Department of Health

Government response to 'A stronger local voice'

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Foreword

By the Rt Hon Rosie Winterton
Minister of State for Health Services

The Department of Health published *A stronger local voice* in July which set out five key elements to enable us to create a stronger voice for local people in influencing the health and social care services in their area. These plans included proposals to establish Local Involvement Networks (LINks), which will gather the views and experiences of people on their health and social care services, as well as plans to update the requirements of NHS bodies to involve and consult patients and the public.

A stronger local voice posed five questions, and sought comments from stakeholders about how these plans could best be implemented. I am delighted that we received almost 500 responses, demonstrating the commitment and engagement of people working in this field. We greatly value this input, especially the views of people currently working within the PPI system, as their input will be vital to successfully establishing Local Involvement Networks. Amongst the responses there were many practical suggestions relating to the five questions posed. In addition, stakeholders raised other questions, and asked for further information on how LINks, for example, will operate.

The responses we have received have been vital to us in the development of our proposals. The attached document seeks to address the comments and questions we have received, and demonstrate how we have used these to develop and improve the system of patient and public involvement. I believe that our proposals represent several key improvements to the involvement system which will deliver a more powerful voice to local people. One of the most significant changes is that the structure of LINks will allow a far greater number of people to become involved in shaping their health and social care services. This is vital in ensuring that providers, commissioners, Overview and Scrutiny Committees, and the regulators take real account of LINks' views.

Widening involvement to cover both health and social care also represents a significant advance, meaning that LINks will be able to involve people, and represent their views, on all the health and social care services that are provided in their area.

I believe that seeking people's views on the services they use is essential to improving both those services and the experiences of the people who use them.

Introduction

i) In July 2006, we published *A stronger local voice: a framework for creating a stronger local voice in the development of health and social care services*. The framework was developed in response to the commitment made in the White Paper, *Our Health, our Care, our Say: a new direction for community services,* to provide a stronger voice for individuals and communities in health and social care services. In developing the White Paper during 2005, we asked local people what was important for their use of services, and we used different methods of involvement including workshops, MORI research, an online survey, and evidence collection sessions. A large number of stakeholders participated including Patient and Public Involvement Forum members (PPI Forums), members of voluntary and community organisations, members of health Overview and Scrutiny Committees (OSCs), health and social care organisations, and members of the public. Following the consultation, an Expert Panel advised the Department of Health on its response to the issues raised. The *stronger local voice* document is the framework that was developed from the consultation and the advice that we received.

ii) The purpose of the new framework is to make sure that the needs, preferences and involvement of local people, including those that are seldom heard, are central to the planning, development and delivery of health and social care services. To ensure that we get the new arrangements right, when we published *A stronger local voice* we asked interested individuals, groups, and organisations to answer five questions and provide us with their ideas about how to implement our plans effectively.

iii) It is clear that there is a lot of interest in the new arrangements for involvement in influencing local services. We have been pleased to receive almost 500 responses from both individuals and organisations. These included some persuasive suggestions for improving the framework that were based on the evidence and experience of, for example, PPI Forum members. Whilst we received responses from a mixture of organisations and individuals, we are aware that there were less from those with a social care interest. We have analysed the responses, and a number of trends have emerged. These are summarised as:

a) wide support for establishing a system that incorporates public involvement into social care as well as health services;

b) the need to make sure that PPI Forum members and other existing networks that involve local people, have the opportunity to become fully engaged in the new framework, and that their knowledge and experience is built upon;

c) concern about the apparent reduction in the statutory powers of monitoring and inspection by members of the public;

d) the importance of clear communication and publicity about what is changing during the period of transition;

e) the need for Local Involvement Networks (LINks) to be independent of local politics and any conflict of interest that may arise if they are too closely allied to local authorities;

f) the need for clarity about the roles and responsibilities of all the different aspects of the new framework, but especially of LINks.

iv) We would like to thank every one who responded to our questions. We would especially like to thank Health Link and other organisations for the time that was spent in collecting evidence-based comments. This document summarises the responses that we received and answers some of the additional questions that we were asked. The document also refers to amendments that we have made to the framework as a result of the responses received, and subsequent discussions with interested parties that we have undertaken. In particular, it sets out more details about how LINks might work and how we plan to take their development forward.

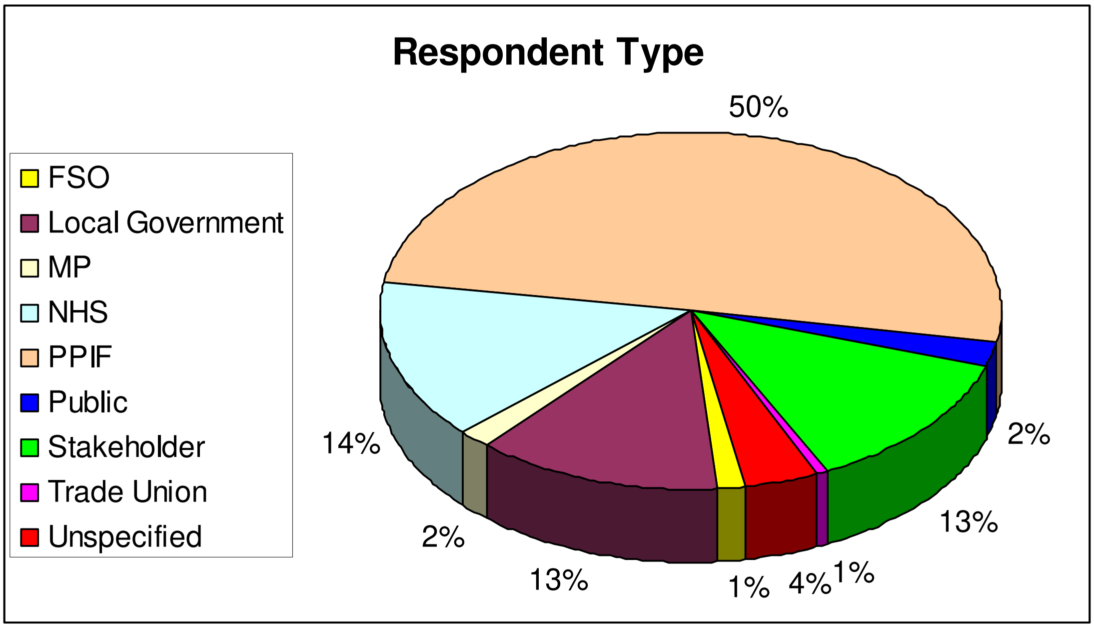
This document is not detailed guidance about how LINks will be implemented and will undertake their role. That cannot be written until the legal framework has been finalised. However, within this document we have sought to provide a clear picture about the role, rights and responsibilities of LINks.

This response document is in four parts.

Part 1	Summary of responses and our comments
Part 2	Other issues raised by respondents and our response
Part 3	More detail about how LINks might work
Part 4	What happens next

Part 1 Summary of Responses and Our Comments

1.0 The following diagram illustrates where the responses came from. Responses from PPI Forums made up 50% of the total response received. Responses from NHS organisations made up 14% of the total response, 13% were received from local authorities, and a further 13% were received from other stakeholders.



The following terms were used to categorise respondents:

Stakeholders - A response from a voluntary sector or a non-NHS medical or health group

FSO – A response from a Forum Support Organisation or employee

Local Government – A response from any council department, including OSC and individual Councillors responses.

Not Specified – No position was given

NHS– A response from a representative on behalf of an NHS Trust or organisation

General public – A response from a member of the public

PPIF – A response from a PPI Forum or individual PPI Forum member

MP – A response from a Member of Parliament

Trade Union – A response from a Trade Union organisation

1.1 All the comments received, including those that were only made by a few respondents, have been considered in the progression of the framework. However, we have included a summary of the main points that were made in response to our five questions.

Question 1: What arrangements can we put in place to make sure there is a smooth transition to the new system? How can we build on existing activity in the voluntary and community sector?

1.2 Responses to this question varied substantially. Some of the responses also linked to question 3, which focuses on the methods of attracting people to join or contribute to LINks. This may be because attracting members and raising awareness is perceived as being important to a smooth transition, and building on existing activity is important to attracting members. Some responses may therefore apply to both questions.

1.3 Of all the categories of response to this question, the following comments were most common:

a) E*xisting groups, especially PPI Forums, should form the basis of LINks membership and the starting point for further recruitment.* Concern was expressed that if Forum members and members of other established patient, service user and public involvement groups were not encouraged to participate, their knowledge and experience would be lost.

b) *PPI Forum and other patient and public involvement successes and experience should be built upon and maintained.* Again, this identifies the concern amongst respondents that the good work of Forum members and the work of other groups is recognised and built on for the future.

c) *There should be early involvement of existing community or stakeholder groups and those that represent and involve those communities that are seldom heard,* e.g. Councils for Voluntary Services and Volunteer Bureaux, and specialist groups, for example those involving people from black and minority ethnic communities, people with disabilities, and those people living in poverty. Respondents considered that the earlier the involvement of existing community and stakeholder groups, the easier it would be to involve these groups in LINks.

d) *Provide clear timescales to all stakeholders for the cessation of PPI Forums.* Clear timescales were thought to be important to enable stakeholders to be informed and involved in the process.

e) *There should be a period of overlap between the establishment of LINks and the cessation of PPI Forums*. It was emphasised that continuity is important.

f) *Maintain good communication with PPI Forums, their networks, all stakeholders and interested parties.* This highlights the importance placed upon involving existing stakeholders through good communication. It was suggested that Forum members might be involved in the dissemination of information to their networks, and perhaps take an active role in the transition process.

g) *Carry out a stock-take of existing patient, service user and support groups, and their activities.* This was considered to be important to identify gaps in representation, particularly among people who do not normally get involved and those who find it hard to give their views, to give LINks a head start by avoiding duplication of existing work, and providing information for building engagement and membership.

How are we taking the issues relating to question 1 forward?

1.4 We are working with the Commission for Patient and Public Involvement in Health (CPPIH) to encourage Forum members to continue their involvement during the transition period and to become involved in LINks as they are established.

1.5 We intend that LINks will build on the valuable work of PPI Forums. We believe that the experience developed by those involved in Forums, as well as the good working relationships that many have established with the health service, will be essential to the success of LINks. We therefore encourage Forum members to consider participating in and contributing to LINks. However, there are several fundamental differences between PPI Forums and LINks, for example LINks will cover social care services as well as health, they will be established for a geographical area rather than a specific organisation, and they will also decide locally how members will be appointed and how others will be able to contribute to their work priorities.

1.6 An important difference is that LINks are specifically designed to reach out to and include, a wide range of existing local groups representing patients and the public and to provide a channel for local health and social care organisations to engage with those groups. LINKs should not be based on methods of involvement that exclude groups of people because of the time commitment involved or unfamiliar ways of working. We are therefore keen for other voluntary and community groups and individuals with experience of different methods of engagement to participate in LINks, bringing expertise from other areas. There is a wealth of established user engagement within the social care field, particularly in the area of independent living, and we believe that service users and carers will be eager to share their experience and skills within LINks.

1.7 We have asked the CPPIH to contribute to the new system by demonstrating what it has learnt in the current system. This may include, for example, experience of patient and public involvement, governance, learning and development, recruitment, communications and community engagement, i.e. the underlying processes that have been developed to establish and improve the involvement of patients and the public in securing improvements in their local health services. This is being implemented through a number of ‘early adopter projects’ to pilot the approach of LINks by the end of this year. They will test the framework by identifying different models and working practices. They will be evaluated to enable learning to be captured, and to help future LINks to be developed effectively. Further information about the early adopters is provided in Annex A at the end of this document. The early adopters will support work that the NHS Centre for Involvement is developing as it establishes itself as a national resource for involvement and participation in health services, and in particular for sharing good practice across the country.

1.8 We are working with the Healthcare Commission to collect learning from two test site projects that it has been running for over a year, which focus on a model that may be applied to LINks. The test sites are based in Leeds and Bradford, and Plymouth and Exeter. These will be evaluated alongside the ‘early adopter’ LINks developed by CPPIH.

1.9 We will ensure that protocols and guidance that have been developed to support the current system, such as the code of conduct drafted by Health Link, and the governance materials they produced for North West London Patients Parliament, are used to inform the effective implementation of the new system.

1.10 We plan to legislate on the new arrangements as soon as parliamentary time allows. Meanwhile, we are working with the CPPIH to ensure there is a smooth changeover to the new arrangements, and to maintain the valuable skills and experience of the people who are currently involved. We are also working to minimise the gap between the systems and to ensure that as far as possible continuity of involvement of patients, service users and the public is maintained. PPI Forums and the support provided for them by CPPIH will remain until Parliament passes the legislation needed to abolish them.

1.11 We know that many PPI Forums are already beginning to work with their local Forum Support Organisation (FSO), voluntary and community sector, NHS and local government partners to discuss and work through how LINks might work in practice. We think this informal networking and partnership working is precisely what is required to prepare the ground for LINks and thus enable the right kind of evolution from old to new systems.

1.12 We recognise that it will also be important to create and develop links with other organisations and joint arrangements that have a remit to commission services. For example, arrangements for involving people with learning disabilities in defining their services, and some services for children and young people are commissioned through children's trusts, which have a requirement to take into account the views of children and families in making commissioning decisions.

1.13 Some respondents raised concerns about the abolition of PPI Forums, and asked instead for work to focus on improving them. We believe that the changing context of health and social care requires a different model of involvement. This is the result of the greater emphasis on more services being provided within community settings and being developed and commissioned in partnership between health and local government, including social care and education. The remit of PPI Forums would need to be radically changed and this would require substantial changes to the legislation relating to Forums. The new approach will focus on strategic commissioning and the whole person experience, rather than on individual provider organisations.

1.14 In July 2006 we published *Health reform in England: update and commissioning framework* in which we explained the importance of commissioning as the means by which we secure the best value for both patients and taxpayers. Effective commissioning makes the best use of allocated resources to achieve the following goals:

- Improve health and well being and reduce health inequalities and social exclusion;
- Secure access to a comprehensive range of services;
- Improve the quality and effectiveness and efficiency of services; and
- Increase choice for people and ensure a better experience of care through greater responsiveness to people's needs.

1.15 As the commissioning process is developed and strengthened within health and social care, it will be for the commissioning organisations such as Practice

Based Commissioning Groups, Primary Care Trusts, Specialised Commissioning Groups, commissioners within local authorities and joint commissioning groups to involve local people and service users. This will enable the commissioners to understand the services people wish to receive, and to then negotiate contracts with local providers, both existing and new, to supply them in a responsive and convenient way.

1.16 The changes that we are implementing by establishing LINks will increase the ways by which people can voice their views and share their experiences, and as a result can improve and change the services they receive. By focusing on health and social care, LINks will better reflect all care provided to individuals.

Question 2: What do you think should be included in a basic model contract to assist local authorities tendering for a host organisation to run a LINk?

1.17 Many respondents provided very specific suggestions. Some responses also included comments regarding LINks and their governance. These are addressed in question 4, which asked specifically about the governance arrangements for LINks. The most frequent comments regarding the contract fall into two categories, i.e. suggestions about the type of organisation that should be commissioned to provide the LINk host function, and suggestions about what the contract with these organisations should include. Commonly held views were that successful host organisations should;

i) have knowledge of the NHS or social care and experience of working in the field of health and social care;

ii) have good knowledge of local circumstances, and work is already being conducted in the area;

iii) have capacity and ability to network not just locally, but also on a national level;

iv) be independent of local authorities and the NHS, i.e. not be providers of health or social care services;

v) include those Forum Support Organisations (FSOs) that can demonstrate effective performance.

1.18 A number of respondents suggested that the following criteria should be included in a model contract:

i) *the contract should state minimum levels for support and service standards*. Respondents felt that clarity of support and purpose was vital to the success of LINks and their host organisations.

ii) *consistent national standards, with local flexibility*. Consistent standards of support would provide a benchmark against which host and LINk success could be measured. However some respondents suggested that each LINk should also have the flexibility to work within the national standards to shape their network in the way that best served their community.

iii) *a clear "role description" of the host function and hence a precise contract should be established* with a clear differentiation between the responsibilities of the host and the LINk members.

iv) *host organisations must be able to support LINks to gather information, analyse the data they collect, write reports and present information.*

v) *host organisations should provide adequate administrative support for the LINks.*

vi) *contracts should contain details of the arrangements for monitoring their performance.*

1.19 A number of concerns were raised about the practicalities of the proposed framework, particularly relating to the role of local authorities in holding the contract with the host organisation, and the allocation of funding to local authorities. These included:

- Funds for LINks should be ring-fenced and not used for any other purpose.
- Some respondents were concerned that local authorities were inappropriate bodies to hold LINk funding, due to concerns about potential conflicts of interest, and a risk that LINks might lose their independence.
- Funding should be allocated in consultation with local authorities and based on the size of the geographical area and other criteria.

How are we taking the issues relating to question 2 forward?

1.20 We are developing a contract specification that will reflect the standard and content of support that should be expected from host organisations, and which will take the views of respondents into account. The contract should specify the support to be provided by the host organisation, which will include:

* holding the finances of the LINk, although decisions on expenditure will be the responsibility of the LINk, not the host;
* recruiting members to the Link;
* the co-ordination of support and promotion of the LINKs' priorities, work plan and activities;
* dealing with, in the main, the correspondence and communication activities of the LINk;
* data management and record keeping;
* providing advice and support to the LINk;
* assisting the development of effective working relationships with local partners, including statutory and non-statutory organisations;
* compliance with and awareness of equality legislation, for example the Race Relations (Amendment) Act 2000 and the new disability legislation from

December 2006. The new duty on gender comes into effect from April 2007, as do the sexual orientation Regulations from April 2007;

* identifying standards of quality for delivery of support.

1.21 We anticipate that the kind of organisation that will bid to host LINks will include those currently engaged in supporting Forums, user-led and not-for-profit organisations, and other voluntary organisations. We would encourage such organisations to become involved in the new system, and would particularly encourage consortium bids from groups working together to combine experience, skills and networks.

1.22 Local authorities will be strongly encouraged to involve local people and organisations in the process of awarding the first contract to provide support to the LINk, and we will encourage Overview and Scrutiny Committees to hold their executives to account for how this is done. We expect that LINk members would be involved in the awarding of subsequent contracts.

1.23 We recognise that there is an important role for the LINk to become involved in the procurement activities and performance management of the host organisation. The local authority will manage its contract with the host, and the host will produce a six monthly report to the authority as part of a formal performance management review process. The regular reviews will also take into account feedback and recommendations from the LINk including proposals about the governance or operational arrangements that would enhance the success of the LINk, and give the LINk a chance to input and comment on the work of the host.

1.24 Work is currently being undertaken to identify an appropriate formula for the allocation of funding to support LINks. This will take into account a variety of factors including geographical issues; population size; population density, i.e. the rural urban split; and the incidence of deprivation.

1.25 Following discussions between the Department of Health and the Department for Communities and Local Government, it has been agreed that the resources to provide for support to LINks will be allocated as a targeted, but not ring-fenced, specific grant. The specific grant for LINks will be separately identified and paid to authorities, and in the initial stages of LINks, will allow councils to identify a separate budget at individual authority level. The authorities will be under a statutory duty to establish LINks to specified standards, with guidance to ensure consistency between authorities. We will encourage OSCs to scrutinise this duty to assess whether the local authority made use of all of its allocation effectively in the support of LINks. The use of the grant will also come under the scrutiny of the Audit Commission.

1.26 We have been asked whether, as local authorities hold the contract with the LINk host organisation, there might be a risk that LINks will lose their independence, and be subject to political influence. For a number of years, local authorities have developed effective compacts with their local voluntary and community sector organisations, which provide a clear framework for their relationships and joint working. It is anticipated that the local compacts will support the changes in the relationships between local authorities and the organisations without any compromise maintaining objectivity and separation.

1.27 The local authorities' role will be to tender a contract for a host organisation to support the local LINk. Local authorities have considerable expertise and experience of holding contracts with local voluntary and community sector organisations. We know that those voluntary and community sector organisations do not feel their independence is compromised even though they receive funding from local authorities and are required to account for it. Local authorities' knowledge of the local circumstances also means that they will be well placed to award and manage these contracts. This will not mean that local authority controls the LINk. Staff that specialise in procurement and contract management, but who have no link to the commissioning or delivery of health or social care services should let the contract. They should be advised by the specialist staff with knowledge of social care and health, and in particular by people with knowledge of commissioning from a social model perspective. The local authority will manage the contract with the host to ensure its contractual obligations are met. It will not however, have any power in determining the LINk's actions or the way in which it spends its money.

1.28 The host organisation will hold the funds on behalf of the LINk, and will be responsible for financial auditing. However, the LINk will have control of those funds. Whatever governance arrangement is agreed upon by the LINk, will have power to direct the spending of those funds.

1.29 Some concern has been raised about the relationship between LINks and OSCs, which review and scrutinise health and social care services. LINks will remain independent from OSCs. They will however, be ideally placed, if they choose and if the OSC would find it useful, to take an active role in OSC review activities, for example acting as an advisor during a particular review. They will be able to inform the OSC on the public needs and experiences, enabling the OSC to pursue critical issues based on the evidence of users' experience. LINks will also have the power to refer matters to OSCs and to receive an appropriate and timely response.

1.30 We wish LINks to be responsive to local circumstances, and to be locally determined. We are therefore not setting up a mandatory structure. It will be one of the roles of the host to facilitate the LINk's governance arrangements for managing and deciding its activities. They will have a role in facilitating the establishment of governance arrangements, enabling members to come to a view of what governance arrangement is required (e.g. how many people sit on the 'board', for how long, decision-making arrangements, election of chair, offices such as secretary etc). The Department of Health will however, issue guidance, which will include model governance structures, which LINks will be able to use, or deviate from, as they choose. Whilst LINks will need to meet core governance criteria, how they achieve this will be their decision.

1.31 The newly established NHS Centre for Involvement will have a specific focus to support and develop the effectiveness of patient and public involvement policy and practice and its outcomes, and so would have a role in identifying and disseminating notable practice and guidance. The Centre may be a source of information and tools on how LINks might carry out their functions.

Question 3: How can we best attract members and make people aware of the opportunities to be members of LINks?

1.32 The suggestions made by respondents included:

i) *Clarify what LINks will and won't do and what their statutory powers will be to attract people to join them.*

ii) *Publicity and advertising are vital to attracting members to LINks.* A number of specific suggestions were made, including:

- *Advertise on local radio, television and in the press*.
- *Undertake a national media campaign, e.g. advertise in national and regional voluntary and community magazines*.
- *Distribute fliers to GP, NHS and local authority premises to hand out to patients, service users and other individuals*.

iii) *Involve local voluntary groups, advocacy organisations and existing networks by contacting them directly and inviting them to participate in LINks.* For example, the Afiya Trust (Black Health Foundation based in south London) have done much work over the years on capacity building with black and minority ethnic communities so that local black and minority ethnic people are able to advocate for themselves in the health services.

iv) *Sending speakers out to community groups and events to recruit members.*

v) *Be realistic about the expectations of LINk members,* including the level of involvement expected, what practical support will be provided such as the payment of expenses, and whether there will be any other form of payment, for example, of a small allowance. A number of respondents emphasised the point that LINk members should never be left worse off, even temporarily, for performing LINk duties.

vi) *Involve Forum members in recruiting LINk members.*

How are we taking the issues relating to question 3 forward?

1.33 We will be considering the proposals for publicity that respondents have made, and will develop an approach so that national messages can complement promotions at the local level. We recognise that already a number of networks and partnerships exist within local authority areas, as a result of other national initiatives to involve citizens, and LINks may be able to draw support from them.

1.34 In addition to learning from CPPIH and the recruitment to PPI Forums and other voluntary organisations, we aim to learn from the experience of the early adopter projects about the challenges for recruiting both individuals and organisation members to LINks. As part of these projects Forum members will have a role (if they wish) in supporting the recruitment and engagement of others.

1.35 It is important for all interested people and organisations to be clear about what LINks are and what they are not. Later in this document we will provide an example of how a LINk might develop and undertake its work. However, in response to this question, it should be remembered that a LINk is not just a group of people and organisations but a <u>network.</u> As we are committed to the flexibility of the new system of LINks, we are not setting any central limits on who can be members of LINks. It will be up to each individual LINk to take decisions on matters of membership and governance. However, in addition to people and organisations becoming members of LINks and actively participating in the work programme, we are keen to see others becoming contributors to LINks. This may involve participating in a relevant and particular piece of research, providing information, or contributing contacts or opportunities for LINks to access other networks without being a member of the LINk.

1.36 We have been asked how we can ensure that LINks can be prevented from following a single issue, as some LINk members may have personal agendas. It is essential to recognise that one of a LINk's functions is to represent the views and concerns of the whole community in relation to health and social care services. This cannot be done by becoming a single-issue campaigning group. The host organisation will guide the LINk to seek to access the views of the whole community, making use of the different powers that LINks will have, and if they are unsuccessful in this they will be failing in one of their contractual obligations, and will be liable to sanctions or removal of contract. The host organisation will also help LINk members to demonstrate that they are able to comply with a standard code of conduct, helping them to develop skills and experience to achieve this, where required. However, if the LINk as a whole, decides through its governance structure, that a particular issue is of major importance to a whole population then of course it is free to focus on that issue.

Question 4: What governance arrangements do you think a LINk should have to make sure it is managed effectively?

1.37 The suggestions that we received identified some of the strongest trends overall. Independence, accountability and statutory powers were the biggest concerns of respondents. The most common responses have been summarised as follows:

a) *LINks must be seen to be independent.* Independence, and the public perception of it, is critical to the success of LINks;

b) *It is important that each* LINk *has terms of reference that include basic standards*, e.g. conduct of LINk members and of their meetings, etc;

c) *LINks must have clear lines of accountability to all the communities within their area*;

d) *There should be a transparent system for being accountable to the public; and,*

e) *Links should publish an annual report and work plan for the coming year*.

1.38 Other comments were made in response to this question, but which relate to the involvement framework as a whole. These include:

- *The inclusion of social care in the new framework is welcomed.*
- *LINks should retain the statutory powers held by PPI Forums.* Respondents from all backgrounds raised concern at the proposed loss of the right to visit and inspect NHS premises. It was an important issue for many, who believed this was where the truly local benefits had come from PPI Forums, and that visits had helped Forum members meet patients and build relationships with NHS Trusts.

How are we taking the issues relating to question 4 forward?

1.39 Each LINk will need to be able to demonstrate good governance and accountability. The Department of Health will provide a number of models of governance that might be applied, which will be informed by the early adopter projects. For example, a LINk may set up a Board-type arrangement, which might be described as a ‘Stewardship Board’. The members of the LINk might, for example, elect members of the Board for a specified period, e.g. two years. The Board would include both individuals and representatives of local voluntary and community organisations, and efforts should be made to include members from a range of groups within the community. The Members of the Board would provide a ‘stewardship’ role, including:

- to agree the overall priorities and work plan of the LINk with the involvement of the wider LINk membership;
- take an overview of the wider LINk membership, including being the arbiter of membership decisions within the governance framework;
- review and make recommendations on the governance framework;
- to sign off external reports;
- to ensure the LINk operates within the agreed governance framework and for the purpose it was intended;
- to support the LINk in collating views received into an organised manner, giving due weight to different views given and issues raised, particularly from people at risk of social exclusion and health inequalities, so that a balanced view is given to commissioners of health and social care;
- to promote the LINk and report on its activities including production of its annual report;
- to agree externally commissioned work;
- seek to involve and communicate with the wider LINk membership in all its activities;
- not act as a consultative body or speak on behalf of the LINk without wider involvement;
- contribute to the performance management of the host by the local authority;
- act in an open and transparent way;
- carry out its function with the guidance and support of the host;
- be accountable for the way that its budget is spent and managed;
- direct the staff of the host to deliver the agreed work programme of the LINk.

1.40 The LINk will be held to account for its activities by the local community. It will provide evidence to the community that it is delivering a credible work programme, based on local priorities that meet local needs. It will need to provide evidence to demonstrate active outreach and engagement with different groups of service users and communities, and the outcome of that outreach. It will also need to demonstrate the impact that it has had on changes to local health and social care provision to better meet locally identified needs, and how these relate to national priorities and guidelines. LINks will therefore need to provide regular information to the community using a variety of methods.

1.41 To enable LINks to gather information from all types of patients and users of services, there will be times when it is right to collect peoples' experiences whilst they are currently using services. We therefore plan to provide LINks with the power to enter health and social care premises (with some exceptions) and to observe and assess the nature and quality of services. A LINk will form a view of services by talking to people using them and by speaking to staff. The standards that services are expected to meet would be either explicit, i.e. those set by the Department of Health such as National Service Frameworks or Better Standards for Better Health, or implicit standards that are more subjective and measurable by users of services, e.g. standards of courtesy and politeness, clarity of signage, or level of cleanliness. Implicit standards would be identified from the expectations of current service users, carers and other people with an interest in and experience of the service.

1.42 LINks will not have the right to enter all premises, for example they will not have the right to enter social care facilities which provide services for children. Not all members of LINks will undertake this role, indeed some members will not want to undertake this type of activity, and that will be acceptable. Those who are able to exercise the right need to:

i) have the right skills;
ii) have received the right training;
iii) be cleared by the Criminal Records Bureau; and,
iv) be able to demonstrate an understanding of patient confidentiality and the right level of sensitivity towards the role.

When we have finalised the details of this role, we will specify which premises a LINk may enter and assess, and we will provide a new Visiting Code of Conduct, which will set out for LINks, for their hosts, and for those organisations who will be visited by LINks, just what 'right' means in practice. LINks will be expected to co-operate and co-ordinate their activities with the regulators. We shall consult widely on the regulations that will detail these rights and relationships.

1.43 LINks will therefore be engaged in monitoring by actively seeking views directly through contributions from individuals and groups, and indirectly from representatives or advocates, from complaints and PALs, through surveys, through comment cards, through websites, and through other methods. Their strength will be that they are able to engage with a large number of people rather than relying on the experiences of a few centrally appointed members.

1.44 Each LINk will report on its activities, on an annual basis, to the Secretary of State for Health. The report will be independent of the local authority and be produced with the support of the host organisation. The report will also be made available to the public. The report should provide details of:

- What it has done in the course of the year including details of whom it has heard from, what subjects it dealt with, what were the outputs of its activities and what happened as a result (where known);
- General themes about the health and social care needs of local people and about the perceptions of health and social care services,
- How much money was made available to it by the local authority;
- How many participants contributed and members were ‘involved’, and how; and,
- Whether a range of people who do not normally get involved and those who find it hard to give their views, have been included and supported to participate.

Examples of the contents of the report will be part of the supportive materials set out in the LINk guidance. This will enable individual reports to be summarised into a national LINKs report.

1.45 An organisation that is a local provider of services may also become a member of the LINk. Such an organisation may wish to be a LINk member or a LINk contributor, i.e. contribute to the work of the LINk but not participate fully in meetings or in the Board. It is up to the LINk to establish a process that ensures that any conflict of interest is dealt with. These issues are commonly dealt with by voluntary organisations that are both lobbying groups and also providers of services, and the LINk can therefore learn from existing good practice, such as Registers of Interest.

1.46 LINk members will need to develop a range of skills to enable them to deliver their roles effectively. It will be the role of the host organisation, working with the LINk members, to ensure that training and development opportunities are provided for members and to make sure that members do not undertake activities that they do not have the skills to carry out, particularly when visiting health and social care premises and talking to patients and other individuals.

Question 5: What is the best way for commissioners to respond to the community on what they have done differently as a result of the views they have heard? For example, should it be part of the proposed PCT prospectus? (As referred to in Health reform in England: Commissioning framework (DH 2006c))

1.47 A limited number of responses were received to this question compared to other questions. They were:

i) *commissioning bodies should use all possible means of communication,* e.g. prospectus, press, radio, TV and Internet;

ii) *results should be posted on their own and other relevant websites;*

iii) *a response should always be provided in writing to the organisation (LINk or otherwise) that initiated or responded to the need for change*; and,

iv) *information should be provided via the prospectus as well as through other mechanisms, recognising that it is more likely that professionals will look at the prospectus rather than the whole community.*

How are we taking the issues relating to question 5 forward?

1.48 We will need to consider the responses to the DH document *Health reform in England: commissioning framework* that was published in July 2006, to help us identify the best way to make use of the prospectus in publicising the influence that LINks develop.

1.49 PCTs will be expected to engage the LINks in the development of the prospectus. It will be essential for PCTs to demonstrate that the views of patients and the public are effectively represented in the prospectus and that the explanations of commissioning decisions made by the PCT have been responsive to the community and are explained so that the public can easily understand them.

1.50 To reflect the broader remit of LINks, we would expect commissioners to make use of existing processes, for example by communicating with community groups, Local Strategic Partnerships and other partnership boards to demonstrate to the community what has changed as a result of what people have said, either through the LINk or through commissioners' wider engagement activity.

1.51 In the same legislation that we are taking forward our plans for LINKs, we will be making it a duty for PCTs to actively respond to local people, explaining the activities they are undertaking as a result of what people have said throughout the year. This new duty will be developed as part of the process of the new PCT prospectus. As well as explaining changes that will be made in response to local views, information should be included where changes are not made following a consultation, and reasons provided for the decision to take no action. A LINk may decide to review how local commissioners are communicating with the public and make recommendations for improvement.

Part 2 Other Issues Raised by Respondents, and our response

2.0 In addition to answering our questions, many of the respondents asked their own questions, and made suggestions on other aspects about how to achieve a stronger voice. These included:

- *why are you abolishing PPI Forums when they were only established in December 2003?*
- *how will LINks create a stronger voice for people who use health and social care services?*
- *concern about the role of LINks in relation to the inspection of health and social care premises*
- *concern about how LINks will maintain a local focus*
- *questions about the membership of LINks*
- *questions about whether there would be a transition period between PPI Forums and LINks*
- *concern about the loss of focus on acute or specialist provider trusts*
- *request for clarification about how LINks will relate to Foundation Trusts,* for example whether Foundation Trust members can be members of LINks

2.1 We have heard the comments and suggestions that you have made, and will be taking these and many other issues into account as we move forward to implement the new framework. At this stage, we are very keen to provide as detailed a picture as possible and would like to set out some further clarification. We have already provided more details about the new framework and how it will work in this document, and we think that the clearest way to address other issues that have been raised is through answers to the main questions.

Why are you abolishing Patient Forums when they were only established in December 2003?

2.2 The nature of health and social care delivery is changing radically. We did not predict this level of change when the thinking behind PPI Forums was formulated; that process of development ran from 2000 to 2002. The changes to the configuration of PCTs; their changing role to focus on the commissioning of services; the role of commissioning as the means through which services are managed, controlled and developed; and the move towards greater choice of service providers and service delivery, are just some examples of how significantly the health care system is changing. Within social care there are also changes, including an increased focus on choice and control with more emphasis on personalisation of services, self-directed support, and the use of direct payments. Other developments include the move towards the integration of health and social care, the delivery of more services within the community, the joining together of inspection of children's social care and education within the new Ofsted, and the emergence of NHS Foundation Trusts, as well as many other providers in the system that are not statutory organisations. We need to ensure that opportunities for the involvement of everyone develop to fully address these changes.

2.3 PCTs and other commissioners are the power base of the new NHS, with 80% of budgets being devolved to them. In the future there will be an increasing mix of providers, meaning that the old system that focussed on individual providers is no longer appropriate.

2.4 We want to build on the excellent work of PPI Forums and other methods of service user and public involvement, creating a new system that is clear and accessible, and that provides more people, young and old, and those from a wide diversity of backgrounds and needs, with the opportunity to influence public services in ways that are relevant and meaningful to them, and will improve outcomes for them all. This needs to be more inclusive than the current system and to do this it must be flexible enough to enable people to participate in different ways. The new approach to involvement will be flexible enough to adapt with its membership as well as when services develop.

How will LINks create a stronger voice for people who use health and social care services?

2.5 The evidence that LINks present to commissioners and to the public, will be based on extensive collection of views, comments and experience from people using or knowing about health and social care services. LINKs will need to involve and engage with all local groups including those that support and mentor people who find it difficult to become engaged because of their language, culture, medical condition or caring commitments. The role of networking and creative involvement will be vitally important to be successful in involving all people and collecting evidence from every part of the community.

2.6 LINks will have a strong relationship with all the decision makers in health and social care to ensure the commissioning of services is informed by the views and preferences of people at all levels. They will become involved in assessing community needs, deciding priorities and influencing decisions about what services should be commissioned. They will be able to collect information and evidence based on the whole journey through health and social care services, involving individuals and groups from all communities and all types of users of services. They will recognise the importance of integrating equality and human rights principles into the strengthening of local voices, and therefore will be heard where currently they are not.

2.7 LINks will be ideally placed to monitor services in a rigorous and robust way by going out to groups and communities, and through input from associated contributors who register interest, knowledge and experience of specific issues. LINks will have the power to:

- enter specified types of premises and assess the services provided as well as collecting the views and experiences of recipients of services;
- request information and receive a response within a specified timescale;
- make reports and recommendations and receive a response within a specified timescale; and,
- refer matters to an Overview and Scrutiny Committee (OSC) and receive a response.

2.8 In addition to bringing together evidence that it has collected, the LINk will also enable health and social care bodies to reach out to local people too. Health and social care bodies can and should approach the LINk and ask it to research views and opinions on its behalf. The LINk may choose to undertake work on behalf of the commissioners of services where it has the capacity to do so. This will add value to the relationship between the two. LINks are a way by which more and more people can be involved in ongoing engagement activity, rather than the LINk speaking on behalf of people

2.9 Health and social care commissioners and providers will be under pressure to talk to local people, to seek their views and insights, and to involve them in how to plan, prioritise and decide their activities. Indeed, this is what section 11 of the Health and Social Care Act 2001, and the new role for the local authority best value regime to inform, consult, involve and devolve are all about.

2.10 The Local Government White Paper sets out plans to reform aspects of the best value regime in order to turn the good practice of local government and the various initiatives of central government into a system where local people in all parts of the country know what to expect in terms of their right to be involved and consulted. Local authorities will be required to take steps, where appropriate, to ensure the participation of local citizens in their activities. In doing this authorities will need to give consideration to engaging with groups that are seldom heard, such as disabled people, or some ethnic communities. Authorities will be required to take steps to ensure participation by other key bodies, such as voluntary and community groups and local businesses.

2.11 It will be for the authorities working with their partners to decide how best to discharge this duty to inform, consult, involve and devolve, taking into account factors such as the effectiveness of engagement activities, the amount of discretion they have over the service, and the differing needs and requirements of the different communities within their area. Health and social care organisations will be regulated on their engagement activities by the appropriate regulator.

2.12 We are confident that these future arrangements will ensure that a stronger voice is built into the improvement of services than currently exists.

Should LINks have the right of entry?

2.13 PPI Forums currently have the right to inspect NHS premises, and many forum members felt that rights of access would be essential to ensure that LINks are as effective as possible. In particular, the survey conducted by Health Link, in which many forum members participated, was extremely compelling. As we have already mentioned on page 22 section 1.41, we agree that there will be times when LINks will need to enter and view premises where services are provided, in order to undertake their functions effectively. Patients, users, carers and the public generally, are experts on the experience they want to have of health and social care services, and in assessing whether these services meet their needs. Properly conducted and co-ordinated visits carried out as part of a constructive relationship between LINks and health and social care providers, will enable service improvement. Where service users receiving social care services are already engaged in visiting premises, as part of the Commission for Social Care Inspection (CSCI) assessment process, they will be able to contribute information, evidence and their expertise to the LINk to avoid any duplication.

2.14 The regulators, i.e. Healthcare Commission, Monitor, the Commission for Social Care Inspection and the Mental Health Act Commission, will be encouraged to involve service users in their work, including:

- involving service users in some inspections;
- directly engaging with service users in the design of their systems and inspection methodologies; and,
- the use of systematic patient and service user feedback to help bring about improvements in the quality of care.

2.15 The right that LINks will be given to enter and observe services is a tool for validating the evidence they will have already collected, rather than an end in itself. Through its activities to gather the experiences of users of services the right to enter and assess facilities will provide an extra element to complete the whole picture.

How will LINks have a local focus? How will their membership be made up?

2.16 LINks will be made up of networks of interested individuals, local user groups, and voluntary and community sector organisations based within a locality. They will focus on the geographical area covered by local authorities with social service responsibilities, i.e. county councils, unitary authorities, metropolitan boroughs, London Boroughs, the Common Council of the City of London and the council for the Isles of Scilly. Every LINk will need to reflect the area for which it is responsible and its membership will need to be appropriately determined for each area.

2.17 The host organisation will need to understand the different communities and groups of people within the locality and to recruit membership that reflects this. They will be able to include organisations that have a countywide remit as well as small GP practice-based patient participation groups or issue-based community groups, which wish to promote and feed in their interests and views at the more strategic commissioning level. LINks will also have skills in reaching out to people who are unused to speaking up or participating, to enable them to become involved. We would expect a LINk to have diverse membership including people with learning disabilities, people with sensory impairments, and people from all age groups, as well as people from different ethnic communities.

2.18 During our consultation we have heard that more people want to become involved and have a greater say about their local services. LINks are being established to enable genuine involvement in a much wider range of ways, bringing real accountability at the commissioning level and enabling a broad spectrum of people to influence how their local services are designed and delivered.

2.19 It is important to note that the term ‘membership of a LINk’ may be misleading. It will be possible, and indeed sometimes desirable, for people to feed their views and experiences into a LINk without seeing themselves as ‘members’. By making a complaint, or filling in a comment card or talking to a PALS officer, an individual is contributing to the evidence-base collected by the LINk. Similarly, LINks’ may want to have their own web sites to which people will be invited to visit and log their thoughts, ideas and experiences. The key issue is that LINks are able to reach out to and hear from as wide a range of people as possible rather than relying on the views of a small group of heavily ‘involved’ people.

How will LINks maintain a focus on acute or specialist NHS trusts?

2.20 The primary function of LINks is to gather the views and experiences of people in their area regarding the health and social care services that they use, and not just to focus on individual organisations. They are designed to cover all the social care and health services in their area, including specialised services, and in this way they will scrutinise the entire journey of someone needing a service. We intend LINks to be flexible, and able to be adapted to best-fit local circumstances. Therefore, whilst we are not prescribing their structure or make up, we imagine that a LINk may well wish to set up specialist interest groups, for example, one that considers all mental health services within its area, looks at services for children and young people, or focuses on an acute trust. Where appropriate, a LINk may wish to join with neighbouring LINks in the discussion of a service that spans their borders.

2.21 Specialist trusts themselves would of course be free to establish and maintain groups of patients and the public with which they can engage. Many trusts have already convened their own designated groups of patients and support them out of their own resources, and there is no reason why this practice should not continue. Such groups would be encouraged to join the LINk.

Other questions that we have been asked

How will LINks relate to children's trusts?

2.22 Children's trusts bring together all services for children and young people in an area, underpinned by the Children Act 2004 duty to cooperate, to focus on improving outcomes for all children and young people. They support those who work every day with children, young people and their families to deliver better outcomes - with children and young people experiencing more integrated and responsive services, and specialist support embedded in and accessed through universal services. This joint commissioning, underpinned by pooled resources, aims to ensure that those best able to provide the right packages of services can do so.

2.23 All of this has required arrangements for governance that ensure everyone shares the vision and give each the confidence to relinquish day-to-day control of decisions and resources, while maintaining the necessary high-level accountability for meeting their statutory duties in a new way. Across the whole system there are some unifying features which help to link the various elements:

- Leadership at every level, not just the director of children's services, but at the front line;
- Performance management driving an outcomes focus at every level, from area inspection to rewards and incentives for individual staff; and,
- Listening to the views of children and young people - on the priorities at a strategic level, and on how day-to-day practice is affecting them personally.

2.24 As processes have already been put in place to engage children and young people, and parents and carers in the development of Children's and Young People's Plans and services within children's trusts, LINks will not have a primary role in relation to them. However a LINk will need to develop a relationship with the children's trust to enable it to signpost people and to pass on information that it collects as part of its day to day work.

How do LINks' powers relate to the independent sector?

2.25 Currently, PPI Forums are able to obtain information about NHS services provided by the independent sector. The same approach will be used for LINks, although they will also be able to obtain information about independent social care providers commissioned by local authorities. Commissioners of services will need to ensure that contracts with independent providers, for health and social care services, include reference to user involvement, provision of information to LINKs, and the requirement to provide an account of how LINk recommendations have been responded to. As the independent sector is a major provider of services within social care, LINks will be able to have real influence over how independently provided services are commissioned.

How will LINks relate to the Community Call for Action outlined in the local government White Paper Strong and Prosperous Communities?

2.26 The local government White Paper outlines a process to enable frontline councillors to trigger action in relation to any community concerns, either by resolving the problem themselves or referring it to their authority's Overview and Scrutiny Committee – the Community Call for Action. If LINks themselves are unable to resolve an issue, for example relating to social care services, they may work with the frontline councillors using the CCfA process.

What about the stronger, national voice that was referred to?

2.27 The established working group of voluntary sector leaders have begun to consider the opportunities for how a network of third sector organisations might effectively come together to influence, challenge and ultimately help improve national policy development. This work is independent of the Department's work on PPI, and the abolition of CPPIH. The initial thoughts and aspirations from the working group are now being tested through a series of engagement activities, targeting organisations that might become members of a National Voices network. The group will be meeting with ministers at the turn of the year to report on the outcome of the work.

Part 3 More Detail about how LINks Might Work

Who will LINks need to work with?

3.0 Whilst LINks are independent and will have the power to develop their own priorities and agendas, they will need to develop relationships with a number of stakeholders to fulfil their statutory role effectively. In certain circumstances LINks may want to work in partnership to scrutinise services across local authority boundaries. LINks may also wish to work together in regional groups, or even nationally to share experience and findings. We believe there is nothing to prevent LINks using some of their funding to establish such a national body if they so wish.

Local groups and organisations, and individual members of the public

3.1 There are likely to be a number of groups, organisations and individuals who have an interest in the role and responsibilities of LINks but are unable to commit to participating on an ongoing basis, or need encouragement to engage with formal processes. It is essential that the way in which the LINk is established and works takes this into account, and that opportunities for a wide range of contributions are built into the LINk methodology. Such relationships may be developed through creative methods including interactive websites, the production of regular newsletters asking for contributions, engagement in project groups, and LINk members undertaking outreach into groups that are unable, unused or unwilling to participate on a regular basis. The benefit of this approach is that it will enable LINks to access views, opinions and information from a vast number of sources without becoming bureaucratic or solely relying on a meetings culture to carry out their role.

Overview and Scrutiny Committees

3.2 We have already referred to the relationship between LINKs and OSCs in the section on responses to question 2, on page 13. It will be important for a LINk to understand the structure of the OSCs within the local authority area that it is based, for example to know whether there is one OSC for health and social care issues or whether a different model has been adopted. There will be opportunities for OSCs and LINks to work in partnership with each other, with the LINk collecting evidence and information from local people and organisations to be used in reviews being undertaken by the OSC. LINks will also have the power to refer matters to OSCs and receive an appropriate response. An OSC should also be able to ask the LINks to undertake work to support a scrutiny review. In such circumstances, the LINk should respond with its decision about whether it will support the OSC review or not. As LINks are developed, the Centre for Public Scrutiny will be supporting OSCs across the country to build effective relationships with their LINks.

Health and social care regulation and the annual health check

3.3 We expect that LINks will develop an active relationship with the regulators of health and social care. As with any other organisation, a LINk will be able to raise its concerns with the regulators. Both the Healthcare Commission and the Commission for Social Care Inspection currently include a user perspective in their regulation and inspection activities. Government guidance will support and encourage them to widen user representation in their work. The regulators will continue to assess how well organisations engage service users and citizens in planning and delivering their services. When LINks have been established, the regulators will look to LINks as a resource from which to find informed and interested people to take part in their work.

3.4 Ofsted manages the integrated inspection of children's services, and it involves all other inspectorates with responsibilities for children and young people. LINks may need to develop a relationship with this process to enable any information that it collects relating to these services to be used by the regulator.

3.5 The new health and adult social care regulator will be able to minimise the burdens on front-line providers of care through a new "gate-keeping" role. This will enable the regulator to intervene if another body proposes to carry out an inspection which could impose an unreasonable burden on the institution providing care. The other public service inspectorates (e.g. for children, local service, criminal justice) will have similar duties for the sectors that they inspect or regulate. Links will have a duty to co-operate with the regulators. It will be helpful for both LINks and the regulators if they develop a good working relationship with each other, and co-ordinate their efforts and the information they gather.

Commissioners: PCTs, GPs and Consortia Engaged in Practice Based Commissioning

3.6 The primary function of LINks is to gather the views and experiences of people using health and social care services in their area. They are designed to cover all the services, and in this way they will scrutinise the entire journey and experience rather than looking at individual organisations. The intelligence that

LINks collect will therefore be of immense interest to commissioners of services both within PCTs and social care, and those engaged in practice based commissioning. They will help the new system of commissioning to evaluate its effectiveness, and are also likely to provide information about the implementation of patient choice.

3.7 It is important that good relationships and strong communication links are developed between LINks and their local commissioners, including the wider range of joint commissioning arrangements as they develop. They will also need to act proactively with commissioners and undertake research and evidence collection on their behalf, where practicable, to be used in the development of commissioning plans.

Health and Social Care Providers

3.8 In the same way that LINks will be a valuable resource to OSCs and to commissioners, they also have a role in providing intelligence and evidence-based information to providers. It is likely that members of Foundation Trusts may wish to join LINks or contribute to LINk research, and it is equally likely that trusts themselves will see the benefit of developing relationships with LINks as a way of gathering information, additional to their own, to be used to inform the development of services. It should be remembered that development of services should involve the commissioners, and will be allowable within the context of the service that has been specified in the contract. An important part of the system reform is that providers work closely with commissioners in the development of services.

Local Strategic Partnerships and other partnerships

3.9 The importance of developing active relationships with local strategic partnerships and other similar groups, will be an important part of the LINk work, although it will be down to individual LINks to decide best how to focus their efforts. During our consultation, a number of respondents raised concerns about the volume of work that LINks will find themselves involved in and the risk of having insufficient capacity to address issues effectively. It has also been raised that a number of networks and partnerships already exist within most localities focusing on local strategies, service development, neighbourhood renewal, specific health and social care projects, and community empowerment. LINks will need to be aware of these and look for opportunities to learn from their experience and to work with them.

How will the LINk carry out its role?

3.10 Each local authority with social services responsibilities will be appropriately funded by the Department of Health to carry out a new statutory duty to make arrangements providing for the establishment of a LINk in its area. Each LINk will have a wide membership which is inclusive, diverse and made up of both individuals and organisations. To reflect this diversity, it will need to make use different methods of involvement and communication amongst members as well as with their local communities. This means that LINks will not solely base their communication and involvement with members through meetings.

3.11 Contributions may range from responding to a comment card that the LINk has provided to all service providers and commissioners asking for general views on health and social care services, to joining a focus group discussing the experience of people receiving a newly implemented service, or participating in a discussion with LINk members that have visited an existing community group. Contributions may be specific to an issue that the LINk is researching, or not. It is therefore important that LINks have mechanisms in place to ensure that there is regular communication with commissioners and providers of services about people's experience on all types of services available.

3.12 LINks will be an important part of the new arrangements to strengthen the public voice, and will have statutory powers enabling them to require NHS and social care bodies to provide information about their services and priorities and to respond to recommendations. LINks will be able to set their own priorities and agenda driven by the priorities for local communities. They will do this taking into account the plans developed by other organisations, networks and partnerships, including Local Delivery Plans, Local Area Agreements, Community Plans, and Children and Young People's plans. This freedom will require LINks to develop strong, credible networks and relationships across their communities, enabling them to involve seldom heard groups and individuals, and ensure that they are not only heard but are also influential. This will need to be demonstrated in their annual report to the Secretary of State for Health.

3.13 As LINks will provide an authentic and inclusive local voice, commissioners and service providers should recognise the value that LINks can provide to help them shape and develop the services, and should therefore be proactive in developing relationships with their local LINk.

What will LINks do?

3.14 Their functions will be:

- promoting and supporting the involvement of local groups and individuals from across the community to influence the commissioning, provision and scrutiny of health and social care services;
- obtaining the views of local groups and individuals about their health and social care needs;
- gathering the views of local groups and individuals about their experience of health and social care services;
- conveying those views to organisations responsible for commissioning, providing, managing and scrutinising health and social care services;
- enabling local groups and individuals to share their skills and experience in order to influence the development and improvement of local health services;
- supporting people within the community to make their voices heard, including people who find it hard to participate in traditional ways or do not choose to;
- supporting the commissioners and providers of health and social care services to engage with the local community, and in particular those groups and individuals who find the services they need difficult to access;
- act as a hub within a network of user-led and community based groups in the area covered by the host local authority, providing a channel for views and information between these groups and the local health and social care organisations;
- LINks will set their own agenda and focus on issues of concern to local people and seek to influence change; and,
- LINks will be required to report on their activities and expenditure to the public, to health and social care bodies, the relevant local authority, the Secretary of State for Health, and other interested organisations.

3.15 Although the functions will be set out in legislation, and whilst guidance will be provided, we will not prescribe how they will be carried out. They will also be able to carry out additional work commissioned and funded by the NHS and/or OSC if they decide that this is appropriate and within their remit. It must be remembered that the primary responsibility is to approach and hear from **all** groups and people within the area.

3.16 The host organisation will enable and support the LINk members to undertake its work. It is therefore vital that the establishment of the LINk takes into account the breadth of remit and the skills and knowledge that will be required, both by the host organisation and among the LINk members and contributors. For the host organisation these will include: understanding equality issues and legislation; experience and understanding of community development approaches; experience of engaging with and involving individuals and groups from diverse communities; experience of using a variety of forms of communication both formal and informal, for example using interpreters or sign language; experience of research methods, e.g. questionnaires, focus groups, participatory appraisal, and community panels; data collection and management; and, administrative support. The methods that the host applies to establishing the LINk are likely to influence how successful the LINk is in effectively fulfilling its role.

How will LINks undertake their role?

3.17 There is no prescribed view about how LINks will undertake their role, although they will be required to demonstrate that they are fulfilling their statutory role, and in particular that they are maintaining their inclusivity, independence, and accountability. LINks will need to act both proactively, in identifying local priorities through contact with the wider communities, and reactively in response to imposed change. Members will also need to be able to identify the different views of groups within the community, recognising that if an area has been through an extensive consultation around changes to a service and gains local approval, there will still be some people who disagree with the final decision.

The following example suggests how a LINk might choose to work.

3.18 <u>Setting the annual LINk priorities</u>

a) At the beginning of the year the LINk might hold an open meeting with local people to discuss what priorities it might have for the forthcoming year. Those members and interested parties that are unable to participate in a meeting could be asked to provide information through a number of ways, for example by letter, telephone call or through the use of computer based questionnaires. Members of the LINk might also visit local groups and community settings to find out the important issues for local people.

b) In order to set the context for the discussion and create opportunities for complementing existing work, the process might include information about existing local and national health and social care priorities, building on the existing formal process for identifying priorities.

c) Using a number of different methods to assess the issues raised, the outcome of the information gathering process would be to identify and agree the main priorities for the LINk to look at, taking into account the likelihood that issues would arise during the year.

Considering a priority area

3.19 One example might be for a LINk to research the experience and needs of older people receiving community based care. To consider this the LINk could undertake the following process:

a) **Team building**: Identify a number of members to act as a project group. This might involve members meeting each other to plan their activities, or might be co-ordinated 'virtually' through the use of e-mails, telephone or other communication methods. The group might include some members with a particular role within the LINk who will collate views and information following visits to patients and service users within premises where services are provided. *The role of the host organisation would be to help the LINk members to find the best methods of engaging with each other without becoming too bureaucratic. The host staff could also advise the LINk members about which other individuals or groups they might inform about the work they are planning, for example the lead commissioners from the PCT and social services, the local medical committee, or any local voluntary organisations that are engaged in the delivery of community services. It might also be appropriate to draw on expertise from relevant national organisations, such as Age Concern.*

b) **Stock take:** Ask all LINk members and interested contributors to pool their current knowledge about what services are available, who commissions and provides them, where they are provided and what problems or issues relating to community based services for older people have been identified. The project group could achieve this in a number of ways. To start with they might need to be briefed by the host organisation on the relevant policies and guidelines such as the National Service Frameworks, or guidance from the Royal Colleges or specialist voluntary sector organisations. This might also include a questionnaire or by making use of its statutory powers, i.e. the right to request information from health and social care bodies. It would also require discussion with the commissioners of services to identify their priorities and how they might impact on local people, for example through proposed service change or development. *The role of the host organisation would be to provide administrative support and guidance, including collating the data collected and 'mapping' it to demonstrate any differences within the geographical area.*

c) **Seeking views and experiences**: From the identified data, members of the LINk could research the experience of patients and service users, carers, and anyone else affected by the service. This might be undertaken through a variety of methods including LINk members talking to lunch clubs, carers groups, and other activity groups involving older people, on-line questionnaires, questionnaires undertaken in GP surgeries, articles in local papers asking for contributors to provide information and explaining how those with less conventional methods of communication can get in touch. Those members who have an interest in monitoring, may collect views from community-based services such as day centres, using the power of entry sensitively to gain access to more difficult to reach users of services. Data could also be collected from Patient Advice and Liaison Services (PALs), complaints, and other user focused services. The methods used would be agreed by the LINk members and should be based on an outreach approach. The resources allocated for the work of the LINk would be used to enable an inclusive process to be followed. *The role of the host organisation would be to provide support including collating the data collected and helping LINk members to identify opportunities to undertake the research, providing skills development for LINk members, holding the budget and using it as agreed by the LINk, and possibly attending meetings with LINk members.*

d) **Report and Recommendations**: When the data have been collected and drawn together, the project group could identify any problem areas, areas of good practice, and issues that might need to be addressed by the commissioners of services. These might be discussed with other LINk members and, depending on the arrangements agreed by the LINk Board. The LINk could make use of its statutory powers, i.e. the right to a response from health and social care bodies to any report or recommendation made by a LINk within a set timescale. It could also consider whether it would be appropriate to refer the issue to the local health and social care OSC or in some circumstances to the appropriate regulator. If the regulator decided to inspect as a result of the referral, the LINk could then provide the relevant input. The conclusions could then be passed to the appropriate stakeholder with the LINks recommendations. *The role of the host organisation might be to provide co-ordination and support in identifying the appropriate stakeholder, and in administering any communication between the LINk and the stakeholder.*

e) **Follow-up:** The project group could follow the actions through before disbanding and establishing another group to focus on a different priority. The annual report produced by the LINk would also publicise the outcomes of a piece of work. *The role of the host organisation might be to 'chase' responses from stakeholders and ensure that the outcomes of the project were incorporated into the LINk annual report.*

3.20 This example demonstrates the role that a LINk might take and also the role for the host organisation. It should be recognised that whilst a LINk project group is undertaking a specific thematic piece of work, it is likely to be receiving data on other issues from local people and organisations. The LINk should have arrangements in place to enable this other information to be collated and considered, and where appropriate passed to other stakeholders, particularly commissioners.

When will these plans be implemented, and how will the transition between the old and the new system work?

3.21 We plan to legislate on the elements of the new arrangements that will require legislation, as soon as parliamentary time allows. PPI Forums and the support provided for them by the CPPIH will remain until the legislation is passed to abolish them. We are working with the CPPIH to ensure there is a smooth transition to the new arrangements and to maintain the valuable skills and experience of the people who are currently involved. Our intention is for PPI Forums and the CPPIH to stay in place whilst local authorities put in place the arrangements to establish LINks through the procurement of hosts. Whilst we cannot predict exactly when PPI Forums will be abolished we anticipate it will be around December next year. The CPPIH would be abolished shortly after that.

Part 4 What happens next?

4.0 An event for stakeholders will be held in December 2006, to discuss the implementation of the framework and an introduction to LINks. We hope that this will lead to other discussions and events in the New Year as the process for implementing the new framework is finalised. In addition to this, the Rt Hon Rosie Winterton MP, Minister of State for Health Services, has written to all local authority Chief Executives asking them to nominate an officer to lead on the procurement of LINks. This will enable us to develop a network of lead officers, that we have commissioned the Care Service Improvement Partnership (CSIP) to support, and to whom we can disseminate information such as the tender specification we are currently developing, share best practice and learning from the early adopters sites, and invite to regional and national events and meetings where appropriate.

4.1 The early adopter LINks will be established by the end of this year in different parts of the country. The early adopters have been identified to reflect the diversity of areas, including urban and rural areas and localities with diversity of ethnic communities. These will test the process of recruitment to LINk membership to ensure diversity of members, accountability mechanisms, the model of support by the host organisation, and relationship with the local authority.

4.2 We recognise that the current system of patient and public involvement must not disintegrate before the new system is in place. We therefore encourage PPI Forums and other patient and service user groups to continue to undertake their roles whilst the new system is finalised and the legislation required is put in place. PPI Forums might also consider how they can ensure that their experience and expertise can best be captured and used by LINks.

What can or should stakeholders be doing now?

4.3 We recognise that the new framework for patient and public involvement in health and social care will require stakeholders to develop new roles and relationships. Whilst the framework and timescales are finalised, it is important that the organisations and individuals who will be engaged in the new system, begin to prepare for their enhanced role. We are pleased that PPI forums are already working together within local authority boundaries to consider issues relating to services and not solely to NHS organisations. We hope that this joint working, and its focus on service issues will continue to grow and will start to concentrate more on the challenges of commissioning services.

4.4 We are aware that the role of local authorities in commissioning the host organisation for LINks is new, and we have been asked for more information about how this might work. All local authorities have experience in procuring a range of services, and we would expect this procurement expertise to be applied when commissioning the LINk host organisation. It is important that local authorities begin to plan how this might be undertaken, and make use of the knowledge held in other parts of the organisation about the experience and capacity of the local voluntary sector within the area. Many local authorities have developed local compacts with their voluntary and community sectors, and many voluntary organisations are actively engaged in Local Strategic Partnerships. These existing relationships may help discussions with the voluntary and community sector about how the host organisation might best be commissioned.

4.5 It is important that OSCs and commissioners begin to plan how they will relate to LINks and how they can support the transition process. We are aware that a number of OSCs are considering how they can most effectively scrutinise health and social care issues, and whether they should amend their internal structure to enable this, and we hope that the information that we have provided within this document will help this process. We are also aware that commissioners of services will need to think about their own methods of involving people in the planning and development of services, and how joint work with LINks will add value to this.

4.6 Community and voluntary groups and organisations that have an interest in participating in LINks, or in supporting and mentoring individuals to participate in LINks, should begin to plan how they can participate in the new system. This might involve discussing with the local authority how it is planning the process of tendering for the host organisation, contacting the local PPI Forum to discuss its plans to support the transition to LINks, or contacting the early adopter projects to keep informed of the developments and learning that they are collecting. It could also include beginning discussions with members of the organisation to start to develop their interest in participating in LINks and to identify the support needs they may have to enable this to happen effectively.

Conclusion

5.0 There is still work to be done before the new framework can be implemented across the country. The development of early adopter LINks will help us to refine the model before it is fully implemented. Your comments on our consultation paper have been extremely helpful in enabling us to clarify how we can effectively implement a stronger local voice, and take these plans forward.

5.1 We recognise that the changes proposed within the new framework may be challenging, but we are confident that the level of interest and expertise demonstrated in the responses to our recent questions, will support the implementation of a new system that is effective in strengthening the voice of patients, service users and the public. We also need to remember that the framework is not an end in itself, but a mechanism for enabling a stronger local voice to be heard by commissioners, and to influence the development and delivery of health and social care services.

Annex A

Early Adopter LINks

The purpose of the Early Adopter Programme (EAP) is to learn as much as possible, as quickly as possible, about:

- How the new public involvement system might work in that area/what it needs to make it work.
- What the local issues in health and social care are.
- What opportunities there are for the LINk.
- What are the challenges and threats?
- Who needs to be involved in the LINk?
- How LINks will improve on equality and diversity.
- The level of interest of potential stakeholders and partners.
- How the LINk might engage with the wider community and stakeholders.
- What is already happening so that the LINk adds value?
- What the governance arrangements might be. This may include addressing a number of issues including, membership, constitution and structures, the balance between individual and organisation membership, how will the LINk be held to account, how might non-members or contributors engage.
- What the LINk relationship with regulators might be, e.g., with regard to the annual health check.
- How will an issue become a LINk issue?
- What kind of support a LINk might need and how the LINk might regulate or manage the relationship.
- How the relationship with NHS and social care providers, PCTs and OSCs might work.
- What the relationship might be with the part of the Local Authority that procures support.
- How the community might be involved in procurement in advance of the LINk.

There will be seven early adopters across the country. These will be undertaken as follows:

1. Each will have a Project Group made of local stakeholders and the group needs to own the project. At a minimum, membership will include PPI Forums, Forum Support Organisations, local authorities, PCT and NHS Trusts, Healthcare Commission and voluntary sector representatives.
2. Each is essentially a community development project looking at the structures required to empower and support community engagement in health and social care.
3. They will have significant freedom to work with local partners in the most appropriate way to look at the issues for LINks. For example, they might set up a formal shadow LINk and test it for 4-6 months, or it might be a series of local working groups looking at local LINk issues, or might be a formal local conference built on series of local working groups looking at individual issues or communities of interest. These activities will run alongside of existing Forum activity.
4. The learning from the early adopter sites will be used to inform the wider implementation process for LINks.
5. The early adopter sites are:
    - South Dorset
    - Medway
    - London Borough of Kensington & Chelsea
    - Hertfordshire
    - Manchester
    - Doncaster
    - County Durham