



House of Commons
Health Committee

Patient and Public Involvement in the NHS

Seventh Report of Session 2002–03



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*Report and formal minutes, together with oral
evidence*

*Ordered by The House of Commons
to be printed 3 July 2003*

The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

Current membership

Mr David Hinchliffe MP (*Labour, Wakefield*) (Chairman)
Mr David Amess MP (*Conservative, Southend West*)
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Simon Burns MP (*Conservative, Chelmsford West*)
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Dr Doug Naysmith MP (*Labour, Bristol North West*)
Dr Richard Taylor MP (*Independent, Wyre Forest*)

The following Member was also a member of the Committee in the course of the inquiry.

Sandra Gidley MP (*Liberal Democrat, Romsey*)

Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the Internet via www.parliament.uk.

Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at www.parliament.uk/parliamentary_committees/health_committee.cfm. A list of Reports of the Committee in the present Parliament is at the back of this volume.

Committee staff

The current staff of the Committee are Dr J S Benger (Clerk), Jenny McCullough (Second Clerk), Laura Hilder (Committee Specialist), Frank McShane (Committee Assistant) and Anne Browning (Secretary).

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Footnotes

In the footnotes of this Report, references to oral evidence are indicated by 'Q' followed by the question number.

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1 Introduction

1. We aim to take oral evidence from each member of the ministerial team for health each year, and as part of this rolling programme of evidence sessions we invited David Lammy MP, then Parliamentary Under-Secretary of State for Emergency Care and Public Involvement, to come before the Committee to discuss his portfolio on 15 May 2003. We are very grateful to Mr Lammy for his co-operation with our work, and for his evidence to us on that occasion.

2. Our aim was not to conduct a full inquiry into any one aspect of his remit, and as such we did not seek oral or written evidence from any other source. However, we did want to question Mr Lammy on the policy surrounding patient and public involvement, and in particular the transition from Community Health Councils to the new systems and structures for patient and public involvement being introduced by the Government, because we knew they were a major cause for concern. Given the public attention surrounding the introduction of these reforms, and their huge significance for the NHS, we felt that if our concerns were to go unreported we would be missing a valuable opportunity to contribute to debate on this issue.

3. We would like to note at the outset of this report that David Lammy, who was appointed Parliamentary Under-Secretary of State for Emergency Care and Public Involvement in May 2002, was not involved in the development of these policies, rather he inherited them from a long line of government Ministers, most of whom dealt only briefly with this important area. In the three years since the launch of the *NHS Plan* in July 2000, patient and public involvement has been the responsibility of no fewer than four separate Ministers, none of whom held the patient involvement portfolio for much over a year.¹ Since we took evidence from Mr Lammy, responsibility for this area has now been passed on to another Minister, Rosie Winterton MP, Minister of State for Health.

¹ Gisela Stuart MP, Parliamentary Under-Secretary for Health 14 February 2000–14 June 2001; Hazel Blears MP, Parliamentary Under-Secretary for Health 15 June 2001–28 May 2002; David Lammy MP, Parliamentary Under-Secretary for Health, 29 May 2002–15 June 2003; Rosie Winterton MP, Minister of State for Health, 16 June 2003—

2 Background

4. Allowing patients the opportunity to have an input into the delivery of local NHS services, as well as enabling them to make complaints, has long been recognised as an important aim. Local Community Health Councils (CHCs), which have a statutory responsibility to represent the interests of patients and the wider community to the health service, were first established in 1974. However, in recent years, the needs, views and rights of NHS patients have rapidly ascended the political agenda, with the Government announcing in 2000 their “vision” of “a health service designed around the patient”.² While measures to improve access, convenience and quality of care for NHS patients form the mainstay of government policy, there have also been significant developments in terms of securing direct patient input into NHS services, and providing enhanced support to patients negotiating the NHS system.

5. CHCs were established in 1974 and have their statutory basis in section 20 of the National Health Service Act 1977, and schedule 7 to the 1977 Act. CHCs have a statutory duty to represent the interests of the public in the health service, to monitor the local operation of the health service, to give advice to health authorities, and to be consulted about substantial service changes. They also have the right to inspect health service premises, but not those premises belonging to GPs without obtaining the owners’ consent. About 500 people are employed full time by CHCs and 5,000 act as unpaid volunteers.³ CHCs have been instrumental in exposing several major NHS failures, including the actions of the disgraced gynaecologist Rodney Ledward in 2000. However, in recent years attention has also been directed towards the perceived weaknesses in CHCs, including: problems associated with the fact that they deliver three distinct functions (advocacy, advice and representation) from within one organisation; their failure to secure adequate representation from minority and young age groups; and the fact that they are located outwith local NHS organisations, potentially creating an unnecessarily adversarial relationship; and the fact that they had historically been unable to cover primary care services. All this formed the backdrop for significant reforms proposed in 2000.

Proposed government reforms

6. Speaking at the launch of the *NHS Plan* on 27 July 2000, the then Secretary of State announced the abolition of CHCs, but very little detail was given about the system that would replace them, causing concern amongst many MPs. The alternative arrangements came to light in a series of other announcements, and included the creation of Patient Advocacy and Liaison Services (PALS) and Patient and Public Involvement Forums (PPIFs); the establishment of Overview and Scrutiny Committees (OSCs) in local authorities, with the remit of holding the NHS locally to account; and the formation of an Independent Reconfiguration Panel to consider the merits of major reorganisations of services which have been contested locally.

2 Department of Health, *The NHS Plan: A plan for investment, a plan for reform*, Cm4818, July 2000, p 17

3 *Improving NHS Performance, Protecting Patients, Modernising Pharmacy and Prescribing Services: the Health and Social Care Bill*, Research Paper 01/01, House of Commons Library, January 2001

7. Provisions to abolish CHCs, to establish a duty on NHS bodies to secure public involvement in the planning of services, and to create OSCs and PPIFs were included within the Health and Social Care Bill in the 2000-01 Parliamentary Session. However, the idea of abolishing CHCs proved exceedingly controversial, and the clauses dealing with the abolition of CHCs and their replacement by PPIFs, Patients' Councils and a national patient body were all dropped when the Bill returned from the Lords to the Commons.

8. In September 2001, the Department of Health put forward new, more detailed proposals on patient involvement in the NHS in the form of a consultation document *Involving patients and the public in healthcare: a discussion document*, reiterating the Government's intention to replace CHCs with PPIFs in every NHS trust and PCT, and to create a national organisation to co-ordinate patient and public involvement in the NHS, the Commission for Patient and Public Involvement in Health (CPPIH).⁴ These reforms, in amended form, were finally implemented through the National Health Service Reform and Health Care Professions Act 2002.

Commission for Patient and Public Involvement in Healthcare

9. The Commission for Patient and Public Involvement in Healthcare, which was established as a statutory non-departmental public body on 1 January 2003 under the leadership of Sharon Grant, sees its own role as:

- Ensuring that NHS services take proper account of the views of the public;
- Providing and facilitating a framework for public involvement; and
- Acting as a champion for patients nationally.

10. The Commission will also channel and co-ordinate all information provided by the individual PPIFs, disseminate good practice to other PPIFs within England, and make representations nationally on key health issues.

PALS

11. According to *Involving patients and the public in healthcare*, PALS should have been established within each NHS Trust by April 2002, to provide on the spot help and information about health services and to act as a gateway to an independent complaints advocacy service (ICAS) where people would be able to obtain help in pursuing formal complaints. PALS are run internally by hospitals and accountable to the Trust Board. The remit of PALS is to:

- resolve problems on the spot;
- provide information to patients, carers and their families about local health services and put people in contact with local support groups;

4 Department of Health, *Involving Patients and the Public in Healthcare—a Discussion Document*, September 2001

- tell people about the complaints procedure and direct people to independent complaints advocacy support;
- act as an early warning system for trusts and PPIFs by monitoring trends and highlighting gaps in service and making reports for action to trust management. These recommendations and the trust/PCT response will be included in the annual patients' prospectus for the trust/PCT in question.

Independent Complaints and Advocacy Services

12. The Health and Social Care Act 2001 places a duty on the Secretary of State for Health to make arrangements for advocacy services to be provided to people wishing to make a complaint about their NHS care or treatment. The delivery of ICAS across the country is to be managed by the CPPIH, through Patient and Public Involvement Forums. A trial ICAS scheme is currently being piloted around the country, but these pilots are due to come to an end at the end of July.⁵

Patient and Public Involvement Forums

13. Patient and Public Involvement Forums (PPIFs), which have a different role, are now being introduced across the NHS and they are due to be introduced in every NHS trust and Primary Care Trust (PCT) by the end of 2003. The role of PPIFs is to influence the day to day management of health services by the Trust, and to monitor the effectiveness of the PALS and ICAS in their area. PPIFs will be run by independent organisations under contract to the CPPIH, to which they will be directly accountable, reinforcing their independence from the trust whose patients they serve. Each PPIF will have the right to appoint a member appointed as a Non-Executive Director on the trust board. The CPPIH will support and facilitate the co-ordination of PPIFs at a regional and a national level. According to the CPPIH:

the public, through the PPI Forums and with access to high quality information provided by the CPPIH, will be able to engage in decision making as never before. This will include the monitoring and shaping of the range and effectiveness of services provided by every Primary Care Trust and NHS Trust in England, as well as influencing the health related decision making of other public bodies. Our strategy is to establish a de-centralised system which provides support as close to the public as possible, and ensures local sensitivity. In this the regional offices will play a major part.⁶

5 *Patient and Public Involvement (PPI): the Future Picture*, Department of Health Position Paper, www.doh.gov.uk/involvingpatients

6 'Milestone achieved towards increased patient and public involvement', Commission for Patient and Public Involvement Press Notice, 1 May 2003, www.cppi.org

14. The PPIFs will each comprise volunteer members, recruited locally and trained appropriately. The forums once established will:

- be the main vehicle for the public to influence strategic priorities and day-to-day management of health services in their local area;
- be an independent critical friend on wider health matters in their community such as environmental health;
- review services from the patient perspective and monitor responses from local health services to complaints from patients.

15. The PPIFs' legal powers will include:

- the right to go where patients go, entering all buildings NHS patients use;
- the right to a response from the NHS to their recommendations;
- the right to refer concerns to local authority Overview and Scrutiny Committees;
- the right to a PPIF member as a non-executive director of the Trust;
- the right to raise concerns with more senior NHS management or a national body.

16. It is anticipated that there will be a total of 571 PPIFs, representing each of the 301 PCTs and 270 NHS trusts.⁷

⁷ 'Milestone achieved towards increased patient and public involvement', Commission for Patient and Public Involvement Press Notice, 1 May 2003, www.cppih.org

3 Discussion

17. Reforms to the ways in which patients and the public are involved in the NHS have already been subject to detailed scrutiny by Parliament. We do not wish to use this report to reopen arguments that that have already been comprehensively discussed elsewhere, believing instead that we, as a Committee, can play a far more useful role in scrutinising the ways in which the Government is now implementing the reforms enshrined in the National Health Service Reform and Health Care Professions Act. This was the main focus of our discussion with David Lammy. Mr Lammy implied that members of the Committee might be “fixated” on the old system of CHCs, which is far from the case.⁸ However, we feel that it is essential that those changes voted through by Parliament are implemented in a well-managed and logical way, consistent with assurances made in the House.

Implementation and transition

Introducing PALS

18. Patient Advocacy and Liaison Services (PALS) have been introduced incrementally across the NHS at the discretion of individual trusts. Mr Lammy informed us that at present 96% of NHS trusts have PALS.⁹ However, it does not seem to be possible to corroborate this figure with a central list of all the PALS in the country, as in answer to a written Parliamentary Question tabled on 30 October 2002 Mr Lammy told the House that this information is not collected centrally, arguing that it was “the responsibility of strategic health authorities to monitor Patient Action and Liaison Services”.¹⁰ **We find it astonishing that the Minister was unable to provide information on the extent to which Government policy was being implemented. Moreover we note with concern the recent ACHCEW survey, *A Friend in Need*, casts considerable doubt on the extent to which NHS trusts have functioning PALS over the country as a whole. We call on the Minister now to collate and publish information on the implementation of PALS as a matter of urgency.**

Introducing OSCs

19. Local government Overview and Scrutiny Committees should have been introduced by January 2003, and ministers have made frequent reference to their usefulness.¹¹ But again the Government appears to have little idea of the number that actually exist.¹² **While we appreciate that the machinations of local government are more properly an issue for the Office of the Deputy Prime Minister, we find it totally unacceptable that the Department apparently does not have access to basic information about an element of public involvement in the NHS it clearly views as so crucial, three months after it should have been introduced. This is particularly worrying given the vital statutory**

8 Q7

9 Q2

10 HC Deb. 30 October 2002 Col. 834W

11 Q4, Q7, Q15, Q27

12 HC Deb. 8 April 2003 403 Col. 237W

function of Overview and Scrutiny Committees with respect to proposed closures and reconfigurations in the NHS.

Introducing ICAS

20. The ICAS pilots will run until the end of July and will spend August closing cases or supporting individuals in preparation for the transfer of service to the new full ICAS provision. This will start across the country from 1 September 2003. During August PALS will also be signposting incoming cases to the new ICAS service. Evaluation of the pilots will inform development of national standards by the Commission for Patient and Public Involvement in Health in the future.

21. ICAS are meant to be the responsibility of PPIFs. However, with PPIFs not yet properly established, the Government has had to step in with an interim measure. The Department of Health is now in the process of establishing an interim system of national or regional ICAS, which will operate until PPIFs are established and in a position to take over responsibility for ICAS.

22. David Lammy gave us a categorical assurance that there would be full coverage, across every NHS trust, by an Independent Complaints Advocacy Service by 1 September 2003.¹³ However, his oral evidence appeared to reveal some confusion of PALS with ICAS, and about how advanced the process for setting up ICAS actually was. First he told us that contracts had already been issued, and then later in the session told us that a call for tenders had only just been put out.¹⁴ Given this confusion, it seems to us highly unlikely that Mr Lammy's commitment will be fulfilled.

Introducing Patient and Public Involvement Forums

23. PPIFs form the cornerstone of the new system for patient and public involvement, and as completely new organisations with a strategic function rather than a specific operational role such as information provision or complaints advocacy, they will arguably be the hardest organisations to get right. Furthermore with over 10,000 voluntary members needed to sit on the PPIFs, the establishment of PPIFs is clearly a large scale undertaking.¹⁵ Sharon Grant, Chair of the CPPH, told the CPPIH Board meeting in May 2003 that she felt it would take at least 3-5 years for PPIFs to be fully operational.¹⁶

24. It is clear that the implementation of such large scale system change is going to require a substantial lead-in time. We believe that with patient involvement, it is also particularly crucial that new arrangements are as clear and simple as possible, so that NHS patients, particularly those from disadvantaged groups, are able to negotiate the system with confidence and ease. It is particularly important that systems work well right from the beginning, as confusion at the launch of a system may erode the public's confidence in it, meaning it has failed before it has started.

13 Q7, Q39

14 Q4, Q15, Q17

15 Commission for Patient and Public Involvement, 'Patient and Public Involvement Forums Frequently Asked Questions', www.cppih.org

16 Private correspondence from Association of Community Health Councils for England and Wales (*not printed*)

25. However, there has been considerable confusion about the lead-in time for setting up PPIFs. From an initial commitment of early 2003, their expected start date has now been put back to 31 December 2003.¹⁷ When we put it to Mr Lammy that the difficulties in establishing a new system would leave a considerable hiatus when patients and the public would have access to neither a CHC or a PPIF, he responded repeatedly that this would not cause problems, as other systems, such as ICAS, PALS and OSCs would already be in place to bridge the gap.

26. For the reasons outlined above, we felt unable to share his confidence that there would be sufficient coverage from each of these organisations by 1 September 2003. But perhaps more worryingly, we felt that Mr Lammy's arguments demonstrated a misunderstanding of the important functional differences between each type of organisation within the new system for patient and public involvement. PALS' primary function is to provide advice on accessing hospital services, including complaints advocacy, and they are a service provided by, and firmly located within, the NHS. ICAS have a narrow remit focused exclusively on providing advocacy services for patients who wish to pursue complaints. OSCs, based within local councils, allow elected local councillors to scrutinise the delivery of healthcare in a given locality. But none of these organisations has the overview, independence, or direct means for patients to input into local services which is promised from PPIFs, and so they cannot, in our view, be described as an adequate replacement for CHCs, even as an interim measure. For a Minister charged with securing better patient and public involvement in healthcare, we are dismayed that at our evidence session Mr Lammy apparently failed to grasp the subtle but extremely important distinctions between the organisations which his Government is currently setting up.

27. Three weeks after giving evidence to us Mr Lammy announced that "to make the position absolutely unassailable" CHCs would remain in operation until 1 December 2003, "at which time all patient forums will be in place to take up this role".¹⁸ We welcome this move in as much as it acknowledges the necessity of ensuring that adequate provision is made for patient and public involvement at all times. However, several concerns remain. Firstly, the need to extend CHCs' period of operation will no doubt have placed those CHC staff who have not already left for alternative employment under great strain and created uncertainty. This extension will also give rise to widespread logistical problems. For example, many CHCs will have already had to give up the leases on the premises from which they operate, effectively rendering them homeless from 1 September 2003. This last date has been widely publicised as the date at which CHCs will close down, and any revision of it will no doubt lead to confusion amongst patients and the public as to where they should go to from September. **We welcome the Commission for Patient and Public Involvement in Healthcare's decision to set up a telephone helpline to help people negotiate the complex and confusing arrangements that will be in place from 1 September, but we feel strongly that with a little more foresight from the Government these problems could easily have been anticipated and avoided. The fact that these**

17 Department of Health, *Involving Patients and the Public in Healthcare: Response to the Listening Exercise*, June 2001, p24; Department of Health, *Local Authority Health Overview and Scrutiny—a Consultation Document*, January 2002, p21; 'Commission invites independent voice to shape the future in Health', Commission for Patient and Public Involvement Press Release, 7 March 2003, www.cppi.org

18 HC Deb. 4 June 2003, Col. 23W5

reforms have been under discussion for almost three years makes this lack of simple planning even harder to justify.

28. Furthermore, we have seen nothing as yet to support Mr Lammy's promise that all PPIFs will be in place by 1 December 2003. Information previously published by the CPPIH suggests a date of 31 December 2003, which was the date that Mr Lammy referred to himself when giving evidence to us.¹⁹ There have also been reports of numerous difficulties in establishing PPIFs, including a greatly truncated deadline for applications of interest, suggesting that if anything, the date at which PPIFs are fully operational is more likely to be put back than brought forward. **We urge the Government to ensure that the establishment of Patient and Public Involvement Forums is fully completed by 1 December 2003, to avoid further confusion and uncertainty for patients and NHS staff.**

29. Equally, setting up new organisations is a difficult process, and it often takes several months before they are operating at full capacity. With this in mind, it may be prudent to allow a period of overlap between CHCs and PPIFs, as was originally promised in Parliament.²⁰ **We urge the Government, in line with commitments made in Parliament, to extend CHCs period of operation until 1 July 2004, by which time PPIFs will have had sufficient time to develop their own systems and will be operating at full capacity.**

Unexpected changes

Appointment of staff to Patient and Public Involvement Forums

30. We were also very surprised to learn that, again contrary to commitments made in the House of Commons, the CPPIH, rather than appointing staff to PPIFs directly, is now delegating this function to local voluntary organisations. In evidence to us, Mr Lammy told us he felt that this distinction was not important in the least, and was in fact no different from a Member of Parliament delegating the appointment of junior office staff to an office manager. However, we feel that the delegation of appointment to PPIFs from the CPPIH to local voluntary organisations represents a significant departure from the policy originally discussed in the House.²¹ The CPPIH is an independent body charged with representing the interests of all NHS patients, and also, crucially, the interests of the wider public. Local voluntary organisations have typically sprung up to represent a particular group of patients or the public, for example people suffering from a particular medical condition, and as such their previous work has been narrowly focused on securing access and benefits for one very particular group of the population. To charge such organisations with appointing staff to PPIFs, which are intended to represent all types of service users as well as the wider public, certainly risks, at the very least, giving the impression that only a small group of users will be having an input.

19 'CPPIH moves to next stage on appointment of Local Network Providers', Commission for Patient and Public Involvement Press Release, 25 June 2003, www.cppi.org; Q4

20 Lord Hunt of King's Heath, HL Deb, 19 March 2001, Col.1253

21 Hazel Blears MP, HC Deb. 22 May 2002, Col. 319; Cols. 349-50

The 'one-stop shop' approach

31. The idea of a 'one-stop shop' has attracted considerable support in the NHS in recent years, offering, as it does, an opportunity for patients and the public to gain quick and easy access to the services or information they want without the need to negotiate a multiplicity of different systems, organisations and individuals. Supporters of CHCs have argued that CHCs provided precisely that, and that the new system risked fragmentation of a previously seamless service. Ministers have strongly refuted this claim, promising that the new system will indeed provide a 'one-stop shop'.²²

32. However, the confused transition arrangements surrounding the implementation of the new system mean that over the coming years, a time when it is crucial for patients to exert a strong force for change in the NHS, there may in fact be up to seven different types of organisation over the next two to three years. PALS or, in the short term, CHCs, will be the first point of contact, with PPIFs being established in December. A patient with a complaint may then be referred to an ICAS pilot (up until July 2003), then be transferred to a new national ICAS service, and then finally to a new ICAS service implemented by the PPIF at some date in the future.

Patient and public involvement in Foundation Trusts

33. Another complication to the system is that, if the Government's plans for introducing Foundation Trusts come to fruition, a growing number of NHS organisations will not be directly served by a PPIF at all. If, as the previous Secretary of State hoped, within four to five years all NHS trusts will have moved to Foundation status, the PPIFs planned to be established by December 2003 could be in operation for a total period of three years, about the same amount of time that the Government has spent preparing and introducing the policy of PPIFs. In answer to a Parliamentary Question tabled in April 2003, Mr Lammy said that he was unable to provide an estimate of the redundancy costs associated with the abolition of CHCs.²³ However, as CHCs across the country employ around 700 staff these are likely to be considerable. It is now possible that the public purse will be facing costs of the same order over the next five years as PPIFs are scrapped when NHS trusts attain Foundation status.

34. We were told by the then Secretary of State that the new arrangements proposed for Foundation Trusts represented a far better form of public involvement than PPIFs, a conclusion we were not able to accept in our report on Foundation Trusts.²⁴ While we explored this issue at great length in our inquiry on Foundation Trusts, we feel it is necessary again to register our amazement that throughout the arduous and comprehensive discussions that preceded the introduction of the new system for patient and public involvement, the Government's plans for a second, more radical overhaul of patient involvement, through the establishment of Foundation Trusts with elected Boards of Governors, were never brought to light. Had the connections between these two divergent and conflicting policies on patient and public involvement been

22 Hazel Blears MP, HC Deb. 22 May 2002, Col. 320; Lord Hunt of Kings Heath, HL Deb, 13 February 2003, Col. 896

23 HC Deb, 10 April 2003, 403 Col. 374W

24 Health Committee, Second Report of Session 2002-03, *Foundation Trusts*, HC395, para 37

drawn out before the new system began to be implemented, the issue of how Boards of Governors and PPIFs might relate to each other and work together could have been very profitably explored, and perhaps a coherent policy involving the best elements of both could have been developed. As it is we are left with the impression that some policy within the Department of Health is formulated in total isolation from other policy, leading to the ridiculous situation the NHS and its patients are now faced with the introduction of two parallel but entirely different systems of patient and public involvement within the NHS within one year.²⁵

25 This report was agreed before the Health and Social Care (Community Health and Standards) Bill reached Report stage. We note that amendments agreed in Committee stage may lead to the extension of PPIFs to Foundation Trusts.

Conclusions and recommendations

1. We find it astonishing that the Minister was unable to provide information on the extent to which Government policy was being implemented. Moreover we note with concern the recent ACHCEW survey, *A Friend in Need*, casts considerable doubt on the extent to which NHS trusts have functioning PALS over the country as a whole. We call on the Minister now to collate and publish information on the implementation of PALS as a matter of urgency. (Paragraph 18)
2. While we appreciate that the machinations of local government are more properly an issue for the Office of the Deputy Prime Minister, we find it totally unacceptable that the Department apparently does not have access to basic information about an element of public involvement in the NHS it clearly views as so crucial, three months after it should have been introduced. This is particularly worrying given the vital statutory function of Overview and Scrutiny Committees with respect to proposed closures and reconfigurations in the NHS. (Paragraph 19)
3. We urge the Government to ensure that the establishment of Patient and Public Involvement Forums is fully completed by 1 December 2003, to avoid further confusion and uncertainty for patients and NHS staff. (Paragraph 28)
4. We urge the Government, in line with commitments made in Parliament, to extend CHCs period of operation until 1 July 2004, by which time PPIFs will have had sufficient time to develop their own systems and will be operating at full capacity. (Paragraph 29)
5. We were told by the then Secretary of State that the new arrangements proposed for Foundation Trusts represented a far better form of public involvement than PPIFs, a conclusion we were not able to accept in our report on Foundation Trusts. While we explored this issue at great length in our inquiry on Foundation Trusts, we feel it is necessary again to register our amazement that throughout the arduous and comprehensive discussions that preceded the introduction of the new system for patient and public involvement, the Government's plans for a second, more radical overhaul of patient involvement, through the establishment of Foundation Trusts with elected Boards of Governors, were never brought to light. Had the connections between these two divergent and conflicting policies on patient and public involvement been drawn out before the new system began to be implemented, the issue of how Boards of Governors and PPIFs might relate to each other and work together could have been very profitably explored, and perhaps a coherent policy involving the best elements of both could have been developed. As it is we are left with the impression that some policy within the Department of Health is formulated in total isolation from other policy, leading to the ridiculous situation the NHS and its patients are now faced with the introduction of two parallel but entirely different systems of patient and public involvement within the NHS within one year. (Paragraph 34)

Formal minutes

Thursday 3 July 2003

Members present:

Mr David Hinchliffe, in the Chair

Mr John Austin
Dr Doug Naysmith

Dr Richard Taylor

The Committee deliberated.

Draft Report (Patient and Public Involvement in the NHS), proposed by the Chairman, brought up and read.

Ordered, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 34 read and agreed to.

Resolved, That the Report be the Seventh Report of the Committee to the House.

Ordered, That the provisions of Standing Order No. 134 (Select Committees (reports)) be applied to the Report.

Several papers were ordered to be appended to the Minutes of Evidence.—(*The Chairman.*)

Ordered, That the Appendices to the Minutes of Evidence taken before the Committee be reported to the House.—(*The Chairman.*)

[Adjourned till Thursday 10 July at 10.00 am.]

Witnesses

Thursday 27 March 2003

Page

David Lammy, a Member of the House of Commons, Parliamentary Under-Secretary, Department of Health

Ev 1

Reports from the Health Committee since 2001

The following reports have been produced by the Committee since the start of the 2001 Parliament. The reference number of the Government's response to the Report is printed in brackets after the HC printing number.

Session 2002–03

First Report	The Work of the Health Committee	HC 261
Second Report	Foundation Trusts	HC 395
Third Report	Sexual Health	HC 69
Fourth Report	Provision of Maternity Services	HC 464
Fifth Report	The Control of Entry Regulations and Retail Pharmacy Services in the UK	HC 571
Sixth Report	The Victoria Climbié Inquiry Report	HC 570

Session 2001–02

First Report	The Role of the Private Sector in the NHS	HC 308
Second Report	National Institute for Clinical Excellence	HC 515
Third Report	Delayed Discharges	HC 617