

EXPLANATORY MEMORANDUM TO

THE NATIONAL HEALTH SERVICE (DIRECTIONS BY STRATEGIC HEALTH AUTHORITIES TO PRIMARY CARE TRUSTS REGARDING ARRANGEMENTS FOR INVOLVEMENT) REGULATIONS 2008

2008 No. 2496

1. This explanatory memorandum has been prepared by Department of Health and is laid before Parliament by Command of Her Majesty.

2. Description

2.1 These Regulations make provision for Strategic Health Authorities (“SHA”) to direct Primary Care Trusts (“PCT”) concerning the arrangements for involvement under section 242(1B) of the National Health Service Act 2006 (“the NHS Act”). These Regulations also amend the National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulations 2002 to make provision for SHAs to exercise the Secretary of State’s general powers so that where a PCT has a duty to involve users in relation to the provision of health services for which it is responsible, SHA can involve those users in relation to those matters.

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

3.1 None

4. Legislative Background

4.1 Section 242(1B) of the NHS Act places a duty on certain NHS bodies, including SHAs and PCTs, to make arrangements to secure that users of health services for which those bodies are responsible are involved in the planning of the provision of those services and in the development and consideration of proposals for change or decisions made where those proposals or decisions have an impact on the way in which services are provided or the range of services provided.

4.2 Section 242B of the NHS Act 2006 gives the Secretary of State the power to make regulations enabling an SHA, in certain circumstances, to direct a PCT about arrangements for involvement.

4.4 Sections 242(1B) and 242B of the NHS Act 2006 are inserted by section 233 of the Local Government and Public Involvement in Health Act 2007.

5. Territorial Extent and Application

5.1 This instrument applies to England

6. European Convention on Human Rights

There are no human rights implications

7. Policy background

7.1 The Department of Health's view is that although over the past few years the NHS has improved at involving users in the development, planning and delivery of health services, involvement is not yet a mainstream activity alongside other policy and performance requirements and that NHS organisations view it as a marginal activity, largely centred on process and dependent on the commitment of individual managers.

7.2 World class commissioning, the Operating framework for 2008 - 09 and Lord Darzi's review reflect the shift of involvement to the forefront of the policy agenda and establish it as one of the key developmental challenges for NHS organisations. High performing organisations are increasingly mainstreaming and embedding involvement activity in all aspects of their work.

7.3 One of the policy objectives of Part 14 of the Local Government and Public Involvement in Health Act (patient and public involvement in health and social care) is to secure improved involvement of service users in the provision of health services by amending the duty placed on certain NHS organisations about involving users. The responsibility for making arrangements for involvement is with the NHS organisation responsible for providing those services and in the Department's view that is best placed to secure the efficient and effective involvement of users in certain circumstances. It has been recognised that in some circumstances SHAs were well placed to lead or coordinate the planning and delivery of involvement arrangements that secure effective and efficient involvement of users. Where involvement and consultation activity might span a number of PCTs there are benefits to be derived from the SHA making the arrangements for involvement activity rather than the individual PCTs but there existed no legal framework for this to happen without the PCT being at risk of failing to discharge the duty to involve under section 242(1B) of the NHS Act.

7.4 Section 242B allows the Secretary of State to make regulations that enable an SHA to give a direction to a PCT in certain circumstances. These regulations set out the circumstances when the SHA can issue such a direction.

A SHA can issue a direction to a PCT concerning involvement if:

- a) a Primary Care Trust has made or is to make arrangements under section 242(1B) to involve users in a particular matter; and
- b) those users will be involved under arrangements made by the Strategic Health Authority.

Directions can only be given where:

- a) in the opinion of the SHA, it would be more appropriate for the SHA to secure the involvement of users; and
- b) the arrangements made by the SHA would satisfy the duty placed on the PCT by section 242(1B).

7.5 The direction must be made in writing and specify the matter to which it relates. A direction can also be given where the PCT has already made its involvement arrangements; in these circumstances the direction from the SHA must specify which part(s) of the involvement arrangements the PCT is to conclude and how the involvement arrangements are brought to a close and communicated to stakeholders. An SHA may direct a PCT, in accordance with the regulations, to act jointly with the SHA to carry out the involvement activity.

7.6 Where a direction has been given by an SHA, the SHA and PCT must make available information that each other may require in order to make arrangements for involvement.

7.7 If an SHA directs a PCT not to involve users or to stop an existing involvement exercise, the PCT would not be in breach of its obligations to involve users under section 242(1B) of the NHS Act provided that it complies with the direction.

Consultation

7.8 These regulations were put out for consultation with key stakeholders from SHAs, PCTs and key external stakeholders such as Centre for Public Scrutiny and Health Link. Responses received were supportive but reinforced the need for supporting guidance.

Guidance

7.9 The Department will be publishing statutory guidance for NHS organisations on section 242(1B) and 242B of the NHS Act 2006. This will provide help and support for NHS organisations in understanding the provisions and impact of the regulations.

8. Impact

8.1 A Regulatory Impact Assessment is attached to this memorandum

9. Contact

Vince Roose at the Department of Health Tel: 02079725002 or email: vince.roose@dh.gsi.gov.uk can answer any queries regarding the instrument.

Summary: Intervention & Options

Department /Agency: Department of Health	Title: Impact Assessment of National Health Service (Involvement) Regulations 2008 (Regulations relating to Section 242 of NHS Act 2006)	
Stage: Final	Version: 1.1	Date: 2 May 2008
Related Publications: Local Government and Public Involvement in Health Regulatory Impact Assessment May 2007		

Available to view or download at:

<http://www>.

Contact for enquiries: Vince Roose

Telephone: 0207 972 5002

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

The primary purpose of the NHS is to provide healthcare services to patients and the public. In managing or administering any public service, the service provided is more likely to meet the needs and requirements of the service users if those users are involved in developing proposals for service development and change and if there is a clear mechanism for that involvement to feed through into decision making. It is widely recognised that NHS bodies were not sufficiently good at these processes. The NHS Act 2006 (amended by the Local Government and Public Involvement in Health Act 2007) seeks to address this by placing a duty of involvement on NHS bodies, under section 242 , 242A and 242B, and a new duty to report on consultation sections 17A and 24A. On some occasions where proposals span the SHA area, it is likely that the SHA will be well placed to secure more efficient and effective involvement arrangements rather than a number of PCTS acting independently ; these regulations enable SHAs to take a lead role or act jointly with PCTS

What are the policy objectives and the intended effects?

The policy objective of the regulations is to provide a mechanism to secure more efficient and effective involvement outcomes by allowing the SHA to take on, lead, coordinate or act jointly with the PCT(s) .

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

- Do nothing: Leave it to NHS bodies to interpret the act.
- Preferred option: provide regulations to allow the SHA to lead , coordinate and or act jointly with PCTS thereby securing effective and efficient involvement outcomes.
- Central direction: Provide detailed regulations setting out the type and style of information and consultation required

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 July 2011 - 3 years from the implementation date of 14 July 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:

.....Date:

Summary: Analysis & Evidence

Policy Option: 1	Description: Do nothing
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COSTS	ANNUAL COSTS	Description and scale of key monetised costs by 'main affected groups' Under the do nothing option, we would still expect PCTs to follow a process to comply with the primary legislation, but there will be a lack of clarity about when to inform, when to involve etc. The costs of do nothing are, by definition, zero.			
	One-off (Transition) Yrs				
	£ nil				
	Average Annual Cost (excluding one-off)				
	£ nil	Total Cost (PV)	£ nil		
Other key non-monetised costs by 'main affected groups' wide variation in interpretation. Some PCTs don't do enough, or are unclear about what to do. Some of the resource invested in informing or consulting will be inappropriately targeted.					

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

Key Assumptions/Sensitivities/Risks As for other options, costs and benefits are difficult to estimate. The do-nothing option would not detract from the benefits of the primary legislation, but the benefits would not be maximised because of inappropriate targeting of effort.

Price Base Year 2007-08	Time Period Years 10	Net Benefit Range (NPV) £ Not applicable.	NET BENEFIT (NPV Best estimate) £ nil
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What is the geographic coverage of the policy/option?	England & Wales			
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

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

Summary: Analysis & Evidence

Policy Option: 2

Description: Regulations to give powers to SHAs to lead coordinate or act jointly on certain areas of s242 responsibility.

COSTS	ANNUAL COSTS		Description and scale of key monetised costs by 'main affected groups' [DN: need to fill in this page once we've agreed the main text]
	One-off (Transition)	Yrs	
	£ nil		
	Average Annual Cost (excluding one-off)		
	£		
Total Cost (PV)			£
Other key non-monetised costs by 'main affected groups'			

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

Key Assumptions/Sensitivities/Risk

Price Base Year 2007-08	Time Period Years 10	Net Benefit Range (NPV) £	NET BENEFIT (NPV Best estimate) £
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What is the geographic coverage of the policy/option?		England & Wales	
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

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

Summary: Analysis & Evidence

Policy Option: 3

Description: To centrally direct or guide the type and style of consultation required to comply with s242.

COSTS	ANNUAL COSTS		Description and scale of key monetised costs by 'main affected groups'
	One-off (Transition)	Yrs	
	£ nil		
	Average Annual Cost (excluding one-off)		
	£		
Total Cost (PV)			£
Other key non-monetised costs by 'main affected groups'			

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

Key Assumptions/Sensitivities/Risks

Price Base Year 2007-08	Time Period Years 10	Net Benefit Range (NPV) £	NET BENEFIT (NPV Best estimate) £
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What is the geographic coverage of the policy/option?		England & Wales		
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

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

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

[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

The National Health Service Act 2006 set out duties, under section 242, for NHS organisations to make arrangements to secure the involvement of service users in:

- a) the planning and provision of services
- b) the development and consideration of proposals for changes in the way those services are provided and
- c) decisions to be made affecting the operation of those services.

This duty was set out alongside a range of duties for NHS organisations to involve and engage with patients and the public, principally via patient forums. The changing structure of the NHS, with an increasing plurality of providers and more focus on commissioning, means that those broader arrangements are no longer appropriate (since, for example, patient forums scrutinise the services of an individual NHS body rather than the range of services provided across a LA area). The Local Government and Public Involvement in Health Act 2007 took a new approach to engaging and involving public and patients. This included the establishment of LINKs (Local Involvement Networks) and the abolition of the Commission for Patient and Public Involvement in Health (CPPIH). This primary legislation was covered by its own Impact Assessment, and this is included at Annex A. Regulations on the implementation of LINKs were also covered by a separate impact assessment.

This impact assessment is concerned with the need to involve patients and users in decisions about the planning and commissioning of services. As in any public service, the service provided is more likely to meet the needs and requirements of the service users if those users are involved in developing proposals for service development and change and if there is a clear mechanism for that involvement to feed through into decision making. It is widely recognised that NHS bodies were not sufficiently good at these processes. The NHS Act 2006 sought to address this under section 242. However, a primary legislative lever, whilst placing clear responsibilities on NHS bodies, will not necessarily ensure that effective and optimised styles of consultation and involvement take place.

The primary legislation was refined in the 2007 act in two ways. Firstly, to require Secretary of State to make regulations extending the duty to consult on any 'prescribed matters' (242A). Second, giving SoS the power to make regulations enabling an SHA, in effect, to take over some of the involvement duties of a PCT and to require appropriate information flows in either direction to facilitate this process (s242B). It is this latter power with which this impact assessment is concerned. The primary legislation is an enabling power, and thus has no effect without the accompanying regulations. This impact assessment assesses the purpose of s242B, the options by which this purpose might have been achieved, and the cost and benefits of the preferred regulatory option alongside alternatives.

Policy objectives

The broad policy objective is to ensure appropriate levels of patients and public involvement in decisions about the planning and commissioning of services. Whilst the existing primary legislation under s242 implies a duty on NHS bodies to do this, there is a risk the PCTs and other NHS bodies will interpret the requirement in a wide variety of ways. The degree of consultation and involvement in some, or perhaps all, areas may be insufficient or ineffective.

The new section 242B, introduced as an enabling power in the 2007 act, provides one means of addressing this. It does so by allowing secretary of state to make regulations enabling SHAs to 'take control' of elements of the consultation process, by issuing directions to PCTs allowing them to take on some of the prescribed tasks allocated to PCTs in the primary legislation.

In this impact assessment we consider the options for making the consultation process work more effectively, and conclude that the preferred option is to make regulations using the powers in section 242B.

Options

1. DO NOTHING

2. PREFERRED OPTION - EXERCISE REGULATION MAKING POWERS to empower SHAs to 'take over' some of the consultation responsibilities from PCTs

3. IMPROVE CONSULTATION BY PROVIDING DIRECT GUIDANCE TO PCTS

[DN: Vince, we need a viable option 3 I think, just to demonstrate that we've given this some thought. Presumably this option is viable, although I'm not sure what powers we currently have to issue guidance in this field]

Consideration of costs and benefits

Option 1 – Do nothing

Under this option 'relevant bodies' (which means PCTs and Trusts) would retain full responsibility for delivering consultation arrangements, as envisaged in section 242 of the 2006 Act (as amended in section 233 of the Health Act 2007).

This would mean that PCTs would need to ensure that users are involved in:

- planning and provision of services
- development of proposals for ways in which those services may be altered
- decisions about the operation of those services.

There would be no direct cost of this option, since the responsibilities already exist in primary legislation. However, there would be no benefit either, over and above the benefits realised by the primary legislation.

It is possible that some PCTs would be unable to comply with the act, or that different PCTs would interpret the act with widely varying degrees of involvement. Some PCTs are likely to take a de minimis approach that would minimise any potential benefit from this important legislative change.

Option2 – Preferred option – Exercise regulation making powers

Under this option, it will be open to SHAs to direct PCTs not to carry out their responsibilities under section 242B and for the SHA to take on those responsibilities instead.

Precise costs of this option are difficult to estimate, but it is extremely unlikely that costs would exceed £5m per year, and hence it is unlikely that a final proposal impact assessment would be needed for this option.

Costs arise in this option when considering the administrative arrangements required to operate the regulations. These arise in two areas:

- Costs for PCTs and SHAs in producing the required information under section 5 of the regulations.
- Staff costs in the SHA in carrying out duties under section 242B.

There would be economies of scale in co-ordinating involvement work at SHA level and it is likely that any costs would be lower than those required for the do nothing option. As an illustration, suppose each SHA appoints two full time members of staff to fulfil this function, at a cost of £30,000 each per annum (including on costs). This is likely to be an overestimate, and we assume that it also captures the small quantities of staff time required by PCTs to provide information.

This estimate would imply a total cost of £600,000 per annum.

Benefits would involve substantial savings for those PCTs who are no longer required to carry out duties under s242B. At the very least, in cases where the SHA takes on the role for one PCT, the costs would exactly cancel out the benefits. If an SHA took on the responsibility for more than one PCT, the savings would already begin to outweigh the costs.

In addition to these administrative savings, there would be direct benefits which are difficult to quantify:

- A more consistent interpretation of the act across PCT areas
- Greater capacity for the SHA to share best practice ideas with those PCTs who retain lead responsibility
- Reducing or removing the risk that some PCTs would fail to comply with the act.

Option 3 – Issue guidance to PCTs

Under this option, the Department of Health would seek to address the difficulty that PCTs may have in understanding their duties under the primary legislation. They might do this by issuing guidance direct to PCTs to clarify the legal responsibilities, provide advice on how this might be interpreted, and provide a focal point for sharing best practice.

Costs would be at least as high as the do nothing. In addition there would be central costs in commissioning, collating and circulating the required guidance. For example, we might assume six months of time for one member of DH staff at a cost of £15,000.

Providing a more substantial focal point for best practice information would incur higher costs. For example, we might estimate that the cost of hosting an effective web portal would be 'at least £100,000'. There would be additional costs to 'exemplar' PCTs in producing the information to feed into such a system.

The benefits would be virtually no different from the do nothing option. It is likely, even in the do nothing option, that local PCTs will share some information on best practice approaches to this legislation. It is unlikely that a process of sharing best practice information would have a substantive impact without effective involvement of SHAs.

There are no specific powers in the act for DH to provide guidance on this area to PCTs, and the guidance would therefore have no direct legal standing. Guidance would be unable to

take account of local circumstances and local issues regarding interpretation of the act and it is unlikely that guidance in this area would substantively change the degree of involvement or consultation.

Summary and recommendation

In summary, we recommend Option 2, that the Government exercise regulation making powers

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.

Screening Questions	Yes/No
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.