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Making a difference with communities, for communities

The Chairman
Secondary Legislation Scrutiny Committee
House of Lords
London SW1A 0PW

24th December 2012

Dear Sir

RE SI 3094 National Health Service,-NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012 (Negative procedure) laid on the 17th December 2012

I am writing to draw the Committee's attention to some shortcomings in the above SI made Health and Social Care Act 2012, relating the structure and governance of Local Healthwatch, a local statutory arrangement funded by local authorities to monitor health and social care and give local people influence over it. Local Healthwatch may subcontract some of its activities and Local Healthwatch contractors have statutory status under the bill, although they are not subject to entirely the same restrictions.

The policy intent underlying this SI is set out in the White Paper *Equity and Excellence* (July 2010) which aims to '*strengthen the collective voice of patients'* through *'a new independent consumer champion within the Care Quality Commission'* manifest at local level as local HealthWatch with *'a strong local infrastructure'.* During the debate on the Report stage in House of Lords on the 8th March 2012, the Minister Lady Northover described Healthwatch as – '*indeed the voice of the people*.' (col.1956)

This policy is particularly pertinent in the light of various recent shortcomings in care highlighted at Winterbourne View, Mid Staffs Hospital and most recently Worcester NHS Acute Hospitals Trust.

The SI relates to the structure, membership and accountability of Local Healthwatch, which are contractual arrangements put in place by each local authority with a 'social enterprise'. Local Healthwatch will seek views from patients and service users, report those views and make recommendations for improvement. Local Healthwatch has various legal powers set out in the principal legislation, including powers to 'enter and view' health and social care premises, seek information, receive a response to its recommendations and escalate issues which it feels are unresolved at local and national level. This system is not new and various versions of it have existed in statutory form since 1974.

To be credible with the public and workable within the services, this system needs the right structure. It must also be led and controlled by members of the public and patients to make sure that those providing services – the local authority, the NHS, the private sector and the voluntary sector – cannot exert undue influence over the decisions it takes. This was reflected in the undertaking given by the Secretary of State to the House of Lords debate at the Report stage of the Health and Social Care Act 2012, on the 8th March 2012 (col. 1980): *"I have listened to the concerns expressed about the need for Local Healthwatch to have strong*

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lay involvement. I completely agree. This will be vital to the success of local Healthwatch. Therefore, I confirm to the House today that we will use the power of the Secretary of State to specify criteria, which Local Healthwatch must satisfy, to include strong involvement by volunteers and lay members, including in its governance and leadership. This will have the effect that a local authority cannot award a Local Healthwatch contract to a social enterprise unless this condition is satisfied. I hope that that provides reassurance to noble Lords. My noble friend Lady Jolly also flagged this up." (Baroness Northover).

I am concerned that the SI does not deliver these policy intentions of impartiality and independence for the reasons set out below.

A. Decision-makers in Local Healthwatch or its contractors: The SI defines two types of 'lay involvement' although the reason for the distinction is not entirely clear.

Section 34.(1) defines

a. 'lay people' to exclude health and social care professionals - but not paid managers or other staff in those services ((34.(1)), nor staff of Local Healthwatch contractors
b. 'volunteers' as unpaid members of the governance of Local Healthwatch or its contractors - which seems circular and fails as an attempt to define who those unpaid people should be, so that they could be staff employed in health and social care or local government in any role, as their 'day job.' but unpaid for their role in Local Healthwatch.

The word between a) and b) of this latter paragraph should probably have been "and" not " or" to ensure that only those members of the public who are engaged in the seeking out of views and monitoring of services should have the designated governance role.

The combined effect of these definitions is that non professional or managerial staff in health, social care or local government can be involved as 'lay people' or 'volunteers' so long as they are not paid by Local Healthwatch and that paid staff from Local Healthwatch contractors can be either lay persons or a volunteer. These definitions fail to deliver lay involvement in the governance of Local Healthwatch or its contractors. Those excluded as 'lay people' could get be involved as 'volunteers' and vice versa.

B. Local Healthwatch as a social enterprise

Section 35 sets out the criteria for a social enterprise applicable to Local Healthwatch. However, these do not apply to Local Healthwatch contractors due to a defect in the principal Act. Local Healthwatch can contract with other organisations but there is no restriction on the type of organisations these can be, other than the exclusion of NHS organisations or local authorities. Local Healthwatch can contract with a non-social enterprise or any number of them to carry out its roles. This is important given that only 50% of the profits from Local Healthwatch needs to be applied to its Local Healthwatch activities, unless it is a charity or Community Interest Company, which have their own restrictions.

C The nature of the involvement of lay people and volunteers as defined.

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Section 38 of the SI requires the 'involvement' of lay persons and volunteer in the 'governance' of Local Healthwatch, but if defines neither involvement nor governance. In the context of the NHS involving patients and the public, a statutory requirement in the principal Act on clinical commissioning groups, 'involvement' is defined as providing information as a minimum, which means that just giving information is adequate to discharge the involvement duty. It seems likely that to avoid this minimal involvement applying in Local Healthwatch relationship with lay people (as inadequately defined) much stronger wording would be needed. This could have been secured in section 40(4) (a) by requiring that appropriately defined lay people were those who made 'the relevant decisions'. This opportunity was not taken and instead 'lay people or volunteers' (not 'and') are to be merely 'involved' in such decisions. They might be told about them afterwards without any say. This would seem to discharge the SI's requirements but not the original policy.

D. Freedom of speech of Local Healthwatch

Section 36 sets out a definition of what constitutes 'community benefit' – a statutory criterion to be a social enterprise eligible to be a Local Healthwatch. Certain activities are excluded from community benefit so Local Healthwatch is effectively banned from these.

Local Healthwatch cannot oppose or promote any national or EU law, any national or local policy or planned or actual changes in either. In addition to not promoting any political party, Local Healthwatch cannot influence voters in relation to any election or referendum. Subsection (2) however legitimises these activities if '*a person might reasonably consider to be activities carried on for the benefit of the community*' as *incidental* to its Local Healthwatch activities. What is '*incidental* in this way is defined in a circular manner which is probably unworkable and certainly incomprehensible to local people who are expected to participate.

The policy which these provisions are intended to implement, is that local people should be able to influence local health and social care for the better and alert the authorities to concerns that it has been unable to resolve. The fact that the mechanism for them to do this is legally powerful but structurally weak because it is funded by local authorities who provide social care, means that

- the governance must be transparent and open to and led by local people with no conflict of interest, but impermeable to any adverse influence
- it must act in a proportionate but effective manner and be free to do so
- the public money being used for its funding must be protected for that purpose and not susceptible to leakage to any unrelated activity, for profit or otherwise.

I do not feel that SI discharges these policy intentions and it will be very hard to explain what it does mean to the people who are expected to participate, especially in terms of their freedom of action. I hope these comments are of assistance to the Committee in its scrutiny of this SI.

Yours faithfully

ELIZABETH MANERO, Director