

RCN Policy Unit

Policy Briefing 08/2007

**The House of Commons
Health Select Committee
Public and Patient Involvement
in the NHS**

May 2007

Background

The Health Select Committee held an Inquiry into patient and public involvement in the NHS and published its report on 20 April 2007¹. The RCN submitted written evidence to the Committee².

The Committee has assessed the current proposals to set up new patient and public involvement bodies- Local Involvement Networks (LINKs)- in the Local Government and Public Involvement in Health Bill. At the same time, the Committee has taken a longer perspective by considering the history of public and patient involvement in the NHS and the role of volunteers. It has also considered the culture that exists in the NHS in relation to consultation, the somewhat confused functions that are considered in debate about public and patient involvement- what does involvement mean, what is it intended to achieve, who funds that involvement- and the precise wording in the Bill about both LINKs and the requirements for public consultation.

There is a blunt and damaging assessment of the Department of Health's work in relation to the abolition of the current public and patient forums and the creation of LINKs- "once again the Department has embarked on structural reform with inadequate consideration of the disruption it causes."

There are many recommendations made which address the cultural issues in relation to public and patient involvement in the NHS, as well as precise recommendations about the current status of the Bill.

Links to other Government initiatives in health reform

1. Cabinet Office Public Service Reform Model

Public and patient involvement is a central tenet of the Cabinet Office model for the reform of public services. In the model being implemented by the Government, one of the key drivers for the improvement of services is "users shaping services from below"³. In this model, Government creates the top down performance management by regulation and standard setting, by performance assessment, direct intervention and

¹ House of Commons Health Committee *Patient and Public Involvement in the NHS* Third Report of Session 2006-07 Volume 1 Report together with formal minutes HC 278-1, 20 April 2007

² RCN evidence to Health Select Committee (PPI 132 Evidence 217) Written evidence in Volume ii (HC 278-II)

³ Cabinet Office The Prime Minister's Strategy Unit *the UK Government's Approach to Public Sector Reform: A discussion paper*, 2006

stretching outcome targets. The Market provides both competition and contestability through a purchaser provider split, and Capacity is created through leadership, workforce development, and organisational development.

Users shaping services requires giving service users a choice and personalisation, it also requires that funding follows the users choice, and thirdly by engaging voice through voice and co-production.

In order for this model to work effectively, it is vital that Government creates a system in which individuals have the ability to make choices in the health market, and where collective voices are also heard so that services can be shaped directly between the providers and commissioners and the users of those services. An excessive degree of direct Government interference will stifle the voice of the individual and the collective while too little direct information will mean there are insufficient structures in place by which both commissioners and providers can hear and respond to the demand of the users of the services.

2. Local Government White Paper

The Government is keen to implement the Cabinet Office model and set out proposals for implementation of the voice model, in which users shape services from below, in the White Paper for Local Government⁴ The Government's stated aim of the White Paper is to give local people and local communities more influence and power to improve their lives. To achieve this, the Government will shift its 10 year approach to drive improvements in public service from the centre- "we must have the courage at the centre to let go."

The Government stresses that this local government White Paper will enhance local leadership on health and well being and will make it easier for local authorities and NHS bodies to work together to tackle health inequalities and to deliver better services in their local area. There are four key areas of focus including an ability to ensure that all patients are able to voice their concerns on health and well being issues in their area/

There will be new duties for local government to work with other public service providers to meet local needs and drive up service standards. This will enhance local leadership on health and well being and will make it easier for local authorities and NHS bodies to work together to tackle health inequalities and to deliver better services in their local area⁵.

⁴ Department for Communities and Local Government *Local Government White Paper Strong and Prosperous Communities* October 2006

⁵ See also RCN Policy Unit Briefing 18/2006 *Local Government White Paper* 2006

3. Local Government and Public Involvement in Health Bill- public involvement issues

The Bill sets out proposals under which local authorities will be under a statutory duty to make arrangements for the establishment of Local Involvement Networks (LINKs) – new bodies designed to involve local people in shaping the services and priorities of health and social care bodies. LINKs will have the power to refer matters of concern to the Overview and Scrutiny Committee. Overview and Scrutiny Committees will be encouraged to look at the work of commissioners and providers of health and social care services.

Powers and responsibilities for local authorities:

- An expansion to Community Call for Action to cover all local government matters, including social care issues. Local councillors will be able to refer matters to the Overview and Scrutiny Committee and this will complement the LINKs system
- Give a new range of powers to Overview and Scrutiny Committees, including the right to require local service providers to provide evidence when requested, and for the OSC to recommend an independent inspection, if it feels the relevant service has failed to adequately address local concerns. This is intended to match powers that already exist in relation to PCTs.
- OSC will scrutinise the response of both local authorities and PCTs to the reports of Directors of Public Health on improving the health of local populations.
- A reformed best value duty to secure the participation of citizens in their activities. The Bill proposes to complement existing plans to strengthen s.11 Health and Social Care Act 2001 by expanding the duty on health bodies to “involve and consult” so that it includes the need to respond to patients and the public.
- New guidance will encourage local authorities PCTs and other relevant partner to co-ordinate their consultations and avoid multiple overlapping plans for the same neighbourhood.
- There will be an expectation that local authorities will work with third sector organisations in proactively consulting with vulnerable and socially excluded groups.

Main issues considered by the Health Select Committee

Patient and Public Involvement-recent history

Community Health Councils (CHCs) were created in 1974 and were in place for almost 30 years. They were the first formal structures to represent the public interest in the NHS. They were abolished at the end of 2003.

Their role was taken over by a range of different organisations in early 2004:

- Overview and Scrutiny Committees
- Patient Advice and Liaison Services
- Independent Complaints Advocacy Service
- Patient and Public Involvement Forums
- Commission for Patient and Public Involvement in Health

In July 2004 the abolition of the Commission for Patient and Public Involvement in Health was announced but no date has been set. In July 2006 the abolition of Patient and Public Involvement Forums was announced but no date has been set. Reasons given for abolition of CHCs was that there was a wide variation in performance, they were not representative of the community, they failed to attract young people and ethnic minorities. The same reasons are now being given for the justification to abolish Patient and Public Involvement Forums.

Patient and Public Involvement- aims

“Patient and public involvement should be part of every NHS organisation’s core business”- recommendation 3. The Committee found that patient involvement and public involvement are distinct from each other and are achieved in different ways. Broadly, this involvement is aimed at improving the quality of services and enhancing accountability for public spending. However, patient and public involvement often appears to be a nebulous and ill defined concept, used as an umbrella term to cover a multiplicity of interactions that patients and the public have with the NHS. Confusion about the purpose of involvement has led to muddled initiatives on the part of Government.

The Committee found that the lack of local accountability in the NHS is often referred to as the “democratic deficit”. There is no clear means for a

role for independent patient and public involvement structures. The NHS has not been linked with local democracy since local councillors were removed from Health Authorities in the 1970s. Accountability has been improved by the establishment of Overview and Scrutiny Committees but they do not have sufficient resources to cover all NHS issues in all areas.

Overall, the Committee found that patient and public involvement mechanisms do have the potential to play a key role in bringing about service improvement and improving public confidence. Good patient and public involvement does not yet happen uniformly across the health service, perhaps because it is not yet fully ingrained into NHS culture.

The Government is keen that public and patient involvement takes place in decisions about commissioning. The Committee found that this may be a lower priority for the LINKs activity given that they may spend more of their time being concerned about the quality of the services that NHS bodies provide. The Committee were not convinced that the Government had been clear about the respective roles for NHS and social care commissioners will be in relation to public and patient involvement.

Patient and Public Involvement- structures

The Committee found that Public and Patient Involvement Forums (PPIFs) should not have been abolished, but should be allowed to evolve. The policy decision to create Local Involvement Networks (to replace PPIF) is not evidence based and there is very limited detail on how they will operate. The Committee was concerned that there are no pilot schemes in place, there is no clarity about the central funding that will be provided to each LINK, and how the abolition of the central body, (the much criticised although praised by Unison) Commission for Public and Patient Involvement In Health will not be replaced by a new national body.

The Committee was concerned that there are a range of unresolved issues around the function of the Local Involvement Network (either a network through which contact can be made with a wide range of communities or the range of activities carried out by Public and Patient Involvement Forums), to whom they are to be accountable and how the reliance on existing volunteers will not be lost.

The Committee believed that Local Involvement Networks can be made more effective with the following activity:

- Clarify the function and ensure they prioritise
- They have neither funds nor volunteers to do all the Minister wanted

- Department must issue guidance on what they should do within their budget
- Clarify how they can be made accountable
- Clarify how conflicts of interest are to be resolved
- Ensure that existing volunteers are not lost in the transition

Patient and Public Involvement- consultation

The Committee asked for expert evidence from Richard Stein, solicitor who has successfully challenged many NHS consultations and from Candy Morris, in charge of reconfiguration of South East Coast SHA. The Committee found that the current s.11 Health and Social Care Act 2001 and accompanying guidance *Strengthening Accountability* both mean that there is “in theory an excellent system in place”. However, there was widespread criticism that people feel they are consulted after decisions have been made, the is evidence of cases in which consultation has been refused in major changes and other cases where the Department of Health has actively challenged (even in court) that consultation was not required in service provision change.

The Committee was concerned that the Bill’s proposed changes to s.11 will weaken the current model of consultation, will lead to confusion and could lead to more court cases to test the definition. They could not find that there is any evidence that the change in the Bill in relation to consultation is needed. They concluded that NHS bodies should follow best practice that already exists, ensure they consult early enough in the process that plans can be changed, and should approach the existing legislation in the spirit of the statutory guidance in *Strengthening Accountability*.

The Committee also found that Overview and Scrutiny Committees have significant weaknesses as effective bodies. Their powers have been extended to health so they can review health and social care services, request information and summon people before them to explain their actions, as well as request an independent inspection of premises. They must be consulted by NHS where there are *major* changes and may refer matters to the Secretary of State⁶. However, the Committee found many doubts expressed about their effectiveness: there is general weakness of scrutiny arrangements; councils have no financial control over health service providers so have no powers to require that NHS services are changed; they lack independence as the committees made up of local

⁶ The requirement to consult OSC in respect of *major* NHS change is higher than the current s.11 requirement which requires consultation on *any* proposal for service change. This distinction can be overlooked by some PCTs who mistakenly assume that only major changes require public consultation.

councillors and in many cases are not independent from local trusts; there is no lay or public representation, so a majority party can fill all the seats on the OSC with members from one party.

Health Select Committee recommendations

- The main purposes of patient and public involvement need to be distinguished: improving the design and provision of services, and increasing accountability.
- Patient and public involvement should be part of every NHS organisation's core business particularly as patient choice becomes established.
- Structures and procedures will have little effect if the health service is not prepared to listen and make changes as a result of what they learn. Effective patient and public involvement is about changing outcomes and putting patients and the public at the heart of what NHS and social care providers do.
- The function of LINks should not duplicate the work of Foundation Trusts Boards of Governors, and at this stage there is a risk this may happen unless the functions of LINks are made explicit. Full trials of LINks should be made to assess the practical and financial requirements to run them, and adequate guidance given by Government for their priorities and how they can avoid duplicating work of other agencies (such as the Picker Institute).
- Consideration should be given to retaining Public and Patient Forums and in particular the need to ensure that current volunteers do not cease their involvement.
- If the Department wishes LINks to become engaged in the quality of commissioning decision making, it must issue effective guidance setting out how it expects this to happen and what steps it proposes to make this happen.
- The law and guidance on consultation is adequate and does not need to be changed. The Department should encourage NHS bodies to undertake guidance in accordance with the law and guidance. "We fear the Bill will weaken s.11. The change of definition it proposes may lead to confusion and could lead to more court cases when the Act is tested. We are not convinced this change is needed."
- Consultations in which a large proportion of the public reject plans which go ahead anyway must not continue to happen.

- Secretary of State should refer all cases to the Independent Reconfiguration Panel before her own intervention takes place.
- National consultations cannot be open to the accusation of being “cosmetic” and consultation on national policy may be valuable both terms of enhancing accountability and improving policy making, even if final decisions rest with elected representatives.

RCN policy position and forthcoming activity

Any future model of public patient involvement must have political teeth and a meaningful voice at a local and national level. Success will depend upon partnerships between patients, carers, communities, practitioners and other health service staff. NHS staff themselves are users of public services and should continue to play an active role in the development of democracy in public services. The RCN believes that the introduction of a statutory duty of public participation for providers, commissioners and regulators would stimulate participation by a wide range of stakeholders.

The RCN is lobbying for the retention of the existing s.11 requirements on service change consultation and will be providing a briefing for MPs on the support of the RCN for the existing legal requirements, and it concerns that this should not be diluted in any way that would possibly diminish the importance of debate before final proposals are put out for formal consultation.

The RCN has already raised concerns about the lack of clarity in the commissioning process for public and patient involvement in its brief on the OJEU tender that was published by the Department of Health in 2006⁷ in which one of the five main commissioning functions is public and patient engagement in which NHS commissioners must respond to patient petitions, referrals and advice of choice as well as effective communication. The RCN has commented that this section of the tender is the least developed in its detail about what is expected of commissioners in this regard.

The RCN will be looking closely at the function of the Overview and Scrutiny Committees, particularly when the final Local Government and Public Involvement in Health Bill. The concerns raised by the Health Select Committee about the weaknesses in Overview and Scrutiny Committee function and structure will be an important factor in the overall relationship between regional officers and local government.

The RCN now has a dedicated policy initiative to deal with Voice and Consultation in the NHS, as a dedicated work stream of the Health and

⁷ RCN Policy Unit Briefing on the Department of Health Tender for commissioning NHS services, Policy Briefing 10/2006, July 2006

Social Care Policy Group under the Nursing Directorate operational plan. This work stream will include further activity on the role of public and patient participation. One key product of this work stream will be the development and production in 2007 of a learning resources pack for activists and members in relation to consultation over service changes in England. This work is being carried out in conjunction with Richard Stein from Leigh Day Solicitors who was invited as an expert to provide evidence to the Health Select Committee on the challenges that face the health service in ensuring that there is effective public and patient partnership across the health economy.

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