



12 August 2010

## **White Paper: Equity and excellence: Liberating the NHS**

Since the last meeting the Departments of Health and Communities and Local Government have embarked on a period of consultation on the White Paper. The consultation period is set to end of the 11 October 2010. Four consultation documents have been issued, as follows:

### **Liberating the NHS: regulating healthcare providers**

It further outlines proposals on foundation trusts and the establishment of Monitor as an independent economic regulator for health and adult social care.

### **Liberating the NHS: commissioning for patients**

Sets out proposals for putting local consortia of GP practices in charge of commissioning services to best meet the needs of local people, supported by an independent NHS Commissioning Board and seeks views on how the Government should implement these proposals.

### **Transparency in outcomes: a framework for the NHS**

The Government's White Paper, 'Equality and Excellence: Liberating the NHS', set out how the Secretary of State for Health will hold the NHS Commissioning Board to account for delivering better health outcomes through a national NHS Outcomes Framework. The Government is seeking views on how they should develop the NHS Outcomes Framework.

### **The review of arm's-length bodies (ALBs)**

Liberating the NHS sets out our proposals for ALBs in the health and social care sector. These proposals form part of the cross-Government strategy to increase accountability and transparency, and to reduce the number and cost of quangos.

### **Increasing democratic legitimacy in health**

This consultation builds on the proposals in the White Paper to increase local democratic legitimacy in health. This will be achieved through local authorities: i) being given a stronger role in supporting patient choice and ensuring effective local voice ii) taking on local public health improvement functions, and iii) promoting more effective NHS, social care and public health commissioning arrangements.

It is proposed that LINK participants:

- a. Should be made aware of the opportunities to comment on the White Paper

- b. Be invited to give views on the above four consultative documents, through the LINK Bulletin and via email
- c. That a collective LINK response be enabled.

In line with the actions agreed at the last meeting, Appendix A sets out a critique of those parts of the White Paper concerning the transformation of LINKs in 2012 into the new proposed local HealthWatch

The White Paper sets out to create HealthWatch England, a new independent consumer champion within the Care Quality Commission; Local Involvement Networks (LINKs) will become the local HealthWatch.

The role of HealthWatch at a local level will be to:

- Ensure the views and feedback from patients and carers are an integral part of the local commissioning across health and social care
- Local authorities will be able to commission local HealthWatch or HealthWatch England to provide advocacy and support, helping people access and make choices about services and supporting individuals who want to make a complaint. In particular, they will support people who lack the means or capacity to make choices; for example, helping them choose which GP to register with
- Local HealthWatch will be funded by and accountable to local authorities, and will be involved in local authorities' new partnership function, described in chapter four of the White Paper. To reinforce local accountability, local authorities will be responsible for ensuring that local HealthWatch are operating effectively, and for putting in place arrangements if they are not
- Local HealthWatch will provide a source of intelligence for national HealthWatch and will be able to report concerns about the quality of providers, independently of the local authority.

Some unanswered questions:

1. LINKs in 2012 will become the local HealthWatch. Does this mean that HealthWatch will retain all the existing powers and functions of LINKs? The consultation document 'Increasing Democratic Legitimacy in Health' suggests that it will retain rights to visit provider services. The notion of LINKs retaining all its existing powers and developing into an enhanced HealthWatch is an attractive proposition, since adding complaints and advocacy will provide intelligence and information directly from users and carers – the strength of Community Health Councils was partly derived from the connection they had with real users and carers, with recent experiences, albeit perhaps from a negative standpoint.

If however, HealthWatch isn't to have the same range of powers as LINK and becomes more akin to a Citizen Advice Bureau, as suggested in the consultation document, then the whole concept may be problematic. The LINK's ability to monitor and scrutinise services on behalf of the community and to hold health and social care commissioner to account on behalf of their respective communities, is an important role LINKs is able to perform - examples being the LINK's work on the Annual Quality Accounts and Hygiene Review of Kent Hospitals. If HealthWatch is only able to derive its intelligence from complaints it

will have a very distorted view of health and social care services and will carry the risk of becoming a very divisive organisation

2. Although HealthWatch is intended to cover health and social care the title may be misleading
3. It is proposed that local authorities will be able to commission HealthWatch to support people who want to make a complaint, a function currently performed by the Independent Complaints Advocacy Service (ICAS). Currently ICAS only cover NHS complaints, what about social care complaints and advocacy?
4. In Kent we already have Healthwatch, a Kent County Council initiative that came out of the Council's concerns over what happened in Maidstone and Tunbridge Wells when so many patients died of *Clostridium difficile* (*C. diff*). It is said that the Government's scheme derives from the Kent model. However, its role appears to be quite different from that envisaged for the new Healthwatch. Concerns over the Kent scheme have been poor take up of the scheme, cost per case and its limitations in terms of being little more than a signposting service
5. The role of the local authority in setting up HealthWatch could be the same as for LINK, ie ensuring independence from the Council through an arms-length body. However, the Government's aversion to arm-length bodies could create a situation whereby the local authority could try to provide this service in-house, thus compromising HealthWatch's ability to investigate issues relating to the council as a provider of social care services
6. HealthWatch's essential links with the regulators appears to be through National HealthWatch. We have found in LINK's local working with regulators, such as the Care Quality Commission, to be essential
7. A key role for LINK has been to stimulate local people's involvement in their health and social care services with the aim of improving social cohesion and addressing the so called 'Democratic Deficit'. It is surprising therefore that given the Government's emphasis on the 'Big Society', this element has been missing from HealthWatch, with its particular concentration on complaints and local people monitoring and scrutinising service providers.

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