Farewell LINks and hello Health Watch

Does it matter that England's Local Involvement Networks (LINks) are in a transition period lasting at least twelve months to turn themselves into shiny, new organisations called Local Health Watch? Assuming we can avoid a re-run of discontinuity, demoralisation and loss of organisational memory that plagued successive involvement initiatives from the ham-fisted 2003 abolition of CHCs to the creation of the current LINks in 2008, then, yes, it does matter.

That's because Health Watch organisations should give a big push to how primary care businesses interact with and respond to their customers.

Two new players on the board

There will be two more three-letter acronyms to learn:

Health Watch England (HWE) - providing leadership, advice and support to Local HealthWatch; advice to the NHS Commissioning Board, Monitor and the Secretary of State and able to propose a Care Quality Commission (CQC) investigation of poor services.

The positioning of HWE within – but not as a wholly owned subsidiary of – the Care Quality Commission is an opportunity to develop a synergistic relationship between LHW and CQC on everything to do with regulating quality.

Local Health Watch (LHW) - developing the role of existing LINks by ensuring that the views and feedback from people who use services, carers and members of the public are integral to local commissioning; providing advocacy and support to people about complaints and helping them make choices about services; and providing intelligence for HealthWatch England about the quality of providers including primary care bodies.

As thinking currently stands, LHW will probably be able to recruit and employ its own staff – a significant change from LINks. Are CHCs are being reinvented by default? There is no indication that Government wants a presence for Local Health Watch in the community analogous to the Community Health Councils which had premises and staff and promoted public access to their services. Things have moved on since shopfronts equalled access. The intention is that LHW will maximise use of websites and other interactive media to "signpost" to services to increase patient choice in health and social care.

Transition to LHW could be delayed

Local authorities received a "transition plan" at the end of March for helping LINks turn into LHW. Local "pathfinders" are being encouraged - reflecting the accelerated development process going on in the commissioning consortia and the health and well being boards .

The problem is, this may all take rather longer than anticipated in the Health and Social Care Bill. David Nicholson's latest "managing the transition letter" of 13 April said that Health Watch England will be delayed from April 2012 to "not earlier than July 2012".

Slippage down the line from the creation of HWE could mean that Local Health Watch bodies won't appear in each local authority area until the end of 2012 or even later. A transition that prolonged and coupled with uncertain funding through cash-strapped local authorities makes for high risks.

LHW impact on primary care beyond patient involvement

Many LINks are already interested in promoting patient participation in primary care. Our Wandsworth LINk has made this a priority for 2011-12, with a project aiming "to ensure patient involvement exists in all Wandsworth GP surgeries and in GP commissioning from the outset." That's significant in itself, but there are two more potential impacts on primary care beyond the obvious one of patient involvement.

<u>"Enter and view"</u>

The "enter and view" power of LINks will transfer to LHW, meaning that visits can be made (including unannounced ones where there is sufficient justification) to any place that care is being given to an NHS-funded patient. Once on site, authorised representatives can talk to patients and others and observe what is going on.

Typically, "enter and view" reports about primary care include things like patients wanting more access, including by telephone, being able to book more appointments in advance and being able to see a clinician of choice. None of this will be news to primary care professionals of course. LINks have powers to refer concerns higher to the Local Authority; Local HealthWatch will have the power to recommend to HealthWatch England to undertake investigation into particular services if there are local concerns about it.

This is quite separate from inspection powers of the CQC and other regulators, though close collaboration between LINks/LHW and regulators is an obvious implication. "Enter and view" rights by LINk authorised representatives (who are trained, CRB checked, etc) include the independent sector and of course all family health services contractors (GPs, dentists, pharmacists, optical services). How would you and your practice colleagues feel about having LHW representatives visit your practice, talk to patients and then publish a report of what they had seen and heard? It is something you should be thinking about now as we move to a more consumer focused primary care system.

Complaints and advocacy

Government has a vision of LHW as an all-round consumer voice working similarly to a Citizens Advice Bureau. Current official thinking is that LHW will also become the focus for health and social care complaints and advocacy. This would be the most significant change in the transition from LINks. This proposition is attractive to some, but it could cut two ways and have unintended consequences.

I asked our patient participation group at Balham Park Surgery for their views on this recently. My question was , "should Local HealthWatch take on new functions around health complaints advocacy and patient choices?" They clearly said this should not happen because health complaints and complaints advocacy are specialised areas which the local authorities should lead on. But, they said, LHW should be involved with providing information and helping people to make good health and care choices.

Debate over complaints vs independence

There are some in the LINks world who would like to see LHW become providers of complaints handling and advocacy services, replacing the existing Independent Complaints Advocacy Service (ICAS). Superficially this may seem an attractive proposition, but it could turn out to be a fatal error. We recently told the Health Select Committee that LHW should not take on a direct responsibility for complaints handling or complaints advocacy because such functions would skew LHW's main purpose.

Among the reasons our LINk in Wandsworth have for opposing LHW taking on these functions is that it would place Local HealthWatch in a position of negotiation with health and care agencies as to what is a 'reasonable' health and care service response. As they point out, this is a different role to the wider representative role of LHW and could compromise its independent position. That is a view from grass roots activists that should be heeded.

There is no doubt that the unified complaints and redress process spanning health and social care introduced in 2009 needs to be better publicised and accessed by the public. Current complaints processes are disjointed and difficult to utilise. They do not meet the needs of service users or service providers in primary care who need to learn from them to make improvements. But this does not mean that the role should be given to LHW.

Complaints advocacy is a specialist service and is best commissioned from specialist providers. The current ICAS service has not been properly evaluated and it should be before any changes are made so lessons can be learned. Memories of CHC days suggest focusing complaints work on LHW would fatally skew its activity in many areas, introduce conflicts of interest and confrontation with local commissioners and providers and could doom LHW as an effective enabler of local voices.

Drowning under the weight of complaints handling was one of the main contributors to the undoing of the Healthcare Commission. Complaints should continue to be handled through local resolution. Commissioners and providers must get better at this, as the Ombudsman repeatedly stresses in her reports.

Don't leave it all to Health Watch

Local Health Watch is intended to be much more than LINks rebranded. As a statutory body, LHW will probably have a seat on the top level governance group – whether or not it is called a "board" - of the GP commissioning consortium and be able to make reports to the wider community following each meeting. It will also sit on the Council's Health and Well Being Board.

Despite this high-profile role, it is essential that people working in primary care don't by default see LHW as a synonym for patient and public involvement. It cannot all be left to Health Watch. There must be integration between viable Local Health Watch and many other types of involvement and engagement at the grass roots of clinical commissioning structures and local providers. To be successful businesses, GP practices and commissioning consortia need many direct "listening relationships" with their own patients.

Andrew Craig is a partner in the user involvement consultancy Moore Adamson Craig Partnership LLP www.publicinvolvement.org.uk

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