

**EXPLANATORY MEMORANDUM TO  
THE LOCAL INVOLVEMENT NETWORKS REGULATIONS 2008**

**2008 No.528**

**THE LOCAL GOVERNMENT AND PUBLIC INVOLVEMENT IN HEALTH ACT 2007  
CONSEQUENTIAL PROVISIONS ORDER 2008**

**2008 No. 526**

1. This Explanatory Memorandum has been prepared by the Department of Health and is laid before Parliament by Command of Her Majesty.

**2. Description**

2.1. These Regulations set out certain requirements to be included in the governance arrangements of local involvement networks (LINKs), impose a duty on services-providers (including some NHS bodies and local authorities) to respond to reports and recommendations from LINKs and set out certain requirements about the transitional arrangements to be made by local authorities. The Schedule to the Regulations and the Order make a number of consequential amendments to other Statutory Instruments.

**3. Matters of special interest to the Joint Committee on Statutory Instruments**

3.1. The Regulations are the first regulations to be made under sections 223, 224, 226(6) and 228 of the Local Government and Involvement in Health Act (c.28) (“the Act”).

**4. Legislative background**

4.1. These Regulations and this Order are being made to implement Part 14 of the Act which includes provision for local involvement networks and the imposition of a temporary duty on local authorities under section 228 of the Act to make arrangements for activities under section 221(2) of the Act to be carried on. Part 14 also includes provision for the abolition of Patients’ Forums and the Commission for Patient and Public Involvement in Health and these Regulations and this Order make consequential amendments arising from this.

4.2. The Local Involvement Networks (Duty of Services-Providers to Allow Entry) Regulations 2008 (“the draft Entry Regulations”) have been laid in draft before Parliament. The draft Entry Regulations would be made under Part 14 of the Act. If approved by both Houses of Parliament the draft Entry Regulations will come into force on 1st April 2008.

**5. Extent**

5.1. These Regulations apply to England only.

**6. European Convention on Human Rights**

6.1 As the instruments are subject to the negative resolution procedure and do not amend primary legislation, no statement is required.

**7. Policy Background**

7.1 Patients’ Forums were established in 2003, primarily to monitor and review the provision of health services on behalf of patients. Since 2003, the Commission for Patient and Public Involvement in Health (“CPPIH”) has represented, supported and managed the performance of Patients’ Forums. It

has also had a role in advising the Secretary of State on arrangements for public involvement in, and consultation on, matters relating to the health service.

7.2 Following the Arm's Length Bodies Review in 2004, which recommended the abolition of CPPIH and an extensive review, the Department of Health published a consultation document, "A stronger local voice: A framework for creating a stronger local voice in the development of health and social services". This document set out the Department's proposals for replacing Patients' Forums with LINKs, which unlike Patients' Forums will, for example, be able to consider the provision of social care as well as health services.

7.3 These proposals, further developed following consultation, formed the basis of Part 14 of the Act, which also makes provision for the abolition of Patients' Forums and CPPIH.

7.4 Part 14 of the Act imposes a duty on local authorities to make contractual arrangements for the involvement of people in the commissioning, provision and scrutiny of health services and social services. Persons engaged in these activities are referred to as LINKs. The person or organisation with whom the local authority makes the contractual arrangements is referred to as the Host.

7.5 Certain amendments were made at late stages of the passage of the Act, concerning the governance arrangements for LINKs and placing a duty on local authorities to ensure that even if arrangements to establish a LINK are not in place by 1 April, there are means by which LINKs activities can take place for a limited period. This duty is referred to below as the transitional duty.

7.6 Part 2 of these Regulations imposes a duty on local authorities to include certain governance provisions in the contractual arrangements with the Host. The provisions include that the LINK must have a procedure about how certain decisions are made, including those decisions regarding the activities the LINK chooses to undertake, the actions the LINK chooses to take about making reports and recommendations, referring matters to other bodies and entering and viewing premises, and the spending of money. The procedure must be published. The decisions and the reasons for them must likewise be made public. This is to ensure that LINKs operate in a consistent and transparent way and to help LINKs to demonstrate accountability to the public, without prescribing the procedures they should follow.

7.7 Part 2 also imposes a duty on local authorities to include provision in the arrangements with the Host that the LINK must comply with certain requirements about authorising representatives for the purposes of entering and viewing premises where care services are provided. These requirements are that the procedure for deciding who can be an authorised representative must be published, that LINK members who wish to be authorised should have a criminal records certificate and be a suitable person to enter and view premises where care services are provided, that a list of authorised representatives must be maintained and that the LINK must provide representatives with written evidence of authorisation. This is to ensure that LINKs follow a consistent, transparent process for authorising representatives and that services-providers can be sure that people seeking to enter and view premises and observe the carrying-on of activities on those premises have been properly authorised for that purpose.

7.8 Part 2 stipulates that the LINK, once established, will have to notify the local authority that it is operational. This is of particular relevance to the transitional duty and ensures that the local authority is aware when the transitional duty has ended.

7.9 Part 2 also imposes a duty on certain services-providers to respond in writing within 20 working days to reports and recommendations from LINKs that concern certain services the services-providers have commissioned. LINKs can therefore expect a formal response to reports within a reasonable timeframe, without there being too great a burden on services-providers.

7.10 Part 3 of these Regulations sets out certain aspects of the transitional duty, including the time when the transitional duty ends. The Regulations set out that the local authority itself cannot undertake the activities which the transitional duty requires to be carried on, nor can an NHS body,

another local authority or the actual or prospective Host organisation. This is to avoid conflicts of interest.

7.11 The Regulations provide that local authorities must ensure that the arrangements they make to comply with the transitional duty include certain governance provisions to apply to the arrangements made with the person carrying-on activities pursuant to that duty: these are similar to those described above for LINKs, except that there is no requirement to publish procedures, just establish and comply with them and publish decisions. This is because in this transitional phase, the procedures themselves may be evolving quickly and although it is important that everything that is done in relation to the transitional duty is documented, it is not the intention to create a lot of bureaucracy relating to this.

7.12 Under these Regulations, services-providers and Overview and Scrutiny Committees of local authorities will also have similar duties towards the people undertaking activities in the transitional period as they do towards LINKs (see also 6.14). For example, certain services-providers will be under a duty to allow entry to individuals who have been authorised to visit certain of their premises in certain circumstances (with the same safeguards and limitations as set out in the draft Entry Regulations) and to respond to reports and recommendations within 20 days. We believe this is a reasonable timescale within which services-providers can consider the content of the report and respond appropriately.

7.12 These Regulations also set out reporting requirements that apply when the transitional duty on a local authority ends. This is because the annual report that the arrangements made by the local authority and the Host must require won't apply to activities carried-on pursuant to the transitional duty. For completeness and to ensure that a LINK can satisfy itself that work begun pursuant to the transitional duty has been resolved, the persons undertaking activities as a result of the transitional duty must, once the transitional duty on the local authority has ended, prepare a report which sets out the activities undertaken and submit it to the local authority to whom that transitional duty applied, a Host in that local authority's area and the Secretary of State.

7.13 Part 4 of these Regulations place a duty on Overview and Scrutiny Committees to acknowledge referrals from LINKs that concern either health or social care matters within 20 working days. In relation to referrals of health matters they also requires those committees to keep the LINK informed about actions they might take, if any, with respect to those referrals. This provides LINKs with a mechanism to refer matters they consider to require further scrutiny to an independent body.

7.14 A twelve-week consultation on a draft of those Regulations that concern the duty on services-providers to respond to reports and recommendations and the draft Local Involvement Networks (Duty on Services-Providers to Allow Entry) Regulations closed on 21 December 2007<sup>1</sup>. 313 responses were received, and the balance of responses was in favour of not making major changes to the draft Regulations. As discussed in debate during the passage of the Act, those Regulations concerning governance and transitional arrangements were not subject to formal consultation because of the limited time available, but they were shared in draft form with a range of key stakeholders and comments were taken into account wherever possible.

7.15 The Schedule to the Regulations and the Order make a number of consequential amendments to other Statutory Instruments which refer to CPPIH, Patients' Forums or Community Health Councils (which preceded Patients' Forums and shared some of their functions). The principles behind these amendments are to ensure that the powers of Patients' Forums are maintained for LINKs wherever possible, but that LINKs are not overburdened by bureaucracy, particularly early in their inception.

## 8. Impact

A partial impact assessment of the draft regulations was published alongside the consultation<sup>2</sup> and an impact assessment for the whole Local Government and Public Involvement in Health Bill was

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<sup>1</sup> [http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH\\_078794](http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_078794), Gateway 8817

<sup>2</sup> [http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH\\_078794](http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_078794), Gateway 8817

published when the Bill was introduced to Parliament<sup>3</sup>. A final impact assessment for the implementation of LINKs is appended to this Memorandum.

## **9. Contact**

Any enquiries about the contents of this Memorandum should be addressed to Sarah Connelly, Patient and Public Involvement, Skipton House 502A, 80 London Road, London SE1 6LH, telephone 0207 97 25679.

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<sup>3</sup> <http://www.communities.gov.uk/publications/localgovernment/localgovernment3>

## Summary: Intervention & Options

Department /Agency:  
Department of Health

Title:  
Impact Assessment of Local Involvement Networks  
(LINKs) Regulations and Directions

Stage: Final

Version: 1

Date: 6 February 2008

**Related Publications:** Local Government and Public Involvement in Health Regulatory Impact Assessment May 2007 and partial impact assessment of Local Involvement Networks (LINKs) regulations(September 2007)

Available to view or download at:

[http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Regulatoryimpactassessment/DH\\_08316](http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Regulatoryimpactassessment/DH_08316)

Contact for enquiries: Sarah Connelly

Telephone: 020 7972 5679

### What is the problem under consideration? Why is government intervention necessary?

Involving patients and public in decisions about health and social care ensures that services are better shaped to meet the needs of those that use them. The old system of patient forums, which was based around individual NHS providers, no longer provides a suitable means to deliver this contribution, given increasing plurality of provision and the need to provide joined up planning across health and social care. Provisions in the Local Govt and Patient Involvement in Health Act abolished the CPPIH, which oversaw the work of forums, and also abolishes forums. It confers a duty on each LA to make arrangements for LINKs activities to be carried out. Regulation is now needed to ensure that the LINKs can operate effectively, within the powers set out in the act, to provide the required level of public and patient involvement.

### What are the policy objectives and the intended effects?

The policy objectives are to ensure that LINKs are able to:

- make reports and recommendations and receive a response within a specified timescale from commissioners of health and social care services (PCTs and local authorities);
- authorise representatives of LINKs to enter certain premises and view certain health and social care services;
- request information from health and social care bodies and receive a response within a specified timescale (to be covered by FOI Act); and
- refer health and social care matters to the relevant Overview and Scrutiny Committee and receive a response.

### What policy options have been considered? Please justify any preferred option.

- 1) DO NOTHING - This would mean that LINKs would exist in line with the Local Government and Public Involvement in Health Act 2007 but would have no powers.
- 2) PREFERRED OPTION - EXERCISE REGULATION AND DIRECTION MAKING POWERS except duties on services-providers to provide information as we consider that LINKs will be able to access the appropriate information by using the powers under the FOI Act
- 3) EXERCISE ALL REGULATION AND DIRECTION MAKING POWERS including duties on services-providers to provide information.

When will the policy be reviewed to establish the actual costs and benefits and the achievement of the desired effects?

The policy will be reviewed in April 2011 - 3 years from the implementation date of 1 April 2008.

**Ministerial Sign-off** For final/implementation Impact Assessments:

*I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.*

Signed by the responsible Minister:

Ann Keen.....Date: 19/02/2008

## Summary: Analysis & Evidence

Policy Option: 1

Description: Do nothing

<b>COSTS</b>	<b>ANNUAL COSTS</b>		Description and scale of <b>key monetised costs</b> by 'main affected groups'  Under the do nothing option, we would still expect LAs to follow a de minimis process to comply with the primary legislation. The costs of this are difficult to estimate, but as an indicative figure we might assume it will be similar to the existing admin costs in supporting forums.	
	<b>One-off</b> (Transition)	<b>Yrs</b>		
	£ nil			
	<b>Average Annual Cost</b> (excluding one-off)			
	£ 4.5m		<b>Total Cost (PV)</b>	£ 38.52m
Other <b>key non-monetised costs</b> by 'main affected groups'				

<b>BENEFITS</b>	<b>ANNUAL BENEFITS</b>		Description and scale of <b>key monetised benefits</b> by 'main affected groups'	
	<b>One-off</b>	<b>Yrs</b>		
	£ nil			
	<b>Average Annual Benefit</b> (excluding one-off)			
	£ nil		<b>Total Benefit (PV)</b>	£ nil
Other <b>key non-monetised benefits</b> by 'main affected groups'				

**Key Assumptions/Sensitivities/Risks** As for other options, costs and benefits are difficult to estimate. The cost figure suggested above is no more than illustrative. There would be no cost-able benefits from this option, so the cost translate directly to a negative net benefit, but the range of possible values on this cost is difficult to estimate, so it is not possible to provide a reliable NPV range.

Price Base Year 2007-08	Time Period Years 10	<b>Net Benefit Range (NPV)</b> £ Not applicable.	<b>NET BENEFIT (NPV Best estimate)</b> £ -38.52m
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What is the geographic coverage of the policy/option?			England	
On what date will the policy be implemented?			April 2008	
Which organisation(s) will enforce the policy?			Not applicable.	
What is the total annual cost of enforcement for these organisations?			£ Not applicable.	
Does enforcement comply with Hampton principles?			Yes	
Will implementation go beyond minimum EU requirements?			No	
What is the value of the proposed offsetting measure per year?			£ 0	
What is the value of changes in greenhouse gas emissions?			£ 0	
Will the proposal have a significant impact on competition?			No	
Annual cost (£-£) per organisation (excluding one-off)	Micro	Small	Medium	Large
Are any of these organisations exempt?	Yes	Yes	N/A	N/A

<b>Impact on Admin Burdens Baseline</b> (2005 Prices)			(Increase - Decrease)		
Increase of	£ N/A	Decrease of	£ N/A	<b>Net Impact</b>	£ N/A

## Summary: Analysis & Evidence

Policy Option: 2

Description: EXERCISE REGULATION MAKING POWERS except duties on services-providers to provide information

<b>COSTS</b>	<b>ANNUAL COSTS</b>		Description and scale of <b>key monetised costs</b> by 'main affected groups' Costs difficult to estimate. Illustrative per-annum figures suggest: running costs £23.5m (based on re-allocation of existing budget), £6m in responding to reports, £600k in providing training and CRB checks and £60k in providing support for visits.
	<b>One-off</b> (Transition)	<b>Yrs</b>	
	£ nil		
	<b>Average Annual Cost</b> (excluding one-off)		
	£ 30.16m		<b>Total Cost (PV)</b> £ 258m
Other <b>key non-monetised costs</b> by 'main affected groups'			

<b>BENEFITS</b>	<b>ANNUAL BENEFITS</b>		Description and scale of <b>key monetised benefits</b> by 'main affected groups' Benefits are almost entirely non-quantifiable and relate to the opportunity for patients and public to be involved in the decision making process in planning local health and social care provision. An illustrative calculation, based on improvements to services that might otherwise generate complaints suggests £9m per year.
	<b>One-off</b>	<b>Yrs</b>	
	£ nil		
	<b>Average Annual Benefit</b> (excluding one-off)		
	£ 9m		<b>Total Benefit (PV)</b> £ 77m
Other <b>key non-monetised benefits</b> by 'main affected groups' Almost all benefits are un-quantifiable and relate to marginal improvements in service, alongside a more general sense of better patient and public involvement.			

**Key Assumptions/Sensitivities/Risk** Costs and benefits are difficult to quantify because of lack of available data and also specifically the costs to LINKs of obtaining information under the FOI Act is not possible to quantify. Whilst illustrative figures can be provided on both sides it is not possible to estimate net benefit accurately.

Price Base Year 2007-08	Time Period Years 10	<b>Net Benefit Range</b> (NPV) £ Not applicable.	<b>NET BENEFIT</b> (NPV Best estimate) £ Not applicable.
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What is the geographic coverage of the policy/option?		England	
On what date will the policy be implemented?		April 2008	
Which organisation(s) will enforce the policy?		Not applicable.	
What is the total annual cost of enforcement for these organisations?		£ Not applicable.	
Does enforcement comply with Hampton principles?		Yes	
Will implementation go beyond minimum EU requirements?		No	
What is the value of the proposed offsetting measure per year?		£ 0	
What is the value of changes in greenhouse gas emissions?		£ 0	
Will the proposal have a significant impact on competition?		No	
Annual cost (£-£) per organisation (excluding one-off)	Micro	Small	Medium Large
Are any of these organisations exempt?	Yes	Yes	N/A N/A

<b>Impact on Admin Burdens Baseline</b> (2005 Prices)		(Increase - Decrease)	
Increase of	£ N/A	Decrease of	£ N/A
		<b>Net Impact</b>	£ N/A

## Summary: Analysis & Evidence

Policy Option: 3

Description: EXERCISE ALL REGULATION MAKING POWERS including duties on services-providers to provide information

<b>COSTS</b>	<b>ANNUAL COSTS</b>		Description and scale of <b>key monetised costs</b> by 'main affected groups'  Costs are very difficult to quantify, but will be at least as high as option 2. There would, in addition be a small unquantified cost in enabling providers to handle two parallel processes for handling requests for information.	
	<b>One-off</b> (Transition)	<b>Yrs</b>		
	£ <b>nil</b>			
	<b>Average Annual Cost</b> (excluding one-off)			
	£ <b>30.16m</b>		<b>Total Cost (PV)</b>	£ <b>258m</b>
Other <b>key non-monetised costs</b> by 'main affected groups'				

<b>BENEFITS</b>	<b>ANNUAL BENEFITS</b>		Description and scale of <b>key monetised benefits</b> by 'main affected groups'  Benefits as per option 2 are difficult to quantify. It is difficult to see any specific benefit from the additional regulation envisaged under option 3.	
	<b>One-off</b>	<b>Yrs</b>		
	£			
	<b>Average Annual Benefit</b> (excluding one-off)			
	£ <b>9m</b>		<b>Total Benefit (PV)</b>	£ <b>77m</b>
Other <b>key non-monetised benefits</b> by 'main affected groups'				

**Key Assumptions/Sensitivities/Risks** As for option 2, costs and benefits are both difficult to quantify and it is not possible to obtain reliable estimates of net benefit.

Price Base Year 2007-08	Time Period Years 10	<b>Net Benefit Range</b> (NPV) £ <b>Not applicable.</b>	<b>NET BENEFIT</b> (NPV Best estimate) £ <b>Not applicable.</b>
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What is the geographic coverage of the policy/option?				England
On what date will the policy be implemented?				April 2008
Which organisation(s) will enforce the policy?				Not applicable.
What is the total annual cost of enforcement for these organisations?				£ Not applicable.
Does enforcement comply with Hampton principles?				Yes
Will implementation go beyond minimum EU requirements?				No
What is the value of the proposed offsetting measure per year?				£ 0
What is the value of changes in greenhouse gas emissions?				£ 0
Will the proposal have a significant impact on competition?				No
Annual cost (£-£) per organisation (excluding one-off)	Micro	Small	Medium	Large
Are any of these organisations exempt?	Yes	Yes	N/A	N/A

<b>Impact on Admin Burdens Baseline</b> (2005 Prices)			(Increase - Decrease)
Increase of	£ N/A	Decrease of	£ N/A
<b>Net Impact</b>		£ N/A	

Key: Annual costs and benefits: Constant Prices (Net) Present Value

## Evidence Base (for summary sheets)

[Use this space (with a recommended maximum of 30 pages) to set out the evidence, analysis and detailed narrative from which you have generated your policy options or proposal. Ensure that the information is organised in such a way as to explain clearly the summary information on the preceding pages of this form.]

### *Background*

Currently patient and public involvement is supported through a system of Patients' Forums. Forums were established in the NHS Reform and Health Care Professions Act 2002, and there is one Patients' Forum for every NHS Trust (Acute Trusts, Foundation Trusts, Primary Care Trusts, Mental Health Trusts and Ambulance Trusts etc). Patients' Forums are supported by the Commission for Patient and Public Involvement in Health (CPPIH).

Currently, the total budget for patient and public involvement is £28m annually. These funds are given to CPPIH, £19m of which goes on direct Forum support with the remainder of funds being spent on central costs, including organisational costs of £4.5m, and costs in the delivery and support of Forums of just over £4.5m, which is of course, CPPIH's function. These delivery costs include the employment and training of CPPIH staff to fulfil those functions. There are currently around 400 Patients' Forums, although this figure changes as PCTs are reconfigured. Each Patients' Forum has on average 10/11 members who are volunteers appointed by CPPIH, meaning that the current system directly involves around 4200 people.

The changing structure of the NHS, with an increasing plurality of providers and more focus on commissioning means that it is no longer appropriate to have a patient and public involvement system which is based around individual providers. In the current system, each Patients' Forum scrutinises the services of its individual body (hospital trust, specialist trust, PCT etc). The broad aim is to provide the means for patients and the public to be involved in decisions about planning local health and social care services, and so to ensure that those services meet the needs of the people who use them. This broad aim can be met more effectively by a system that is capable of following the whole user experience, rather than looking at services in isolation. It should apply equally to health and social care and encourage involvement and input from people who use, or might use, any health or social care services in the local area.

Primary legislation has already been enacted to support these policy aims. It was announced as part of the Arms Length Body Review in 2004 that CPPIH would be abolished. Provisions contained in the Local Government and Public Involvement in Health Act, which received Royal Assent on 30 October 2007 will have the effect of abolishing CPPIH and Patient Forums and establish Local Involvement Networks (LINKs) in their place. The Act confers a duty on each local authority with social services responsibilities to make contractual arrangements to ensure there are means for LINKs activities to be carried out. (It should be noted that the redirection of funds from the Commission for Patient and Public Involvement in Health (CPPIH) to the front line supports a wider agenda set by the Arms Length Body Review. )

This primary legislation was supported by a full impact assessment, and this is attached at Annex A for information.

The primary legislation gives the Secretary of State a power to make regulations and Directions imposing duties on commissioners and certain providers of health and social care services to:

- respond to LINKs (to requests for information and to reports and recommendations made to them by a LINK) and
- to allow entry by LINKs to premises under certain conditions).

The Act also gives the Secretary of State powers to make regulations in respect of a transitional period between Forums winding down their activities and LINKs coming into being and to make regulations in respect of LINKs governance arrangements.

To address the aim of involving patients and public in decision about health and social care, it is necessary to consider in detail how LINKs might operate (or indeed whether there are other means to deliver the same result). In reality the only viable regulatory step is to consider what regulations the Secretary of State should make under the powers conferred in the act. This impact assessment examines the options of different approaches to these regulations and Directions, and provides the case for the recommended option which will come into force from 1<sup>st</sup> April 2008.

### ***Policy Objectives***

The policy objectives of LINK regulations and Directions is to ensure that LINKs are able to operate effectively to allow patients and public to be involved in decisions about planning local healthcare services. Specifically, the Act provides powers to allow Secretary of State to make regulations to ensure that LINKs are able to:

- make their own governance arrangements (decision making, authorisation of representatives, spending, contravention of arrangements, etc) in an open and transparent way and submit annual reports to the Secretary of Health.
- make reports and recommendations and receive a response within a specified timescale from commissioners of all health and social care services;
- authorise representatives of LINKs to enter certain premises and view certain health and social care services;
- request information from health and social care bodies and receive a response within a specified timescale (to be covered by FOI Act); and
- refer health and social care matters to the relevant Overview and Scrutiny Committee and receive a response.

In this impact assessment we consider how these powers might be exercised in order to ensure that LINKs can carry out the activities set out in the Act, and to ensure that patients and the public have the necessary levers to be able to become involved in the scrutiny of the commissioning and provision of services.

### ***Options***

- 1. DO NOTHING**
- 2. PREFERRED OPTION - EXERCISE REGULATION AND DIRECTION MAKING POWERS** except duties on services-providers to provide information as we consider that LINKs will be able to access the appropriate information by using the powers under the FOI Act.
- 3. EXERCISE ALL REGULATION AND DIRECTION MAKING POWERS**

#### Option 1 – Do nothing

This would mean that Patient Forums and CPPIH would be abolished, LINKs would be established but with no powers. This would mean that LINKs would be unable to:

- make their own governance arrangements (decision making, authorisation of representatives, spending, contravention of arrangements, etc) in an open and transparent way and submit annual reports to the Secretary of Health.

- make reports and recommendations and receive a response within a specified timescale from commissioners of health and social care services (PCTs and local authorities);
- authorise representatives of LINKs to enter certain premises and view certain health and social care services; and
- refer health and social care matters to the relevant Overview and Scrutiny Committee and receive a response.

They would only be able to request information from health and social care bodies and receive a response within a specified timescale, under the FOI Act. Therefore creating PPI mechanisms without the teeth or levers to use in their activities. This would mean that patients and the public would lose out.

Option2 – Preferred option – Exercise regulation making powers except duties on services-providers to provide information. We consider that LINKs will be able to access the appropriate information by using the powers under the FOI Act.

The regulation and direction powers contained in the Local Government and Patient Involvement in Health Act are similar to those that currently exist for Patients Forums, however, the main difference is that they largely extend to social care bodies as well, because LINKs will cover health and social care matters. The regulations and directions place duties on service commissioners, providers and Overview and Scrutiny Committees, where appropriate to ensure that LINK are able to:

- Make their own governance arrangements (decision making, authorisation of representatives, spending, contravention of arrangements, etc) in an open and transparent way and submit annual reports to the Secretary of Health.
- Make reports and recommendations and receive a response within a specified timescale.
- Request information and receive a response within a specified timescale.
- Refer social care matters to an Overview and Scrutiny Committee and receive an appropriate response.
- Enter and assess health and some social care premises.

This option would have the effect of establishing all of the powers listed above except from the power for LINKs to request information and receive a response within a specified timescale.

Since the Patient Forum Regulations were made in 2003, the Freedom of Information (FOI) Act has come into force. Following legal advice and views expressed in our public consultation on LINKs' access to information, we are of the view that LINKs will be able to access the appropriate information by using the powers under the FOI Act. We therefore do not consider it necessary to make regulations at this time, although we think it is important to review the need for a regulation making power in case there becomes a need in future to extend LINKs powers above and beyond the provisions of FOI. This power would also be used if the definition of services-provider was extended to include bodies to which the FOI does not apply.

The Freedom of Information Act provides for a general right of access to information held by a public authority and includes the right to be informed in writing whether the authority holds the information requested and if it does, to have that information communicated. However, information can be refused under various exemptions, or even in some instances, a department may, or may not confirm nor deny that information is held. A public authority must comply with a request promptly and should generally provide information within 20 working days (though in some cases this can be extended). The bodies that are services-providers within the definition contained in the Local Government and Patient Involvement in Health Act are all public authorities to whom the FOI Act applies.

As part of our consultation on the regulations, we set out our reasons for this preferred option and ask for comments on whether services-providers should have duties to provide information

to LINKs that go beyond the obligations imposed in the FOI Act 2000, and if so, what should they be and why.

### Consultation findings

The majority of respondents to this section of the consultation were in favour of our proposals. In total, 219 respondents expressed a view and 133 of those (61%) were content with the proposal that LINKs should have no further powers to request information, beyond those already covered by FOI.

However, some respondents were concerned that the powers under FOI would not be sufficient for LINKs to obtain the information they would require. The three main concerns raised were:

- That obtaining information under FOI would be a lengthy process.
- That there would be a potential cost to the LINK.
- That public bodies might abuse the FOI exceptions to avoid giving information to LINKs

Having considered these concerns carefully, we remain of the view that FOI is the most appropriate and effective way to ensure that LINKs receive the right information. The FOI has several strengths in this regard, including:

- A time limit for response is stipulated in FOI.
- Specific enforcement measures are attached to FOI duties, which mean that if an FOI request is not complied with, there is a way to escalate the issue.

Further, whilst we are very sympathetic to the concerns raised around cost and potential refusal by a body on commercial grounds, we believe that separate regulations - because they could not carry a separate enforcement measure in the same way - would actually weaken LINKs' position. From the consultation comments received, we were not able to identify any specific categories of information that LINKs should not be able to access, and for which FOI does not permit access. For this reason we want to encourage LINKs and their partners to build strong working relationships so that all reasonable and necessary requests for information are met without charge and within the usual FOI timescale.

### Option 3 – Exercise all regulation making powers

This option would mean that all the regulation and Direction powers contained in the Local Government and Patient Involvement in Health Act are exercised. The regulations and Directions place duties on services providers to ensure that LINK are able to:

- Make their own governance arrangements (decision making, authorisation of representatives, spending, contravention of arrangements, etc) in an open and transparent way and submit annual reports to the Secretary of Health.
- Make reports and recommendations and receive a response within a specified timescale.
- Request information and receive a response within a specified timescale.
- Refer social care matters to an Overview and Scrutiny Committee and receive an appropriate response.
- Enter and assess health and some social care premises.

This option would require regulations or directions on the operation of requests for information. It is likely that these regulations would, in large part, duplicate existing provisions of the FOI act.

### *Costs and benefits*

As part of the consultation we sought respondents' views on existing costs relating to LINKs

activities and for any available information on the potential costs and benefits of the options, particularly the preferred option.

Regrettably, respondents did not provide estimates of costs and impacts but rather expressed general concern about potential costs relating to FOI requests and Criminal Records checks. In this section we consider the likely impact of the 3 options on different sectors and groups affected. Whilst it is not possible to provide firm costs, this impact analysis allows some comparison between options and provides a reasoned argument in support of the preferred option.

#### Sunk costs that have not been included in the costings

It is noted that local authorities have already been allocated a payment of £10,000 each to help them administer the procurement process for LINKs and to alleviate the costs of initial set up. This one-off allocation of funds is, in effect, a sunk cost. It does not impact on the assessment of relative merits of each of the 3 options, because the funds have already been allocated and apply under all 3 options. This amount is therefore not included in the summary of costs sheets for options 1 to 3.

#### Sectors and groups affected

These regulations and Directions relate to public and independent sector health and social care providers.

#### Option 1 – Do nothing

##### **Benefits**

There would be no additional benefits from doing nothing. In effect, LINKs would have been set up in primary legislation but would have no powers to fulfil their core activities. The creation of patient and public involvement mechanisms without any teeth or levers to use in their activities would mean that patients and the public would lose out. It is likely that the Department would be heavily criticised for failing to fulfil policy commitments made to the public and in Parliament.

##### **Costs**

Local Authorities would still have a duty, under the primary legislation, to put contractual arrangements in place to allow LINKs activities to be carried out. Without the secondary legislation to establish precisely what those activities are, it is possible that some LAs would be unable to comply with this legal requirement. However, for the purposes of this impact assessment we must assume that local authorities would take measures to comply with the act. There would be procurement costs involved in establishing the contracts for LINKs, although we might expect that these costs would be lower than they would be for a fully operational LINKs programme, or indeed for patient forums. Figures on current arrangements suggest that the costs of delivering and supporting forums under existing arrangements is £4.5m per annum.

This figure might be considered an estimate of the 'do minimum' requirements of the Act, although there are uncertainties around this figure. Without a clear set of regulations and directions, different local authorities will take different approaches to fulfilling their obligations under the act. Staff costs within LAs to interpret the act and develop proposals could be higher than the costs under existing arrangements. However, some LAs are likely to take a 'de minimis' approach that would reduce costs.

Option2 – Preferred option – Exercise regulation and Direction making powers except duties on services-providers to provide information as we consider that LINKs will be able to access the appropriate information by using the powers under the FOI Act.

## Benefits

This proposal will have beneficial effects for all those involved in the Patient and Public Involvement system:

- **For the public** – the new system will allow many more people to become involved in health and social care. A wider diversity of views will be heard, and local voice will be strengthened. The ultimate benefit of a wider-ranging PPI system is that more people will have the opportunity to be involved, in ways that suit them, in decisions about their health and social care system. This should lead to greater clarity about priority setting, and improvement in services as they will be better shaped to suit the needs of those that use them. Exercising LINKs powers will mean that people involved in LINKs will be able to use the duties placed on health and social care commissioners and providers and OSCs to influence decision makers and create improved services.
- **For commissioners** – the LINK will provide commissioners with a first point of contact for involvement and engagement. It will be a pool of local knowledge and expertise which will help commissioners assess the needs of local populations. Involving the public through consultation with the LINK will be a way in which commissioners take decisions which best reflect the public's need. Exercising LINKs powers will mean that commissioners will be required to respond to LINKs' reports and recommendations explaining what action, if any, they intend to take. This will mean commissioners have evidence based input from local people about what is important to them on which to set priorities and make decisions.
- **For providers** – We hope providers will benefit from having a close working relationship with their LINK, who will be able to give them data on patients views from the information they gather, and assist them to improve their services. LINKs powers, for example to enter and view premises, will obviously have an impact on providers as well as commissioners of services. Any feedback gathered from these visits will enable providers to understand their services better from the user perspective and make any necessary improvements.
- **For Overview and Scrutiny Committees (OSCs)** – Local authority OSCs currently scrutinise health and social care services. LINKs will benefit OSCs as they will bring issues affecting the local community to the OSCs' attention for review. In addition, they will also be a resource for the OSCs to help them understand issues which the local community feels strongly about.

This option would ensure that the new powers did not conflict with FOI, which is the established and appropriate manner to access publicly held information. Further, although we do not think it necessary to make regulations at this time, we think it is important to maintain this regulation making power in case a need arises in future to extend LINKs powers above and beyond the provisions of FOI.

It is difficult to place a financial value on these benefits. They are, in general, non-quantifiable. The tangible effect of these benefits is likely to be a long term improvement in the synergy between service provision by the NHS and social care and the needs and wants of patients and the public. An indication of the scale of the benefit can be obtained by considering the extent to which existing services are 'amenable to adjustment' to better meet patient needs. If we consider inpatient care, for example, we find that there were around 14 million inpatient episodes in 2006-07 attracting 27,825 written complaints – roughly one complaint for every 500 episodes. If we make the (very bold) assumption that this ratio applies across all user-service interactions in the NHS and social care, then around 1 in every £500 spent on services is spent on services that do not fully meet the needs or expectations of patients (to the extent that they wish to complain in writing). This gives a value of services that are 'amenable to adjustment' of £180m (based on the current NHS budget of £90bn per year). The adjustment likely to be realised by LINKs is a proportion of this amount. We would not expect LINKs to operate in a way that removes the need for all written complaints, but on the margins we might expect some

improvement in these services. If we assume (again boldly) a 5% improvement in these areas, then the value of benefit is £9m per annum.

This estimate is no more than indicative. Moreover, it focuses purely on services where the level of provision is sufficiently poor to generate written complaints. It is likely that LINKs would also have a more positive impact, allowing local health economies to focus investment on new areas that are most relevant to emerging patient needs and priorities.

## Costs

We are unable to provide an accurate and fully robust estimate of the costs and burden of administering the new Patient and Public Involvement system because of a current lack of suitable data, likely differences in the circumstances/set-up of individual LINKs and because of difficulties discriminating between expenditure on policy costs and administration costs. The following paragraphs set out who will be affected by this proposal, and how the proposal might impact.

- **Health providers** – Health providers will need to provide access to authorised LINK representatives to visit their premises. Patient Forums already have access to health providers so we do not expect there to be any more of a burden on providers than there is currently. In fact, if anything we expect LINKs visits to be less burdensome on individual providers, as LINKs will cover a geographical area rather than single provider as Forums do and we expect LINKs to visit premises based on user feedback and evidence. We know from looking at information collected from a random sample of 10 Patient Forums<sup>4</sup> that on average Forums carried out 5 visits per year. We cannot of course claim that this information is statistically robust or that this truly represents the spread of work across all Patient Forums, as we know some Forums will use the Knowledge Management System more than others.

The provision of information is not attributable to this option as we are not proposing to exercise the regulation making power relating to information (as explained above, we consider that LINKs will be able to access the appropriate information by using the powers under the FOI Act).

As part of our consultation on the regulations, we asked respondents for information on the cost to Health providers of allowing access to Patient Forums, including the amount of staff time devoted to such visits. Regrettably, we did not receive specific feedback on this issue from respondents. If we assume that there is one LINKs organisation per LA area, and each one organises 5 visits per year (as outlined above) then this would imply 750 visits nationally. In the absence of any robust estimates of impact 'per visit', we might make an indicative assumption that each visit requires one day of staff time at an indicative salary of £30k per annum. This would generate a cost per visit of approximately £80, giving an impact of £60k per annum. Again this figure is no more than illustrative.

- **Social care providers** – Social care providers will need to provide access to authorised LINK representatives to visit their premises. Patient forums do not have access to social care providers currently so LINKs' access will create an additional burden.

LINKs regulations relate to public providers – i.e. local authority or NHS social care provided services and LINKs Directions will relate to the independent sector. Whilst we recognise the additional burden in relation to social care, we do not expect this burden to be a large one. We also expect that the effect will be minimised, as we know those responsible for providing social care already receive many approaches from individuals,

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<sup>4</sup> based on information posted on the CPPIH's Knowledge Management System from a selection of different types of Forum (PCT, Trust, Foundation Trust, Care Trust, Ambulance & Mental Health Trust) across the country.

groups and organisations, and even the busiest of LINKs is unlikely to increase the burden by any noticeable amount.

We cannot quantify the projected numbers of LINKs visits as this will depend on the focus of LINK activity, although if the level of visits were comparable with those of health providers then we could estimate that this might be in the order of 5 visits per year or less – as set out above. Although, as also set out above, if anything, we expect LINKs visits to be less burdensome on individual providers, as LINKs will cover a geographical area rather than single provider as Forums do and we expect LINKs to visit premises based on user feedback and evidence.

The provision of information is not attributable to this option as we are not proposing to exercise the regulation making power relating to information (as explained above, we consider that LINKs will be able to access the appropriate information by using the powers under the FOI Act).

Again, as part of our consultation on the regulations, we invited to contribute any evidence that will enable us to estimate the likely frequency of access visits to public sector social care providers, and the likely cost to providers of facilitating such visits. Regrettably, we did not receive specific feedback on this issue.

- **Health and social care commissioners (Local authorities and PCTs)** - Local authorities and PCTs will need to respond to LINKs reports and recommendations. It is again difficult to quantify the projected numbers of LINKs reports, as this will depend on the focus of LINK activity, however we do not expect it will prove very costly to respond to these reports.

We know from looking at information collected from a random sample of 10 Patient Forums (as referenced above) that on average Forums made 4 reports and recommendations per year. We cannot of course claim that this information is statistically robust or that this truly represents the spread of work across all Patient Forums, as we know some Forums will use the Knowledge Management System more than others.

As the remit for LINKs extends to social care as well as health (unlike Patient Forums which only relate to health), this does mean that those responsible for commissioning social care will be required to respond to approaches made to them by LINKs. Therefore, local authorities will be under a duty to respond to the reports and recommendations made by LINKs. Although this could represent a new burden, we expect the effect will be minimal as those local authorities already receive many approaches from individuals, groups and organisations, and even the busiest of LINKs is unlikely to increase the burden by any noticeable amount.

The provision of information is not attributable to this option as we are not proposing to exercise the regulation making power relating to information (as explained above, we consider that LINKs will be able to access the appropriate information by using the powers under the FOI Act).

Respondents to the consultation were invited to submit evidence on the cost to local authorities and PCTs of responding to patient and public involvement reports and recommendations. (This could be based on the costs relating to Patient Forum reports, or to those from other organisations.) Regrettably, specific costing information was not received. The indicative figures above suggest that LINKs might generate 600 reports and recommendations per year nationally. The costs of responding to those reports and recommendations are very difficult to quantify, but we might expect that LINKs would only comment on areas where substantive changes in services or process are required. If we assume, for purely illustrative purposes, an impact of £10k per report, this generates a total cost of £6m across health and social care.

- **Host organisations to support LINKs** – Hosts will have to ensure authorised LINKs participants are able to carry out any visits with appropriate levels of training, having had the necessary Criminal Records Bureau (CRB) checks. Hosts will also provide administrative support in writing up any reports LINKs may choose to make. As well as the dissemination of any advice and guidance from central Government. Much of this administrative support would be supplied to LINKs to support them in their general activities irrespective of the regulations. So in effect, it is the training and CRB checks that will create additional costs. It is again difficult to quantify the projected numbers of LINKs participants that will take part in visiting activity, as this will depend on the focus of LINK activity, although we expect a small core group of participants to undertake this activity rather than this being widespread as it is recognised that it will require specialist training and checks.

Drawing on figures provided by CPPIH, the average cost of CRB checks for Patient Forum, per applicant, is £29.75 in 2006-07 prices. The average number of checks per year is 2709, although we believe this number has been boosted by the number of initial checks that were necessary in the set-up stages.

The average cost of training for Patient Forum members per course place was £551 in 2006-07 prices. The average number of trainees was 1253, at a total cost of £690,160 per year. Though, there were almost four times as many trainees in 2005-06, so the average of 1253 may be an overstatement. If we estimate that people need retraining every three years (for example) then the average cost would be £556,720 per annum.

In the case of LINKs, we anticipate that no more than 10 people would need to be authorised to carry out visits and that, typically, around 5 people would already be authorised as a result of their work in patient forums. In other words, an additional 5 people in each LINK would be expected to undergo a CRB check. With 150 LINKs set up, this would mean that approximately 750 CRB checks would be undertaken. This is a decrease in number from Patients' Forums and we do not view it as a significant burden for local authorities or host organisations.

As a courtesy, we have also contacted the Criminal Records Bureau to ask if they would have concerns about a possible increased demand for CRB checks. They advised us that the practice of carrying out under 1,000 standard checks per year would not have a significant impact on their office and, as Forums would be closing on 31<sup>st</sup> March 2008, an overall increase in demand for checks was unlikely.

These calculations imply an approximate annual cost of £600k per annum.

- **Overview and Scrutiny Committees (OSCs)** – OSCs will need to respond to LINK referrals either by scrutinising the issues or telling the LINK why they have decided to take no action. Health OSCs are not currently under a duty to respond to Patients' Forums referrals in this way, and referrals from LINKs can additionally cover social care issues. There is therefore some potential for additional costs for OSCs arising from the new duty. From looking at the numbers of OSC referrals collected from Patients' Forums, we know that most OSCs on average, are currently likely to receive at least one referral of a health issue per year. We expect that LINKs will make the same level of social care referrals as health issues, so we estimate that most health and social care OSCs will receive at least 2 LINK referrals per year. As LINKs will be coterminous with OSC areas, we hope that they will work closely with one another so that fewer formal referrals are made but instead work together collaboratively.

We know from talking to the Centre for Public Scrutiny (CfPS) and a number of OSC officers that although dealing with Forum referrals does not currently constitute a large

proportion of their workload, the new duty to respond to referrals about health and social care matters could have some costs implications in terms of carrying out detailed scrutiny reviews. However, as OSCs are likely to undertake these as part of a planned programme of work, we do not expect there to be any significant cost burden associated with this.

As part of the consultation, we asked respondents for their comments on the cost to OSCs of responding to referrals and whether 20 days was an appropriate timescale to expect an OSC to respond to a LINK referral. Several respondents argued that, as OSCs did not always meet in any given 20 day period, it was only reasonable to expect the OSC to acknowledge receipt of the referral in that time. It would not be reasonable to expect an OSC to provide a full response or a detailed action plan within 20 working days.

We were sensitive to claims that the regulations would place an added burden on OSCs and having considered these responses carefully, we amended the draft regulations to ensure that OSCs would only be required to acknowledge receipt within the 20 day timescale.

We do not have reliable estimates of the cost implications for OSCs in providing resources to respond to referrals, but in the context of the figures detailed elsewhere in this impact assessment we consider the resource implications to be negligible (although the impact will be noticeable to individual OSCs who receive a small additional burden against relatively small resource).

### Option 3 – Exercise all regulation making powers

#### **Benefits**

The benefits of this option would be the same as above but would mean we would be creating an unnecessary duty on health and social care commissioners and providers, to provide information that could already be accessed under the FOI Act. There are potential benefits in providing LINKs with a more clearly defined 'lever' in pursuing requests for information, but it is also likely that LINKs could achieve the same end by appropriate application of their rights under FOI. It is possible that any potential benefits would be lost because of the potential for confusion about which power the LINK was engaging to support the information request.

#### **Costs**

The costs would be the same as above, although there may be small additional costs for health and social care commissioners and providers in dealing with separate queries from LINKs which could be picked up under FOI queries. The cost would largely be realised as a need to provide alternative processes for handling 'LINK' information requests. Whilst the number of requests per LA is likely to be small (for illustrative purposes we assume 5-10 requests per year), the relevant organisations would need resource to understand and handle those requests under a different set of criteria to FOI. This cost would be small, but not zero.

#### ***Summary and recommendation***

In summary, we recommend Option 2, that the Government exercise regulation making powers except duties on services-providers to provide information as we consider that LINKs will be able to access the appropriate information by using the powers under the FOI Act.

We invited comments on this approach in the 'Have your say – consultation on the regulations for Local Involvement Networks' document and, whilst a range of views were expressed, the majority of respondents supported our proposals. 81% supporting proposals on responding to reports and recommendations, 78% agreeing with our proposals on organisations to be covered by the regulations and 87% agreeing with our proposals on the timescale for OSC responses.

## Specific Impact Tests: Checklist

Use the table below to demonstrate how broadly you have considered the potential impacts of your policy options.

**Ensure that the results of any tests that impact on the cost-benefit analysis are contained within the main evidence base; other results may be annexed.**

Type of testing undertaken	<i>Results in Evidence Base?</i>	<i>Results annexed?</i>
Competition Assessment	No	No
Small Firms Impact Test	No	No
Legal Aid	No	No
Sustainable Development	No	No
Carbon Assessment	No	No
Other Environment	No	No
Health Impact Assessment	No	No
Race Equality	Yes	Yes
Disability Equality	Yes	Yes
Gender Equality	Yes	Yes
Human Rights	Yes	Yes
Rural Proofing	Yes	Yes

# Annexes

## Further information on Specific Impact Tests

### Further information on Specific Impact Tests

#### Equity and fairness including race equality assessment

We consider that there will be no disproportionate effect on any group as a result of Options 2 and 3. Option 1, whilst imposing no effect itself, would have a negative effect in terms of doing nothing to strengthen patient and public involvement of all sectors of the community.

Screening Questions	Yes/No
1. Do different groups have different needs, experiences, issues and priorities in relation to the proposed policy?	Yes
2. Is there potential for or evidence that the proposed policy will promote equality of opportunity for all and promote good relations between different groups?	Yes
3. Is there potential for or evidence that the proposed policy will affect different population groups differently (including possibly discriminating against certain groups)?	No
4. Is there public concern (including media, academic, voluntary or sector specific interest) in the policy area about actual, perceived or potential discrimination against a particular population group or groups (or potential or actual damage to good race relations)?	No

It is likely that different groups will have different needs, experiences and issues in relation to this policy. Some groups, for example, the elderly, or disabled, may need extra help in being able to input their views into a LINK or undertaking the activities to which these regulations relate, or those who are socially unused to giving their opinions may need more encouragement to become involved. A LINK will need to make particular efforts to access the views of these groups, to ensure that they are able to represent the views of the entire community.

There is a potential for this policy, of which the regulation powers are part, and the introduction of LINKs to have a great influence in promoting equality of opportunity. Currently Patient Forums have on average ten members each, this small number of people cannot hope to be representative of the whole community. LINKs will offer opportunities for many more people to become involved. They will also offer a much more flexible membership, people will be able to dip in and out of involvement in a way that suit them. Currently, the time requirement of being a Patients Forum member stops many people from volunteering because it is too onerous. We hope that offering people the opportunity to become involved in different ways will encourage much wider participation.

#### Steps to promote equality of access and representation

During the process of developing this policy, the question of equality of access and representation in LINKs has been a primary concern and this is reflected in the *Getting Ready*

for *LINKs* guidance, which emphasises that a LINK should make efforts to be representative of the whole community.

The diversity and representation of the LINK may be one of the factors on which the host is performance managed and it is written into the model contract contained in the *Getting Ready for LINKs guidance*, which aims to assist local authorities in their tendering for an organisation to host the LINK. In it, we recommend that one of the contractual duties of the host organisation will be to ensure that the LINK represents all sectors of its community.

### Small Firms' Impact Test

There will be no impact on small firms as a result of LINKs regulation making powers.

### Rural proofing

These plans are designed to give a local voice to people, allowing communities to express their views and influence the services in their area. The geographical area as well as population of the local authority areas for which LINKs will be established vary widely. The LINKs will therefore have to develop ways of working that suit their population, whether it be urban, rural, large or small. The amount of funding given to each local authority will be dependent on a formula that takes into account its population size and circumstances, therefore, all LINKs should have appropriate funding for their area. It will also be a requirement that LINKs take steps to ensure that all the people in their community have the opportunity to become involved, therefore, we do not believe that these plans should have any differential rural impacts.

### Title of proposal

#### **Future Structures for Patient and Public Involvement (PPI)**

#### *Purpose and intended effect*

#### Objective

1. These new proposals aim to establish new arrangements for the patient and public involvement system which fit the new NHS and social care structure. The aim of PPI is twofold: firstly, it aims simply to involve people in the commissioning and provision of services, which their taxes pay for. Secondly, we know that services are better, more convenient and more efficient when they are designed to suit those that use them. PPI aims to improve services by placing users at the centre of the design of these services. PPI therefore has a democratic value, as well as value in terms of improving people's experience of and confidence in services.

2. With 80% of the NHS budget being devolved to PCTs and the increase in joint commissioning between health and social care, commissioners will be the power base of the NHS system. It is therefore vital that mechanisms to support patient and public involvement are positioned at a level which can consider commissioning decisions, as well as more local provision, so that those affected by decisions can have a real influence over the services that are provided in their area. As well as being locally determined, we aim for a system which presents value for money by involving as many people as possible. We also want to ensure that a far greater proportion of the funds go directly to support local involvement activity.

#### Background

3. Currently patient and public involvement is supported through a system of patients Forums. Forums were established in the NHS Reform and Health Care Professions Act 2002, and there is one Patients' Forum for every NHS Trust (Acute Trusts, Foundation Trusts, Primary Care Trusts, Mental Health Trusts and Ambulance Trusts etc). Patients' Forums are supported by the Commission for Patient and Public Involvement in Health (CPPIH).

4. Currently, the total budget for PPI is c. £28m annually. These funds are given to CPPIH, £19m of which goes on direct Forum support with the remainder of funds being spent on central costs, including organisational costs of £4.5m, and costs in the delivery and supporting the delivery of Forums of just over £4.5m, which is of course, CPPIH's function. These delivery costs include the employment and training of CPPIH staff to fulfil those functions. There are currently around 400 Patients' Forums, although this figure changes as PCTs are reconfigured. Each Patients' Forum has on average 10/11 members who are volunteers appointed by CPPIH, meaning that the current system directly involves around 4200 people.

5. It was announced as part of the Arms Length Body Review in 2004 that CPPIH

would be abolished. The redirection of funds from the Commission for Patient and Public Involvement in Health (CPPIH) to the front line supports a wider agenda set by the Arms Length Body Review.

#### Rationale for government intervention

6.. The changing structure of the NHS, with an increasing plurality of providers and more focus on commissioning means that it is no longer appropriate to have a PPI system which is based around individual providers. In the current system, each Patients' Forum scrutinises the services of its individual body (hospital trust, specialist trust, PCT etc).

7. We wish to create a system of PPI which is capable of following the whole user experience, rather than looking at services in isolation. For this reason, we wish to create a system which can apply equally to health and social care, which can encourage involvement and input from people who use, or might use, any health or social care services in the area.

8. Currently CPPIH has the role of supporting Patients Forums and recruiting Forum members. Once CPPIH is abolished, there will be no means of supporting Forums, meaning that the existing system is unsustainable over the medium to long-term.

9. The changes in the health system, and the move towards joint commissioning of health and social care services also means that, unless updated, the current system will increasingly be unable to support user involvement in all relevant services.

#### **Consultation**

10. Department of Health officials and Ministers have been working closely with other government departments in the development of these proposals. As the proposals have a bearing on local government, and are closely related to government policy in this area, the Department for Communities and Local Government has been particularly involved in the development of these plans.

11. Following the publication of *Commissioning a Patient Led NHS* and the reconfiguration of PCTs, Ministers announced a strategic review of the PPI system. The review of PPI formed part of the consultation leading up to *Our health, our care, our say: a new direction for community services* White Paper, which was published in January 2006.

12. Following the publication of the White Paper an Expert Panel was established to consider all the evidence collected during the review and made recommendations to Ministers on the future for PPI. This evidence included the messages we heard from all those involved in the review activities. Forum members directly influenced the national review of PPI through a series of regional events in Autumn 2005 which over 150 Forum Members attended, as well as CPPIH staff and representatives from Forum Support Organisations, and through the online survey which received over 300 responses from Forum members. In addition, we received detailed email and written correspondence from a large number of Forum members.

13. Following the Expert Panel Report, Ministers published *A Stronger Local Voice*, in July 2006, a document for information and comment. This represented a limited

consultation on specific issues regarding the proposed policy, and was eight weeks long, given the extensive consultation that had already been conducted.

14. In addition, policy officials have held a number of workshops with key stakeholders to discuss policy development, and give those affected a chance to influence and shape these plans. This includes working with the Local Government Association, Local Government Representatives, NHS Representatives and people from the voluntary and community sector.

15. The Department held a national *Getting Ready for LINKs* event in December 2006 together with 9 regional events designed to increase awareness.

### ***Options***

16. Three options have been identified:

A) Do nothing;

B) Replace Forums with Local Involvement Networks (LINKs);

C) Replace Forums with LINKs and strengthen Section 242 (The duty on the NHS to involve and consult patients and the public)

### Option A – Do nothing

17. This would involve no change to the current arrangements for involving the public. This carries with it some risks:

- a. the current system is not engaging the public as widely as possible, as only 4200 people are directly involved in Patient Forums.
- b. Forums are based around NHS institutions in a system which is changing to have an increasing plurality of providers from different sectors. Currently the system is focused on individual institutions rather than the whole patient journey, the increase in joint commissioning between health and social care also means a more joined up system is required.
- c. once CPPIH is abolished there will be no means of supporting Forums, meaning that no members are recruited or trained, and there is no infrastructure to pay expenses.

### Option B – Replace Forums with Local Involvement Networks

18. The Government is already committed (in the Arms Length Body Review 2004) to abolishing the CPPIH as soon as legislation permits. As CPPIH supports Patients' Forums, this cannot be done without a change in the current system for supporting Patients' Forums.

19. In this option, Forums would be replaced by Local Involvement Networks (LINKs). There will be one LINK for every local authority with social service responsibilities, which are largely co-terminus with the new map of PCTs.

20. A LINK's activities would be:

- Promoting and supporting the involvement of people in the commissioning, provision and scrutiny of health and social care services;
- Obtaining the views of people about their health and social care needs;
- Gathering the views of people on their experiences of health and social care services;
- Enabling people to monitor and review the commissioning and provision of care services; and
- Conveying those views to organisations responsible for commissioning, providing, managing and scrutinising health and social care services, and making reports and recommendations to those bodies on how services may be improved.
- A LINK must prepare an annual report addressing such matters as the Secretary of State may determine, including details of any monies that have been spent in respect of the LINK and how those monies have been used sending a copy to the local authority that is providing funding, PCT(s), the SoS, their SHA, local OSC(s) and it should be publicly available.

21. It is intended that the powers of LINKs will be set out in regulations.

These include the power to:

- make reports and recommendations and receive a response within a specified timescale.
- request information and receive a response within a specified timescale.
- refer matters to an Overview and Scrutiny Committee and receive an appropriate response.
- enter and assess health and some social care premises.

22. We intend to conduct a full consultation, and produce a further IA on these powers before the secondary legislation is brought before parliament. These powers are, similar to those that currently exist for Patients Forums, however, the main difference is that they will largely extend to social care bodies as well, because LINKs will cover health and social care matters, whereas Forums only consider health issues.

This option (B) carries some potential risks:

- (i) Asking local authorities to procure a 'host' organisation to support the LINK could place an additional burden on local authorities. However, we intend to ensure that any additional burden is paid for out of the funds given to local authorities from the Department of Health. We estimated that the cost to local authorities to administer and monitor contracts with host organisations will vary according to the nature of their area and each local authority's infrastructure. As most local authorities already have procurement departments in place, we do not expect this cost to be too high, that is this month we have given £10,000 to each local authority to aid them in initial set-up and procurement.
- (ii) Possible disillusionment of Forum Members at a change in the system and the abolition of Forums. We are very clear that we hope that Forum members will become involved in the new system, and that their expertise

built up over the past years will be vital to the success of LINKs. We are sending out key messages to this effect. In addition, we are running Early Adopter Projects around the country to test out how LINKs will work in practice and to learn from the experience of Forums, and work on the transition arrangements.

- (iii) There have been concerns expressed that LINKs could be subject to being dominated by a vocal single issue group. It will be the responsibility of the 'host' organisation to ensure that LINKs seek to be representative of the concerns of the whole community. This is set out in the model contract specification, which we issued together with the £10,000 to assist local authorities in tendering for an organisation to 'host' the LINKs. This risk is no more likely than that which exists currently under the Patients' Forum arrangements.

### Option C – Replace Forums with LINKs and strengthen Section 242

23. This option would include all of Option B, and in addition, the requirement set out in Section 242 of NHS Act 2006, for NHS bodies to involve and consult the public would be clarified and strengthened in order to place a new duty placed on commissioners of healthcare to respond to these groups.

24. The updated Section 242 would state that all NHS organisations must have regard to statutory guidance issued by the Department of Health, in meeting the requirements of this duty.

25. The clarification seeks to ensure that the duty to consult users would only apply when developments and decisions affecting services would have a substantial impact on services. The aim is to ensure that consultation is only undertaken when a change is being considered that would have an actual impact on users of services and Departmental guidance would be issued to support this change. The objective is to ensure that all consultation undertaken is meaningful, and that 'consultation fatigue' is avoided.

26. This option carries some potential risks:

- i. It is not intended that this would extend to social care, meaning that there could be criticism that the legislation is not joined up across the system. However, there is a different legislative framework in place in the social care system, the duty to involve local representatives, which is also provided for in this Bill, will also mean that local authorities will safeguard and strengthen arrangements by which social care services are informed by the needs and experiences of the people using them.
- ii. There is potential for uncertainty about what constitutes a 'substantial' change, and when consultation should be undertaken. The Department of Health will work with key stakeholders, such as the NHS Confederation, to issue guidance on this in due course.

### ***Costs and benefits***

#### Sectors and groups affected

27. The proposals will affect those involved in the current system, such as Patient's Forum members, Forum Support Organisation staff and CPPIH staff. They will also affect commissioners, providers of health and social care services, patients and the public, as well as voluntary and community sector, who will have the opportunity to be involved in the new system.

28. Patient and public involvement is a significant challenge, potentially affecting all who use health and social care services.

## Benefits

### Option A – Do nothing

29. There will be no additional benefits from doing nothing. Over time, the system will become less effective and offer fewer benefits without CPPIH to support Forums. Currently £28m is spent on CPPIH, Forum support organisations and Patients' Forums. This money goes towards supporting the involvement of a relatively small number of people, and in that context, does not represent value for money.

### Option B – Replace Forums with Local Involvement Networks

30. There are two key benefits to Option B:

- a) the opportunity for the involvement of a greater number of people and a stronger voice for the community.
- b) better use of funds spent on PPI.

31. It is intended that the same amount of funding will go to the new system as is currently spent on PPI. These measures are not about saving money, but about better use of existing funds.

32. The new networks will provide a flexible vehicle for communities and groups to engage with health and social care organisations, and will promote public accountability in health and social care through open and transparent communication with commissioners and providers.

33. LINKs will aim to build on the existing expertise of the voluntary and community sector as well as current Patient Forum members, to tap into existing knowledge, assist good work already being done and build capacity in these areas.

34. The approximate annual spend for supporting CPPIH is £9m, which represents 32% of the total PPI budget. Whilst, CPPIH's work is dedicated to supporting Patients Forums, we believe that some of these funds could be better spent at the local level. For example, the cost of employing a CPPIH staff member to assist in recruiting members to Patients Forums could be better spent by employing someone at the local level to facilitate a LINK's activities, including seeking members and wider public involvement.

35. We expect the same amount of funding will go to the new system as is currently spent on PPI, however, the current £9m spent by CPPIH will be distributed, along with the rest of the funds, to local authorities to establish LINKs. There will of course still be administrative costs involved in undertaking LINK activities, however, spending money

at the local level offers particular advantages, not least, that each LINK will have control of its own funds which will be held for it by its host organisation. The LINK will be able to decide how best to spend them in support of their activity according to local need and circumstance.

36. We are unable to provide a detailed estimate of the costs of administering the new PPI system because of a lack of suitable data, likely differences in the circumstances/set-up of individual LINKs and because of difficulties discriminating between expenditure on policy costs and administration costs.

However, this proposal will have beneficial effects for all those involved in the PPI system:

- **For the public** – the new system will allow many more people to become involved in health and social care. A wider diversity of views will be heard, and local voice will be strengthened. The ultimate benefit of a wider-ranging PPI system is that more people will have the opportunity to be involved, in ways that suit them, in decisions about their health and social care system. This should lead to great clarity about priority setting, and improvement in services as they will be better shaped to suit the needs of those that use them.
- **For commissioners** – the LINK will provide commissioners with a first point of contact for involvement and engagement. It will be a pool of local knowledge and expertise which will help commissioners assess the needs of local populations. Involving the public through consultation with the LINK will be a way in which commissioners take decisions which best reflect the public's need.
- **For providers** – We hope providers will benefit from having a close working relationship with their LINK, who will be able to give them data on patients views from the information they gather, and assist them to improve their services. LINKs powers, for example the power to enter and view premises, will obviously have an impact on providers as well as commissioners of services. We will conduct a further Impact Assessment following our consultation on the regulations, which will set out these duties.
- **For Overview and Scrutiny Committees (OSCs)** – Local authority OSCs currently scrutinise health and social care services. LINKs will benefit OSCs as they will bring issues affecting the local community to the OSCs' attention for review. In addition, they will also be a resource for the OSCs to help them understand issues which the local community feel strongly about.

#### Option C – Replace Forums with LINKs and strengthen Section 242

37. This will include all the benefits listed under Option B. Decision making will be much more transparent, as PCTs will be required to explain how their decisions have been reached, and how they have taken account of local views. In addition, consultation activity will be more effectively targeted at those issues which affect patients most.

38. Much of the evidence we have heard from those involved in the current system, is that though members of the local community may be fully engaged, they are often frustrated as they cannot see how their views have affected decision making. The duty to respond will address this, as commissioners will be required to state how they have consulted with people, what views they have heard, and how they have taken these views on board. This should lead to a constant dialogue between the public and commissioners, involving the public at all stages of the decision making process, rather than merely consulting once decisions have been taken.

39. The duty should promote the meaningful involvement of patient and the public, where the public can see how their views are being taken on board. This should foster a better relationship between local communities and NHS bodies. This in turn could benefit commissioners and providers, as it will promote local buy-in for decisions taken, ultimately leading to a more effective dialogue.

### *Costs*

#### Option A – Do nothing

40. It has already been decided that CPPIH will be abolished, if Forums are not also replaced, then an alternative system to support Forums would need to be found, this would require funds to support, meaning that the savings from the abolition of CPPIH would most likely not be realised.

#### Option B – Replace Forums with Local Involvement Networks

41. The cost of managing the contracts of those supporting LINKs will be funded out of PPI budgets, so these will incur no additional cost for the local authority. Using the example of IMCA (Independent Mental Capacity Advocates), which uses a similar set up, whereby local authorities commission services and manage contracts, we predict that the commissioning and managing of contracts with hosts should not take more than 6 weeks of a local authority employee's time, and therefore should cost no more than between £10k - £15k.

42. There will be no additional costs arising from this option. The cost of establishing LINKs will be met by re-directing money from CPPIH and Forums once these are closed down. There will be no additional burden.

43. As the remit for LINKs extends to social care as well as health, this does mean that those responsible for commissioning and providing social care will be required to respond to approaches made to them by LINKs. For example, local authorities will be under a duty to respond to requests for information, and to the reports and recommendations made by LINKs. Although this could represent a new burden, the effect will be minimal as those responsible for commissioning and providing social care already receive many approaches from individuals, groups and organisations, and even the busiest of LINKs is unlikely to increase the burden by any noticeable amount.

#### Option C – Replace Forums with LINKs and strengthen Section 242

44. There could be very minimal extra costs associated with this option, as the duty to respond could require some additional work for staff working in PCTs to explain their decision making process.

However, we think that any extra costs will be negligible, as they will be off-set by the following factors:

- Some PCTs already involve, consult and respond to the public very well. For those performing well, this new duty will require no extra effort or resources.
- PCTs' consultations will be more efficient, as they will engage with a single LINK rather than a variety of different Forums representing different trusts. This will make consultation much more efficient, and PCTs will be able to use the expertise already existing in the voluntary and community sector to consult local people, and specifically hard to reach groups. (PCTs will of course need to continue consulting more widely than simply the Forum or LINK.)
- More explicit guidance on consultation will benefit PCTs as their duties will be clearer, and it will be easier for them to comply with rules regarding involving the public.
- There will be no additional costs on NHS or independent sector providers, as the current duties on NHS providers are only being clarified, not increased, and responsibility for involvement and consultation on services provided by the independent sector will continue to lie with the NHS commissioners.

Equity and fairness including race equality assessment

45. We consider that there will be no disproportionate effect on any group as a result of Options B and C. Option A, whilst imposing no effect itself, will do nothing to wider involvement of all sectors of the community.

<b>Screening Questions</b>	<b>Yes/No</b>
5. Do different groups have different needs, experiences, issues and priorities in relation to the proposed policy?	Yes
6. Is there potential for or evidence that the proposed policy will promote equality of opportunity for all and promote good relations between different groups?	Yes
7. Is there potential for or evidence that the proposed policy will affect different population groups differently (including possibly discriminating against certain groups)?	No
8. Is there public concern (including media, academic, voluntary or sector specific interest) in the policy area about actual, perceived or potential discrimination against a particular population group or groups (or potential or actual damage to good race relations)?	No

46. It is likely that different groups will have different needs, experiences and issues in relation to this policy. Some groups, for example, the elderly, or disabled, may need

extra help in being able to input their views into a LINK, or those who are socially unused to giving their opinions may need more encouragement to become involved. A LINK will need to make particular efforts to access the views of these groups, to ensure that they are able to represent the views of the entire community.

47. There is a potential for this policy, and the introduction of LINKs to have a great influence in promoting equality of opportunity. Currently Patient Forums have on average eight members each, this small number of people cannot hope to be representative of the whole community. LINKs will offer opportunities for many more people to become involved. They will also offer a much more flexible membership, people will be able to dip in and out of involvement in a way that suit them. Currently, the time requirement of being a Patients Forum member stops many people from volunteering because it is too onerous. We hope that offering people the opportunity to become involved in different ways will encourage much wider participation.

#### Steps to promote equality of access and representation

48. During the process of developing this policy, the question of equality of access and representation in LINKs has been a primary concern and this is reflected in the *Getting Ready for LINKs* guidance, which emphasises that a LINK should make efforts to be representative of the whole community.

49. The diversity and representation of the LINK may be one of the factors on which the host is performance managed and it is written into the model contract contained in the *Getting Ready for LINKs guidance*, which aims to assist local authorities in their tendering for an organisation to host the LINK. In it, we recommend that one of the contractual duties of the host organisation will be to ensure that the LINK represents all sectors of its community.

50. The impact this policy has in terms of diversity will also be monitored. There will be specific things that a host will need to report to their local authority on the work they have done to access the views of the whole community will be included in this. The Bill gives the Secretary of State the power to direct what LINKs activity must be addressed in their annual report.

#### ***Small Firms' Impact Test (SFIT)***

We envisage no impact on small firms as a result of this measure.

#### Rural proofing

51. These plans are designed to give a local voice to people, allowing communities to express their views and influence the services in their area. The geographical area as well as population of the Local Authority areas for which LINKs will be established vary widely. The LINKs will therefore have to develop ways of working that suit their population, whether it be urban, rural, large or small. The amount of funding given to each local authority will be dependent on a formula that takes into account its population size and circumstances, therefore, all LINKs should have appropriate funding for their area. It will also be a requirement that LINKs take steps to ensure that all the people in their community have the opportunity to become involved, therefore, we do not believe that these plans should have any differential rural impacts.

## Enforcement, sanctions and monitoring

52. A LINK must be held to account for its activities by the local community. It must provide evidence that it is delivering a credible work programme, based on local priorities, that meets local needs. This evidence needs to demonstrate active outreach and engagement with communities and the outcome of this work. It needs to demonstrate the impact the LINK has had on local health and social care provision.

53. The LINK will report to the Secretary of State for Health on an annual basis on its activities. The report will be independent of the local authority and be produced with the support of the host organisation. This report should also be made publicly available and provide details of:

- How much money was spent on the LINK at a local level;
- How many people were ‘involved’ and how – 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; and
- General themes about the health and social care needs of local people and about the perceptions of health and social care services.

54. Examples of the contents of the report were included in *Getting Ready for LINKs* guidance – thus enabling individual reports to be summarised into a National LINKs report at a later date. Depending on the outcome of the consultation on the draft regulations, the Secretary of State may also issue Directions on what should be included in the LINKs report.

55. The newly established NHS Centre for Involvement will have a specific focus to evaluate the effectiveness of PPI Policy and Practice and their outcomes, and so would have a role in monitoring LINKs. This does not have any additional cost implications as it has already been funded for the next two and a half years.

Option C – representing the updated Section 242 will be monitored by the Healthcare Commission, through their Core Standards which they inspect against.

56. In addition, the newly funded NHS Centre for Involvement will fulfil a support mechanism – disseminating best practice amongst NHS bodies, and offering advice on how to fulfil the duties set out in Section 242. This support will also make it easier for NHS bodies to be sure they are fulfilling their duties.

## ***Summary and recommendation***

57. In summary, we recommend Option C, that Patients’ Forums be abolished and Local Involvement Networks should be established in their place. In addition, we recommend that Section 242 should be clarified and strengthened, setting out duties to involve and consult the public on health services.

58. Whilst we recognise that there is uncertainty regarding costs and the monetisation of benefits, one of the factors behind the net cost attached to Option C is the difficulty of assigning a monetary value to the benefits. However, we believe that the changes proposed in Option C would represent a PPI system that matches the changes in the structure of the NHS as well as the closer working between the health and social care systems. It should also represent some significant improvements as it

should enable a far greater number of people to become involved in improving their health and social care services.