Surrey County Council
Hampshire County Council	London B of Tower Hamlets	Tameside MB Council
Hartlepool Borough Council	London Borough of Wandsworth	City of Wakefield M Dist. Council
Hereford County Council	Medway Council	Warrington B Council
Council of the Isles of Scilly	Norfolk County Council	West Berkshire Council

LAs that replied to FOI request but did not complete the questionnaire		
Barnsley MB Council	Northamptonshire C Council	City of London Council
Bolton Metropolitan Council	South Gloucestershire Council	

LAs that did not reply to the FOI requests and did not complete the questionnaire		
Halton Borough Council	London Borough of Ealing	Middlesborough Council