BEDFORDSHIRE LOCAL INVOLVEMENT NETWORK (LINk)

BEDFORDSHIRE LINk RESPONSE TO THE NHS WHITE PAPER REGARDING HEALTHWATCH

A task group of the Bedfordshire LINk was formed to formulate a response on behalf of the LINk; this group met on Friday, 20 August 2010 to discuss one aspect of the NHS White Paper, to do with HealthWatch and the implications for LINk volunteers and the communities it serves.

It was agreed that the whole White Paper was relevant to the LINk, but the main focus of the meeting was on HealthWatch, its role nationally and locally, its functions and funding. The whole of the East of England LINks network were asked to speak to their LINk members and make a response.

Discussions focussed on the roles of CQC, HealthWatch (England) and local authorities, and their influence on how local HealthWatch functions.

The main concerns were how little connection there had been throughout LINks existence with CQC, and remaining under local authority control to ensure the operational side of local HealthWatch would not only take away independence but put in another layer of authority.

The consensus view from the meeting was that LINk should remain with its current function of ensuring that quality care and access to services is available to all in the health and social care structure, and be able to commission a consortia of local organisations to take on the complaints advocacy and the advisory role described in the White Paper.

There follows a more detailed response from members, including a brief history of how patient and public involvement has evolved over many years.

The History of Patient and Public Involvement

It is important in our response to review the history of patient and public participation in health and social care in order to set the advent of HealthWatch (HW) both in context and to emphasise that is not new. It is an idea of some years' gestation.

The Community Health Council was the first structure that emerged and was abolished in 2001 by the then Secretary of State, Alan Milburn MP. In 2003 the representative and inspection role was taken over by Patient and Public Involvement Forums (PPIF) supported by an arms length body called the Commission for Patient and Public Involvement in Health (CPPIH). The complaints aspect which is now proposed to be included in the HealthWatch structure, was given to the Patient

Advisory and Liaison Service (PALs) which were aligned to each NHS Trust and an Independent Complaints Advocacy Service (ICAS), locally this is an organisation called PohWer. During the formation time of PPI an idea floated by the Department of Health (DH) was that all GP surgeries would have an Advisor who would guide patients to make informed choices, but this did not materialise.

The Patient Advisory Liaison Service (PALs) is often criticised from a number of organisations because it lacks independence and patients frequently report difficulties related to their non-independent nature, lengthy delays and failing to provide complainants with explanations of what went wrong, or apologies for mistakes. ICAS appears to operate behind a veil of confidentiality and did not connect with either the PPI Forums or the current LINk structure in any significant way; it is known that in 2008/9 ICAS locally were handling about 46 cases per month.

A number of PPI Forums underperformed as are some LINks because of the way they were set up, with Forums there were difficulties recruiting members and the cost of supporting them within the first few months, they were limited to monitoring their Trust area only and they had no authority to monitor social care services. Underperformance could also be connected to the fact that PPI Forums had only a fairly short life of three years, and LINks will only have been running for four years when it evolves into local HealthWatch organisations. The inception of LINks in 2008 did not go smoothly, and this time involved the Local Authority who appointed Host organisations all with different ideas and no conformity throughout the country.

In addition, LINks structure was left very vague in order for local areas to decide their governance and structure, but on reflection it is felt by many that national governance and written ethos and rules would have assisted many LINks to set up more quickly and give it more credibility. However, the DH report that more people have been involved in LINks and LINks around the country have contributed to making many service improvements in health and social care.

Is HealthWatch the answer?

And now we arrive at HealthWatch; what is HealthWatch – LINks with a different name, less or no money but huge responsibilities being laid upon the current and future members of LINks? Local authorities will play a big part in commissioning "health complaints advocacy" from local HealthWatch or HealthWatch England.

The concerns here are :

a) Do the Government assume there are ranks within LINks that are experienced and trained in health advocacy advice?

b) Will they have the resources to pay and house these facilities?

c) Could they be run along the same lines as Citizens Advice Bureaus?

We understand that HealthWatch will be established in shadow form around the Autumn of 2011 and be up and running six month's later in April 2012. As the current funding for Bedfordshire LINk will cease at the end of 2010/11 it would be reasonable for the local authority to extend this for a further year to the present Host in order to mitigate the various changes involved with the creation of the local HealthWatch. Members felt strongly that there should be one HealthWatch for Bedfordshire including Luton because of the extent of the current cross-over with work programmes; this would save the costs involved of running three offices and duplicating each others efforts in the areas of dissemination of information to members and the need to have separate panels of members to report in each of the three areas. A central office should be set up with meeting facilities.

Keeping our independence and an integrated approach

There is generally an unease felt by Bedfordshire LINk members that the local authorities will be given much more say and hold the purse-strings for local HealthWatch, ensuring it is operational. This does challenge the independence of local HealthWatch organisations as it does with LINks. This may mean that local councillors rather than lay representative sit on key boards and consortia groups. There is also no apparent working together of the unitary local authorities; they work as separate entities with regard to policies, complaints and so on. For LINk/local HealthWatch it is vital that integrated working happens as there is no use undertaking enter and view visits to do with mental health or shared clinics/services and then find the other LINk/local HealthWatch is also doing a similar exercise. If the current system of LINks is to emerge as three separate local HealthWatch organisations, than one of these organisations needs to act as a hub or central co-ordinating office for the others. It will be imperative that Healthwatch Bedfordshire will need to be centralised even though the component authorities of Bedfordshire are not.

An example of where working together is imperative

An example of where the local HealthWatch establishments could work together is in the areas of hospital discharge. Bedfordshire has two NHS hospitals, Luton & Dunstable and Bedford. The large area of Central Bedfordshire has no hospitals in its unitary area; this leads to problems when patients are discharged who are not within the boundaries of Luton & Bedford. There is also the mockery that every patient has a choice of its hospital preferred for the operation that is to be undergone. You have the choice, yes, but discharge and after care leaves a lot to be desired.

a) If you elect or maybe are sent to a specialising hospital by your GP to use a hospital out of your area. i.e. to get immediate service, or some other reason than at the present moment your chance of after care are very remote.

Hospitals for some reason out of your local area, do not contact your local social care or PCT even though they will have a discharge document to complete before letting you leave. In some cases you may have the discharging hospital contact your local after discharge from hospital services, who inform you it will be take some days or weeks before they can assist you.

b) The government must make provisions for ensuring no matter what hospital you attend, as is your right that the providing hospital must be made aware of whom they should contact on your release from hospital what social care at NHS PCT must be notified of you discharge. It is not the hospitals job to organise after care on release, but they must tell the required departments handling such matters in your area what help is required. The government must ensure that the discharge document is passed to the NHS/local authority so that immediate action is taken on notice of release from hospital.

It is imperative that we know who should be contacted in the first instance? The GP consortia would appear to be the group that could do the most good, they know the patient and they should have good information available to contact the other services required. In Bedfordshire LINk we have formed a Task & Finish Social Care Group with Central Bedfordshire Council in order to work on the monitoring of quality of care nursing/residential home. A similar working arrangement should be made with the GP Practice Based Consortia in the area to set up some reciprocal agreements to assist with ensuring accessibility to services and quality care for patients.

Local HealthWatch needs to be autonomous, but as indicated earlier, this does not mean it doesn't need guidance and support, and this could be funnelled down from HealthWatch England to each local HealthWatch who would have an Official Administrator/Executive with good organisational and communicative skills to bring pull everything together.

Members had several concerns about taking on the role of advocates or advisors and opinion was that these roles required expert knowledge covering legal, commercial and financial aspects. A lay person would have problems dealing with the complicated problems raised by those suffering from worries, there would have to be some form of legally binding confidentiality clause for volunteers who will of necessity gain information which should be confidential to the authority or individual patients or associate during the course of their work in this field.

It was clearly felt that there are organisations already out there that can be pulled in to work with local HealthWatch in matters of advocacy and advice.

Reservations about this, is that this sort of enlisted support needs to be co-ordinated well. There is a sense that there although there is a great deal of good work going on out there in terms of voluntary and charitable work, it is often patchy, lacks co-ordination and is often being duplicated rather than organisations working together. It would be useful for there to be a consortia of partners such as MIND, British Red

Cross, St John's Ambulance, Age UK, Older Peoples Forums, capacity building organisations like the local community voluntary sector and so on who would collaborate for local HealthWatch to provide the advisory/supporting arm of local HealthWatch. The culture at the moment is that many organisations are fighting for the same "pot of money", and this does not breed a culture of partnership working and sharing of information.

What are the options?

Firstly, it is time for people to become accountable for their lifestyle choices because the days of counting on our over-burdened healthcare and social systems to make up for unhealthy lifestyles may be coming to an end. It is a bubble that is due to burst as the health privileges we have enjoyed for so long are stretched to the breaking point. We need our Health Service and Care Service so let's not use and abuse it, let's champion it.

Assuming that our local authorities are given, as indicated in the White Paper, the responsibility of ensuring that local HealthWatch is operational.

- Central Bedfordshire (CBC) establishes CB HealthWatch and fund activities listed under the White Paper proposals including complaints advocacy and support (the ICAS function). It is not yet known how comprehensive the function of helping local people access and make a choice will be. It may include access and choice (personal budgets) in both social and health care. The complaints service would be similar to that provided currently by PALS to NHS Trusts but also include social care issues. It is recognised that providers of care need to maintain some of these functions which may lead to confusion.

- CBC establish the local HealthWatch and assist the local HealthWatch to sub-contract the functions covered by ICAS, PALS and Choice advice. All would come under the local HW organisation as a HealthWatch Consortia.

- establish the local HW and then contract HealthWatch England to provide those services not undertaken by the present LINk.

- Central Bedfordshire, Bedford and Luton Unitary Authorities establish a Bedfordshire and Luton HealthWatch to provide county-wide services as outlined in the White Paper.

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