

Department of Health

Liberating the NHS: Legislative framework and the next steps

Chapter 2. Putting patients and the public first

Introduction

2.1 *Liberating the NHS* articulates a profound ambition to transform the culture of care. The Government proposes a shift in power that puts patients and their carers in charge of making decisions about their health and wellbeing, gives them more information, choice and control over how their care is delivered, and strengthens the voice of the public through HealthWatch, a new consumer champion. As Optua, a user-led disability organisation, told us in its response to the White Paper, putting patients and the public first is “*life-changing and long overdue*”.

2.2 Patient-centred care is at the heart of our plans for the NHS. It underlies each of the following chapters, which consider in more detail the structural changes needed to improve outcomes and give professionals and providers more freedom to respond to their patients.

2.3 The Government has given careful consideration to what people have said in response to the White Paper consultation and during engagement events over the summer. Responses have shaped and, in some cases, changed how we will move forward, and responses to ongoing consultations on choice and information will continue to do so. For example, in view of some of the concerns expressed, the Government has decided to: provide additional funding to local authorities for local HealthWatch; change our approach to how NHS complaints advocacy will be provided; and take steps to give HealthWatch England a distinctive identity and role within CQC.

2.4 The Health and Social Care Bill will help to bring about the Government's vision. It contains provisions about the NHS Commissioning Board and GP consortia's duties in relation to patient engagement and choice, the creation of HealthWatch, and changes to support the Parliamentary and Health Service Ombudsman's work.

2.5 This chapter considers in turn:

- A. Shared decision-making: no decision about me without me
- B. Greater choice and control
- C. An information revolution
- D. Advice and support for shared decision-making and choice
- E HealthWatch
- F NHS complaints

A. Shared decision-making: no decision about me without me

2.6 The White Paper explained that patients should expect there to be ‘no decision about me without me’. Only by putting people at the heart of their care and involving patients and their carers as much as they want to be in every decision about their care will the best outcomes be achieved. As Sir Derek Wanless recognised in 2002 as part of his long-term vision for health, increased participation of patients in decisions about their own health and care is key to securing the health system of the future.

2.7 Many respondents welcomed a move to shared decision-making. The Royal College of General Practitioners “*would always argue that health outcomes are maximised by consultation and cooperation between patients and their doctors*”, whilst many charities and user-led organisations showed strong support. Stonewall, for example, believe it could be “*a key driver for the health service to tackle discrimination*”, while a patient “*Very much welcome[d] the recognition of the value of shared decision making*”.

2.8 We also received many helpful suggestions about the issues to be addressed and changes that are needed in order to make shared decision-making a reality.

A cultural change

2.9 Respondents such as Arthritis Care felt there needs to be a “*cultural shift*” towards shared decision-making - a change from both patients and clinicians. The Neurological Alliance said that “*for shared decision making to work there needs to be significant workforce development, including a culture shift in professional attitudes*”, whilst a GP commented that patients will not necessarily wish to share decisions unless they can see the advantages of doing so. The Local Government Group argued from the experience of social care that “*the personalisation agenda... has resulted in a complete change in the relationship between professionals and service users so that the service users are informed, supported and empowered by professionals to become their own commissioners, making decisions about the services that best meet their needs. This requires a major culture change, a redefinition of the ‘doctor/patient’ relationship... it will succeed or fail in the quality of face-to-face relationships between health practitioners and patients.*”

2.10 There is already a strong basis for shared decision-making in clinical practice, with training emphasising the importance of the consultation as a real conversation between practitioner and patient. Organisations including the British Medical Association (BMA), General Medical Council and the Royal Colleges of GPs, Nursing and Midwives said that shared decision-making is in line with their core professional values and guidance, and is actively being practised by many clinicians. But the Government also heard that it is not the norm for many patients. The National Family Carer Network, for example, was “*glad that sharing decision making is to become the norm. We still hear from families that they are not listened to, that their knowledge and expertise is*

ignored... 'Nothing about us without us', which comes from Valuing People, needs to be taken seriously".

2.11 The Government agrees that a cultural change is needed, which should be brought about through leadership and action across the health community. As National Voices said, "*progress requires... effective leadership, practical support and patient and public pressure*". We ask for views about how to bring about the cultural change in the consultation entitled *Greater choice and control*, which is open until 14 January 2011.

2.12 The direction of the cultural change needs to be guided by a clear and shared vision of the patient–clinician relationship. As the Patients Association said, patients have "*different requirements and definitions as to what it means to be involved in decisions regarding their healthcare*". The Children's Commissioner and the Black Health Agency also emphasised the need for opportunities and support for shared decision-making to be available to all, including those who need different levels of support and/or different communication techniques, such as children, young people, adults with a learning disability, and other vulnerable or marginalised communities. The Government agrees that there needs to be more systematic and sophisticated approaches to profiling and understanding people's needs and preferences, which will support all sections of the community to have a greater say in their health and care. We will work with clinical and patient leaders to help them develop an understanding of how a new type of patient–clinician relationship can work in practice, including respective responsibilities and entitlements, and how clinician and patient education can help.

Building shared decision making into commissioning

2.13 Shared decision-making is not only relevant to patients and clinicians. As Leicester City PCT says, "*Patient choice should be top of the agenda when purchasing services*". Commissioners will need to make pathways flexible enough to allow patients the scope to make decisions about their care, using decision aids where appropriate, and to promote self-care.

2.14 The Government agrees with South East Coast SHA that measures to promote choice within commissioning should not be over-prescriptive or "*stifle innovation*". The Bill will place the NHS Commissioning Board under a duty, in exercising its functions, to have regard to the need to promote the involvement of patients and their carers in decisions about the provision of health services to them. The NHS Commissioning Board will also be under a duty to issue guidance on commissioning to GP consortia, which could include guidance about how to fulfil their duties in relation to public and patient involvement.

B. Greater choice and control

2.15 The White Paper proposed giving people more choice over their health and care services. Many people value choice and would like more opportunities to make choices about their health and care services. Choice should also create a more responsive NHS, as providers are encouraged to tailor their services to what people want, improve the quality and efficiency of their services, and ultimately improve outcomes.

2.16 Many responses to the White Paper consultation supported our vision of greater choice and control for patients and carers. The National Clinical Homecare Association *“really welcomes the commitment to greater patient choice and, in particular, the emphasis on allowing ‘any willing provider’ to step forward. This is very much the essence of clinical homecare and what our members stand for”*, while Leicestershire County Council *“is committed to extending choice to people which it sees as the way forward in offering care and support that is tailored to individual needs”*.

2.17 There was also support for the extension of choice for users of particular health services. Rare Disease UK welcomed in particular the White Paper commitments to extend choice for people who need diagnostic testing, care for long-term conditions or end of life care, and to provide more information about research studies. A member of the public felt that choice for mental health service users *“is a great empowerment tool”* which will *“aid and increase many service users’ recovery experience”*. And the Royal College of Surgeons of England, Faculty of Dental Surgery said that *“In particular for hospital based medical, surgical and dental services the Faculty strongly supports the introduction of the patient... having the choice of a consultant led team who will provide elective care”*.

2.18 Respondents such as the Health Foundation called for strong leadership and a consistent vision in order to achieve greater patient involvement and choice. The Bill will therefore place duties on the NHS Commissioning Board and GP consortia to, in the exercise of their respective functions, have regard to the need to enable patients to make choices with respect to aspects of health services provided to them.

2.19 The Government has also noted that a number of people and organisations have concerns about patient choice. Some respondents suggested that choice is not right for the NHS, with one GP saying that *“‘Choice’ is a luxury people should expect to pay for.”* Respondents, including the Royal College of Nursing, were uncertain about how choice would work in practice, asked for more detail about the proposals, and highlighted some of the issues that will need to be addressed before greater choice and control is a reality for all.

2.20 We have launched a consultation, *Greater choice and control*, which is open until 14 January 2011. It gives more information about the Government’s proposals and how we believe choice will benefit people and the NHS. It also addresses some of the key concerns we have seen raised. Responses to

Greater choice and control and the White Paper consultation will inform more detailed proposals on choice to be set out in early 2011.

Supporting choice through personal health budgets

2.21 The Government is pressing ahead with the personal health budgets pilot programme as a high priority. Many respondents welcomed this enthusiastically, with CLIC Sargent “*particularly*” supporting it and Rethink commenting, “*we would also like to see personal health budgets implemented more widely. This would provide an even greater level of choice, with patients acting as their own commissioners in choosing the services most suitable to them*”. Others highlighted the need for careful management: the Staff Side of Nottinghamshire County PCT said “*We are pleased the government recognises the complexity of personal health budgets and welcome that more work will be done in this area. Use of personal health budgets for continuing care could work very well providing there are safeguards in place to protect the vulnerable and ensure that budgets were spent appropriately and compassionately*”.

2.22 The Bill will retain current legal provisions for piloting direct payments in healthcare as one of the ways to offer a personal budget. This includes the power to extend direct payments nationally (with the approval of both Houses of Parliament) following the pilot evaluation, which is due to report in October 2012.

C. An information revolution

2.23 An information revolution will be vital to put patients in the driving seat of their health and care. The White Paper stressed how information can drive better and safer care, improve outcomes, support people to be more involved in decisions about their treatment and care, and, through extending opportunities for people to provide feedback on their service experience, improve service design and quality. It proposed that patients should be able to control their own health records and share their records with third parties of their choosing.

2.24 Respondents showed strong support for the Government's vision of an information revolution. Bexley, Bromley and Greenwich Local Pharmaceutical Committee's view was that the "*'NHS information revolution' in which patients have ownership of their records is very positive; they should be able to share their records with all health professionals, so that decisions about their care are transparent*". Which? said that information is key to empowering patients to take control of their care, and a survey by the Patients Association showed that 79% of people surveyed agree.

2.25 Respondents particularly emphasised the important link between information and the improvement of services. National Voices agrees that there should be "*maximum transparency about performance, in particular to drive improvements in professional behaviour through benchmarking and peer to peer challenge*", while Breast Cancer Campaign noted that "*Without appropriate data collection and a baseline of how different services are performing now, we cannot expect to improve outcomes and be able to identify particular areas in need of attention*".

2.26 Respondents such as English Community Care Association, Choices Advocacy and BRAME highlighted some important issues to address in order to make the information revolution truly transformative; for example how to use information and technology in a cost-effective way, safeguard confidentiality and ensure that information is accessible to all. The King's Fund also recognised the challenge of communicating effectively, noting that recent research suggests that "*many people find it difficult to understand and interpret data about the quality of providers*". A recent report published by Martha Lane Fox, the UK digital champion, also called for the Government to take advantage of digital technologies to deliver services, particularly to disadvantaged users.

2.27 The Government agrees that these are important issues. We have launched a consultation, *An Information Revolution*, which is open until 14 January 2011. It gives more information about our proposals and asks questions, the responses to which will help us to shape plans to help make the information revolution a reality.

Health and Social Care Information Centre

2.28 Respondents recognised the important role of the Health and Social Care Information Centre. Bury Council, for example, “*recognise[s] the need for effective information and data sharing, subject to the appropriate protocols for the safeguarding and sharing [of] data*” and “*broadly support[s] the role of the Health and Social Care Information Centre*”. Likewise, the Local Public Data Panel said that there may be “*a useful role for the Information Centre in collating and analysing data over a longer time period, and in publishing raw data*”.

2.29 Given its importance, the Bill will establish the Health and Social Care Information Centre on a firmer statutory footing as a non-departmental public body. It will collect data that needs to be collected centrally to support the central bodies in discharging their statutory functions. It will have powers to require data to be provided to it when it is working on behalf of the Secretary of State or the NHS Commissioning Board. It will be able to consider additional requests from other arm’s-length bodies, and carry out those data collections if specific criteria are met. It will also have a duty to seek to reduce the administrative burden of data collections on the NHS, with powers to support this.

2.30 As the authoritative source of centrally collected data, the Information Centre will unlock the potential for making better use of information and become the focal point for national data collections for health and social care. It will generally publish the data that it has collected in a standard, aggregated format.

2.31 We intend to separate the collection and presentation of data. While the Information Centre has a vital role in the efficient collection of national data sets, we expect other third party organisations to use this data in many different ways – presenting the information in formats that best fit the needs of specific groups. There are many examples where government data has been used in innovative ways by third parties to improve services offered to citizens. The consultation, *An Information Revolution*, considers these issues in more detail and seeks views on how these ‘intermediaries’ can be as effective as possible.

D. Advice and support for shared decision-making and choice

2.32 Many respondents said that, in addition to the right information, the right tools need to be in place to help people to be involved in decisions and make choices about their health and care. Citizens Advice said that *“Whilst online information may be suitable for many individuals, more vulnerable people may need additional support to understand and implement the choices they are able to make”*, while the Sefton Recovery Group Network said that *“the public need to be equipped with the tools and skills to self manage their lives”*. Respondents also stressed the need for the level and type of advice and support provided to be tailored to the needs of individual patients and their carers and family, and that the vulnerable and those in need of specific support, such as children, should be empowered to be as involved as they can and want to be. The Children’s Society, for example, felt strongly that *“Until there are mechanisms in place to ensure that every child can have a say about care they receive and that they are supported to do so if needed the ‘no decision about me without me’ agenda will not become real for many children, particularly for the most vulnerable groups”*.

2.33 Whilst we are still consulting on how to best bring about shared decision-making and greater choice, the White Paper responses suggest that the Government should build on tools for support and advice that are already working well, including personalised care planning, self-care, and patient education programmes. In particular, respondents said that we should broaden the use of patient decision aids, which can be useful for some types of decision. FPA, for example, *“welcome[s] the Government’s recognition that some people will require decision aids and support to be able to make their own choices, for example support for people with disabilities so that they can access information.”* As part of the Quality, Innovation, Productivity and Prevention programme, East of England SHA is already developing and piloting patient decision aids with a view to embedding them in practice. Use of decision aids could also be incorporated in commissioning guidelines and quality standards developed by the National Institute for Health and Clinical Excellence (NICE).

2.34 Respondents also said how important the support patients receive from their clinicians will be. The King’s Fund said that, although decision aids can help, *“in many cases patients will also benefit from a discussion to enable them to make sense of information. It will be important to ensure that ... clinicians have the skills needed to involve patients effectively in shared decision-making.”* Clinicians will continue to be a key source of advice and support for their patients, but some respondents, for example the BMA, were concerned that involving patients more fully in decisions could take extra time. The Government does not believe that this will necessarily be the case: evidence shows that encouraging patients to ask questions does not appear to have a significant effect on the length of consultations. Moreover, involving a person in decisions about their care, as the BMA also pointed out, should create longer-term gains such as *“improved patient satisfaction, possibly fewer follow-up appointments and possibly improved health outcomes”*.

E. HealthWatch

2.35 The White Paper proposed to evolve Local Involvement Networks (LINKs) into local HealthWatch, supported and led by HealthWatch England as an independent consumer champion within the Care Quality Commission (CQC). Local HealthWatch will ensure that the views of patients, carers and the public are represented to commissioners and provide local intelligence for HealthWatch England. It will work alongside the role of public members and governors of foundation trusts in influencing providers. Local authorities will be able to commission HealthWatch to provide advocacy, advice and information to support people if they have a complaint and to help people make choices about services.

2.36 The Government has seen strong support for a stronger patient, carer and public voice. The Foundation Trust Network said that this is “*vital to ensure the system is in balance*” and the Academy of Medical Royal Colleges’ Patient Lay Group believes mechanisms to enable a strong patient, carer and public voice that can “*speak freely, be listened to carefully, and have their views acted on*” are “*crucial*”. The Association of Directors of Adult Social Services said that HealthWatch “*is completely in line with the intention to ensure that patients and users have choice, control and involvement in the commissioning of health and social care services*”.

Functions of local HealthWatch

2.37 Respondents highlighted the excellent work of many LINKs and, like the British Heart Foundation, called for local HealthWatch to build on this. The Government recognises that many LINKs organisations around the country are effectively supporting patients and helping to shape and hold to account health and social care services. But we also know that some patient needs - such as support to make choices - are not necessarily being met. We agree with the individual respondent who told us that a wider role for HealthWatch “*would be excellent and much needed*”. The Bill will therefore give HealthWatch additional functions on top of LINKs’ current role.

2.38 There was broad support for local HealthWatch to continue to have a role in service design and delivery, to make sure that, through a “*robust local involvement in commissioning... local people’s views influence the evaluation, design and development of services*” (in Picker Institute Europe’s words). Respondents stressed that HealthWatch should ensure that the views of people of all ages and communities are heard. The Joint Forum emphasised that, in particular, “*the most socially marginalised and vulnerable must have their needs represented at commissioning level*”. The Bill will therefore provide for local HealthWatch to continue LINKs’ role in promoting and supporting public involvement in the commissioning, provision and scrutiny of local care services.

2.39 When scrutinising local care services, HealthWatch could decide to take into account patients’ views, including whether they feel their rights have been met under the NHS Constitution. Although one respondent told us that this

would be “*difficult in practice*” and some LINKs organisations commented that HealthWatch staff would need additional training, others felt that HealthWatch would benefit from using the NHS Constitution. As Stockport LINK said, a “*deeper understanding of the constitution will aid HealthWatch and its membership to hold commissioners and providers to account. Using the NHS Constitution as a way to hold providers and commissioners to account is one way which the HealthWatch can carry out its functions but not the only way*”.

2.40 Many respondents agreed with the proposal that local HealthWatch would also support patients to make choices. Existing LINKs organisations, such as Isles of Scilly LINK, would “*welcome a broader role in providing information and supporting individuals in making choices*”, with appropriate training and support to do this effectively, whilst Partnerships in Care hope that HealthWatch will “*ensure that patient choice in all sectors of health transcends dogma and becomes a driver for quality of service and agreed outcomes*”. The Bill will therefore provide for local authorities to commission HealthWatch to provide advice and information to enable people to make choices about health and social care. This could include helping people to access and understand information about provider performance and safety, and the NHS Constitution.

2.41 Respondents such as Plymouth LINK particularly supported proposals for local HealthWatch to be able to escalate concerns about the quality of health and care services to CQC, which (as the regulator) hears concerns of individuals and organisations and makes decisions about which to investigate. The Bill will therefore give local HealthWatch the power to make recommendations to the HealthWatch England committee of CQC for CQC to carry out investigations into health and care services.

2.42 But there was clear unease about proposals for local authorities to commission local HealthWatch to provide advocacy services for NHS complainants. The Parliamentary and Health Service Ombudsman was concerned about “*a potential conflict of interest in the role of local HealthWatch as advocate for an individual complainant - and the part envisaged for HealthWatch in the local commissioning decision-making process*”. Support Empower Advocate Promote, which provides advocacy services, also noted that advocacy is “*a skilled professional function that requires in-depth training and robust quality, risk, people and service management tools and techniques*”, which could therefore require significant time and resources.

2.43 After careful consideration, the Government finds these responses persuasive. With local HealthWatch’s recognisable public profile, we believe that it should have a role in the NHS complaints advocacy process, but this does not need to be by providing the service through its own staff. We will therefore provide flexibility concerning whom local authorities will commission NHS complaints advocacy services from – this could be either local HealthWatch, or other organisations with HealthWatch signposting these services to people.

2.44 Respondents such as the Centre for Public Scrutiny were concerned that the name 'HealthWatch' does not properly reflect its social care role. We were also told of existing organisations that use the name 'Health Watch'. Whilst the Government understands these concerns, we believe that service users do not tend to draw strict lines between health and social care. Through proper engagement with local communities and services, the HealthWatch brand should become well known and be associated with both health and social care.

Resources for local HealthWatch

2.45 Respondents who supported HealthWatch's new functions were uncertain whether these could be provided with LINKs' resources. The National Pharmacy Association echoed many when it said if HealthWatch has "*adequate support, resource and understanding of the full range of providers available to patients, then we believe that they will be able to deliver a valuable service*". The Association of Directors of Adult Social Services added that HealthWatch "*will need sufficient resources and an appropriately qualified workforce to deliver its key roles*", while the Local Government Group similarly questioned "*whether an organisation comprising mainly volunteers will have the capacity, resources and expertises to provide reliable consumer advice.*"

2.46 Funding for LINKs will therefore continue through the transition into local HealthWatch, and will be enhanced to reflect HealthWatch's responsibilities. Local authorities will have funding for HealthWatch built into their existing allocations, including additional funding for NHS complaints advocacy and providing advice and information for people making choices. We anticipate that HealthWatch will have available funding of £53.9 million for 2012/13 plus £3.2 million for start-up costs. In 2013/14, when local authorities take on responsibility for commissioning NHS complaints advocacy, the combined funding available for local HealthWatch and NHS complaints advocacy services will rise to £66.1m. We also agree with the individual respondent, who said that local HealthWatch "*should be able to employ their own staff according to their perceived requirements*", and the Bill will provide for this.

2.47 Many LINKs organisations called for local HealthWatch funding to be ring-fenced within local authorities' budgets. However, the Government believes that it is important that local authorities can manage local priorities; moreover, as local HealthWatch is a representative on local authority health and wellbeing boards, it is important that local HealthWatch should remain within local authority funding mechanisms.

A new role for local authorities

2.48 The Bill will set up local HealthWatch organisations and will place local authorities under a duty to make sure that it arranges with them to deliver the above functions. Local authorities currently commission a broad range of support services for local people, and we know from the consultation responses that many do so very effectively through a range of models. For example, some local authorities contract with well established and influential

organisations to provide effective LINKs services. As one member of the public said, “*LINKs are already demonstrating that they can make a difference*”. But the Government has also heard that, in CQC’s words, “*some LINKs are not as effective as others*”. UNISON highlights that some have found it difficult to provide support for users of social care services, while the Royal College of Surgeons England commented that patient involvement “*has often been fragmented with [the] influence of Local Involvement Networks (LINKs) being limited*”. As Leeds City Council said, this could mean that “*in many areas we will be building on shallow foundations, depending upon the legacy of the LINK and other local arrangements*”.

2.49 Respondents such as the National Autistic Society commented on the importance of consistency in how local HealthWatch operates, whilst recognising that the priorities of each local HealthWatch may vary. Some, in Kent County Council’s words, argued for local authorities to “*have the freedom to commission what is best for the population they serve*”. The Government agrees that there needs to be a clear and consistent vision for local HealthWatch, which HealthWatch England will provide. The Bill will also provide for regulations to be made setting out what local HealthWatch membership should look like. But we also agree that local authorities are best placed to manage local priorities, and the Bill therefore will not prescribe exactly how each local HealthWatch should provide people with advice and information.

2.50 Some respondents were concerned that local HealthWatch would not be a fully independent voice when commissioned by local authorities. The NHS Confederation reflected the views of many when it said that there are “*inherent conflicts of interest*” between local HealthWatch being funded by the local authority and scrutinising local authorities’ commissioning decisions.

2.51 The Government believes that if local HealthWatch are to play a full part in their local communities, it would not be appropriate for them to be funded nationally. We have also seen excellent examples of the relationship between LINKs and local authorities working well in a collaborative yet challenging way. HealthWatch England will support local HealthWatch to continue to do this. For example, HealthWatch England will agree standards against which local HealthWatch organisations and local authorities could benchmark performance and spread good practice.

2.52 The Government will set out proposals for governance and stakeholder engagement at the time of the publication of the Bill. An early priority will be to set out how relationships and accountabilities will work, especially the relationship between local authorities, local HealthWatch and HealthWatch England.

2.53 Responsibility for commissioning independent mental health advocacy under the Mental Health Act will also move from PCTs to local authorities, together with the role of the supervisory body in respect of hospitals under the Mental Capacity Act deprivation of liberty safeguards. However, owing to its highly specialised nature, mental health advocacy will not be a part of the

NHS complaints advocacy services that local authorities will be able to commission from HealthWatch.

HealthWatch England

2.54 From the consultation responses, the Government is clear that HealthWatch England will address a real need. It will provide guidance and leadership to support local HealthWatch to maintain a collaborative and challenging relationship with local authorities, meet Age UK's call for "*better consistency across the country*", and enable best practice to be shared. Hammersmith & Fulham LINK agreed that CQC should "*work in partnership with HealthWatch to ensure that the experience and knowledge about poorly performing services are brought to account*". HealthWatch England, supported by intelligence from local HealthWatch, will be able to escalate concerns about the quality of health and care services to CQC.

2.55 Respondents suggested a number of alternative functions for HealthWatch England, including acting as an arbiter in local disputes (from the British Association for Counselling and Psychotherapy and others) and holding employment contracts on behalf of local HealthWatch (from Rutland LINK and others). The Government has given these suggestions careful consideration, but has decided not to include them in arrangements for HealthWatch England's remit. HealthWatch England is intended to provide direction, leadership and support for local HealthWatch, but this is not a substitute for good local practice and decision-making.

2.56 There were mixed views on proposals that HealthWatch England should be a part of CQC. Some, in the Newcastle LINK host's words, "*would support a strong and equitable relationship between the two*", whereas others would prefer HealthWatch England to be an independent national body. The National Association of LINKs Members, while fully supporting the HealthWatch model, "*fundamentally disagree with the dependent relationship that HealthWatch is intended to have on the CQC and local authorities*".

2.57 The Government believes in the importance of a stronger voice for patients – and that this needs to be backed by a powerful and effective structure. Working in partnership with CQC with the ability to escalate local concerns, HealthWatch England should have real influence, adding a vital dimension to CQC's work on improving services and reflecting the importance we place on the high quality regulation that CQC provides. As NICE said, "*The connection between local HealthWatch and HealthWatch England, based in the Care Quality Commission, should greatly increase the likelihood that public and patient concerns about the quality and safety of local NHS services will be heard and acted upon*". In the words of a member of the public, it would give HealthWatch "*substantially more weight*".

2.58 As a committee of CQC, HealthWatch England will be able to take advantage of its infrastructure and expertise – for example, for data analysis and informatics – supporting HealthWatch England to provide a truly professional and efficient service. Black Country Housing, the host

organisation for Sandwell and Walsall LINKs, said that locating HealthWatch England within CQC was therefore “*highly appropriate and desirable*” to ensure the smooth transition of information from CQC to HealthWatch.

2.59 We intended to assure HealthWatch’s independence by establishing it within CQC, which is wholly independent from the Government. But, recognising the concerns raised, HealthWatch England will also have a distinctive identity and role within CQC to support its independence. We agree with Southampton City Council and Southampton PCT that there should be “*clear separation from the more general areas that are the responsibility of the CQC*”. The Bill will therefore establish a HealthWatch Committee within CQC. We intend that the Committee will be represented on CQC’s board by its chair, who will be appointed by the Secretary of State for Health. The HealthWatch England Committee will carry out the work of CQC related to HealthWatch England and have powers to provide advice to the NHS Commissioning Board, Secretary of State for Health, CQC and Monitor.

2.60 The White Paper proposed that HealthWatch England would provide advice to the Information Centre on the information which would be of most use to patients to facilitate their choices about their care. However, in view of the NHS Commissioning Board’s role in relation to public and patient involvement and choice (discussed in more detail above), we believe it would simplify matters if HealthWatch England provided their advice directly to the Board in respect of health services and to the Secretary of State in respect of social care services.

2.61 The Government has noted the comments of respondents, including East Riding of Yorkshire LINK, that the Committee and governance of HealthWatch England need to be built up from the grass-roots and include good representation from local HealthWatch and other voluntary and user-led organisations. It will need the right mix of skills to ensure it is effective, particularly in supporting local HealthWatch. The Government is committed to working openly in considering how this can best be achieved. The Bill will include a power for the Government to set out in regulations how the HealthWatch Committee should be appointed.

Transition

2.62 The next 15 months will be critical for the successful transition of LINKs into local HealthWatch. As Sheffield LINK noted, this is the time to explore the outstanding “*questions to be asked about the practicalities of expanding the role of LINKs as local HealthWatch*” including “*governance, independence and accountability, relationships with other significant players, the transitional arrangements, the ability to speak authoritatively on behalf of patients and service users and... the national and local framework for delivery.*”

2.63 In early 2011, the consultations on choice and information will close, and the responses will be instrumental in shaping further detail about how HealthWatch will carry out its functions.

2.64 From 2011, the Government will be working with local authorities as they prepare for their new role in commissioning support for choice and complaints advocacy for patients. The Department of Health will publish a transition plan early in 2011, which will provide for LINKs to continue to influence local services while local HealthWatch prepares to start exercising functions.

2.65 From April 2012, local authorities will fund local HealthWatch to deliver most of their new functions. In view of comments such as those of the College of Occupational Therapists, stressing that the transition of advocacy service commissioning must not detract from the delivery of advocacy services, we have decided that responsibility for commissioning NHS complaints advocacy will transfer to local authorities in April 2013. This phased introduction will give local authorities the opportunity to focus on putting in place robust and effective arrangements for the new local HealthWatch roles. It will better ensure that the quality of NHS complaints advocacy services continues throughout the transition to local authority commissioning.

2.66 There were many calls from respondents – in particular existing LINKs such as Wakefield LINK – for HealthWatch to be tested during the transition period. The Government will invite local authorities to develop pathfinder organisations to help with preparations for local HealthWatch. Pathfinders will be able to explore more fully a number of issues that the consultation has raised and look at how these can best be resolved to make sure that HealthWatch gives patients and the public the strong voice that the consultation responses called for.

2.67 For example, pathfinders will be able to test which models most effectively deliver locally commissioned services to support patient choice and complaints advocacy. They can highlight any potential conflicts that arise between HealthWatch's different roles and test ways of addressing these. Pathfinders for HealthWatch will also be able to test different structures for governance and accountability of local HealthWatch, including the role of hosts. It has been widely acknowledged, for example by Leicestershire LINK Board, that, as LINKs hosts, voluntary sector organisations provide vital support and their role too will need to be addressed.

2.68 Pathfinders will also be able to explore how different patient engagement organisations can work in a complementary way, responding to consultation respondents who said that current structures for providing public and patient engagement and involvement can appear complex and overlapping. A retired clinician, for example, commented that there are "*parallel and overlapping groups often with overlapping representation and unclear boundaries tackling similar problems with some level of public funding.*" Pathfinders can explore how to make this less complicated, making sure that seldom-heard communities feel able to get their views heard and acted on.

2.69 Many GP practices engage with their patients through Patient Participation Groups (PPGs), while trusts' Patient Advice and Liaison Services (PALS) help people who have questions or experience problems when using NHS services. Foundation trusts also have links to their patients and the

public through their members and governors. Respondents stressed the importance of relationships between HealthWatch and existing organisations: the National Association for Patient Participation said that it is “*vital to build long lasting and open relationships based on respect and openness*”. Pathfinders will be able to identify how best to work together with these organisations, any overlaps in the provision of information by these bodies, and how best to address these.

2.70 It will also be important for GP consortia pathfinders to develop their understanding of local communities by working closely with groups that represent and involve local patients – for example, current LINKs organisations and HealthWatch pathfinders – as they consider how best to ensure patients and the public are involved and engaged in commissioning.

F. NHS complaints

2.71 In the light of events at Mid-Staffordshire and elsewhere, it is crucial that people know how to make complaints about health services, and that information about the complaints raised is used to improve services. In response to the White Paper, one individual said that “*Complaints, investigations, actions and feedback are essential to the operation of a safe service*” while another commented, “*complaining should be made much easier and every complaint looked at on its merits*”.

2.72 In the first instance, a complaint about NHS services should be made either to the organisation where the problem or incident occurred, or to the body responsible for commissioning those services. Where a complainant is not satisfied with the outcome at local level, he or she can ask the Parliamentary and Health Service Ombudsman to investigate the case. The Ombudsman carries out independent investigations about unfair, improper, or poor service by the NHS in England. The Ombudsman’s office works to put things right where it can, and shares lessons to improve services.

2.73 The Ombudsman wants to ensure her work leads to improvements in the quality of NHS services. To this end, in December 2009, she consulted on sharing and publishing information on complaints. The Ombudsman is subject to some significant legislative constraints in relation to sharing and publishing information about the complaints she receives. The Government agrees that it is important for complaints information to be shared more widely than the current legislation allows to help drive improvements in healthcare and, where appropriate, to be used by regulators to trigger further investigations and inform risk management meetings between relevant bodies. We will therefore use the Bill to change the Ombudsman’s legislation to strengthen the arrangements for her to share more widely with the NHS and others investigation reports and the statement of reasons in those cases where she decides not to investigate a complaint. However, whilst allowing for the sharing of complaints information as widely as is appropriate, it remains important to have regard to protecting the privacy of the Ombudsman’s casework.