REFGOV

Reflexive Governance in the Public Interest

Services of General Interest

REFGOV Case Study – Final Report

Patient and Public Involvement in Healthcare Governance
Summary and Institutional Recommendations
England and Wales

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REFGOV CASE STUDY – FINAL REPORT

Patient and Public Involvement in Healthcare Governance: England and Wales

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Introduction

This Report begins by introducing the UK healthcare case studies on patient and public involvement (PPI), explaining differences in the coverage of the subject-matter in England and Wales. The second section outlines the statutory framework for the NHS in England and Wales following devolution of power to the Welsh Assembly in 1999. Part 3 sketches the main features of the first wave of modern PPI reforms in England in the period 2000-2006. Part 4 highlights the deficiencies of this PPI system as reflected in Government reviews and Parliamentary scrutiny, and in academic policy analysis. Part 5 describes the 'new regulatory landscape' of further reforms introduced in England by legislation in 2007 and 2008. Parts 6 and 7 discuss respectively the divergent policies on PPI followed in Wales and some limitations of the Welsh approach. Part 8 considers the prospects offered by the PPI systems in England and Wales for improved healthcare governance from a social learning perspective. The conclusion suggests that, while PPI policies tend to be justified in terms of increasing both democratic legitimacy and the responsiveness of public services to local needs, there is a further rationale in the establishing of conditions and building of capacities for social learning.

1. PPI case studies – background and theoretical framework

PPI provides an obvious focus for the study of reflexive governance. Health services are necessarily co-produced by medical professionals and patients, who arguably also have an important part to play in the effective organization and management of healthcare. The involvement of patients and other stakeholders is clearly amenable to analysis in

terms of the theory of social learning set out in the Synthesis Reports.[1] Furthermore, while policy initiatives aimed at increasing participation have been a feature of UK healthcare policy for many years, the contrasting implementation of PPI in England and Wales offers scope for rich comparison. PPI has acquired a fresh impetus in England through radical organizational reforms under the Local Government and Public Involvement in Health Act 2007 and the Health and Social Care Act 2008, while Wales is adopting an incremental approach to reform building on more traditional structures.[2]

Our analysis in the two countries is conditioned by such differences. In England we consider how the PPI system implemented after 2000 is being reformed under the 2007 and 2008 Acts. The main sources for this part of the research are government policy documents (Green and White Papers), parliamentary committee reports, and the legislation itself. The principal aim here is to provide a critique of the new governance framework, focusing on its potential to facilitate (or impede) the development of institutions and processes for the involvement of patients and other stakeholders that are necessary pre-conditions of effective social learning. In Wales, where autonomy from Westminster following devolution has resulted in a more moderate approach to reform and a greater degree of continuity in healthcare policy, the emphasis is more on policy implementation and the practical operation of relatively stable governance arrangements in securing such conditions.

Before proceeding further, we summarise the REFGOV theoretical perspective outlined in the second synthesis report, and indicate how this framework will be adapted in our analysis of the conditions of social learning in healthcare governance in contemporary Britain. In REFGOV terms, PPI initiatives in England and Wales will be evaluated with reference to the potential of the different PPI governance arrangements to facilitate the development of institutions and processes that are conducive to more effective social learning.[3] The basic criterion of the adequacy of governance is the degree of reflexivity in the organisation of conditions of social learning in collective actions to resolve problems in the general interest. Reflexive governance (here equated with 'maximisation of fulfilment of normative expectations held by participants in a collective action'[4]) cannot result spontaneously from the expression of individual preferences, as assumed by neo-classical economics, but requires instead the creation and maintenance of specific institutional conditions. Such conditions vary according to the particular analytical level (economic institutionalist, collaborative/relational, pragmatic, or genetic) at which the evaluation of reflexivity of learning operations is conducted. The four approaches and their associated conditions are supplementary rather than mutually exclusive – each adding value in building our understanding of the

1 J. Lenoble and M. Maesschalck, 'Beyond Neo-institutional and Pragmatist Approaches to Governance', Working Paper Series: REFGOV-SGI/TNU-1, Centre de Philosophie du Droit, UCLouvain 2006; 'Reflexive Governance: Some Clarifications and an Extension and Deepening of the Fourth (Genetic) Approach', Working Paper Series: REFGOV-SGI/TNU-2, Centre de Philosophie du Droit, UCLouvain 2007.

2 D. Hughes and P. Vincent-Jones, 'Schisms in the Church: NHS Systems and Institutional Divergence in England and Wales,' (2008) 49 *Journal of Health and Social Behaviour* 400.

3 In section 4 below, we point to the limitations of an evaluative approach conducted in terms of the imbalance of power between bureaucrats/professionals on the one hand and patients/citizens on the other hand, as is typical of much academic and policy analysis. It should be clear that the focus on social learning does not deny the importance of power relations, or of 'empowerment' in the sense of capacitation.

4 J. Lenoble and M. Maesschalck, 'Reflexive Governance: Some Clarifications and an Extension and Deepening of the Fourth (Genetic) Approach', Working Paper Series: REFGOV-SGI/TNU-2, Centre de Philosophie du Droit, UCLouvain 2007.

role of reflexivity in social learning, rather than displacing or simply superseding the less developed approach.

(1) The first conception of social learning, implicit in the new institutional economics, emphasizes the need for external ordering or coordination of economic interaction through institutions designed to improve efficiency by altering incentives and representations among local economic actors. In section 8 below, we analyze this aspect of healthcare governance in England and Wales under the heading: *economic coordination*.

(2) At the second level of analysis (referred to variously as deliberative, collaborative/relational, and dialogic) the focus is on the development and aggregation of communicative competencies, through the design of specific fora of representation and negotiation combined with 'capacitation' strategies directed at strengthening argumentative capabilities and increasing opportunities for dissent and counter-argument in dialogic processes. We discuss this dimension under the heading: *capacitation and communicative competence*.

(3) The third, pragmatist approach specifies two further sets of conditions of success of learning operations: (i) Democratic experimentalism builds on the deliberative conditions established at the second level by emphasizing the 'experimentalist' forms of joint inquiry and investigation in which social actors must engage in order to achieve effective social learning, involving specific techniques of benchmarking, co-design, and learning by monitoring. Here we use the sub-heading: *experimentalism and joint inquiry*. (ii) The Schönian strand of pragmatism re-focuses attention on the issue of capacitation of social actors, with reference to specific cognitive processes of representation and re-representation, the adjustment of frames and reframing, and governance techniques capable of overcoming 'defensive strategies' and of challenging preconceptions and hitherto entrenched positions of social actors and stakeholders in the healthcare environment. We consider this aspect in terms of *capacitation and cognitive reframing*.

(4) The fourth, genetic approach to social learning specifies conditions of collective identity-making and reframing going beyond the simple substitution or replacement of one representation by another – the major purported limitation of the second pragmatist strand. In the language of the second synthesis report, fully reflexive governance in the learning operation is said to be dependent on the process of 'terceisation'. Analysis in terms of the genetic approach is beyond the scope of this overview, and will be considered in a separate case study of the changing role of NGOs (non-governmental organizations) in health and social care networks.[5] For the purposes of our preliminary survey of the conditions of social learning in healthcare governance in England and Wales, this approach is subsumed under *capacitation and cognitive reframing*.

The analysis in both countries draws on empirical research currently being conducted in four local health economies in England and Wales in a project linked to but separate from REFGOV, funded by the UK Department of Health.[6] The PPI case studies explore three overlapping aspects of healthcare governance: patient and public involvement in the commissioning of secondary care; the role of bodies representing the patient and public interest; and the regulation of involvement.

(a) Patient and public involvement in commissioning

[5] C. Mullen and P. Vincent-Jones, 'The Changing Role of NGOs in Healthcare Governance'.

[6] NIHR Service Delivery and Organisation Programme, 'Contractual Governance in a System with Mixed Modes of Regulation.'

The introduction of the NHS internal market in 1991 replaced centralized planning with a commissioning system in which health authorities purchased care on behalf of patients from semi-autonomous NHS Trusts on the basis of negotiated contracts.[7] PPI initiatives may be understood as part of the attempt to counter the tendency of the contractual process to exclude the interests of stakeholders who are not party to the principal exchange by enabling citizens to be 'connected' with commissioning and other aspects of healthcare governance through the operation of mechanisms of voice and/or choice.[8]

In England, Primary Care Trusts (PCTs) choose among competing providers in the public and independent sectors in purchasing secondary care services on behalf of patient populations. Contracts with NHS Foundation Trusts are legally binding in the same way as contracts with private and non-profit providers. Prices are fixed nationally, so competition is restricted to quality. Remuneration 'follows the patient' through a system of 'Payment by Results', according to tariffs based on health resource groups (HRGs). In addition to choice exercised by the PCT, patients may be directly involved in the selection process through a computerised 'Choose and Book' scheme which, when fully implemented, will allow choice among at least four providers of hospital operations.[9] The choice (made in consultation with a general practitioner) cannot, at least in theory, be blocked by the PCT. The encouragement of choice has an explicit economic purpose, intended to influence the pattern of commissioning by enhancing quasi-market competition and incentives on service providers. However, patient involvement in commissioning is not just about choice. Patient *voice* is presented in policy documents: (i) as a necessary supplement to choice, 'shaping and extending the range of choices/opportunities on offer'; and (ii) as a means of ensuring the 'best fit' or responsiveness of services to patient needs and preferences, through improved communication between patients and the PCT responsible for purchasing and specifying services on their behalf.[10]

By contrast in Wales, the purchaser-provider split has entailed less competition and a greater emphasis on partnership and 'collegiate contracting' with hospital providers that remain more firmly within the NHS. Since there are no corporatized semi-independent NHS Foundation Trusts, contracts between Local Health Boards (LHBs) and NHS providers are not legally enforceable. Prices are fixed locally through negotiation rather than nationally. Besides reduced choice and diversity of service provider compared with England, there is a lack of direct patient choice of secondary care. In the comparatively

[7] An alternative form of economic organization, also combining an element of public control with market incentives, involves *integration* of purchaser and provider functions in Health Management Organisations, with competition between them – see C. Ham, *Commissioning in the English NHS: The Case for Integration* (London: The Nuffield Trust, 2007).

[8] PPI includes policies encouraging involvement in economic as well as political processes – see A. Thompson, 'The Meaning of Patient Involvement and Participation in Healthcare Consultation: A Taxonomy' (2007) 64 *Social Science and Medicine* 1297 (distinguishing the 'consumerist' model of involvement espousing individual choice and the power of 'exit' when dissatisfied, from the 'democratic' model espousing collective freedom and emphasizing 'voice' as a direct mechanism for exerting change).

[9] The fourth principle of public sector reform adopted by New Labour following the 2001 general election was 'more choice for customers and the ability, if provision is poor, to have an alternative provider' (Cabinet Office, 'The Second Phase of Public Sector Reform: the Move to Delivery', 22 March 2002) (http://www.cabinet-office.gov.uk/eeg/secondphase.htm). Choice in this sense remains a central plank in the present government's modernisation program. The choice agenda was reinforced by the policy statement, 'Creating a Patient-led NHS', following the reform strategy set out in the NHS Development Plan in June 2004. The role of PCTs is not to direct patients to particular providers, but to offer a choice amongst local NHS hospitals, Foundation Trusts, and 'nationally procured' Independent Sector Treatment Centres (ISTCs).

[10]

limited 'Second Offer' scheme that has been introduced as a temporary measure in Wales, patients may be offered an alternative hospital for an operation where the standard waiting list time is exceeded. Here 'choice' is restricted to a yes or no answer, and many patients do not take up the second offer. Since there is no intention that the patient's involvement should subject commissioners or providers to incentives, or directly influence the pattern of commissioning by LHBs, 'voice' also carries different connotations. The most recent reforms in Wales have seen the abolition of the purchaser-provider split and even the replacement of the concept of 'commissioning' by that of planning.

Our on-going research in the two countries is examining the different forms of patient and public involvement in commissioning and service planning with reference to the institutional economics and collaborative/relational approaches to social learning. English reforms directed at strengthening competitive incentives and improving the quality and availability of information to commissioners and patients are clearly illustrative of economic institutionalism. In Wales as well as England, social learning presupposes communicative competence both in relations between the various parties involved in the planning and production of services, and in their relationship to patients and the public more generally.

(b) The role of representative bodies

As described in detail below, the government in England has sought to increase stakeholder involvement through the replacement of Community Health Councils (CHCs) by a plethora of new representative bodies. Some of the bodies created after 2000 will themselves be abolished, or their roles redefined, under the 2007 Act. The legislation has also established a completely novel type of representative organization in the form of Local Involvement Networks (LINks). In Wales, the voice agenda is more concerned with increasing democratic legitimacy through improved stakeholder representation in political processes at both local and national levels. To this end Wales has retained the twenty or so Community Health Councils (abolished in England in 2003) and indeed extended their remit.

We are examining the role of representative bodies primarily with reference to the collaborative/relational and pragmatic (democratic experimentalist) conceptions of social learning. In the past such bodies may be regarded as having been more or less deficient (as 'channels of communication') in *presupposing* the existence of cognitive, institutional, and personal capacities on the part of patients, users and other stakeholders that are necessary for their effective participation in, and contribution to, social learning. We are comparing how far the conditions of more effective social learning in this sense may be being established in England and Wales through contrasting strategies of capacitation, combined in the former country with radical institutional reform, and in the latter with the flexible adaptation and evolution of traditional representative structures.

(c) Economic regulation and the regulation of involvement

In England the PPI reform agenda includes stronger and more integrated economic regulation under the Health and Social Care Act 2008, with the merger of three existing regulatory bodies (the Healthcare Commission; the Commission for Social Care Inspection; and the Mental Health Act Commission) into a single agency – the Care Quality Commission (CQC) – with increased powers analogous to established models of independent regulation in the privatized public utilities sector. This part of the reform agenda is clearly amenable to analysis in terms of economic institutionalism.

In addition, however, under the 'New Framework for User and Public Involvement' introduced by the 2007 legislation, certain NHS organisations are being required to respond to patients and the public in planning and decision-making (strengthening the existing duty under the Health and Social Care Act 2001 to 'involve and consult'). Commissioners of services are under a duty to report regularly on what they have done differently as a result of consultations. As regards the 'regulation of involvement', the CQC has powers to develop assessment criteria whereby the performance of NHS bodies in involving patients and public may be taken into account in Annual Performance Reviews. This part of the reform agenda in England is considered with reference to the second (Schönian) strand of the pragmatic approach, together with the genetic approach to social learning. Here we are investigating the social learning potential of requirements on the part of commissioners of healthcare to 'respond' to patients and public, and to 'report' on what they have done differently as a result, compared with more narrowly construed legal duties to consult and involve.

2. Statutory framework and devolution

Despite different policy processes and administrative structures in England and Wales, the organisational framework of the NHS has traditionally been governed by primary legislation of the Westminster Parliament applying to both countries. Prior to the consolidation of legislation in separate Acts,[11] the common statutory framework consisted of the National Health Service Act 1977, amended and supplemented by the National Health Service and Community Care Act 1990, the Health Authorities Act 1995, the National Health Service (Primary Care) Act 1997, the Health Act 1999, and the Health and Social Care Act 2001. The Health Act 1999 abolished GP fundholding in England and Wales, made provision for the establishment, functions and funding of PCTs, and reformed the legislative framework governing NHS Trusts. The Health and Social Care Act 2001 imposed a duty on NHS organisations (each Health Authority, PCT, and NHS Trust) in England and Wales to make arrangements with the aim of involving patients and the public in the planning and decision making processes of that body, and provided for the creation of Overview and Scrutiny Committees to scrutinise NHS bodies and represent local views.[12]

The Government of Wales Act 1998 devolved powers to the National Assembly for Wales and the Wales Assembly Government (WAG) in a number of areas, including

[11] See National Health Service Act 2006, and the National Health Service (Wales) Act 2006, together with the National Health Service (Consequential Provisions) Act 2005. The purpose of the consolidation is to make the statutory framework more accessible, rather than to effect substantive legal changes. The Acts affected by consolidation are: Health and Social Care (Community Health and Standards) Act 2003; National Health Service Reform and Health Care Professions Act 2002; Health and Social Care Act 2001; Health Act 1999; National Health Service (Private Finance) Act 1997; National Health Service (Primary Care) Act 1997; National Health Service (Residual Liabilities) Act 1996; Health Authorities Act 1995; National Health Service and Community Care Act 1990; Health and Medicines Act 1988; Hospital Complaints Procedure Act 1985; Health and Social Security Act 1984, Health Services and Public Health Act 1968, and the Ministry of Health Act 1919.

[12] The majority of provisions of the Health and Social Care Act 2001 were implemented at different times as specified in separate statutory instruments in England and Wales. For example, section 11 was brought into effect in Wales on 1st December 2002 by Welsh Statutory Instrument 2002 No. 1475 (W.147)(C.41) [The Health and Social Care Act 2001 (Commencement No.2)(Wales) Order 2002]. Section 13 (on Assembly intervention powers) was brought into effect by Welsh Statutory Instrument 2003 No. 713 (W.87)(C.36) [The Health and Social Care Act 2001 (Commencement No.4)(Wales) Order 2003].

education, local government, social services, and health and health services.[13] While the devolution settlement retained ultimate powers to legislate on the NHS within the UK Parliament, it nevertheless heralded the beginning of a period of increasing divergence in health policy in England and Wales. The most radical reform of the structure and organisation of the NHS since devolution has occurred through primary legislation applying to England only. The National Health Service and Health Care Professions Act 2002 modified the structural framework of the health service in England by replacing Health Authorities (HAs) with Strategic Health Authorities (SHAs), responsible for the performance management function for the health services provided within their boundaries. Most of the functions of the old HAs were transferred to PCTs. In Wales, the Act made separate provision for the creation, functions and funding of Local Health Boards (LHBs), in effect extending the role of existing Local Health Groups. It placed a duty on each LHB and each Local Authority to formulate and implement a 'health and well-being strategy' for the population in the area, and to have regard to the strategy in exercising their functions. The Act also empowered the National Assembly for Wales to make regulations imposing a duty on LHBs and Local Authorities to co-operate with other persons and organisations (such as NHS Trusts, Community Health Councils, voluntary bodies and local businesses) in formulating their strategy.

The Health and Social Care (Community Health and Standards) Act 2003 introduced further structural reform in England by establishing Foundation Trusts as public benefit corporations authorized under the Act to provide goods and services, subject to regulation by a new regulator (Monitor). The Healthcare Commission was given responsibility for operating the new inspection and monitoring regime for other NHS bodies. Due to the increasingly distinct legal frameworks of the NHS in England and Wales in the post-devolution era, separate statutes were deemed necessary for consolidation: 'Health law in England and Wales now diverges in so many respects that one Act covering both would be neither concise not comprehensible to users of the legislation.'[14] In keeping with this trend for separate legislative treatment by the UK Parliament of the NHS in England and Wales, the provisions on PPI in Part 14 of the Local Government and Public Involvement in Health Act 2007 (such as the revised 'section 11' duty and the creation of Local Involvement Networks) apply to England only.[15] The new Care Quality Commission, which is due to be established in April 2009 under the Health and Social Care Act 2008, will have responsibilities in England only.[16]

[13] Sections 22-26 of the Government of Wales Act 1998 made provision for the statutory powers and duties hitherto exercised by the Secretary of State for Wales to be transferred to the Assembly – see National Assembly for Wales (Transfer of Functions) Order, SI 672 of 1999, in force on 1st July 1999. The Secretary of State for Wales retains overall responsibility for specifically Welsh provisions in the UK Government's legislative programme.

[14] The note continues: 'A separate Bill for Wales has no constitutional implications; it does not affect the position of the Assembly, which currently has no primary law making powers and the Bills do not substantively change the law' - www.dh.gov.uk/assetRoot/04/13/42/47/04134247.pdf. See *Devolution and the Centre Monitoring Report*, Devolution Monitoring Programme 2006-08, September 2006.

[15] The legislation confers on the Welsh Assembly 'framework powers' to make provision on a range of local government matters in accordance with amendments to Schedule 5 to the Government of Wales Act 2006. Schedule 17

[16] By contrast, the Healthcare Commission had a limited range of statutory responsibilities in Wales, working alongside Healthcare Inspectorate Wales (HIW). The 2008 Act provides for a duty of cooperation between CQC and HIW, and for a duty on the part of CQC to inform Welsh Ministers in the event of significant failings in healthcare provision by a Welsh NHS body (s47, 'Failings by Welsh NHS bodies'). Other parts of the Health and Social Care Act 2008 (for example Part 2, 'Regulation of Health Professionals and Social Care Workforce') extend throughout the UK.

The Government of Wales Act 2006 (GOWA) has increased the scope for divergence on healthcare policy through the powers granted the Welsh Assembly and the WAG. The Act implemented the Richard Report recommendations that the WAG should be established as an entity separate from the National Assembly (separating the executive and legislative functions), and that the Assembly should be able to make primary legislation for Wales.[17] The legislative competence of the Assembly may be extended by three main mechanisms:

- The simplest means of ceding increased control to the Assembly is through 'framework powers' contained in Parliamentary Bills. The expansion of competence is achieved simply by delegating to the National Assembly the right to pass Assembly Measures in a particular field, for example local government under the Local Government and Public Involvement in Health Act 2007.[18]
- Under Part 3 of GOWA, legislative competence on certain matters may be granted the Welsh Assembly with the specific approval of the UK Parliament by Order in Council.[19] Following this 'Legislative Competence Order' (LCO) procedure,[20] Assembly Measures may then be made on those matters without further reference to Parliament.
- Finally, Part 4 of GOWA defines the 'primary' legislative competence of the Assembly with reference to subject-matter listed in Schedule 7, in relation to which the Assembly may legislate *without further recourse to the UK Parliament* provided that approval has been obtained in a referendum.

The number of UK Acts transferring powers directly to the Assembly has slowed almost to a halt since 2007 (The Health and Social Care Act 2008 confers only executive powers on Welsh Ministers).[21] 'It can be inferred that devolution under the new system remains highly pragmatic, and the devolution of powers, and their form (legislative and/or executive), depends on each particular bill'.[22] Whichever legislative vehicle is adopted (i.e. use of framework powers or Order in Council) the extension of competence involves amendment to Schedule 5 of the Act.[23] As more matters are added to Fields within Schedule 5, so the areas in which legislation for Wales could be passed

[17] Report of the Commission on the Powers and Electoral arrangements of the National Assembly for Wales, March 2004.

[18] This reflects the White Paper proposal in 'Better Governance for Wales' that 'The Government intends for the future to draft Parliamentary Bills in a way which gives the Assembly wider and more permissive powers to determine the detail of how the provisions should be implemented in Wales'.

[19] Post-devolution, the UK Ministry of Justice (previously Department for Constitutional Affairs) has published 'Devolution Guidance Notes' (DGNs) setting out advice on working arrangements between the UK government and devolved administrations - http://www.justice.gov.uk/guidance/devolutionguidancenotes.htm. Devolution Guidance Note 16 sets out the procedure whereby legislative competence may be conferred on the Welsh Assembly by Order in Council.

[20] A 'proposed LCO' becomes a 'draft LCO' after scrutiny in the Assembly, finally becoming an LCO made by the Queen following the 'affirmative resolution' procedure in Westminster.

[21] Wales Devolution Monitoring Report, September 2007, para. 2.1.

[22] Wales Devolution Monitoring Report, May 2008, para.

[23] Schedule 5 categorises the existing areas of policy responsibility devolved to the Welsh Assembly Government into 20 broad areas known as 'Fields.' The Fields will be populated with 'Matters', either by Orders in Council made under Part 3 of the Government of Wales Act 2006, or through framework power provisions in UK Bills.
Both framework powers in Bills and Orders in Council will require policy agreement with relevant Whitehall departments.

by either the UK Parliament or the Assembly increases.[24] The Assembly's website now shows progress of all legislative instruments (LCOs, Measures).[25]

It can be seen therefore that the devolution settlement for Wales is becoming increasingly generous, and that both the Assembly and the WAG are in practice acquiring greater powers relative to those located in Westminster and Whitehall. Furthermore, while the UK Parliament retains ultimate authority to legislate for Wales on any issue after devolution, including matters on which the Assembly has legislative competence, the Memorandum of Understanding (MoU) between the UK Government and the Devolved Administrations states that 'the UK Government will proceed in accordance with the convention that the UK Parliament would not normally legislate with regard to devolved matters except with the agreement of the devolved legislature.'[26] A further constitutional buffer against any future attempt by Parliament to reclaim control over health policy in Wales exists in the new duty under Article 3b(3) of the Lisbon Treaty, which expressly includes regional and local government within the scope of the principle of subsidiarity.[27]

Against the background of this trend towards increasing Welsh autonomy, our immediate focus is on health policy divergence in the early post-devolution period (say 1999-2006). Given that in this period the UK Parliament continued to legislate on the NHS in Wales, how was health service policy in the two countries able to diverge so significantly?[28] The simple answer appears to lie in the relative lack of prescription of the key legislation in relation to Wales. The irony here is the coexistence of increasing autonomy for Wales with growing centralization and control from Whitehall of the NHS in England. A further irony in the NHS case is that:

> … While the UK Parliament has deliberately retained sovereign authority that allows it to over-rule policy in the devolved assemblies, it is the Westminster Parliament itself that promulgated the radical policies that have led to schism. Central government might well have intervened had policy divergence occurred in a reverse direction, with a traditional

[24] 'In such cases the normal expectation is that the Assembly would legislate in relation to Wales. It is however possible that the Welsh Assembly Government will wish to take the opportunity to include provisions in a relevant Parliamentary Bill, rather than promoting a separate Assembly Measure. Such provisions should be included in a Bill at introduction in the UK Parliament', DGN 9, para. 9.

[25] http://www.assemblywales.org/bus-home/bus-legislation/bus-legislation-progress-lcos-measures.htm

[26] Devolution Guidance Note 9, 'Post-Devolution Primary Legislation affecting Wales', last updated June 2007. 'The implementation of the Government of Wales Act 2006 therefore places new responsibilities upon Whitehall Departments to consult the Welsh Assembly Government, to obtain the agreement of the Welsh Ministers in certain circumstances and to only proceed with certain provisions in Parliamentary Bills if the National Assembly for Wales agrees to their inclusion', para 1.

[27] Wales Devolution Monitoring Report, May 2008, para. 5.1.2. While the article does not prescribe how subsidiarity should be implemented at the sub-national level, this might be achieved through the drafting of a 'subsidiarity protocol' between Westminster and the devolved administrations (ibid.).

[28] The situation is different in Scotland where health is one of the areas of competence devolved to the Scottish Parliament, and greater policy divergence is to be expected. Since devolution the development of the health service has emphasized partnership and collaboration within existing structures, with no Foundation Trusts, and only a very limited role for the market. The Scottish National Party administration is considering issuing bonds as a means of raising finance for new hospitals, ending private involvement through the Private Finance Initiative which has become the standard mode of procurement in England. Free personal care for older people, introduced in 2002, is being extended. The Government has a manifesto commitment to work towards the abolition of prescription charges by 2012 – *The Gurardian*, 22nd August 2007.

integrated NHS led from England threatened by radical market reforms from the Assemblies in Wales or Scotland.[29]

We consider later the relationship between governance structures at European, national, and sub-national levels following devolution, and the significance of multi-level governance for the development of conditions of social learning in the healthcare context.

[29] D. Hughes and P. Vincent-Jones, 'Schisms in the Church: NHS Systems and Institutional Divergence in England and Wales,' 49 *Journal of Health and Social Behaviour* (2008) 49 *Journal of Health and Social Behaviour* 400.

3. PPI in England 2000-2006

The traditional model of governance in the NHS attached little importance to public and patient involvement. In the immediate post-war period, the public interest in healthcare was maintained through a combination of professional self-regulation, voting in elections and ministerial responsibility to Parliament, with an emphasis on trust in clinicians and deference to managers.[30] Within this paternalistic system, patients were the passive recipients of technocratic and medical expertise.[31] While limited representation was achieved through the creation in 1974 of Community Health Councils (CHCs), by the end of the 1990s such bodies were considered as failing due to a combination of lack of consistency in working practices and an inability to reflect adequately the diversity of local communities.[32] Just as a series of medical scandals was contributing to a further loss of confidence in existing management structures and accountability mechanisms,[33] the UK government was coming under pressure from European institutions to increase citizen participation in decision making affecting healthcare. In 2000 the Council of Europe recommended that governments of member states develop participation in all aspects of healthcare systems at national, regional and local levels. Governments were enjoined specifically 'to create legal structures and policies that support the promotion of citizens' participation and patients' rights', ensuring that accompanying guidelines be reflected in their law.[34] Policies directed at increasing citizen and user involvement in public services are generally justified on two main grounds: first, as part of the agenda for 'democratic renewal', increasing the legitimacy of decision making processes and supplementing traditional accountability through elections;[35] and second, as contributing to improved quality and the better adaptation of public services and facilities to the needs of the population.[36]

Against this background we distinguish two main waves of modern PPI reform in England, the first occurring roughly between 2000 and 2006, and the second beginning around 2006. In this section we outline the main features of the PPI system in the first phase of reform.

(a) Overview and Scrutiny Committees (OSCs)

OSCs were established by local councils under section 21 of the Local Government Act 2000, amended by section 7 of the Health and Social Care Act 2001 (now section 244

[30] Citizen participation initiatives in the UK are part of a world-wide trend towards the development of more direct democratic mechanisms, in response to declining public confidence in representative democracy and established political institutions – P. Abelson, G. Forest, J. Eyles, A. Casebeer, and G. Mackaen, 'Will It Make a Difference if I Show Up and Share? A Citizen's Perspective on Improving Public Involvement Processes for Health System Decision-making' (2004) 9 *Journal of Health Services Research and Policy* 205-212, p 206.

[31] R. Rowe and M. Shepherd, 'Public Participation in the New NHS: No Closer to Citizen Control?' (2002) 36 *Social Policy and Administration* 275-290, p 276.

[32] J. Tritter and A. McCallum, 'The Snakes and Ladders of User Involvement: Moving Beyond Arnstein' (2006) 76 *Health Policy* 156-168, 158.

[33] I. Kennedy, *Learning from Bristol: The Report of the Public Inquiry into Children's Heart Surgery and the Bristol Royal Infirmary 1984-1995* (London: Bristol Royal Infirmary Inquiry, 2001).

[34] Council of Europe, 'The Development of Structures for Citizen and Patient Participation in the Decision-Making Process Affecting Healthcare', Recommendation Rec(2000)5, adopted by the Committee of Ministers of the Council of Europe 24 February 2000, Council of Europe, Strasbourg, p 9.

[35] Citizen participation is a 'fundamental and integral part of any democratic society' (Council of Europe, Guideline 1.1, p10).

[36] Council of Europe, p p22. See also M. Barnes, J. Newman, and H. Sullivan, *Power, Participation and Political Renewal: Case Studies in Public Participation* (Bristol: Policy Press, 2007), pp 23-25.

of the NHS Act 2006). The 2001 Act gave OSCs an extended role in reviewing health and social care services. OSCs have powers: to request information and summon people before them to explain actions; to examine the efficacy of efforts to involve patients and public; to request action to be taken; to scrutinise any subsequent report; and to recommend an independent inspection of premises. OSCs must be consulted by NHS organizations in the event of proposed major changes to health services. They may investigate matters referred by Patient and Public Involvement Forums, and may refer matters upwards to the Secretary of State for review in certain circumstances (see below).[37]

(b) Patient Advice and Liaison Services (PALS) and Independent Complaints Advisory Service (ICAS)

PALS and ICAS were set up to take over the advisory and redress functions previously performed by CHCs. Based in each NHS Trust, PALS provide a range of information, advice, and support to patients, families and carers.[38] The replacement of the original term 'Advocacy' in the acronym by 'Advice' is a reflection of the current emphasis on resolving problems reported by patients in an informal manner, rather than through resort to litigation. Local formal complaints are now dealt with by ICAS,[39] an independent charity commissioned by the Department of Health to provide support for patients with complaints regarding their NHS treatment.[40]

(c) Foundation Trust Boards of Governors

The first Foundation Trusts (FTs) created under the Health and Social Care (Community Health and Standards) Act 2003 came into existence in 2004. By the end of 2007 there were sixty five FTs, with Foundation status expected to be open to all NHS Trusts by 2008. The legislation places FTs under a duty to engage with their local community, and to encourage local people to become members of the organisation. Accordingly FTs are required to establish a Board of Governors (also called 'Members Council'), nominated and elected by the local community. The majority of places on the Board must be taken by representatives elected from the public and patient membership of the Trust. At least three governors must be elected from staff membership, with a further one from the Local Authority, one from the local PCT, and one from a local university if there is one. The legislation provides for the appointment and removal of the Chair and non-executive directors of the Board; the approval and appointment of a Chief Executive; the appointment of auditors; and consideration of the Trust's annual forward plan.[41]

(d) The Healthcare Commission

The Commission for Healthcare Audit and Inspection, known as the Healthcare Commission, was established under Part 2 of the Health and Social Care (Community Health and Standards) Act 2003 with wide-ranging responsibilities for promoting

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37 House of Commons Health Committee (HCHC), *Patient and Public Involvement in the NHS*, Third Report of Session 2006-07, HC 278-1, 20 April 2007, para 51.

38 Department of Health website, http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/PatientAndPublicinvolvement/PatientadviceandliaisonservicesDH_4081305, accessed

39 ICAS was established under s 12 of the Health and Social Care (Community Health and Standards) Act 2003. The creation of PALS did not require legislation.

40 http://www.seap.org.uk/icas/

41 HCHC, para. 60.

improvement in the quality of health and healthcare.[42] The Commission's PPI responsibilities include conducting the patient survey programme, and involving patients groups through service user consultation in examining specific issues.[43] The Commission applies Core Standards on PPI in its 'annual health check' of NHS organisations: 'The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services.'[44] The Commission also supervises the process of self-assessment by Trusts on whether they have achieved this and other Core Standards, seeking additional views on this from patient groups and representatives, OSCs, FT Boards of Governors, SHAs, and Patient and Public Involvement Forums (below).[45]

(e) Duties to involve and consult

Under section 11 of the Health and Social Care Act 2001 (s 242 of the NHS Act 2006), SHAs, PCTs, and NHS Trusts, were required to involve and consult patients and the public in: (i) the planning of the provision of services; (ii) the development and consideration of proposals for changes in the way services are provided; and (iii) decision making by the body affecting the operation of those services.[46] Under section 7, NHS organizations are under a further duty to consult OSCs in the case of any 'substantial development or variation' of health services (the section 11 duty is different in not limiting the duty to 'substantial' changes). Under this section OSCs have powers to review and scrutinise matters relating to the health service in the authority's area, and to make reports and recommendations. Regulations further provide: 'In any case where an OSC considers that the proposal would not be in the interests of the health service in the area … it may report to the Secretary of State in writing who may make a final decision on the proposal and require the local NHS body to take such action, or desist from taking action, as he may direct.'[47] The Secretary of State, who has extensive

[42] A key new responsibility is for regulating the independent healthcare sector, a task previously performed by the National Care Standards Commission (NCSC). The term 'independent healthcare' refers to any private, voluntary, not for profit or independent healthcare establishment under the regulatory remit of the Commission. This is defined as any establishment (or service, agency, practice or business) required to register with the Commission under the Care Standards Act 2000, as amended by the Health and Social Care Act 2003, and to comply also with Private and Voluntary Health Care (England) Regulations 2001. Associated responsibilities are: to maintain a register of independent (private and voluntary) healthcare providers; to inspect registered services annually to ensure that they are meeting national minimum standards; to assess the performance of healthcare organizations generally; to award annual performance ratings for the NHS; to coordinate reviews of healthcare by other bodies; to encourage improvement in the quality, effectiveness, economy, and efficiency of healthcare provision; to track how well public resources are being used; to carry out investigations into serious service failures; to report serious concerns about quality to the Secretary of State; to publish annual performance ratings for all NHS organisations and produce annual reports to parliament on the state of healthcare; to collaborate with other relevant organisations including the Commission for Social Care Inspection (CSCI)(created under the same Act); and to carry out an independent review function for NHS complaints. The Commission takes over the role previously performed by the Commission for Health Improvement together with the NHS 'value for money' work previously carried out by the Audit Commission, in addition to regulation of independent sector bodies previously performed by the NCSC.

[43] HCHC, para. 68.

[44] Department of Health, *Standards for Better Health* (July 2004),Core Standard C17

[45] HCHC, para. 71.

[46] Under s11(1), the duty was owed literally to 'persons to whom … services are being or might be provided'. The duty to consult on changes in health services was not new. A duty on SHAs to consult on proposals for any substantial development or variation to health services was introduced in 1996 – Community Health Council Regulations 1996.

[47] Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 (SI 2002, No 3048).

powers of intervention under the NHS Act 1977, may also refer the case to the Independent Reconfiguration Panel for advice.

(f) Independent Reconfiguration Panel (IRP)

The IRP was established as an advisory non-departmental public body in 2003 to provide independent expert advice to the Secretary of State for Health on contested proposals for health service change in England, in cases where local agreement on service changes cannot be achieved.[48] The Panel also offers ongoing support and advice to the NHS and other interested bodies on successful service changes, with the aim of sharing good practice and avoiding formal referrals at a later date. The Chair, Chief Executive and Panel members represent a wide range of expertise in clinical healthcare, NHS management, and public and patient involvement. This breadth of expertise is claimed to enable independence, transparency and credibility in the conduct of the Panel's work.[49]

In providing expert advice, the Panel is required by its terms of reference to take account of: (i) patient safety, clinical and service quality; (ii) accessibility, service capacity and waiting times; (iii) other national policies, for example, national service frameworks; (iv) the rigour of consultation processes; (v) the wider configuration of the NHS and other services locally, including likely future plans; and (vi) any other issues Ministers direct in relation to service reconfigurations generally or specific reconfigurations in particular.[50] The terms of reference further provide that: 'The advice will normally be developed by groups of experts not personally involved in the proposed reconfiguration or service change, the membership of which will be agreed formally with the Panel beforehand.'[51] Furthermore: 'The advice will be delivered within timescales agreed with the Panel by Ministers with a view to minimising delay and preventing disruption to services at local level.'[52]

Once the referral of a contested proposal has been accepted, the Panel consults with interested parties and may make site visits, hold meetings, conduct interviews, and request written evidence. While the focus throughout is on the quality of patient care, a principal concern is with the rigour of local involvement and consultation processes. On completion of the review, a final report containing recommendations is published and submitted to the Secretary of State, who makes the final decision on any disputed proposal.[53]

(g) Patient and Public Involvement Forums (PPIFs)

Created under the National Health Service and Health Care Professions Act 2002, PPIFs (approximately 550 in number – one for every NHS Trust, PCT, and later Foundation Trust) became operational at the same time as CHCs ceased to exist on 1st December 2003. The Forums (now abolished) were supported by approximately 140 Forum Support Organisations – not-for-profit bodies working under contract to the Commission for Patient and Public Involvement in Health (below). Each Forum consisted of around eight volunteer members appointed by the Commission.

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48 http://www.irpanel.org.uk/view.asp?id=0 Before a case can be referred to the Panel, 'all other options for local resolution need to have been fully explored'.

49 The Patients' Forums (Functions) Regulations 2003 (SI 2003/2124)

50 Terms of Reference, para. A2.

51 Terms of Reference, para. A3.

52 Terms of Reference, para. A4.

53 The Panel therefore has no powers of enforcement, its recommendations being advisory only.

The statutory duties of Forums were: (i) to monitor and review the operation of services; (ii) to obtain the views of patients and their carers, and report on those views to the trust; (iii) to provide advice, and make reports and recommendations; and (iv) to make available to patients and their carers advice and information about those services. Reflecting their importance in the overall governance regime, PCT Forums were originally allocated additional functions. Under secondary legislation PPIFs were granted further powers to refer matters to the relevant OSC, to enter and inspect premises, and to require NHS bodies to supply information as requested. In the case of independent providers, Forums had a similar power through terms in the contract with the PCT, made in accordance with Directions issued by the Secretary of State. The work of PPIFs included conducting patient surveys, carrying out investigations, compiling service review reports, maintaining a presence on PCT and hospital trust boards/committees, and visiting and inspecting hospital premises. Investigations typically focused on issues such as infection control, GP services, transport and parking, mental health, and community involvement.

(h) Commission for Patient and Public Involvement in Health (CPPIH)

The 2002 Act also established on a statutory basis the CPPIH as a non-departmental public body to oversee the new system of PPI. Most of the £28m annual budget was spent on contracts with independent organisations to support Patient Forums, with approximately one third on administration. The Commission (also now abolished) set up, managed and appointed members of Forums; established quality standards and carried out national reviews of services from patients' perspective; and submitted reports to the Secretary of State and to bodies such as the Healthcare Commission.

4. Evaluation of first wave PPI reforms in England

There is an abundance of evidence from a variety of sources pointing to the deficiencies in this system of PPI in England, and its failure to achieve policy objectives. In this section we focus on the recent PPI debate as reflected in the government's own policy documents and parliamentary papers, and in the wider academic literature.

(a) Practical issues

Some aspects of the PPI system introduced after 2000 were overtaken by organizational changes in the NHS. By October 2005, the government had plans in place to reconfigure PCTs into a reduced number of bodies covering larger geographical areas. This rendered impracticable the original model of PPIFs with special powers and responsibilities based in old-style PCTs, leading to the announcement by Ministers of a strategic review of the entire PPI framework. The government justified its ensuing decision to abolish Forums, which had only been in existence since 2003, by reference to unanticipated and fundamental changes in the nature of delivery of health and social services.[54] These changes included the move towards greater choice of service providers and service delivery, the increased emphasis on the role of PCTs as service commissioners, and the growing importance of the commissioning process as a means of managing, controlling, and developing services. Similarly unanticipated, according to the government, was the shift in social care towards greater individual choice and control through personalisation of services, self-directed support, and direct payments.

[54] Department of Health, *Government Response to 'A Stronger Local Voice'* (December 2006).

The extent of integration of health and social care, the delivery of more services within the community, and the emergence of NHS Foundation Trusts were also unforeseen.[55]

The CPPIH's contribution to the review of PPI in 2006 pointed to major failings in the operation of Forums,[56] recommending their replacement by a system of 'local networks'. Deficiencies included: (i) excessive preoccupation with monitoring and review of services, stifling innovation and creativity; (ii) the attempted performance of too many functions (improving services, engaging the community, holding the NHS to account, etc); (iii) unrealistic expectations as to what could be achieved in many cases, especially given the over-reliance on volunteers; (iv) lack of diversity in the pool of participants, with current arrangements failing to be representative of local populations and tending to exclude employed people or those with other commitments such as caring responsibilities; (v) failure to encompass the patient's journey through a variety of health and social care services, due to the attachment of Forums to particular NHS institutions; (vi) confusion in the relationship between internal PPI activity of Trusts, the role of Forums, and the role of OSCs; (vii) confusion also between the functions of service improvement and long-term service planning; and finally (viii) the undermining of the accountability role of Forums, resulting in loss of public confidence in their ability to engender service improvements.[57]

Other problems with PPI arrangements were more far-reaching and not associated with organizational changes just described.[58] While in theory there existed an effective and comprehensive system of public consultation, the practical experience was often disappointing. For example, 'section 11' consultations were widely perceived as insincere,[59] with many NHS bodies suspected of seeking to avoid their statutory duties or interpreting narrowly the range of situations in which they were required to consult, often with the collusion of the Department of Health. This has been the case with decisions on the role of Independent Sector Treatment Centres (ISTCs), which the government has been particularly keen to promote as part of its agenda for increasing patient choice. The lack of public consultation on ISTCs followed clear Ministerial direction that this was not necessary either before the making of the contract or in its

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55 *Response*, para. 2.2. This justification for the abolition of PPIFs was doubted by many witnesses in evidence given to the House of Commons Select Committee scrutinizing proposed further legislative reform. The suggestion instead was that this was connected with the Government's reform agenda for the CPPIH: 'Some witnesses did not believe that the Department had given the real reasons for the changes' (HCHC, para 83), several arguing that Forums could be improved without being abolished and that their role could be extended (HCHC, para 91-92). The Government had already announced plans to abolish CPPIH in its review of NHS arm's length bodies carried out in 2004, (Department of Health, *Reconfiguring the Department of Health's Arm's Length Bodies*, 22nd July 2004)) as part of a strategy for saving at least £500m and channeling resources to frontline NHS patient care. Despite the impending demise of CPPIH, the widely held view at that time was that Forums would remain a cornerstone of PPI, with the appointment of members being taken over by NHS Appointments Commission.

56 Overview Paper: Input into PPI Review Panel*, Keeping Accountability Alive* – (CPPIH 2003-2006).

57 CPPIH, para 50.

58 'There is much confusion. There is lack of clarity about scope and purpose. Should patient and public involvement be about more accountability, better services or health promotion?' (HCHC, para 3); 'Just as the landscape of organisations through which patients and the public can express their views is complex and confusing, equally the overall aim of patient and public involvement often seems elusive … used to serve several different purposes simultaneously' (HCHC, para 20). For an overview of main criticisms of the current system, including under-resourcing, lack of capacity, and complexity and fragmentation, see R. Baggott, 'A Funny Thing Happened on the Way to the Forum? Reforming Patient and Public Involvement in the NHS in England' (2005) 83 *Public Administration* 533-551.

59 HCHC, para 239. There is evidence in some cases of outright dishonesty, with decisions having already been taken and peoples' views consequently ignored – para 241

award.[60] Similarly, according to the government, there was no need to consult on the reconfiguration of PCTs since this was a managerial and administrative matter having no direct connection with service delivery.[61] In those instances where PCTs have consulted with OSCs, and OSCs have then referred the issue to the Secretary of State, there is evidence of significant under-use of the Independent Reconfiguration Panel. Among the estimated hundreds of organizational changes within the remit of the statutory scheme at the time of the Health Committee hearing, approximately twenty-three were referred to the Secretary of State, who referred only four cases to the Panel.[62]

Witnesses to the Health Committee stressed the limited powers of OSCs following investigations, and their perceived ineffectiveness especially at the time of elections when no scrutiny was carried out at all, creating incentives for the NHS to push through unpopular changes at this time.[63] Others pointed to the lack of independence of OSCs, perceived by many as being too close to NHS Trusts; there is no public or lay representation, local councillors fill all the seats, and the seats may be occupied by the majority party rather than being representative of the council as a whole. In addition, the Committee was told that 'OSCs can only be reactive rather than proactive.'[64]

There are significant weaknesses elsewhere in the PPI system. While the official national evaluation of the first year of operation of PALS concluded from case study research that 'the results have been very positive … PALS enable and empower patients and others to use services effectively and appropriately, and usefully address the issues they have,'[65] evidence given to the HCHC was highly critical of their lack of independence. Concerns were also expressed over the marginalisation of PALS, with some services threatened with closure due to financial constraints.[66] As to ICAS, witnesses criticized poor standards in arrangements for handling complaints, lack of consistency throughout the country, and weak public profile and lack of capacity in the service.[67] In particular, there were difficulties accessing the complaints system 'due to perceived reluctance by trusts to advertise the procedure and support services available'. Access problems were exacerbated by lengthy delays, with both trusts and the Healthcare Commission failing to deal with complaints within their targets. Generally there was 'a culture that is defensive rather than responsive, failing to provide complainants with explanations of what went wrong, or apologies when mistakes were made.'[68]

Finally, the Health Committee received mixed evidence on FTs' patient and public involvement arrangements. The British Medical Association criticised the new governance arrangements as 'a failing area in terms of PPI … there is a lack of evidence to show that they may be working.'[69] The Independent Regulator of Foundation Trusts (Monitor) pointed to the lack of coordination with other aspects of PPI policy, warning of the danger of duplication of effort: 'Where patient and public involvement initiatives

60 Department of Health lawyers have a vested interest in avoiding consultation – HCHC para 251
61 HCHC, para 253.
62 HCHC, para 268.
63 HCHC, para 52.
64 HCHC, para. 54
65 Department of Health, 'Developing the Patient Advice and Liaison Service: Key Messages for NHS Organisations from the National Evaluation of PALS', http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/
66 HCHC, para. 56
67 HCHC, para 57.
68 HCHC, para 58
69 HCHC, para 64

overlap there is a potential for confusion as to the different responsibilities of each organisation.[70]

(b) The academic debate

While the introduction of an element of democratization into healthcare governance has generally been welcomed in the academic literature, policy analysts have remained sceptical of the 'new architecture' of PPI.[71] The reforms coincided with a period of financial stringency in the public sector generally, suggesting that they may be part of a strategy for legitimating unpalatable changes such as rationing or user charges.[72] Tokenistic patient and public involvement has arguably served as a means of co-opting citizens into a political agenda of downsizing,[73] at the same time as legitimating quasi-markets as the predominant form of organization of health and social care.[74] In this vein, Rowe and Shepherd view public participation as a management technique whereby the 'public interest' on healthcare issues remains defined by clinical and managerial professionals through their continued ability to mediate the views expressed by citizens as to their needs.[75] The failure of early PPI initiatives is attributed to their incorporation within the paradigm of the New Public Management, which is not concerned with democratic renewal or increasing responsiveness to consumer or citizen needs, but rather values public participation as an aid to organizational learning.[76] Generally, consultation has too often been used by those with decision making power to mask hidden agendas, or as a means of claiming public support for predetermined policies.[77] Increased participation, where it may be observed as occurring, may

70 HCHC, para 67

71 T. Milewa, 'Local Participatory Democracy in Britain's Health Service: Innovation or Fragmentation of a Universal Citizenship' (2004) 38 *Social Policy and Administration* 240-252.

72 D. Rutter, C. Manley, T. Weaver, M. Crawford, and N. Fulop, 'Patients or Partners? Case Studies of User Involvement in the Planning and Delivery of Adult Mental Health Services in London' (2004) 58 *Social Science and Medicine* 1973-1984, p 1974.

73 J. Church, D. Saunders, M. Wanke, R. Pong, C. Spooner, and M. Dorgan, 'Citizen Participation in Health Decision-making: A Conceptual Framework' (2002) 23 *Journal of Public Health Policy* 12-32. 'Given the growing potential gap between what political elites and the public are thinking, governments may be afraid that too much citizen participation will derail the political agenda.' (p 14).

74 S. Harrison and M. Mort, 'Which Champions, Which People? Public and User Involvement in Health Care as a Technology of Legitimation' (1998) 32 *Social and Policy Administration* 60-70, pp 67-8. The authors argue that quasi-markets cannot be legitimized in the same way as markets (by reference to outcomes not intended by any individual actor but made according to the hidden hand) or hierarchies (by reference to traditional sources of authority).

75 Rowe and Shepherd, p 279. '…Patient and public involvement could be seen as a means of manipulating patients and the public rather than empowering them. Those concerned with funding of the NHS have acknowledged that partnership with patients and carers may promote a more efficient and cost-effective system, financially sustainable in the long term' – R. Baggott, 'A Funny Thing Happened on the Way to the Forum? Reforming Patient and Public Involvement in the NHS in England' (2005) 83 *Public Administration* 533-551, p 546.

76 This pejorative use of the term 'organizational learning' is not contextualized with reference to any particular theoretical literature. In any event, the concept of social learning is radically different to that of organizational learning – see for example: C. Agyris and D. Schon, *Organizational Learning: A Theory of Action Perspective* (Reading: Addison Wesley, 1978); D. Miller, T. Lant, and F. Milliken, 'The Evolution of Strategic Simplicity: Exploring Two Models of Organizational Adaptation' (1996) 22 *Journal of Management* 863-887; H. Berends, F. Boersma, and M. Weggeman, 'The Structuration of Organizational Learning' (2001) Working Paper 01.12, Eindoven Centre for Innovation Studies, submitted to *Organization Studies* for special issue on 'Knowledge and Professional Organizations'; M. Easterby-Smith, 'Disciplines of Organizational Learning: Contributions and Critiques' (1997) 50 *Human Relations* 1085-1114.

77 J. Abelson, P.-G. Forest, J. Eyles, A. Casebeer, and G. Mackaen, 'Will It Make a Difference if I Show Up and Share? A Citizen's Perspective on Improving Public Involvement Processes for Health System Decision-making' (2004) 9 *Journal of Health Services Research and Policy* 205-212, p 209.

reinforce dominant managerial and medical discourses through the 'proto-professionalization' of patients and public who may more readily submit to existing inequalities in power relations.[78] Again, citizens may be unwilling or unable to engage in the type of role that government assigns to them.[79] Health providers and service users may have different aims in collaborating on PPI schemes, the former focusing on the process of involvement and the need to widen participation, while the latter are more concerned with the agenda for reform and with influencing change in policy and practice.[80] Were citizen control to be achieved through PPI, and the policy regarded as 'successful', this might 'lead to service provision that meets the needs of some people more than others.''[81]

The majority of such criticisms of the existing PPI system are based on an analysis of healthcare governance in terms of power relations.[82] The underlying problem with the reforms, it is argued, has been the failure to alter existing patterns of power and influence,[83] particularly at the local level.[84] The dominant 'discourse of power' in the academic policy literature owes much to Arnstein's seminal study of user involvement:

> Citizen participation is a categorical term for citizen power. It is the redistribution of power that enables the have-not citizens, presently excluded from the political and economic process, to be included in the future.[85]

In the 'ladder' ranking different degrees of citizen participation and non-participation, citizen control is presented as the pinnacle of involvement.[86] For models derived from Arnstein, user involvement is conceived as 'a contest between two parties wrestling for control over a finite amount of power. Involvement is conceptualised in competitive terms: 'a zero-sum game.''[87] Closely linked with citizen control is the role of citizens in

[78] M. Dent, 'Patient Choice and Medicine in Health Care: Responsibilization, Governance and Proto-Professionalization' (2006) 8 *Public Management Review* 449-462. Consultation may be manipulative in obscuring the exercise of power – see G. Callaghan and G. Wistow, 'Publics, Patients, Citizens, Consumers? Power and Decisionmaking in Primary Health Care' (2006) 84 *Public Administration* 583-601, p 596

[79] Church et al, 24. Thompson concludes that 'many patients support greater involvement in service delivery, but they want professionals to recognize that this needs to be optional and varies according to the context and probably over time too' – A. Thompson, 'The Meaning of Patient Involvement and Participation in Health Care: A Taxonomy' (2007) 64 *Social Science and Medicine* 1297-1310, p 16 of Science Direct version.

[80] Rutter et al.

[81] Tritter et al, p 163.

[82] For case studies of public participation in different sectors underpinned in various ways by the power perspective, see M. Barnes, J. Newman, and H. Sullivan, *Power, Participation and Political Renewal: Case Studies in Public Participation* (Bristol: Policy Press, 2007).

[83] For example, Rowe and Shepherd contend that attempts to establish relationships between the public and the NHS on a partnership basis have been unsuccessful due because 'the distribution of power is still heavily weighted towards professionals working in the NHS' – R. Rowe and M. Shepherd, 'Public Participation in the New NHS: No Closer to Citizen Control? (2002) 36 *Social Policy and Administration* 275-290, p 288.

[84] T. Milewa, 'Local Participatory Democracy in Britain's Health Service: Innovation or Fragmentation of a Universal Citizenship' (2004) 38 *Social Policy and Administration* 240-252, p 245. 'The perception of a centralist bureaucracy has remained' – Tritter et al, 158.

[85] S. Arnstein, 'A Ladder of Citizen Participation' (1969) 35 *Journal of the American Planning Association* 216-224, p 216 (quoted in Tritter and McCallum, 157).

[86] At the lowest rungs Arnstein locates two forms of non-participation (manipulation and therapy), followed by three degrees of tokenism (informing, consultation, and placation), and finally three degrees of citizen power (partnership, delegated power, and citizen control). In the gloss provided by Tritter and McCallum: 'The sole measure of participation is power to make decisions and seizing this control is the true aim of citizen engagement' – Tritter et al, p 157

[87] Tritter et al, p 165

decision making processes,[88] whether as taxpayers concerned with what services should be funded by the state, as residents concerned with how services are provided to the local community, or as patients concerned with the criteria for the allocation of services based on clinical or socio-demographic considerations.[89] The success of PPI in these terms depends on the extent of citizen participation in decision making at these different levels.

Rejecting this model on the ground that it is unduly adversarial and tends to underestimate the importance of collaboration,[90] Tritter and McCallum focus instead on deliberative processes and the difficulties inherent in attaining consensus: 'A truly empowering system would demonstrate safeguards … to provide space for people with dissenting views, or those for whom services need to be tailored differently.'[91] The plea here is for a more nuanced model of user involvement, entailing 'constructive dialogue aimed at reshaping the relationship between patients, healthcare professionals and the public and as a catalyst to more widespread cultural change.'[92] The role of users in framing problems as well as contributing to the design of solutions is argued to be a missing element in Arnstein's model.[93] In place of a linear, hierarchical ladder representing degrees of power, the authors propose a 'scaffold' model in which multiple interests and types of expertise are represented in varying relationships:

> One aim of user involvement may be to break down boundaries, share experience, and build understanding. This suggests not a hierarchy of knowledge – relevant professionals versus irrelevant lay – but rather a complementarity between forms of knowing, set within a willingness to acknowledge differences.[94]

Similarly, Dent stresses the potential contribution of patients to processes of dialogue and deliberation, in contrast to voting systems that are suitable only as the 'ultimate arbiter' in cases of disagreement. In this conception, communicative competence is at the heart of the ideal of participation.[95] Such Habermasian analyses are consistent with the collaborative and relational approach to social learning, and may even be suggestive of elements of democratic experimentalism. However, they remain limited in failing explicitly to consider social learning as an alternative rationale for increasing patient and public involvement in healthcare governance.

(c) Conclusion

The deficiencies in the design and operation of the current PPI system are numerous and widely acknowledged. Proposals for reform (including pleas for increased clarity of purpose and improved accountability mechanisms[96]) have done little to address the

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88 These processes tend also to be conceived in 'zero-sum' terms. For Thompson, the distinction between the lower and higher 'levels' of patient involvement and participation respectively concerns 'the degree to which patients take part in the decision-making process, connoting a degree of transfer of power from the professional to the patient in the form of increased knowledge, control, and responsibility' - A. Thompson, 'The Meaning of Patient Involvement and Participation in Health Care: A Taxonomy' (2007) 64 *Social Science and Medicine* 1297-1310, p 16 of Science Direct version.

89 Church et al, p 24

90 Tritter et al, p 164

91 Tritter et al, p 163

92 Tritter et al, p 158

93 Tritter et al, p 162

94 J. Tritter and A. McCallum, 'The Snakes and Ladders of User Involvement: Moving Beyond Arnstein' (2006) 76 *Health Policy* 156-168, p 162.

95 M. Dent, 'Patient Choice and Medicine in Health Care: Responsibilization, Governance and Proto-Professionalization' (2006) 8 *Public Management Review* 449-462, p 457, citing J. Newman, *Modernising Governance: New Labour, Policy and Society* (London: Sage, 2001).

96 Abelson et al, p 210.

fundamental question of how PPI is supposed to lead to improved quality in the management and organisation of healthcare. This limitation remains even where power is conceived as a variable set of capacities for involvement that can be developed and maximised simultaneously by stakeholders through different forms of knowledge and social capital, rather than as a finite resource to be gained by one group at the expense of another.[97]

In REFGOV terms, the disappointing results of PPI to date may be explained by the failure, both in official discourse and in the wider policy literature, to consider the potential contribution of patient and public involvement to improved healthcare governance from the perspective of social learning. In this light, the key question for the next wave of PPI is not whether it will result in a significant shift of power, but whether the new framework is capable of facilitating the development of institutions and processes for such involvement that are conducive to more effective social learning.

[97] G. Callaghan and G. Wistow, 'Publics, Patients, Citizens, Consumers? Power and Decisionmaking in Primary Health Care' (2006) 84 *Public Administration* 583-601, p 586.

5. The 2007/2008 reforms – a new regulatory landscape?

As has been seen, the government's plans for the reconfiguration of old-style PCTs into larger units, coupled with other organizational and policy changes including the creation of Foundation Trusts, led in 2005 to a fundamental review of the PPI system.[98] The Expert Panel set up to examine evidence from the review concluded:

> There is insufficient focus on involvement in relation to commissioning, generating a real risk that services do not meet the changing needs and preferences of the people who use them. Above all, it would be fair to say that patient and public involvement in health has suffered badly from a combination of stop-start policy, complicated legislation, duplication of functions and an over-prescriptive, centralised model (CPPIH and Patient Forums) of how to achieve it. The result is disjointed and resource-intensive, and cannot be justified either by clear outcomes or as value for money.'[99]

Just two months after this report, in July 2006 Ministers issued the White Paper, *A Stronger Local Voice*.[100] This was followed in December by the publication of the government's own response to the key questions that had been set out in the White Paper,[101] and subsequently by the Local Government and Public Involvement in Health Act 2007. Both the Expert Panel and the White Paper maintained that PPI should reflect four principles. Systems of PPI should be (i) independent of, but (ii) engaged in debate with, commissioners and providers, and they should provide (iii) transparency and (iv) accountability on the part of service commissioners and providers.[102]

This section analyzes the proposed new regulatory landscape (Annex A) and its rationale. The different areas of reformed PPI policy in England show variation in a number of respects: in the range and scope of issues intended to be subject to public and patient involvement; in the forms or structures of involvement and engagement; in the role of government, commissioners and providers in PPI; in the role of participants as service users and members of the public; in the power of participants to influence decisions or exercise choice; and in the support provided for development of capacity for effective involvement of patients and public. These dimensions are considered with reference to the core principles of independence, engagement, transparency and accountability. Although legislation and guidance indicate the possible future direction of PPI, at present there is significant uncertainty over the form of implementation, so many questions remain open.

(a) Local Involvement Networks (LINks)

In its report of May 2006, the Expert Panel was highly critical of the £28m expenditure on CPPIH in support of Patient Forums for every NHS Trust, FT, and PCT in England, and of the scope and workings of the Forums themselves.[103] The Panel recommended

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98 The White Paper on the future of primary care and community services, published in January 2006, set out broad policy towards PPI but without going into details – Department of Health, *Our Health Our Care, Our Say: A New Direction for Community Services*, Ch. 7.

99 Department of Health, *Concluding the Review of Patient and Public Involvement: Recommendations to Ministers from the Expert Panel* (12th May 2006), para. 3.4. (hereafter Expert Panel).

100 Department of Health, *A Stronger Local Voice: A Framework for Creating a Stronger Local Voice in the Development of Health and Social Care Services*, July 2006 (hereafter ASLOV).

101 Department of Health, *Government Response to 'A Stronger Local Voice'*, December 2006 (hereafter GovResp)

102 ASLOV, 11-12, Expert Panel, sections 4 and 5.

103 Members of Forums were themselves dissatisfied, their work often not taken seriously by local NHS organisations. Inspections were cosmetic activities achieving little real change (para 11.2). Membership was drawn from too narrow a section of the population (para 7.4) Since Forums had failed

their replacement by LINks, a new type of representative body with functions spanning health and social care, supported by a Local Involvement Fund to encourage the development of a stronger public and user voice. The subsequent White Paper adopted this recommendation as one of five key elements of the 'New Framework for Public and User Involvement', and the Local Government and Public Involvement in Health Act 2007 accordingly makes provision for the creation of LINks. With the support of £84m in funding over three years, 150 LINks began setting up from April 1st 2008.

The 2007 Act provides that LINks will be engaged in 'promoting, and supporting, the involvement of people in the commissioning, provision, and scrutiny of local care services.'[104] This wide remit contrasts with the revised 'section 11' duty (discussed below) which limits consultation to issues affecting service users' experiences and choice. LINks are further required to 'ensure that equality and human rights principles are integral to [their] work.'[105] In principle, this could mean that LINks have to make judgments on issues of human rights and equality in commissioning and service provision which go beyond representation of the needs and preferences of service users.[106] In keeping with the principles intended to underlie PPI, the White Paper described one purpose of LINks as ensuring that purchasers and providers of local health and social care services are more accountable to the public.[107] Another key role is the promotion of increased responsiveness to the needs and preferences of users, through information gathered from a wide range of sources.[108] The White Paper described the intention that "LINks will have the flexibility to work with the changing landscape of the NHS and social care systems and to fit in with their local circumstances."[109] In contrast to Patient Forums, LINks will be 'separated from institutions,' a move which the Expert Panel recommended in light of 'the introduction of increased plurality of providers, payment by results and focus on commissioning'.[110] The White Paper set out a further aim:

> LINks should operate in an inclusive way with a membership that includes user groups, local voluntary and community sector organisations and interested individuals. It is

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to keep pace with developments such as increased plurality of providers, payment by results and practice based commissioning, they should not continue in their present form. It should be noted that the abolition of the CPPIH had been announced in the Department of Health Report *Reconfiguring the Department of Health's Arm's Length Bodies* (2004) p 18. However this report did not anticipate the abolition of the Patients' Forums.

104 Local Government and Public Involvement in Health Act 2007, s221(2)(a). Other activities in which LINks will engage include the 'obtaining of views of people about their needs for, and their experiences of, local care services' (s221(2)(c), and making such views known, and making reports and recommendations about how local care services could or ought to be improved, 'to persons responsible for commissioning, providing, managing or scrutinising local care services' (s221(2)(d).

105 Department of Health *Getting Ready for LINks: Contracting a host organisation for your Local Involvement Network* (August 2007), p 18

106 For instance, there may be tensions between needs of different groups, or between the preferences of a majority and significant needs of a smaller group. Concern for principles of equality may require that judgement is made as to the way in which competing preferences and needs should be met.

107 ASLOV, 14

108 ASLOV, 14. In their role of promoting increased responsiveness LINks can: (i) gather information from range of people and sources, about needs and experiences of using services in areas, from PALS, complaints, surveys, websites, user groups, focus groups; analyse information and make recommendations to commissioners, providers, managers, OSCs, regulators; (ii) serve as a means whereby OSCs, commissioners, and regulators access the views of the local population; and (iii) encourage and support users in participating in commissioning.

109 ASLOV, 14

110 Expert Panel, para 7.3

> important that these arrangements offer scope to groups such as children and young people, especially those who are not always included.[111]

This statement reflects the concern that membership of Patient Forums 'despite good intentions, is drawn from a relatively narrow section of society.'[112] It also implies a broader aim of 'build(ing) the capacity of local populations as well as voluntary and community organisations to engage with health and social care.'[113] The emphasis on involvement of local voluntary organisations is consistent with the government's wider belief in the value of the third sector in engaging service users,[114] and in the ability of non-profit bodies to campaign and act as advocates.[115]

LINks will obtain views from people about health and social care needs, convey those views to organisations responsible for commissioning, providing and managing local health and social care services, and make reports and recommendations to those bodies on how services may be improved. LINks will have powers to enter NHS premises and observe and assess the nature and quality of health and social care services[116] (a lesser power than that enjoyed by Patient Forums to inspect NHS premises including those providing primary care[117]). LINks will engage in monitoring by actively seeking views directly through contributions from individuals and groups, and indirectly from representatives or advocates, complaints and PALS, surveys, comment cards, websites, and other methods.[118] LINks will also have powers to refer matters relating to social care to Oversight and Scrutiny Committees.[119] While the 2007 Act makes no reference to referral of health matters to OSCs,[120] the Department of Health noted in its 2007 consultation on regulations for LINks that the government intends to 'amend the current secondary legislation in relation to the referral of health matters to OSCs to mirror the policy set out for social care OSCs in the Bill.'[121] In replacing Patient Forums powers with those of LINks to refer matters to OSCs, the PPI reforms are in keeping with the Expert Panel's view that:

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111 ASLOV, 15

112 Expert Panel, para 7.2

113 ASLOV, 12

114 An ability attributed to the third sector by Ed Miliband on BBC Radio 4 *Analysis* (5 July 2007). For discussion of the government's view of third sector involvement in health and social care, see for instance, L. Marks and D. Hunter, *Social Enterprises and the NHS; Changing patterns of ownership and accountability*, Centre for Public Policy and Health, Durham University (July 2007).

115 See for instance, Speech by Ed Miliband at the Fabian conference on democracy (8 September 2007) available at http://www.cabinetoffice.gov.uk/upload/assets/www.cabinetoffice.gov.uk/publications/speeches/milibande/pdf/democracy_speech.pdf (Accessed 10 April 2008)

116 2007 Act s225. Although not included specifically in the 2007 Act, independent providers will also be subject to the exercise of powers of observation and assessment by LINks, but only in respect of health and care services that are funded by taxpayers (i.e. not those provided solely to people paying in full for their own care). The DH explains that 'the Secretary of State will direct commissioners of services to amend new contracts so that the same duties will apply. These include contracts awarded by Primary Care Trusts (PCTs), NHS trusts and local authorities with social services responsibilities' – Department of Health, *Local involvement networks: briefing for independent providers* (April 2008), p3. Commissioners will also be directed to make arrangements with independent providers requiring them to provide information about their services to LINks when requested. An 'independent provider' is 'a provider with which a local authority with social services responsibilities, NHS Trust, SHA or PCT contracts … usually a private or voluntary sector organisation' (ibid, p5).

117 National Health Service Act 2006, s239

118 GovResp para 1.43

119 s226. On OSCs, see Ch2, ss119-128.

120 Patients' Forums had the power to refer health matters to OSCs

121 Department of Health *Have Your Say: Consulting on the regulations for Local Involvement Networks (LINks)* (September 2007)

> The role of overview and scrutiny is an important and increasingly effective mechanism to deliver public accountability. It has the benefit of a democratic mandate, coupled with existing powers which both NHS and social care organisations are now familiar.[122]

Each LINk will report annually to the Secretary of State for Health. The report will be independent of the Local Authority, providing details as prescribed in the legislation and regulations.[123]

The 2007 Act and associated secondary legislation impose duties on 'services-providers' to respond to requests for information or to reports or recommendations made by a LINk.[124] Regulations provide that the response must 'provide an explanation to the referrer of any action it intends to take in respect of the report or recommendation or an explanation of why it does not intend to take any action in respect of that report or recommendation.'[125] It may be noted that this requirement echoes the new duty that the 2007 Act places on PCTs and SHAs to report on the influence that the results of consultation have on their commissioning decisions,[126] discussed further below. This duty could be understood as formalising a method of engagement between services-providers and the LINk, as well as providing a degree of accountability on the part of services-providers, therefore reflecting two of the principles intended to inform PPI. However, whether and to what extent engagement and accountability will be secured through this duty will depend on the way in which services-providers respond to referrals, particularly as regards the depth of reasoning in any explanations for acting or not acting on the reports or recommendations.

According to the government, a major advantage of the new LINks compared with previous representative bodies will be their ability to work with commissioners across health and social care boundaries. While LINks will build on the work of PPIFs, they will be established for a geographical region (corresponding with the 150 local authority areas in England) rather than based within a particular organisation.[127] While intended to 'include a wide range of existing local groups representing patients and the public and to provide a channel for local health and social care organisations to engage with those groups,'[128] LINks will be free to decide locally on appointments, work priorities, membership and participants.[129] In these respects, LINks offer the prospect of meeting two concerns of the Expert Panel: that a PPI body should be independent of, rather than 'controlled or influenced by the health or social care organisation with

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122 Expert Panel, para 5.3

123 2007 Act, s227; see also GovResp para 1.44

124 2007 Act, s224(1). 'Services-provider' is defined in s224(2) as meaning (a) a NHS trust; (b) an NHS foundation trust; (c) a PCT; (d) a local authority; or (e) a person prescribed in regulations. 'Services-provider' is defined in regulation 1(3) of Statutory Instrument 2008, No. 528, *The Local Involvement Networks Regulations 2008* as meaning: '(a) a National Health Service Trust; (b) an NHS foundation trust; (c) a PCT; and (d) a local authority. Included within this definition therefore are bodies which in the terminology of the 'purchaser-provider' split have traditionally been described as *purchasers/commissioners*, as opposed to *service providers*.

125 Statutory Instrument 2008, No. 528, *The Local Involvement Networks Regulations 2008*, regulation 5(2)(b). The explanation must be provided within 20 working days from the date of receipt of the report or recommendation (regulation 5(2)).

126 s234 LGPIHA 2007, inserting a new s17A (SHAs) and s24A (PCTs) into Part 2 of the National Health Service Act 2006.
2007 Act, s24A

127 GovResp (2006), para 1.5

128 GovResp (2006), para 1.6.

129 The difference between a member and a participant of a LINk is explained in Department of Health Guidance*: Getting Ready for LINks: Planning your Local Involvement Network* (August 2007), paras 1.7-1.8.

which it is involved;'[130] and that PPI should look 'at the individual's journey through a variety of health and social care services.'[131] Furthermore, leaving issues of membership open to local determination appears to offer the opportunity to meet the government's aim that LINks will include 'user groups, local voluntary and community sector organisations and interested individuals.'[132] During the transition period from PPIFs to the full implementation of LINks, Forum members are being encouraged to become involved in their successors. A number of 'early adopter' projects developed by CPPIH are being used to pilot LINks. The Healthcare Commission will 'collect learning from two test site projects that it has been running for over a year, which focus on a model that may be applied to LINks.'[133]

The 2007 Act requires each Local Authority with social service responsibilities to make contractual arrangements with someone other than the authority (the 'Host') for the establishing of a LINk in its area, roughly corresponding with the new geographical map of PCTs.[134] The contracts tendered and awarded by Local Authorities must conform to a specification developed by the Department of Health, which takes into account the views of respondents to the White Paper consultation.[135] The support to be provided by the Host organization includes the recruitment of members, the coordination of priorities and activities, data management and record keeping, compliance with equality legislation, and assisting in the development of effective working relationship with partners.[136] Not-for-profit bodies that currently support Forums are expected to bid for contracts to support LINks. Local Authorities are being strongly encouraged to involve local people and organisations in the process of awarding the first contract, after which LINk members are expected to be involved in the awarding of subsequent contracts.[137] It may be suggested that the Local Authority's roles in awarding the contract to the Host and in commissioning and providing social care are in tension with the aim of independence for LINks. There may be a further threat to such independence where the body contracted to host the LINk is itself a provider of health or social care services, whether located in the private or not-for-profit sector.[138] In this regard, the Department of Health has stated that any prospective host 'will need to state what interests it has and show that it has a protocol or plan in place to address potential conflicts of interest.'[139] The government has responded to the further concern raised in the White Paper that LINks could become dominated by single issue campaigns by stating that:

> The host organisation will guide the LINk to seek to access the views of the whole community, making use of the different powers that LINks will have, and if they are

130 Expert Panel, para 4.1. The Panel expressed concern that there were cases in which Community Health Councils and Patient Forums had suffered either from being to close to, or too independent of, the institution to which they were attached.

131 Expert Panel, para 7.3

132 ASLOV, 15

133 GovResp, para 2.8

134 2007 Act s221(1)

135 The Department of Health has published guidance, *Getting Ready for LINks: Contracting a host organisation for your Local Involvement Network* (August 2007)

136 GovResp, para 1.20

137 GovResp, para 1.22

138 Julian Le Grand makes the general point that not-for-profit organisations may have an agenda which 'isn't necessarily concerned with the same agenda as the government or indeed the users' of health or social care services. BBC Radio 4 *Analysis* (5 July 2007).

139 DH *Getting Ready for LINks: Contracting a host organisation for your Local Involvement Network* (August 2007), p 13

> unsuccessful in this they will be failing in one of their contractual obligations, and will be liable to sanctions or removal of contract.[140]

While the proposed relationship between Local Authorities and Hosts appears reasonably clear,[141] there is considerable uncertainty as to both the form that LINks will take and how they will operate in relation to other representative bodies. The Department of Health maintained that the lack of detail in the Bill was deliberate in order to promote flexibility.[142] The HCHC described how LINks might be based on one (or a combination) of two models.[143] A first model builds on best practice of current Forums, having a core group of members running the LINk, sitting on Trusts' boards, undertaking surveys or visits, producing reports, challenging Trusts on various aspects of their work, and developing expertise on NHS issues.[144] The second model is very different from current PPIFs, having no real core so the concept of membership does not apply in the same way. Rather than attempting to operate on behalf of patients and seeking to represent the community, in this interpretation LINks will be 'a sort of junction box or a sort of facilitative mechanism.'[145] In both models the emphasis is on the organization as a network with no limits on the number or diversity of participants;[146] for example, it is envisaged that local service providers may also become a member of the LINk.[147] The HCHC felt that the government intended LINks to use a combination of the two models,[148] and the DH guidance, *Planning Your Local Involvement Network,* appears to allow for this while emphasising that the structure of the LINk should be dependent on local decisions and conditions.[149] The government maintains that '[t]he changes that we are implementing by establishing LINks will increase the ways by which people can voice their views and share their experiences, and as a result improve and change the services they receive.'[150]

Despite the potential benefits of such flexibility, the lack of detail about the structure and workings of LINks may also be a source of problems. The HCHC noted:

> The lack of clarity about LINks role and structure is likely to create confusion and inactivity. This may mean that LINks will have difficulty deciding what they are going to do and how to do it and as a result lose the interest of volunteers. This would be particularly unfortunate at a time when significant change is occurring in the NHS and social care services.[151]

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140 GovResp, para 1.36

141 The Local Authority will agree with the Host indicators for monitoring the performance of the Host – see Contracting a host organisation for your Local Involvement Network, Ch 2 Section 4.1. Local authorities will be at one remove from LINks, their control being indirectly exercised through the contract – a classic example of the New Public Contracting (see P.Vincent-Jones, *The New Public Contracting* (Oxford: Oxford University Press, 2006). The role of the Local Authority will be to manage the contract with the host, and ensure that its contractual obligations are met (GovResp, para 1.27).

142 Discussed in ASLOV, 14

143 House of Commons Health Committee, *Patient and Public Involvement in the NHS, Third Report of Session 2006-7*, Vol. 1, paras 115-126

144 HCHC, para 115

145 HCHC, para 116. A number of potential problems exist with this 'conduit' model, including lack of focus; limited ability to hold NHS bodies to account, duplication of effort with existing networks, and ineffectiveness in increasing representation of hitherto marginalized groups (para. 150).

146 GovResp, para 1.35

147 GovResp, para. 1.45

148 HCHC, paras 122-126

149 Planning your Local Involvement Network, Para. 5

150 GovResp, para 1.16

151 HCHC, para 152

There are further uncertainties as to the approach that any LINk will take in its work, how it will decide this approach, and how it will arrive at recommendations or reports. The LINk may maximise the range of stakeholders, or restrict deliberation to a small forum in order to facilitate greater depth of debate. The LINk may aim to present a single agreed judgement to health and social care bodies, or choose to allow members to present their own, possibly conflicting, recommendations.[152] The form of engagement of LINks with health and social care bodies to whom recommendations are made is also unclear. Such bodies might be excluded from the deliberative process initiated by the LINk or may participate in it – in which case doubt may be cast on the independence of the LINk.

As regards accountability, the government places considerable faith in the ability of the LINk and the Host jointly to resolve any problems: 'the host and the LINk will need to clarify expectations about accountability early on in their relationship.'[153] The DoH guidance, *Planning Your Local Involvement Network,* explains:

> In the context of LINks, we think of accountability as the process for explaining or justifying actions and decisions, and demonstrating the progress of work that the LINk has undertaken in relation to its roles. No national system of accountability has been put in place, as this should be determined locally.[154]

However, the government has stated that it will 'be developing national quality benchmarks for LINks, including tools for localised performance management, peer review and recognisable success criteria for key areas, including the performance of hosts.'[155] Furthermore, the Act and secondary legislation impose specific requirements on LINks to develop and publish procedures for making decisions.[156] In addition to producing an annual report to the Secretary of State, LINks will need to 'measure and demonstrate how they have performed to the local communities, to the host, to the local authority and, through this local approach, to the government.'[157]

(b) Service commissioning

One of the government's main justifications for the abolition of Forums was that the centrality of commissioning and the increasing plurality of healthcare providers in England had made the performance of representation and scrutiny functions within individual healthcare bodies no longer appropriate.[158] Rather than looking at services in isolation, the aim is for the 'joined-up' PPI system to follow the whole user experience across health and social care, with the involvement of all those people who use, or might use, any health or social care services in the area.[159]

The 2007 Act accordingly imposes new duties on SHAs and PCTs to report on any consultations carried out or proposed to be carried out (as required by the Secretary of State) before the making of commissioning decisions, and on the influence that the

152 By comparison, 'National Voices' intends to take both the approach of presenting a unified case, and of enabling members individually to put their own case to government (see sub-section (e) below).
153 Planning Your Local Involvement Network, para. 9.5
154 Planning Your Local Involvement Network, para. 9.1
155 Planning Your Local Involvement Network, para. 9.14
156 2007 Act s223; Statutory Instrument 2008, Number 528, Sections 2,3,4
157 Planning Your Local Involvement Network, para. 9.11
158 DCLG, Local Government and Public Involvement in Health Bill: Regulatory Impact Assessment, December 2006, para. 7, p 49. Commissioners are the 'power base of the NHS system' – para. 2, p 49.
159 DCLG para. 8, p 50

results of consultation have had on those decisions.[160] SHAs and PCTs will have to demonstrate that views of patients and public are effectively represented in their prospectus, and show how commissioning decisions have been responsive to the community. The Update and Commissioning Framework published in July 2006 specifies a number of objectives of effective commissioning. This should be directed at improving health and well-being; reducing health inequalities and social exclusion; securing access to a comprehensive range of services; improving the quality, effectiveness and efficiency of services; increasing choice; and ensuring a better experience of care through increased responsiveness to peoples' needs.[161] Commissioning organisations (such as Practice Based Commissioning Groups, PCTs, Specialised Commissioning Groups, commissioners within local authorities, and joint commissioning groups) will have to decide how to involve local people and service users. 'This will enable the commissioners to understand the services people wish to receive, and to then negotiate contracts with local providers, both existing and new, to supply them in a responsive and convenient way'.[162]

As outlined in section (a) above, the government intends that LINks should play a major role in commissioning:

> LINks will have a strong relationship with all the decision makers in health and social care to ensure the commissioning of services is informed by the views and preferences of people at all levels. They will become involved in assessing community needs, deciding priorities and influencing decisions about what services should be commissioned … They will recognize the importance of integrating equality and human rights principles into the strengthening of local voices.'[163]

The government maintains that LINks will be ideally placed to monitor contract performance and service provision in a rigorous and robust way by going out to groups and communities.[164] The aim is that they will form part of the incentive structure encouraging commissioners and providers 'to talk to local people, to seek their views and insights, and to involve them in how to plan, prioritise and decide their activities.'[165]

(c) Revised 'section 11' consultation duty

The original section 11 of the Health and Social Care Act 2001 had required NHS bodies to make arrangements, in respect of health services for which they were responsible,[166] for persons to whom those services were provided or might be provided to be 'involved in and consulted on – (a) the planning of the provision of those services, (b) the development and consideration of proposals for changes in the way those services are provided, and (c) decisions to be made by that body affecting the operation

160 s234 LGPIHA 2007, inserting a new s17A (SHAs) and s24A (PCTs) into Part 2 of the National Health Service Act 2006.

161 DH, *Health Reform in England: Update and Commissioning Framework*, July 2006, Gateway reference 6865, para 1.14

162 Update and Commissioning framework, para 1.15

163 GovResp, para 2.6

164 GovResp, para 2.7

165 GovResp, para 2.9.

166 The section applied to Health Authorities, PCTs, NHS trusts, and (later) Foundation Trusts. A body was defined as 'responsible' for health services '(a) if the body provides or is to provide those services to individuals, or (b) if another person provides, or is to provide, those services to individuals (i) at that body's direction, (ii) on its behalf, or (iii) in accordance with an agreement or arrangement made by that body …' – s11(3).

of those services.'[167] The HCHC was highly critical of the practical implementation of this duty:

> Too often it seems to the public that decisions have been made before the consultation takes place. Too often NHS bodies have sought to avoid consultation under Section 11 about major issues. Unfortunately the Department of Health has supported those NHS organisations in trying to limit the scope of Section 11.[168]

The Committee felt that these concerns could be better addressed through guidance and a willingness to follow cases of good practice than by further legislation. Nevertheless, the 2007 Act amended the 'section 11' duty by altering the range of issues on which the public must be involved, and changing the definition of 'public involvement'.[169] Against the recommendation of the Expert Panel, however, the revised duty does not extend to independent sector providers.[170]

It appears that the effect of the new 'section 11' will be to narrow the range of issues on which involvement will be required, and to alter the nature of the involvement.[171] The 2007 Act amends section 242 of the National Health Service Act 2006 ('Public Involvement and Consultation') as follows:

> (1B) Each relevant English body must make arrangements, as respects health services for which it is responsible, which secure that users of those services, whether directly or through representatives, are involved (whether by being consulted or provided with information, or in other ways) in –
> (a) the planning of the provision of those services,
> (b) the development and consideration of proposals for changes in the way those services are provided, and
> (c) decisions to be made by that body affecting the operation of those services.
>
> (1C) Subsection (1B)(b) applies to a proposal only if implementation of the proposal would have an impact on—
> (a) the manner in which the services are delivered to users of those services, or
> (b) the range of health services available to those users.
>
> (1D) Subsection (1B)(c) applies to a decision only if implementation of the decision (if made) would have an impact on—
> (a) the manner in which the services are delivered to users of those services, or
> (b) the range of health services available to those users.
>
> (1E) The reference in each of subsections (1C)(a) and (1D)(a) to the delivery of services is to their delivery at the point when they are received by users.
>
> (1F) For the purposes of subsections (1B) to (1E), a person is a 'user' of any health services if the person is someone to whom those services are being or may be provided'[172]

Subsections 1C and 1D restrict the range of issues on which users must be involved to those which would affect the user's experience of the service (where implementation of

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167 Consolidated as s242 of the National Health Service Act 2006.

168 HCHC, para 271

169 The new duty applies to 'relevant English bodies' (SHAs, PCTs, NHS trusts, and NHS Foundation Trusts) – Local Government and Public Involvement in Health Act 2007, s233(2)(1A). The new duty applies also to 'relevant Welsh bodies' – s233(2)(1).

170 Expert Panel, see para 10.3 - 10.5

171 However, as discussed above, the Act further imposed new duties on SHAs and PCTs (as required by the Secretary of State) to report on any consultations carried out, or proposed to be carried out, before the making of commissioning decisions, and on the influence that the results of consultation have had on those decisions – s234 LGPIHA 2007, inserting a new s17A (SHAs) and s24A (PCTs) into Part 2 of the National Health Service Act 2006.

172 Local Government and Public Involvement in Health Act 2007, s233.

the proposal or decision 'would have an impact … on the manner in which the services are delivered to users'), or the choice of service available ('impact on … the range of health services available'). It is instructive to compare this section of the Act with the corresponding clauses in early versions of the Bill. The Bill had also sought to limit the areas in which consultation was required, by providing that they must be 'significant' – meaning those changes/decisions which have a 'substantial' impact on: (i) the manner in which services are delivered to users of those services at the point when they are received by users; and (ii) the range of health services available to those users.

The restriction of the range of issues on which involvement should take place might be defended on the ground that there is a need to specify 'circumstances in which formal … consultations should not take place either because they would be a waste of money or because they would compromise safety.'[173] However, such reasoning does not adequately explain or justify the reform. One suggestion is that the government's motive here was 'to remove the case law relating to section 11', thereby giving the Department a better chance in court in instances of legal challenge by way of judicial review.[174] In any event, it is clear that the intention was to limit involvement to issues which directly affect user experience and choice. The reformed consultation duty precludes public involvement in more fundamental issues of how services are provided and by whom (for example by public or independent providers). Indeed the government has explicitly acknowledged this restriction:

> We want consultation activity to be meaningful and we certainly want to avoid consultation being undertaken when there is no significant change or decision with which local people can meaningfully engage. For these reasons, we are placing a requirement for consultation only to be required when there is a meaningful impact on the range of services or the manner in which they are provided – for example, this would cover a change in opening hours, or a change of site, rather than managerial changes that do not affect service provision.[175]

Further clarification was given by Phil Woolas (then Minister for Local Government) who explained that the government did not accept there should be pubic involvement in decisions to change service providers, where this did affect not service provision.[176] This begs the question whether it is plausible to maintain that a change in provider would *not* affect service delivery. A further question is whether 'changes in the way services are provided' is interpreted as referring to the short-term or long-term (for example as might be argued to result eventually from the introduction of independent providers).

Whereas the 2001 Act had required that that patients and the public should be 'involved in and consulted on' the planning of services, decisions affecting their operation, and proposals for changes in their provision, the 2007 Act requires that 'users of services' should be 'involved (whether by being consulted or provided with information, or in other ways).'[177] The government has denied that 'involvement' should be understood as

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173 HCHC, para 257

174 The use of the term 'users of services' in place of 'persons to whom services are being or may be provided' betrays the consumerist philosophy behind the reform of 'section 11'. The change is of little significance otherwise since 'service user' is defined in subsection (1F) as a 'someone to whom (those) services are being or may be provided'.

175 Government Response to the Health Committee's Report on Patient and Public Involvement in the NHS, 2007, p 22.

176 House of Commons Public Bill Committee on the Local Government and Public Involvement in Health Bill, 6 March 2007 (afternoon), Column 570

177 Local Government and Public Involvement in Health Act 2007, s242(1B)

something less than 'consultation.'[178] While the wording of the Act literally allows this interpretation, it also implies that the duty may be discharged by simply providing information. Such flexibility might be defended with reference to the criticism of the 2001 Act that it did not provide for differentiation of the level of consultation required in different cases, 'however minor they may be.'[179] The government has stated that the form of involvement – whether by consultation, provision of information, or another method – should depend on the circumstances of that case.[180] The 2007 Act imposes a duty on NHS bodies to take account of Department of Health guidance that will be issued on the level of involvement which should be used in different circumstances.[181]

The new duty imposed on each PCT and SHA under the Act to report on consultations that they have carried out or propose to carry out before making commissioning decisions, and on the influence that the results of consultation have on such decisions,[182] goes some way to addressing the concern that too often in the past 'decisions have been made before the consultation takes place.'[183] Furthermore, this reporting duty appears to be in keeping with the principles of engagement and accountability which the government believes should underlie PPI more generally. As with the analogous duty on the part of 'services-providers' to respond to recommendations and reports from a LINk, the evaluation of the effectiveness of the new duty will require an assessment of the account and reasons that PCTs and SHAs provide in demonstrating how they have responded to points raised either by the LINK, or by members of the public directly in any consultation process. Such assessment may be undertaken in part with reference to criteria contained in forthcoming guidance from the Department of Health, to which PCTs and SHAs must have regard. To date there has been little indication of what will be expected of PCTs and SHAs in responding to consultation, although the government has said that LINks may choose to review the ways in which responses are made.[184] Two further factors are likely to be relevant in determining the effectiveness of the new duty to report on consultation in relation to commissioning. First, the requirement to report under this section is dependent on the specific direction of the Secretary of State. A second limiting factor concerns the nature and scope of the consultation.[185] If this is limited to issues which affect user experience and choice, then the responses (and hence the degree of engagement and accountability) will be similarly constrained.

As already indicated above, the Expert Panel had recommended that section 11 be strengthened and its scope extended 'to require *every body* which is responsible for delivering health and social care services (commissioners and providers) to involve, consult, and respond to users and the public', including in relation to the reconfiguration

178 Baroness Morgan of Drefelin, Lords Hansard, 15 Oct 2007, Column 592. Baroness Morgan states that the government's position on this is in contrast to a Court of Appeal judgement, which ruled that in at least one case, involvement may be less than consultation (Court of Appeal, R. (on the application of Fudge) v South West Strategic HA [2007] EWCA Civ 803; (2007) 10 C.C.L. Rep. 599; [2007] LS Law
Medical 645; (2007) 98 B.M.L.R. 112)

179 Phil Woolas, House of Commons Public Bill Committee, 6 March 2007 (afternoon), Column 568.

180 Baroness Morgan, Lords Hansard, 15 Oct 2007, Column 592

181 The DH have said that guidance will be issued in Spring 2008 (See Department of Health, *Duty to Involve Patients Strengthened, Briefing on s 242 of NHS Act 2006* (December 2007))

182 2007 Act, s234

183 HCHC, para 271

184 GovResp, para 1.51

185 s24A(3) provides that the Secretary of State may give directions as to the form and content of reports, the matters to be dealt with, the periods to be covered, and publications.

of services and significant organisational change.[186] This recommendation was expressly acknowledged as entailing new obligations on *providers* to involve the public in processes of service improvement: 'This should be delivered through contractual arrangements with commissioners'.[187] This broad vision is not reflected in the 2007 Act, which restricts the duty to consult to NHS bodies. While the Secretary of State is issuing directions to commissioners requiring them to impose a contractual duty on independent providers to respond to requests for information from LINks,[188] it does not extend to involving the LINks (or the wider public) in making changes to service provision.[189]

(d) Independent review

The HCHC had been critical of the failure of the Secretary of State to make proper use of the procedure for referring proposed organisational changes to the Independent Reconfiguration Panel (IRP):

> The Secretary of State's interventions following extensive local consultations threatens to undermine public confidence in the consultation procedure system. We are also concerned that few referrals from Overview and Scrutiny Committees are subsequently referred by her to the Independent Reconfiguration Panel. We recommend that the Secretary of State refer all OSC referrals to the Panel. She should also seek the advice of the Panel before exercising her extensive powers to intervene in reconfigurations. The Panel is also available for advice before formal consultation begins and wide use of this advisory service should help to make formal consultation more acceptable. [190]

The 2007 Act does not address these concerns. The government response to the Committee emphasised that since the Secretary of State is accountable for the NHS, she is right to take 'a view on important contested service changes, where asked to do so through the local democratic process.' The government view is that the IRP should be used only as last resort so few referrals should be expected,[191] and that the IRP is in any case well utilised by organisations seeking informal advice on the development of proposals for NHS service change.

(e) National voice

Both the Expert Panel and the HCHC agreed on the need to strengthen and make more systematic the role of patient and public involvement in debates on national healthcare policy. The HCHC states that:

> [W]here patient and public viewpoints can make a genuine contribution to debate, consultation on national policy may be valuable both in terms of enhancing accountability and improving policy making, even if final decisions must ultimately rest with elected representatives. We have heard that at a national level patient and public involvement is fragmented and lacking a coherent strategy; we recommend that the Government should address this as a priority.[192]

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186 Expert Panel, para 10.5

187 Expert Panel, para 10.5

188 As discussed above, the contractual duty will also enable LINks to enter and observe premises of independent providers.

189 This duty was promised in the *Local Government and Public Involvement in Health Bill Committee Stage Report* (March 2007), p 21. It has been explained in Department of Health, *Local Involvement Networks, Briefing for independent providers* (April 2008).

190 HCHC, para 273

191 '[I]t is for the Secretary of State to determine when she wishes to seek independent advice from the IRP' – Government Response to the Health Committee's Report on Patient and Public Involvement in the NHS (June 2007), p 23

192 HCHC, para 278

The government has welcomed the setting up of 'National Voices', a charitable body comprising voluntary sector organisations with interests in supporting users of health and social care services.[193] The National Voices Working Group has emphasised that the body will be independent while complementing government measures on PPI.[194] The government's view is that:

> National Voices could have two new and valuable roles in helping the DH to engage with users and the public in a more coherent manner. Firstly, to gather and articulate views on generic issues, such as choice, system reform or electronic patient records where it is recognised there are often gaps in engagement, as there is no obvious user group with which to initiate discussions. Secondly, to act as a broker to put the Department in touch with specialist groups and with seldom-heard voices in user groups.[195]

This reference to 'users and the public' suggests wider engagement at the national level than will be possible under the revised 'section 11' duty, which will be confined to issues of user experience and choice. However, while including within its remit such matters as 'payment by results, commissioning, patient and public involvement [PPI], access, information, self care, care plans, reorganisations or regulation,'[196] National Voices will focus mainly on users and carers:

> 'National Voices' will create an 'organisation of organisations', a network of national not-for-profit organisations that champion the interests of service users, patients and carers and will give them a complementary, co-ordinated voice.[197]

National Voices will represent user interests by developing policy recommendations and working with the government 'in a systematic and officially recognised way to help formulate health and social care policy, and … (provide) feedback on implementation of policy'. This will be achieved by arranging and co-ordinating engagement between member organisations and government bodies,[198] and by helping member organisations 'to build their capacity to influence.'[199] The intention is to '[w]ork to enable all service user, patient and carer voices to be heard, including those that often find it difficult to be heard.'[200] A two-pronged approach will be taken to increasing user voice in policy development. First, policy recommendations will be developed through an internal process ('based on shared ownership and shared learning' among members, in which 'all voices have equal value'[201]), then presented to government. The second approach entails setting up systems giving member organisations the opportunity to debate with government officials, for example through roundtable discussions. The aim here 'is not to communicate a single view to ministers but rather to enable a range of views to be heard in one place and at the same time.' [202]

(f) Economic regulation

193 Gov Resp to HCHC, p 24

194 Emma Taggart, on behalf of National Voices Working Group *National Voices; A proposal to strengthen the voices of service users, patients and carers in national health and social care policy making* (January 2007), pp 8-9. Page 18 of the same document raises the possibility of National Voices working with LINks in the future.

195 Gov Resp to HCHC, p 24

196 National Voices proposal, p 7

197 National Voices proposal, p 5

198 National Voices proposal, p 11

199 National Voices proposal, p 12

200 National Voices proposal, p 12

201 National Voices proposal, p 10

202 National Voices proposal, p 16

Economic regulation is an integral part of the government's current strategy for the reform of healthcare governance in England. The 2006 consultation paper, *The Future Regulation of Health and Adult Social Care in England*,[203] specified the regulatory conditions necessary for the choice mechanism to function to ensure that services are made more responsive to the needs and preferences of patients and service users:

> The simplest and most direct way to increase peoples' control is to give them more choice. The Government aim for reform of public services is that, wherever practical, individual service users should be offered a choice over what is provided and how it is provided and have better information on which to make these choices. This will create healthy competition and encourage providers to develop new models of care. Once chosen, providers will need to cooperate with other providers to deliver smooth pathways of care.[204]

The equation of patient choice with patient power was underlined in Gordon Brown's statement in Parliament outlining his legislative programme shortly after becoming Prime Minister in 2007. The government's aim was 'to put power in the hands of patients and staff and ensure that every patient gets the best possible treatment,'[205] while integrating the separate systems of regulation and assessment of health and adult social care.[206] To this end the Health and Social Care Act 2008 merges three current regulators (the Healthcare Commission, the Commission for Social Care Inspection, and the Mental Health Act Commission) into a single 'super-regulator' – the Care Quality Commission (CQC) – with a wide range of new regulatory powers and duties. The remit of the independent regulator of NHS Foundation Trusts, Monitor, is specific to FTs and will remain unchanged.[207] The Audit Commission also retains its existing role in ensuring that public money is spent economically, efficiently, and effectively.

The new regulatory framework is intended to promote continuous improvement in quality, efficiency, and responsiveness by maximising economic incentives for organisations to achieve excellence. This part of the reform rationale is set firmly within the institutional economics paradigm. Five main risks to the effective operation of economic incentives were identified in the 2006 consultation paper: monopoly power (where customers cannot choose to go elsewhere); asymmetric information (one party has more information than another – providers tend to have more information than commissioners, patients and service users); externalities and public goods (unintended consequences and indirect impact on others, either immediately or later); agency (the tendency for choices to be made by patients on the basis of quality rather than price, since citizen is not paying for services directly); and finally, equity (while competitive markets create incentives to improve quality, they do not necessarily achieve equity of provision either geographically or across all population groups).[208]

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[203] Department of Health, *The Future Regulation of Health and Adult Social Care in England*, (Consultation Paper, November 2006).

[204] Para 1.14

[205] 10 Downing Street, 'PM reveals plans for reform', 11th July 2007 http://www.number10.gov.uk/output/Page12417.asp

[206] Para 1.15. This analysis focuses on Part 1 of the Act, 'The Care Quality Commission'. The regulation of health professions and of the health and social care workforce is governed by Part 2.

[207] The Office of the Independent Regulator of Foundation Trusts (Monitor) was created under Part I of the Health and Social Care (Community Health and Standards) Act 2003. While FTs are not subject to central direction by the Secretary of State, the regulator is required to exercise regulatory functions in a manner consistent with the performance by the Secretary of State of duties under the National Health Service Act 1977 (s 3). The regulator is required to make a code for determining borrowing limits of any FT (s 12). The regulator is charged with administering the process of 'authorisation' of FTs to provide goods and services for purposes related to the provision of health care.

[208] Para 2.4

According to the consultation paper, the remedies to these risks (the seven 'regulatory functions') are suggested by the experience of regulation in other public service utilities contexts, and of health and social care systems around the world:[209] (i) Independent safety and quality assurance; (ii) Promoting choice and competition – encouraging diversity of provision and creating choice and competition as key drivers of quality and innovation; (iii) Assurance of effectiveness of commissioning – through performance management and/or performance assessment; (iv) Information provision and performance assessment of providers – patients and users need timely and reliable information on which to base choices, while commissioners need such information on which to base commissioning decisions and manage contracts; (v) Price setting and equitable allocation of resources; (vi) Stewardship of publicly owned assets; and (vii) Distress and failure interventions – entailing a clear rules-based regime which holds publicly owned providers to account for performance, enables intervention to deal with significant failings, makes possibility for failure real, but ensures continuity of services in the event of failure of provider in any sector.

Accordingly Part 1 of the Act makes provision for various functions of the CQC,[210] including registration (Ch 2), review and investigation (Ch 3), and inspection and enforcement (Ch 6). Several significant amendments to the original Bill were made in respect of the introductory chapter of the Act.[211] Section 3(1) sets out the Commission's main objective 'to protect and promote the health, safety and welfare of people who use health and social care services.'[212] Section 3(2) provides that the Commission is to perform its functions 'for the general purpose of encouraging – (a) the improvement of health and social care services, (b) the provision of health and social care services in a way that focuses on the needs *and experiences* of people who use those services,[213] and (c) the efficient and effective use of resources in the provision of health and social care services.' Section 4(1) specifies matters to which the Commission must have regard in performing its functions, including:

> (a) views expressed by or on behalf of members of the public about health and social care services,[214]
>
> (b) experiences of people who use health and social care services and their families and friends,[215]
>
> (c) views expressed by local involvement networks about the provision of health and social care services in their areas,[216]
>
> (d) the need to protect and promote the rights of people who use health and social care services (including, in particular, the rights of children, of persons detained under the

209 Para 2.5

210 'The Commission will be an independent, responsive and proportionate regulator with safety and quality at its core' (Parliamentary Under-Secretary of State for Health, Lord Darzi, introducing the second reading of the Bill in the House of Lords), col. 449, 25th March 2008.

211 Here we consider sections 3 and 4. The new section 5 on 'user involvement' is considered below, in part (g) on 'the regulation of involvement'. A new section 58 provides that 'the Secretary of State may publish guidance about steps which regulatory authorities may take in exercising relevant powers with a view to avoiding the imposition of unreasonable burdens on those in respect of whom the powers are exercisable' (s68(1)).

212 s3(1).

213 The wording of the original clause 2(5)(b) provided for the encouragement of 'the carrying on of such activities in a way that focuses on the *needs of those for whose benefit the* activities are carried on'.

214 The original clause 2(3)(a) referred to views expressed by *members of the public* only.

215 new sub-section

216 new sub-section

> Mental Health Act 1983, of persons who are deprived of their liberty in accordance with the Mental Capacity Act 2005 (c.9), and of other vulnerable adults),[217]
>
> (e) the need to ensure that action taken by the Commission in relation to health and social care services is proportionate to the risks against which it would afford safeguards and is targeted only where it is needed,[218]
>
> (f) any developments in approaches to regulatory action,[219] and
>
> (g) best practice among persons performing function comparable to those of the Commission (including the principles under which regulatory action should be transparent, accountable and consistent).'[220]

Persons carrying out 'regulated activities' in health or social care in England are required to register with the Commission as service providers.[221] The registration regime includes NHS service providers for the first time.[222] Introducing the second reading of the Bill in the House of Lords, Lord Darzi stated:

> It is right and proper that NHS services should be subject to the same rigorous registration regime as applies to providers in the social care or independent setting. Providers will be able to offer regulated health or social care services only if the regulator assesses them as meeting the registration requirements, giving patients an assurance of safety and quality wherever they choose to be treated across the health and adult social care system.[223]

The Secretary of State is empowered to issue regulations in respect of 'regulated activities' as regards the provision of information,[224] the quality of services, and the health, safety and welfare of recipients of services.[225] The Commission has powers to vary, suspend, or cancel registration.[226] For each PCT and English NHS provider and local authority, the Commission must conduct periodic reviews of the provision of health/adult social services, and publish a report on its assessment.[227] Again reinforcing the choice agenda, the assessments of providers and commissioners are intended to 'provide an independent view of performance and support both patient choice and local decision-making.'[228] The Commission has specific powers to undertake comparative or other studies designed to enable it to make recommendations for improving economy, efficiency and effectiveness of PCTs and NHS/local authority providers.[229] Powers of entry onto, and inspection of, regulated premises are granted the Commission for the purpose of carrying out its regulatory functions.[230] In accordance with regulations made by the Secretary of State, prescribed persons may be required by the Commission 'to provide an explanation of any relevant matter to the Commission … in circumstances where the Commission considers the explanation necessary or expedient for the purposes of any of its regulatory functions.'[231] The Commission enjoys a wider range of

217 The original clause 2(3)(d) referred to 'the need to safeguard and promote the rights and welfare of children and vulnerable adults'.
218 Formerly clause 2(3)(c).
219 Formerly clause 2(3)(e).
220 Formerly clause 2(3)(f).
221 Health and Social Care Act 2008, s10
222 House of Lords, col. 450, 25th March 2008.
223 Parliamentary Under-Secretary of State for Health, Lord Darzi, col. 450, 25th March 2008.
224 s20(3)(g).
225 s20(2).
226 ss16-18.
227 s46. Under s 48 the Commission has powers in respect of 'special reviews and investigations'.
228 Parliamentary Under-Secretary of State for Health, Lord Darzi, col. 450, 25th March 2008.
229 s54.
230 ss60-63.
231 s65(1)

enforcement powers than those available to previous regulators, including the issuing of penalty notices and the commencement of criminal proceedings.[232]

The adult social care system in England is said already to benefit from many of the regulatory features advocated in *The Future Regulation* consultation paper: 'As this develops within the NHS, the role of independent regulation will change and focus on public accountability to the taxpayer and assurance to patients and service users that all providers meet national standards of safety and quality.'[233] In further support of this agenda, the Co-operation and Competition Panel (CCP) began work on 30th January 2009, charged with helping to ensure value for money for taxpayers and high quality care for patients for NHS funded services. Its regulatory remit, set out in terms of reference agreed by the Department of Health and Monitor, includes: monitoring compliance with the Principles and Rules of Co-operation and Competition (PRCC); investigating potential breaches of the Rules, conducting inquiries, and making of recommendations to SHAs, the DH, and Monitor (in relation to Foundation Trusts) on how such breaches should be resolved; reviewing proposed mergers, and providing advice on the wider development of co-operation, patient choice and competition within the NHS; hearing procurement dispute appeals in accordance with the Rules of Procedure and Procurement Dispute Appeal Guidelines; and hearing appeals in cases involving complaints concerning advertising or misleading information, where commissioners and/or providers are alleged to have failed to provide accurate and reliable information to enable patients to exercise choice and control over their healthcare. According to the CCP's website:

> The CCP's approach is grounded in the established principles of economic and competition analysis. However, in applying these principles, the CCP ensures that it takes account of the special features of the healthcare sector, such as it being free at the point of service for patients, the not for profit nature of many organisations providing healthcare services and the help many patients need to make informed choices between service providers.[234] -

To the extent that the new regulatory regime embodied in the Act succeeds in improving information flows, increasing competition, and promoting transparency, benefits to the individual and society in terms of price and quality should result. However, two doubts were raised during Committee Stage debate regarding the role of the CQC.[235] First is the concern that the Commission will not be sufficiently independent of government, particularly in view of the requirement in the Bill that it 'must have regard to such aspects of government policy as the Secretary of State may direct.'[236] The worry here is that government policy may be in conflict with judgements that the Commission would otherwise make. In debate in the House of Commons, the Health Minister (Ben Bradshaw) denied this clause would be used to prevent the Commission from acting as it judged fit.[237] The second concern is that the Commission's 'need to drive efficiency from an economic point of view might conflict with the need to warn about the potential of declining standards.' In denying this possibility, the Health Minister maintained that there was a strong correlation between sound financial management and service quality.[238]

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232 Respectively ss86-90.

233 Para 2.10

234 http://www.ccpanel.org.uk/about-the-ccp/index.html

235 Health and Social Care Bill Committee Stage Report, (11 February 2008) p 13

236 Health and Social Care Bill 2007-08, Chapter 1, s2 (4)

237 House of Commons, Public Bill Committee on the Health and Social Care Bill, Tuesday 15 January 2008 (Morning)

238 Health and Social Care Bill Committee Stage Report, p 13

(g) The regulation of involvement

The Expert Panel made two main recommendations for 'a stronger voice in regulation', both of which were accepted in the subsequent White Paper.[239] First, there should be increased user involvement in regulatory processes, including the work of regulatory bodies.

> The input of users and the public into assessing service quality should be central to the regulators' work … We recommend that the legislation merging the regulators should set out how the single organisation will both regulate stronger voice and how it will involve users of services and the public and put their interests at the heart of its regulatory activities. [240]

While this proposal for the reform of 'voice' were only weakly represented in the original Bill, this aspect was strengthened by amendments in the House of Lords. The 2008 Act provides that the CQC must have regard to both views expressed by or on behalf of members of the public about health and social care services,[241] and experiences of people who use health and social care services and their families and friends.[242] Section 5 further provides that the Commission must publish a 'statement on user involvement', describing 'how it proposes to – (a) promote awareness among service users and carers of its functions, (b) promote and engage in discussion with service users and carers about the provision of health and social care services and about the way in which the Commission exercises its functions, (c) ensure that proper regard is had to the views expressed by service users and carers, and (d) arrange of any of its functions to be exercised by, or with the assistance of, service users and carers.'[243] The government has indicated that the regulators will be encouraged to involve service users in their work (for example in some inspections, in the design of systems and inspection methodologies, and in the use of systematic patient and user feedback to help bring about improvements in the quality of care).[244]

The second and more far-reaching proposal was for the regulation of involvement itself.[245] This part of the vision set out in *A Stronger Local Voice* is concerned to ensure that NHS organisations comply with and fulfil their duties to involve and consult.[246]

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239 'Whilst we are not seeking any legislative change in this area, the proposed merger of current health and social care regulation and inspection bodies does provide an opportunity to integrate and build on the current strengths', ASLOV White Paper, 20.

240 Expert Panel, paras 11.4 -11.5.

The Government has accepted this recommendation. The regulators (i.e. Healthcare Commission, Monitor, CSCI, and the Mental Health Act Commission) will be encouraged to involve service users in their work, including: in some inspections; in the design of systems and inspection methodologies; the use of systematic patient and service user feedback to help bring about improvements in the quality of care (GovResp, para 2.15). This is echoed in DH guidance which states that '[LINks] should also feed their findings into key bodies such as the Healthcare Commission and the Commission for Social Care Inspection. This will enable them to establish a local agenda driven by the priorities and interests of local communities.' *Contracting a host organisation for your Local Involvement Network*, Annex A, para 1.5 (p17)

241 s4(1)(a)

242 s4(1)(b)

243 s5(1). For the purposes of this section, 'service users' are defined in s5(4)(a) as 'people who use health or social care services.' 'Carers' are defined in s5(4)(b) as 'people who care for service users as relatives or friends'.

244 GovResp, para 2.15. DH guidance states that '[LINks] should also feed their findings into key bodies such as the Healthcare Commission and the Commission for Social Care Inspection. This will enable them to establish a local agenda driven by the priorities and interests of local communities', *Contracting a host organisation for your Local Involvement Network*, Annex A, para 1.5 (p17).

245 We recommend that explicit assessment criteria are established to enable regulators to assess the performance of commissioners … including an assessment of how local arrangements for involving

> The regulators will seek to develop assessment criteria to measure performance against national standards … Current core standards for the NHS include the need to seek out and take account of the views of patients, carers and others in designing, planning, delivering, and improving healthcare services. LINks and OSCs will help commissioners be more accountable to local people. There is a formal line of accountability from PCTs to SHAs, and LINks and OSCs will be able to make formal representation to an SHA if they have concerns.[247]

The assessment criteria should form part of an organisation's annual performance rating, including (i) assessment of how local arrangements for involving service users, the public and the LINks are supported and utilised; and (ii) how well commissioners and providers of health and social care services have sought and responded to the views and needs of the communities and groups within the populations.[248]

The 2008 Act provides that the Secretary of State may direct the Commission to devise indicators which will be used to assess the performance of PCTs, English NHS providers and English Local Authorities.[249] The Commission must also: '(a) prepare a statement describing the method that it proposes to use in assessing and evaluating a body's performance … and (b) submit the statement to the Secretary of State for approval.'[250] However, it is not clear whether such indicators will be required for the assessment of public and patient involvement.[251] An advisory committee will be established 'for the purpose of giving advice or information to it about matters connected with its functions,' to which the Commission must have regard.[252] In the Commons Committee Stage debate the Health Minister stated that the advisory committee would cover patients' and users' views.[253] In response to concerns that this provision for public and patient involvement was not sufficiently strong, the Health Minister gave an assurance that he was still reflecting on issues connected with public and patient involvement.'[254]

(h) Conclusion

The Foreword to *The Future Regulation of Health and Adult Social Care in England* by the Secretary of State for Health states:

> In public services, we are making a radical shift from top-down, target-driven performance management to a more bottom-up, self improving system built around

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service users and the public, in particular the LINks, are supported and utilised, and how well commissioners have sought and responded to the views and needs of communities and needs within their populations – Expert Panel, para 11.6

246 ASLOV, 20

247 ASLOV, 20

248 ASLOV, 21

249 'The assessment of a body's performance is to be by reference to such indicators of quality as the Secretary of State may devise or approve' (s46(5). The Commission must also: '(a) prepare a statement describing the method that it proposes to use in assessing and evaluating a body's performance … and (b) submit the statement to the Secretary of State for approval' (s46(6)). The Commission's assessment of performance will be conducted with reference to the published indicators and method statement, in the context of standards set by the Secretary of State under powers conferred in s45.

250 s46(6). The Commission's assessment of performance will be conducted with reference to the published indicators and method statement, in the context of standards set by the Secretary of State under powers conferred in s45.

251 Bill as introduced to House of Lords 20 Feb 2008.

252 Schedule 1 (6)

253 Health and Social Care Bill: Committee Stage Report (House of Commons Research Paper 08/14, 11th February 2008), p. 12.

254 Health and Social Care Bill: Committee Stage Report (House of Commons Research Paper 08/14, 11th February 2008), pp 12-13.

> individual needs of service users and influenced by effective engagement with the public. Increasingly, improvement will be driven by the choices made by service users and healthy competition between different service providers. The NHS and adult social care are no exception.[255]

It is doubtful, however, whether the PPI reforms really reflect the claimed policy shift from top-down prescription by central government towards more bottom-up processes built on genuine engagement with patients and the public. The government has been highly selective in what it has taken from the various reviews of the current PPI system. In the relatively narrow terms of the official discourse on PPI, it must be doubted whether the proposed new system of PPI will resolve the problems of excessive complexity, centralization, and duplication of functions referred to by the Expert Panel in its review of the first wave of reforms.

The government has rejected outright the HCHC's criticisms of inappropriate political interference in the consultation process, defending the role of the Secretary of State in discouraging referrals to the IRP. Many of the Expert Panel and White Paper recommendations have been diluted in the legislation. The new 'section 11' duty deliberately limits the scope of involvement to matters of user experience and choice. It thereby precludes public engagement on the issue of how (and by whom) services are provided, despite its likely importance for users in the long term. The remit of the new Care Quality Commission firmly supports the choice agenda, with relatively little emphasis on voice and the regulation of involvement. While it appears that National Voices is also developing a relatively narrow concern with the interests of service users, there nevertheless exists a potential for other forms of public involvement. The scope of issues pursued at the national level might be broader than the government envisages, not only due to the formal independence of National Voices but also because it will be making recommendations on behalf of whole groups of users. In this sense its role extend beyond straightforward representation of needs and preferences to considering how to deal with possibly conflicting interests of different users, in light of equality and human rights principles. There may similarly exist a potential for LINks move beyond the narrow concern with user experience through its open remit of 'promoting, and supporting, the involvement of people in the commissioning, provision and scrutiny of local care services.[256]

6. Divergent PPI Policies in Wales

During the 1990s Welsh policies on patient choice and public involvement did not differ greatly from those of England. The discourse of patient as consumer accompanying the introduction of the NHS internal market, while perhaps embraced less enthusiastically in Wales than across the border, brought improving services for patients to the top of the policy agenda. Although uptake of the GP fundholder scheme was weaker in Wales, there was the same appeal to the notion that competition would bring increased choice of hospital treatment location and to the role of the GP as surrogate decision maker for the patient. Following the introduction of the Patient's Charter in 1992, Charter guarantees (especially those on surgical waiting times) became a major preoccupation of the Welsh Office Health Department. Breaches of Charter targets led on many occasions to strong top-down action, and most Welsh purchaser/provider contracts of this period incorporated financial penalties for delayed

255 *The Future Regulation*, p 4.

256 Local Government and Public Involvement in Health Act 2007, s221

treatments.[257] As in England, consumerist policies co-existed with another policy strand promoting improved consultation and greater public participation in service planning. The 1992 policy document, *Local Voices: The Views of Local People in Purchasing for Health*,[258] resulted in a plethora of initiatives in Welsh health authorities aimed at incorporating public views into local commissioning strategies, though the effect of these in changing patterns of purchasing was limited.[259] This section examines how this picture of broadly similar approaches gave way to significant policy divergence between England and Wales over PPI and the health care system more generally.

(a) Early differences

The 1997 English White Paper, *The New NHS – Modern, Dependable* promised a re-integrated national service in which competition would be replaced by co-operation and greater attention to quality, within a of stronger performance management framework. The Welsh White Paper, *Putting Patients First*, also signaled a reassertion of central control and stress on managing performance, though with less emphasis on formal targets. The document focused more on improving service quality for patients than on any radical extension of patient or public involvement *per se*. It stated that the NHS 'should be people centred, managing its services for the benefit of patients and informed by patients' views'.[260] There were references to developing a new NHS charter with a content reflecting the views of the public, and a short section on 'Patient Responsiveness' mentioning 'involving patients in decisions about their treatments'. However, these aspects of the paper lacked detail. Health authorities were to continue in a strategic role, but new Local Health Groups (LHGs) – created initially as sub-divisions of Health Authorities – would be developed to take over responsibility for commissioning.

Interviews carried out for our related SDO project with two special advisors who became involved with NHS Wales at this time suggest a growing preoccupation with the health of local communities and the development of bottom-up policy initiatives. This meshed with concerns about health inequalities and awareness that Wales contained some of the most disadvantaged and least healthy communities in Western Europe. Although the notion of 'community' had received no more than a passing mention in the White Paper, it quickly assumed greater prominence in health policy discourse. The Assembly's first major policy document, the 2001 NHS Plan for Wales,[261] articulated a new vision of partnership encompassing both individual patients and communities. The Health Minister's introduction set the Plan firmly in the context of Assembly policies to counteract disadvantage and social exclusion, emphasizing 'the importance of building and supporting strong *communities* where the values of citizenship and collective action can grow.'[262] The Plan sketched out a vision of an NHS 'driven by the views and involvement of individuals and communities in the design, delivery and monitoring of health services.'[263] Chapter 3, entitled 'The people's NHS: public and patient involvement', gave equal prominence to public engagement ('developing further the involvement and participation of the people of Wales in their

[257] Hughes, D. and Griffiths, L. 'On penalties and the Patient's Charter: centralism v decentralised governance in the NHS', *Sociology of Health and Illness*, 21(1): 71-94, 1999.

[258] London: Department of Health, 1992.

[259] Griffiths, L. and Hughes, D. 'Purchasing in the British NHS: does contracting mean explicit rationing', *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, 2: 349-71, 1998.

[260] NHS Wales 1998, 1.13.

[261] NHS Wales, *Improving Health in Wales: A Plan for the NHS with its Partners*, Cardiff, 2001.

[262] NHS Wales, 2001, p.5.

[263] NHS Wales, 2001,p.32.

National Health Service') and the role of patients in influencing patterns of care ('building the health service around their perceptions of need.'). Patient choice was not ruled out, but it was 'patient voice' – the right to be informed, to express views and be understood – that received explicit endorsement.[264]

The Plan proposed a radical strengthening of LHGs as autonomous bodies working in close relationship with local authorities, with membership extended to include local authority representatives.[265] This was the basis of the 'new localism' of the NHS in Wales.[266] The creation in 2003 of 22 Local Health Boards operating alongside 22 local authorities saw the emergence of a system different from anything else in the United Kingdom NHS. Together with the retention of Community Health Councils, this was the central plank of the Assembly's strategy to 'bring a greater local voice to NHS decision making.'[267]

(b) Public involvement and community regeneration projects

The institutional infrastructure to support PPI polices was developed through initiatives at various levels. At the community level, a number of umbrella social development programmes provided programme or project-based funding for schemes initiated by local people and organisations. In most cases these did not have an exclusive health focus but were concerned with more general issues of disadvantage and social exclusion. There was the paradox that while most schemes were brought into being as part of the strong policy direction set first by the Welsh Office and then the Assembly, their *raison d'etre* was the creation of sustainable bottom-up developments whose content by definition could not be determined from above. Those featured in the NHS Plan were: (1) *Communities First*, a project to support bottom-up social development projects launched by the WAG's Department for Social Justice and Regeneration in 2002, which continues to the present time aided by European funding and has so far encompassed 142 communities. (2) *Local Health Alliances*, a Welsh Office initiative dating back to 1999 which required local authorities, NHS bodies and other stakeholders to come together to identify and deal with health issues in local communities. (3) *Sustainable Health Action Research Programmes*, an initiative arising from *Better Health Better Wales*[268] to support action research projects in the areas of health, housing, unemployment, social distress and poor access to services, and which encouraged local people and agencies to participate and provide evidence of what works and does not work. Other programmes that could be linked to the broader engagement policies included: (4) The *Inequalities in Health Fund*, a programme dating from 1991 aimed at developing community-based health promotion and prevention, initially focusing on coronary heart disease; and (5) *Health Challenge Wales*, a 2004 initiative encouraging individuals and organisations to share responsibility for health with the NHS, and providing information and support to help with this.

In addition Wales benefited from UK national schemes such as *Communities that Care*[269] and *Sure Start*,[270] both of which funded projects concerned with the well-being

264 'The importance of the patient's voice is recognised as being centrally important in the drive for service improvement. Patients want to be seen quickly in conditions that respect their privacy and dignity. They want to be cared for by professionals who understand their needs and concerns.' (p.31)

265 NHS Wales 2001, p. 62.

266 L. Scott Greer, 'Four Way Bet: How devolution has led to four different models for the NHS' (London: The Constitution Unit, 2004).

267 Jane Hutt, Assembly Record, 20 October, 2002.

268 *Better Health, Better Wales* Cm 3922. TSO, 1998, 8.5.

269 Fairnington A. Communities that care: a case study of regeneration from Wales, *Critical Public Health* 14, 1, 2004 , pp. 27-36.

of young people. Many of these projects are directed at health promotion and prevention, including a community view of how these objectives should be taken forward, rather than acute hospital care. This accords with the notion that health policies are not just concerned with an illness service, and that measures to influence the social determinants of health need to have a PPI dimension just as much as the core NHS.[271]

(c) PPI in the NHS and other formal organisations

As far as NHS bodies are concerned, NHS Trusts and LHBs were required to undertake a baseline assessment and annual reports on progress in PPI, which are an element in the performance assessment framework monitored by WAG. Some Trusts have created patients forums of various kinds but there is no equivalent to the English PALS. The independent Patient Information Forums (PIFs), established by the King's Fund in 1997, exist in both England and Wales. There is a Welsh Patient Involvement Forum which operates as an additional conduit for information relevant to service users. In 2002 the WAG funded six 'pathfinder' projects to provide patient support services in NHS Trusts, giving 'on-the-spot' help and advice to service users requiring assistance. These were encouraged to try a range of approaches and were subject to formal evaluation from university-based researchers. After a positive evaluation report on the PSS projects, the initiative was rolled out to all Welsh NHS Trusts.

Following the publication of the NHS Plan, more detailed and practical suggestions for the elaboration of Welsh PPI policies were set out in the guidance paper, *Signposts*.[272] The paper distinguished the collective level, 'the involvement of patients and the wider public in decisions concerning the delivery and planning of services', from the individual level, including 'the involvement of patients in discussions and decisions concerning their own individual care and treatment'. It allowed that the latter may include 'getting involved in choices about care and treatment options', but significantly the main emphasis was on greater responsiveness to patient needs. *Signposts* provided greater detail and discussion of the PPI proposals from the NHS Plan, and included illustrative case studies from Health Authorities, and NHS Trusts and Local Authorities. The latter describe local initiatives to promote inclusive communication, build relationships and assess patient satisfaction, and outline several projects that had experimented with engagement techniques such as stakeholder conferences, targeted consultation meetings, citizens' juries, panels, focus groups, service user interviews, patient questionnaires and participatory appraisal. In late 2003 a follow-on document, *Signposts Two*,[273] was prepared with the intention of assisting NHS organisations to develop PPI in a more mature form. The theme of engaging communities continued to feature prominently, with a discussion of how different kinds of communities can be defined, targeted and reached. There was a self-assessment tool to help NHS bodies to gauge progress in increasing PPI in areas such as better patient information, improved feedback and greater opportunities to influence service delivery. The last has been the

[270] M. Goodwin and D. Armstrong-Esther, 'Children, social capital and health: increasing the well-being of young people in rural Wales', *Children's Geographies* 2, 1, 2004: 49 – 63.

[271] Questions have been raised about the sustainability of individual projects when core funding ends, and a degree of disconnection between micro level projects and macro policy (which cannot be overly prescriptive about grassroots schemes), As time passed most schemes moved away from funding shorter term projects to offer support for at least 3 years. Welsh policy makers continue to see these programmes as 'slow growth', long term ventures that will need to learn lessons over time. The Assembly has delivered substantial annual funding for programmes of this kind up until the present time.

[272] Welsh Assembly Government, *Signposts – A Practical Guide to Public and Patient Involvement in Wales*. London: OPM, 2001.

[273] Welsh Assembly Government, *Signposts 2: Putting public and patient involvement into practice in Wales*. London: OPM, 2003.

most difficult to achieve. One of the major claimed examples in NHS Wales was significant public participation in the agreement of the standards incorporated in National Service Frameworks (NSFs).[274]

(d) Retention of Community Health Councils

The more incremental approach to PPI reform adopted in Wales is illustrated by the WAG decision, announced in January 2001, to retain Community Health Councils when they were due to be abolished in England. Section 22 of the National Health Service Reform and Health Care Professions Act 2002 (abolishing CHCs in England) made provision for the National Assembly to exercise power under the 1977 Act to retain CHCs in Wales and establish a new body to advise and assist them. Welsh policy makers responded to the alleged shortcomings of CHCs by giving them significant additional powers. The Health (Wales) Act 2003 – based on the first all-Wales Bill to undergo pre-legislative scrutiny by the National Assembly and the Westminster Parliament – amends the 1977 Act to make provision for a range of new duties and powers for Welsh CHCs.[275] These include a statutory right for CHCs to be consulted about major service changes. Subject to certain caveats, relevant NHS bodies have a duty to involve CHCs in 'the planning and provision of (…) services' and 'the development and consideration of proposals for changes in the way those services are provided, and decisions to be made by that body affecting the operation of those services.'[276] NHS bodies are required to provide a CHC 'with such information about the planning and operation of health services in its area as the Council may reasonably require in order to discharge its functions'. One identified weakness of CHCs had been their inability to exercise scrutiny over primary care. The new regulations extended their remit to allow entry to, and inspection of GP and dental surgeries, opticians and pharmacies, and also to visit private nursing homes where NHS patients are being treated. CHCs were given responsibility for providing on behalf of the Assembly the independent advocacy services required to be provided in England and Wales under section19A of Health and Social Care Act, 2001. In this role, CHCs assist members of the public who wish to make complaints, guiding and supporting them through the relevant formal complaints making processes. Additionally, the regulations provide for the creation of a statutory all-Wales body, the Board of Community Health Councils, to support and advise CHCs.

Currently there are 19 CHCs in Wales,[277] each having between 12 and 20 members appointed by the Assembly Minister for Health and Social Care. Half are local authority nominees, and about a quarter are nominated by voluntary agencies. Each CHC has a full-time Chief Officer and a small number of employed staff. The link to local communities through local authority and voluntary agency representation was seen by Welsh politicians as part of a conscious strategy to strengthen local democratic accountability. Thus, in commending the Health (Wales) Bill to the House of

[274] NSFs set out standards and an outline of the desirable pattern of services for a number of conditions and service user groups. For example, current NSFs include those for cancer, coronary heart disease, mental health, children, young people and maternity services, and older people.

[275] Welsh Statutory Instrument 2004 No. 905 (W.89), *Community Health Councils Regulations 2004* (March 2004).

[276] Para 18.1. This 'shall not apply to any proposals on which the relevant NHS body is satisfied that, in the interests of the health service or because of a risk to safety or welfare of patients or staff, a decision has to be taken without allowing for consultation; but in such case, the relevant NHS body shall notify the Council immediately of the decision taken and the reason why no consultation has taken place.' (para 18.4)

[277] They coincide roughly with the 22 LHBs, but there are some differences because certain CHCs had been merged.

Commons, the member for Aberavon, Hywel Francis, suggested that: 'it is thoroughly appropriate that the CHCs have a strong democratic element that is achieved through local authority and other representation. That is a major local democratic reaffirmation and a return to the best values of the Tredegar Medical Aid Society and other similar voluntary health organisations of the past'.[278] However it is debatable whether real CHC power increased greatly compared with the previous regime. A special advisor interviewed for the SDO project observed wryly that initially the new model of 'involvement' meant only that CHC members (not wider communities) were involved.

(e) 'Clear red water'

By 2002 the return to the managed market in England was gathering pace. The Secretary of State for Health, Alan Milburn, had started his term with a drive to strengthen performance management and targets, but was becoming increasingly sympathetic to an injection of market incentives and choice. Plans were taking shape for a provider market constructed from the building blocks of Foundation Trusts, greater private sector participation, and increased consumer choice. In December 2002 Assembly First Minister, Rhodri Morgan, gave a lecture in which he launched a thinly veiled attack on the Blairite policies.[279] Bluntly rejecting the English patient choice approach, The First Minister said: 'Approaches which prioritise choice over equality of outcome rest, in the end, upon a market approach to public services, in which individual economic actors pursue their own best interests with little regard for wider considerations.' Morgan criticized the English plans for Foundation Trusts and enhanced patient choice, and predicted that 'the experiment will end, not with patients choosing hospitals, but with hospitals choosing patients.' He said that in the Assembly's second term there would be 'clear red water' between Cardiff Bay and Westminster. Public services in Wales would remain free at the point of use, universal and unconditional. Foundation hospitals and the privatisation of public services would be rejected.

Morgan's stand had an obvious ideological content,[280] which was not shared fully by all those advocating a different path for Wales. Some within the Welsh policy community, including many civil servants, articulated a different set of concerns bound up with issues of geography, population sparsity and local monopoly/monopsony situations with a single purchaser and acute provider, which would all limit the applicability of competition and choice. There was a perception that, while patients might well exercise choice where local alternatives existed, they would not travel to do so, and also that choice implied excess capacity which did not exist in NHS Wales. However, it was political rather than merely pragmatic opposition that strengthened markedly as the English choice policies came to be seen as part of an overall market package encompassing Foundation Trusts, practice-based commissioning, independent sector treatment centres, and widespread use of PFI funding. The mood was well captured in a public lecture in which the WAG Health Minister approvingly quoted the words of the commentator Julian Tudor Hart: 'Though the market model may give patients a louder

[278] 27th November 2001. http://hywelfrancis.co.uk/articles/Health%20(Wales)%20Bill%2027.11.02.doc

[279] R. Morgan, Third Anniversary Public Lecture, National Centre for Public Policy, University of Wales Swansea, December, 11th, 2007. See also: S. Davies, 'Across the clear red water', www.publicfinance.co.uk: the internet magazine of the public sector. http://www.cipfa.org.uk/publicfinance/search_details.cfm?News_id=16332, 2003.

[280] P. Chaney and M. Drakeford, The primacy of ideology: Social policy and the first term of the National Assembly for Wales, (2004) 16 *Social Policy Review*.

voice, this will be the shrill cry of consumer choice, not the sceptical thought and responsible voice of the citizen.'[281]

The developments in Wales provide an unusual example of how national and regional politicians from the same political party, both dependent on an electoral mandate, had to accommodate divergent policies within a shared legislative programme. Ultimately national politicians took a step back from trying to prescribe Welsh policies, but this does not tell the full story of the conflict and tensions that arose along the way. Senior civil servants and advisors interviewed for our SDO study reported strong and sustained attempts by Westminster politicians and civil servants to push Wales closer to the English position in certain key areas. In the period before full devolution, Welsh policy makers were well aware of the fundamental divide between policies that could be implemented through administrative means, and those requiring legislation, which at that time constituted a major stumbling block in the absence of support in Westminster. Among other things, this helps to explain Wales' incremental approach to the development of Local Health Groups, and the delay in the emergence of the stronger Local Health Boards.

Pressure from the English side was applied at several points. The determination of Welsh politicians to retain CHCs was one early area of disagreement, which rumbled on from the original policy announcement in 2001 to the legislation in 2003. Informants in our SDO interviews recounted how the then Health Secretary met with the Assembly First Minister and his special advisors to tell them that there were limits to what would be accepted. By then the 'clear red water' speech had raised further tensions, and resulted in a visit to Cardiff Bay from the Prime Minister's special advisor in which there was a discussion about the rationales of the English and Welsh policies with counterparts. There was a serious wrangle about Wales' decision to create an independent inspectorate more attuned to Welsh standards and public engagement policies. There were further spats over Westminster's alleged failure to consult Wales on the changes in primary care policies proposed by Sir Nigel Crisp, and later regarding the issue of access and Welsh surgical waiting times in the run up to the 2005 general election. One factor that helped Welsh policy makers hold the line was support from the other UK Celtic countries, who lined up alongside Wales in common opposition to the English market reforms. There was also the issue of the electoral needs of a single governing party, consisting of a New Labour wing in England and more traditional wings in the other countries. Effectively a pact was made in which Welsh Labour politicians, in return for delivering the Labour votes necessary for a general election victory, were given flexibility by national leaders to adapt policies that fitted with local political preferences. The publicity attracted by high profile internal rows about waiting lists and greater use of the private sector in the 2005 election campaign seems to have had costs for both sides. Informants in the SDO study reported that after 2005, there was a virtual cessation of interference from Westminster in Welsh health policy making.

(f) The 'Second Offer' scheme

Against this background there was never any prospect that Wales would emulate the English 'Choose and Book' reforms. However, despite resistance from opposition politicians on the ground that it was choice policy, the WAG did introduce a 'Second Offer' scheme in April 2004,[282] offering an alternative treatment option for patients

[281] Nye Bevan Lecture 2004, Unpublished manuscript – delivered by WAG Health and Social Services Minister Jane Hutt, 1st December 2004.

[282] See: WHC(2004)15; WHC(2004)27..

experiencing excessive delays on surgical waiting lists. Initially this scheme offered treatment at a second hospital for patients waiting more than 18 months, but the threshold was reduced to 12 months in March 2005. The cost of transfers of patients falls either on the Trust or the LHB in accordance with official pricing rules and the responsibilities of the respective parties as set out in service agreements. A CHAI report published in July 2005 found that about 11,500 patients had taken up a second offer by that date, and identified the scheme as one of the main factors accounting for a reduction in the numbers of long waiters in Wales. Nevertheless it has also been reported that significant numbers of patients declined to participate, usually because of reluctance to travel. Currently the WAG Health Department is developing a strategy to reduce maximum waiting times to 26 weeks within three years ('Access 2009'), and it is anticipated that this will lead to a winding down of the Second Offer scheme.

It is important to note that 'Second Offer' plays a much less central role in the NHS commissioning process than does 'Choose and Book' in England. There is no attempt in Wales to develop a patient choice mechanism that will shape initial referral pathways and patterns of service purchasing. The scheme is not about allowing patients to choose between alternative providers, but a means of achieving targets on reduced waiting times. Patient choice is restricted to exercising the option of stepping out of a long queue into a shorter queue at a different hospital. WAG Health Department guidance states that routine recourse to the scheme should be avoided through a combination of effective commissioning and effective delivery. Welsh LHBs and Trusts must therefore steer a careful path between over-use and failure to use a mechanism which may help to facilitate the achievement of waiting times targets.

(g) Health Inspectorate Wales

In April 2004 the former Commission for Health Improvement became part of a new body, the Commission for Healthcare Audit and Improvement (CHAI), responsible in England for setting and monitoring standards in the NHS, voluntary and private healthcare sectors. Its significance as an arms length regulatory body, able to oversee the plurality of providers participating in the new English market and providing information on quality for patients making choices, was not lost on Welsh policy makers. From the Welsh perspective CHAI was perceived as part of the English market framework that the Assembly had rejected. In particular there was a concern that CHAI would not be sufficiently responsive to Welsh health care standards and the different approach to public engagement. Informants in our SDO study suggested that these were the main factors behind the decision to establish a separate oversight body in the shape of Health Inspectorate Wales (HIW).[283]

HIW currently assesses the performance of NHS bodies against the Welsh Health Standards, last revised in 2007. Patient Experience is one of four domains to which the Welsh Health standards apply, with at least four standards relating directly to PPI.[284] HIW investigates progress towards achieving standards relating to PPI both by scrutinising inspection data from LHBs and Trusts and through its own direct information gathering exercises with the public, using methods such as focus groups, questionnaires and telephone polling. The latter are used to corroborate the information provided by NHS bodies, partly through self-assessments. These are incorporated into

[283] Chapter 4 of the Health and Social Care (Community Health and Standards) Act 2003 gives the Assembly primary responsibility for reviewing the provision of health care by and for NHS bodies in Wales and this duty is discharged through HIW, an operational independent body within WAG.

[284] The original circular WHC(2003) 69 listed 5 domains including patient experience and information. Later there were six PPI domains, now amended by the arrangements described.

the overall assessments and ratings of LHBs and Trusts contained in HIW inspection reports.

Two senior HIW staff interviewed for our SDO project conceded that PPI assessments had not always gone well and involved a steep learning curve. From 2004 onwards HIW had experimented with a number of approaches to engagement with the public, using different methods in different exercises, and trying to avoid prescription regarding the favoured PPI process. Early PPI developments in Trusts and LHBs had often been tokenistic, for example where limited patient representation on Trust committees was assumed to equate to genuine participation. HIW's own engagement exercises, especially in the early days, often experienced problems in reaching beyond the 'usual suspects' to get views from a more representative cross-section of the population.

(h) Consolidation of 'Voice' not 'Choice'

While ten years of implementing PPI policies in Wales since Labour's election victory in 1997 have arguably seen considerable progress towards framing a coherent macro-policy vision, the development of structures and processes at the micro-level has been patchy. PPI policies emerged during a period of considerable turmoil in the National Assembly, a time when there was no formal legal separation of the legislative and executive arms, uncertainty about the terms of the devolution settlement and much ongoing re-engineering of the constitution.[285] Nevertheless the Assembly was successful in imprinting its distinctive stamp on PPI. The policies evolved from an amalgam of somewhat unconnected ideas concerning the public and the patient to a more particular focus on engagement and voice, with people cast in the role of citizens rather than consumers. Generally the emphasis has been on collective rather than individual action, at the level of the community or the patient group rather than individual or single treatment decisions. As stated in the 2005 policy document *Designed for Life*, the WAG's strategy is to: '… empower the community to have its voice heard and heeded, rather than simply being given a choice of treatment location.'[286]

Over time an attempt has been made to align the health policies more closely with policies on inequalities and community regeneration, and also with the Assembly's more general strategy for the public sector. Thus the 2004 policy document *Making the Connections* sets out the case for an integrated, collaborative model of public sector service organisation, better suited to Welsh conditions than the English model of autonomous provider units in a quasi-market. The paper explains how such services will be citizen focused, responsive to the needs of communities, concerned with equality and social justice, and also efficient and effective. The issue of better integration of local services is considered in the 2006 Beecham Report,[287] which proposes the formation of 'local service boards' bringing together the service delivery organisations in each local government area. All these developments supported a policy strand emphasising citizenship and engagement that was fully compatible with the direction of travel of policies on PPI.

(i) The 2008 Consultation Paper Proposals

[285] McAllister, D. and Stribu, D. Measuring the Richard Commission's contribution to Wales' evolving constitutional debate: influence, impact and legal. Paper presented at PSA Conference, Bath, April 2007. http://www.psa.ac.uk/2007/pps/McAllister.pdf

[286] Welsh Assembly Government (2005) Designed for Life: Creating World Class Health and Social Care for Wales in the 21st Century Cardiff: Welsh Assembly Government.

[287] Welsh Assembly Government, Beyond Boundaries: Citizen-centred Local Services for Wales (Beecham Review Report) (Cardiff: WAG, 2006)

The future direction of PPI policies has been thrown into doubt by proposals to end the purchaser/provider split and restructure the Welsh NHS published in April 2008.[288] Although a commitment to abolish the internal market was included in the *One Wales Coalition Agreement* between the Labour and Plaid Cymru Parties made in 2007,[289] the details and timetable outlined in the recent Consultation Paper surprised many observers. Among other things there are plans to channel funding to hospitals via a single central NHS Board, and an intention to replace the present 22 LHBs with 7 merged bodies, that will then act in the role of primary care providers rather than purchasers. The Consultation Paper appears to foreshadow a return to centralism and seems to threaten the 'localism' associated with LHBs, small country governance and the associated PPI policies.

As yet the revised structure of the Welsh NHS remains unclear. If the proposals to move to seven LHBs go ahead, each of these new bodies will be aligned with an NHS Trust and a grouping of local government authorities. The previous arrangement of one-to-one coterminosity of LHBs and local authorities will be lost, and the principle of securing democratic accountability via inclusion of local government representatives on NHS bodies will be weakened. The Consultation Paper acknowledges that: 'With fewer organisations, patient and public engagement will have to be secured in new ways.'[290] Although the Consultation Paper states that 'the principle of localism is of fundamental importance'[291] there is an obvious question about how this can be reconciled with the new more centralised organisational framework. For instance, there are no easy answers concerning how larger LHBs will be able to work with the several local service boards that will exist within each of the new LHB catchment areas,[292] or how the boards of the new LHBs will be constituted to retain genuinely local connections. There is also the question of how local voices can influence the deliberations and decision making of a powerful new National Board, which while technically not a purchaser organisation, will assume some of the old LHBs' powers to determine patterns of resource allocation

The planned changes were to be made by April 2009, but this was then amended to allow certain benchmarks to be achieved by October 2009. Even so this is a timetable for organisational re-structuring that is unprecedented in recent NHS history in terms of its rapidity. Several NHS insiders interviewed in the course of our SDO project believed that the proposals and compressed time scale had a clear political dimension, linked to the recently announced retirement date of the Assembly First Minister and his determination to end the internal market before he leaves office. There were concerns that this was a rushed, politically-driven initiative that would undermine much of the ongoing development work that had been taking place sin areas such as commissioning and PPI. There was also an anticipation that many LHB staff in particular would need to move to new posts and that a time of considerable organisational turbulence was ahead.

7. Evaluation of existing PPI arrangements in Wales

[288] Welsh Assembly Government, Consultation Paper, Proposals to Change the Structure of the NHS in Wales, Cardiff: WAG, April 2008.

[289] Welsh Assembly Government. *One Wales*: *A progressive agenda for the government of Wales;* June 2007

[290] WAG Consultation Paper, p. 6.

[291] WAG Consultation Paper. p. 9.

[292] These are the multi-agency boards for local service delivery organisations introduced in the wake of the Beecham Report, and coterminous with the local authority areas. At present local service boards have been implemented in six experimental areas but they will cover all areas by 2010.

While the Assembly has undoubtedly succeeded in articulating a distinctively Welsh version of PPI, a number of problems have arisen during policy implementation. At times, the engagement policies have been overshadowed by more pressing policy concerns, which may have impeded progress. There have also been concerns about a degree of disconnection between the macro policies and grassroots developments, and the coordination of engagement policies across government. Furthermore there are questions about whether participation has extended to representative actors who understand the policy context. The recent Consultation Paper proposals raise question marks about the continuity of PPI policies over time, and may signal a shift away from the pattern of incremental development that had been emerging.

(a) Policy displacement by high-profile issues

The PPI policies were introduced in a period when both the details of the devolution settlement and the wider shape of the NHS in Wales were being worked out, and against a background of sharp party political differences and lack of a clear Assembly majority for the governing Labour Party. From 2001 onwards there was a series of crises and controversies that knocked PPI from the top of the list of Health Department priorities. These revolved around criticisms of management in NHS Wales and unfavourable comparisons with English waiting lists, culminating in 2004 in the Assembly's initial refusal to approve the WAG's health and social care programme.[293] In the early days of the WAG much energy was expended on further strengthening of performance management, which our informants characterised as very weak at that time, and development of national standards, to be incorporated in National Service Frameworks and used in the performance management and inspection regimes. Perceived poor performance in the area of access and waiting times tended to re-focus attention on the acute sector. Funding continued for the community initiatives described earlier. However some of our civil servant and advisor respondents suggested that the macro policies now risked disconnection from micro-level programmes and projects.

(b) Disconnection of macro policy and grassroots developments

The difficulty for central policy makers was that community-based engagement projects had almost by definition to be driven forward by local communities. Although policy makers could establish a national framework of engagement policies, any attempt to prescribe the content of micro level initiatives would be self-defeating. Here they were reliant on longer-term processes of education, developing community capacity and building social capital which extended beyond the sole remit of the Health Department. For example, a recent action research study from the Sustainable Health Action Research Programmes (SHARPs) describes how the scale of the problems of working in areas of multiple deprivation still recovering from economic dislocation, policy failure and scepticism about regeneration initiatives were underestimated.[294]

Where central policy makers may make a difference is in supporting intermediate institutions that contribute to community initiatives, and in creating spaces in formal NHS processes for deliberation and participation. The early experience in Wales suggests that developments in this area have been quite limited and that the gap between grass roots and public organisations been difficult to bridge. A senior civil servant interviewed for our research suggested that PPI policies had travelled a long way but policy makers had now reached the stage where they needed to decide how

[293] Institute of Welsh Affairs *Wales is Waiting: Monitoring the National Assembly September - December 2003*

[294] M. O'Neill and G. Williams, Developing community and agency engagement in an action research study in South Wales, (2004) 14 *Critical Public Health*, 37–47.

serious they were about the new direction, and whether public engagement would become a core activity necessitating a change in decision making processes that had developed over the past 60 years of the NHS. In this view the spaces so far created for the public to exercise voice within bodies such as Health Commission Wales, the LHBs and the NHS trusts are still not adequate to allow sufficient participation in decision making.

(c) Co-ordination of public engagement policies across government departments

Over time public engagement policies have expanded to feature in the work of several of the departments of the Welsh Assembly Government. In the Health and Social Services Department a strand of work, driven initially in the Quality, Performance and Regulation division, centred first on PPI and more latterly 'patient experience', and there are also small teams working on areas such as community health councils and the expert patients programme. Health Inspectorate Wales was located not in Health and Social Services, but in a new Department of Public Services and Performance (DPSP), mainly to provide some operational independence from Health. DPSP was also the base for the *Making the Connections* team, and more recently the *Citizens' First Wales Team,* which have worked to advance the policy agenda arising from the Beecham Review Report. Activity has included development work on local service boards and mechanisms for engaging the public, grants for projects that support engagement and two collaborative pilot projects aimed to support citizen-centred change. The Department of Social Justice and Local Government contains the Communities Directorate, which oversees *Communities First,* and also the Local Government Policy Division which is responsible for delivering aspects of the policy changes connected with local service boards.

Our interviews suggest that while adequate liaison on policy co-ordination is said to occur at the division heads level, liaison between middle-level operational teams in different departments appeared to be infrequent or even non-existent. A number of informants in both the Department of Health and Social Services and DPSP acknowledged that they had little detailed knowledge of policies in the other department, and the detail of parallel policies did not appear to have been deigned to mesh closely together. While 'making the connections' had been one of the key policy motifs of the past few years, the connections *within* government did not appear to have been developed adequately. After the first draft of this report was produced we learned that a new senior management structure within WAG was being introduced with six Director Generals working more closely across departments and ensuring better co-ordination in the management of cross-cutting policy themes. It may be that this change will begin to address the past weaknesses in co-ordinating policies in areas such as regeneration and citizen engagement.

(d) Representativeness and capabilities of grassroots actors

In our ongoing fieldwork in Wales, one recurrent theme among informants in the WAG, Health Inspectorate Wales, Health Commission Wales, LHBs and Trusts has been the difficulty of developing engagement mechanisms that reach beyond 'the usual suspects' to include people of all kinds. This and the related issue of how well health policies have been communicated to the general public were brought to the fore by some particularly acrimonious public consultations on service changes that occurred in 2006-07. The 2002 Wanless Review called for a radical redesign of health and social care in

Wales,[295] a message reiterated in the strategy document *Designed for Life*. By 2006 these proposals had worked their ways through to plans for re-configuration of the NHS in Wales, including rationalisation of tertiary neurosurgical services, maternity and community hospital services. The public consultations on these planned changes provided a dramatic illustration of how public involvement could lead, not to the development of consensus, but to the exposure of deeply held differences of opinion. In essence the organisations and individuals consulted were concerned more with proposed closures of local services than with arguments about advantages of scale or cost economies that had been central to the policy discourse. There was strong opposition to change. A press briefing from the Board of Community Health Councils wrote of a 'failure to appreciate that the public are not interested in strategies but in the nuts and bolts of how changes will affect the services they use,' and stated that the 'health economist's view of health services is not acceptable to the public.'[296] Opposition politicians joined in a chorus of criticism that the consultation arrangements had paid little attention to dissenting local voices. Several senior informants interviewed in our SDO study were concerned that the consultation process had been captured by unrepresentative interests and in some cases hijacked by political opponents of the government. For some informants this was a clear indication that the reconfiguration policy had not been adequately communicated to the public, and that more thought needed to be given to how engagement could reach representative groups.

Looking back on the May 2007 NAW elections, the First Minister, Rhodri Morgan acknowledged that the most important 'bread and butter' issue had been opposition to hospital closures. He requested the health minister to re-examine the hospital reconfiguration programme and determine what had gone wrong. The First Minister suggested that a 'full rethink process … will be able to look for different ideas and approaches to the public, to persuade people to get onboard, and to listen to alternative ways forward.'[297]

(e) Policy continuity

While it is too early to predict whether the proposals in the 2008 Consultation Paper will be implemented in anything like their present form, there is a risk that a reform programme that is primarily about the balance between markets and planning in the Welsh NHS will have unanticipated consequences for PPI policies. Whatever its other drawbacks, the WAG approach to localism and integrated service delivery within a small country governance model had a clear logic and connected well with policies based on enhanced community participation and strengthened deliberative mechanisms. A shift to larger bodies and the creation of a powerful central NHS Board seems certain to cast the vision of 'localism' into doubt. If such changes go ahead they would seem to have more to do with the political agendas of the ruling parties and their determination to safeguard an integrated state NHS, than with lessons gained in the course of implementing the downstream PPI policies considered in earlier sections.

8. PPI – prospects for social learning

[295] Welsh Assembly Government, *Review of Health and Social Care in Wales* (Wanless Review Report) (Cardiff: WAG).

[296] Press Briefing, NHS service reconfiguration consultations, 21 June 2006, http://www.wales.nhs.uk/sites3/Documents/236/Press%20Release%20NHS%20Reconfiguration%20210606.pdf

[297] IWA http://www.iwa.org.uk/publications/pdfs/Wales_Sept07.pdf.

To recap, our evaluation of PPI focuses on the potential of the different PPI governance frameworks in England and Wales to facilitate the development of institutions and processes that are conducive to more effective social learning.[298] The basic criterion of the adequacy of governance is the degree of reflexivity in the organisation of conditions of social learning in collective actions to resolve problems in the general interest. Reflexive governance cannot result spontaneously from the expression of individual preferences, as assumed by neo-classical economics, but requires instead the creation and maintenance of specific institutional conditions. Such conditions vary according to the particular analytical level (economic institutionalist, collaborative/relational, pragmatic, or genetic) at which the evaluation of reflexivity of learning operations is conducted. The four approaches and their associated conditions are supplementary rather than mutually exclusive – each adding value in building our understanding of the role of reflexivity in social learning, rather than displacing or simply superseding the less developed approach.

As explained in section 1 above, we consider the neo-institutionalist and collaborative/relational approaches to social learning in healthcare governance in England and Wales under the respective headings: *economic coordination*, and *capacitation and communicative competence*. We proceed to examine the democratic experimentalist and pragmatic approaches respectively in terms of *experimentalism and joint inquiry*, and *capacitation and cognitive reframing*.

(a) Economic coordination

In markets and in quasi-markets for healthcare services in England, a variety of external mechanisms is directed at overcoming obstacles to efficiency, including economic regulation and the exercise of governmental control through arm's length regulatory agencies. The government's economic reform agenda may be seen as an attempt, through hierarchical framing or external integration, to correct market deficiencies by subjecting players in the healthcare environment to incentives that will lead to improved economic performance. Our empirical focus here is on the success or failure of the reforms (most notably the recent merger of the three existing Commissions into the Care Quality Commission with new powers and a revised regulatory remit under the Health and Social Care Act 2008) in combating the problems of monopoly power and asymmetric information that are portrayed as barriers to competition and the effective operation of the choice mechanism. As regards the exercise of choice by PCTs and local authorities that commission health and social care services on behalf of patients and citizens, the fundamental problems of quasi-market organisation (acknowledged in the 2006 consultation paper[299]) are likely to continue to prove intractable and difficult to address through further regulation. The exercise of choice by patients is still more problematic, with major doubts as to the workability of the 'Choose and Book' scheme and uncertainty surrounding the future of this strand of PPI policy.

The Welsh strategy for policy development in the public sector, *Making the Connections*, explicitly rejects the model of decentralised semi-independent providers operating in a quasi-market with an arms-length regulator in favour of integrated public provision and direct coordination. The key question here is how far traditional bureaucratic organisation is being modified through the incorporation of novel forms of

[298] i.e., the evaluation should be not simply in terms of the balance of power between bureaucrats/professionals on the one hand and patients/citizens on the other hand, as portrayed in the majority of academic and policy analysis (section 4 above).

[299] Department of Health, *The Future Regulation of Health and Adult Social Care in England*, (Consultation Paper, November 2006).

performance management and inspection that serve to promote social learning by aligning individual behaviour with the goals of the organization.

(b) Capacitation and communicative competence

The importance of patient and public involvement in healthcare governance has long been recognized, although usually more for reasons connected with democratic accountability and legitimacy than with the improvement of services through social learning. We suggested in section 7 that the Habermasian strand in the current academic and policy literature on PPI is consistent with (while not expressed in terms of) the collaborative/relational approach. At this level we analyze in both England and Wales different forms (venues, fora, conduits) of negotiation and representation of patient and public interests, together with respective 'empowerment' strategies directed at building communicative competencies, strengthening argumentative capabilities and increasing opportunities for dissent and counter-argument in dialogic processes.

In England, the government's agenda for 'voice' reform is more complex and difficult to evaluate that that involving 'choice'. The most significant *organizational* change to the existing PPI system is the abolition of PPIFs and their replacement by LINks. An implicit policy objective is to improve communication, deliberation and participation among key stakeholders with interests in the service in question. One criterion of success here is the quality of dialogue, and the building of some form of weak consensus among the network of significant actors as to the nature of governance problems and how to address them, in spite of the presence of conflicting interests. What is required *in addition* to this quality is the development of cognitive, institutional, and personal capacities among all stakeholders, especially consumers and users of services, in order that they may more effectively participate in and contribute to learning processes. The Expert Panel emphasized the need for a sustained effort to build capacity in voluntary and community organisations and among citizens.[300] While this commitment is carried over into *A Stronger Local Voice*, there is little indication as to how it is to be achieved. In the absence of successful strategies for capacitation, and given persistent problems of inequality, under-representation and social disadvantage, there must be major doubts as to how far organizational reforms will lead to significant service improvements. Furthermore, while suitable voice mechanisms and capacities are essential preconditions of effective social learning in the healthcare context, they are not sufficient (see (c) and (d) below).

It remains unclear whether and if so how LINks will overcome widely acknowledged deficiencies of existing representative bodies. Potential problems with the implementation of LINks include confusion and lack of clarity in their role, excessive local variation, the danger of taking on too much, and the duplication of work with FT Boards of Governors if they focus on service delivery.[301] While Ministers have been optimistic that LINks would attract many new members, relatively few people are likely to be prepared to make general commitments to PPI beyond particular issues that have always attracted vociferous local support such as campaigns for hospital closures.[302]

In the Welsh context, certain deliberative (collaborative/relational) conditions of social learning may be regarded as having been established to some degree through the

[300] D. Hughes, L. Griffiths, and J. McHale, 'Do quasi-markets evolve? Institutional analysis and the NHS', (1997) 21 *Cambridge Journal of Economics* 259-76; Expert Panel, para 6.1

[301] HCHC, para 150 (? check this)

[302] HCHC, para 196. Given the inherent difficulty and complexity of the commissioning process, not enough thought has gone into making this more attractive to the public, who from past experience are more likely to be interested in service delivery (para. 179).

creation of new fora for public engagement with NHS bodies, and the redefinition of the duties of CHCs, LHBs, and NHS Trusts. Many grassroots community engagement programmes are primarily about developing new deliberative mechanisms, as are initiatives within some NHS Trusts and LHBs to develop non-standard fora to engage with particular community or service user groups. It is uncertain how far relations between service providers and service users have developed within the new deliberative fora to promote productive forms of co-operative working, though the recent furore over consultations regarding service reconfiguration suggest that progress has been limited.

In both England and Wales, the shift in focus from building consensus to encouraging dialogue among different constituencies and conceptions of the general interest may be interpreted as an attempt to establish further necessary conditions of social learning at the collaborative/relational level. Productive engagement may involve the expression of dissent, the brokering of compromises or the accommodation of difference. One academic criticism of the conception of active citizenship in Welsh political circles is that it is overly preoccupied with consensus and does not provide sufficient opportunities for dissent and constructive counter-argument.[303] The general disquiet concerning the recent consultations on service re-configuration suggests that this may be a weak spot in the institutional framework supporting PPI. However, top-down policies that seek to drive patient and public involvement by helping to build intermediate institutions and appropriate stakeholder capacities are problematic for the reason mentioned earlier: too much 'steering' from the centre risks subverting the grassroots developments that policy seeks to encourage. Yet there remains the need for some facilitation and support, beyond simply funding a range of projects. Arguably PPI policy in Wales has still not paid sufficient attention to the capacitation of actors and there may be a need to develop more systematic support mechanisms to build communicative competencies.

(c) Experimentalism and joint inquiry

At this level it is necessary to distinguish the practical and potentially 'experimental' nature of development of policy and organisational decision-making on healthcare generally, from 'democratic experimentalism' as a way of approaching particular governance problems through techniques of joint-working, co-design, and benchmarking, characterised by qualities of 'learning how to learn' and 'choosing how to choose'.[304] As regards the former, in England there is little evidence that radical reforms are the product of policy learning. While the government contends that the proposals for LINks were informed by nine 'early adopter' or pilot schemes running since December 2006,[305] witnesses to the HCHC referred to the schemes as 'pathfinders' rather than 'pilots', concerned with 'testing out ways of working … given a set of objectives asking them to focus on particular aspects.'[306] The publication of the Local Government and Public Involvement in Health Bill and the issuing of guidance while the pathfinders had been operating for such a short period mean that LINks

[303] L. Hodgson, 'Citizenship, Civil Society and Community in Wales', (2006) 18 *Contemporary Wales*, 91-105.

[304] Here we accept the criticism made in the second synthesis report of our first draft of the case study of PPI in England and Wales, which incorrectly associated the encouragement of different and competing conceptions of the general interest with democratic experimentalism, whereas the facilitation of such increased dialogue in fact remains trapped within 'wholly "deliberative" logic'- fn 18, second synthesis report, above.

[305] Two have been run by the Healthcare Commission, and seven by the CPPIH.

[306] HCHC, para 109.

cannot be evidence-based as the government has claimed.[307] In Wales, by contrast, healthcare reform has been more incremental, with new structures building on the experience of past consultation and representation from the health authority period, and a good deal of 'learning by doing' in the organisational reform process. There has been a strong mimetic dimension to the reform process as the NHS has tried to emulate and build upon the experience of comparable projects initiated somewhat earlier in the fields of community regeneration, justice and economic development. Umbrella programmes such as *Communities First* have encouraged a range of approaches and structures within projects, with an emphasis on the development of best practice. Many projects have been subject to formal evaluations and an attempt to use feedback to modify behaviour. The action research project funded under SHARPs had the explicit objective of determining 'what works and does not work', again relying on a broadly experimental model. Regulation and inspection has itself been an evolving process, with a very steep learning curve associated with the creation of HIW in 2004, rapidly followed by a period of consolidation and recently an attempt to pick out best practice by a review of approaches across all the inspection and audit bodies involved in health and social care.

Democratic experimentalism describes a form of social learning in which actors engage continually in processes of joint inquiry, benchmarking and peer review. For Sabel, 'learning by monitoring' is an experimentalist practice involving the 'creation of institutions that make discussion of what to do inextricable from discussion of what is being done', such that 'discrete transactions among independent actors become continual, joint, formulations of common ends in which the participants' identities are reciprocally defining.'[308] While originally used to analyze the superior performance of Japanese production systems in private industry, this perspective is arguably particularly applicable to English healthcare governance which is similarly characterized by a form of vertical disintegration and the breakdown of hierarchy as the instrument of collective problem solving. The actors in this context (commissioners and service providers, regulators and rule-makers, patients and citizens) may also be seen as collectively engaged in 'a continuous discussion of joint possibilities and goals' in which 'their understanding of their situation is limited.' Democratic experimentalism requires that groups of such actors 'jointly specify what they believe they understand so as to expose and begin exploring the limits of that understanding. Just as in a conversation they must accept the possibility that their views of themselves, or the world, and the interests arising from both – their identities, in short – will be changed unexpectedly by those explorations.'[309]

Benchmarking may be defined simply as the comparison of practices, systems or organizations according to accepted standards or indicators. While international benchmarking of healthcare systems was pioneered by the OECD in the 1980s, the use of this technique at the national level began a decade later as part of the government's NPM drive for increasing efficiency and service quality.[310] Other forms of

[307] HCHC, para 111. LINks are less of a 'trial' and more of a discussion with stakeholders – what can be expected from Hosts is not being addressed (para 112). There is no fixed budget for each 'early adopter' making it difficult to determine what can realistically be achieved with money that will be available (para. 113).

[308] C. F. Sabel, 'Learning by Monitoring; The Institutions of Economic Development', in Smelser, N. J., and Swedberg, R. (eds.), *The Handbook of Economic Sociology* (New York: Russell Sage Foundation, 1994), 138.

[309] Ibid, 145.

[310] S. Waite and E. Nolte, 'Benchmarking Health Systems: Trends, Conceptual Issues and Future Perspectives' (2005) 12 *Benchmarking* 436.

benchmarking have developed recently at the initiative of various groups of actors in healthcare networks. Benchmarking may be used by government as a tool for driving up standards through performance metrics and rankings, or by organizations performing similar roles or located in the same sector as a more collaborative mechanism for joint improvement and dissemination of best practice.[311] A further distinction may be drawn between 'indicator' and 'ideas' benchmarking, the former associated with league tables and 'star-ratings' while the latter focuses on organisational learning and process improvement.[312] There exists in this regard a fundamental ambivalence in New Labour policies which emphasize the value of collaboration and service improvement on the one hand, while pursuing competition and penalizing poor performers on the other hand. The suspicion is that: 'as long as benchmarking metrics are employed for political purposes, the more desirable results of this tool will be difficult to achieve.'[313]

In any event, benchmarking can only operate effectively as an experimentalist mode of learning if it is accompanied by internal reflection by members of the organisation on its methods and processes. There is little evidence that state-imposed benchmarking is having this effect. The current scheme in the NHS, 'Essence of Care', is a supposedly new benchmarking approach launched by the Department of Health in England in 2001 to provide incentives for continuous quality improvement in areas such as privacy and dignity, nutrition and hygiene. In practice the use of this 'tool kit' is patchy, with NHS managers tending to focus their efforts on quantitative rather than qualitative aspects, and on measurability of comparative performance data.[314] There appear to be significant problems of regulatory ineffectiveness and unintended consequences, for example the encouragement of a short-term culture of box ticking, deflection of attention from aspects of health care which are more important but more difficult to measure, and perverse incentives to alter recording methods to achieve higher rankings at the expense of actual performance improvement.[315] Such problems with this form of performance management apply across the whole field of public services regulation in England.[316]

(d) Capacitation and cognitive reframing

The Schönian strand of the pragmatist approach re-focuses attention on the issue of capacitation of social actors, as distinct from (while nevertheless building upon) the experimentalist concern with forms of inquiry and investigation. Capacitation in this sense refers to a very different set of conditions than those required by the collaborative/relational approach. The question here is whether, in England and/or Wales, we can find examples of 'learning operations' involving cognitive processes of representation and re-representation, the adjustment of frames and reframing, double vision ('seeing the other's point of view'), and evidence generally of governance techniques capable of overcoming 'defensive strategies' and of challenging preconceptions and hitherto entrenched positions of social actors and stakeholders in the healthcare environment.

In England, the major legal *institutional* change accompanying the replacement of PPIFs by LINks is the reform of the 'section 11' duty to consult and involve patients and the public, coupled with other duties and regulatory powers conferred on LINks.

311 D. Northcott and S. Llewellyn, 'Benchmarking in UK Health: A Gap Between Policy and Practice?' (2005) 12 *Benchmarking* 419.
312 Northcott and Llewellyn 2005, 423.
313 Ibid, 431.
314 J. Ellis, 'All Inclusive Benchmarking' (2006) 14 *Journal of Nursing Management* 377.
315 Waite and Nolte 2005, 444
316 P. Vincent-Jones, *The New Public Contracting* (Oxford: OUP, 2006).

The original Expert Panel and White Paper proposals for the 'regulation of involvement' may be interpreted as advocating a kind of meta-regulation – the regulation (by the CQC and LINks) of the role of patient and public involvement in healthcare governance. This system of regulation includes incentives on commissioners and providers of healthcare to consult, involve, and 'respond' by showing what they have done differently: (i) in response to reports and recommendations made by LINks (in the case of the duty on 'services-providers' to respond under section 221 of the LGPIHA 2007); (ii) in response to consultations on commissioning (in the case of the duty on PCTs and SHAs to consult users of services under section 234); and (iii) in response to an request for explanation made by the CQC (in the case of the Commission's exercise of the 'power to require explanation' conferred by the Health and Social Care Act 2008.[317] The key question here is whether the duties to involve, consult and report can serve to promote reframing or re-representation, or even perform the function of 'terceisation' in the sense required by the genetic approach to social learning. The answer to this question may depend on how far the new duties to 'respond' succeed in provoking genuine re-thinking or re-framing of governance problems – evidence for which might be sought in the quality of explanations for, and reasoning behind, decisions to act or not to act in accordance with recommendations or the results of consultations. At present this element of our analysis remains underdeveloped and implicit. A crucial issue for further research is how far the potential for social learning in this sense has been undermined by the government's dilution in the legislation of the original White Paper proposals to extend the scope of the 'section 11' duty beyond commissioning bodies.

It seems clear that this 'regulation of involvement' approach will not be transplanted to Wales. The PPI provisions in the Local Government and Public Involvement in Health Act apply only to 'relevant English bodies' and not to the NHS in Wales.[318] While the Act provides for the exercise of the Assembly's framework powers to make legislation (Assembly Measures) in some of the areas of England-only provision, these relate to local government and do not signal any intention on the part of the Assembly to introduce a Measure in the PPI area.[319] LINks are being introduced in England in part because of the increasing plurality of providers associated with the creation of Foundation Trusts and growing private sector involvement. Given the pursuit of 'clear red water' policies intended fundamentally to differentiate the direction of reform in Wales from that in England on the issue of choice and competition, there is no place for new representative bodies such as LINks, and correspondingly no need for a complex governance framework involving arm's length regulation. Meta-regulation in this context has centred mainly on internal hierarchical control through the performance management framework and the work of first CHAI and then HIW. Welsh policy makers have preferred to keep inspection bodies within an integrated public service, largely on grounds of democratic accountability.[320] 'External inspection' in the Welsh context refers only to 'operational independence' within WAG, rather than a more fundamental organizational separation. The new forms of regulation and inspection

[317] s65.

[318] The explanatory notes say: "the amendments do not change how section 242 applies to NHS trusts all or most of whose hospitals, establishments and facilities are located in Wales".

[319] The single planned measure in the health domain relates to the area of NHS redress, and aims to simplify the process by which the public can seek compensation for torts that arise as a consequence of NHS treatments.

[320] At a time when a number of Assembly Sponsored Public Bodies (ASPBs) were brought back into WAG with the aim of increasing democratic accountability, as part of the 'bonfire of the QUANGOs', there was no appetite for creating independent inspectorates.

referred to in *Making the Connections* relate primarily to joint reviews by the inspectorates in different domains, re-directing the focus of inspection to put more weight on the experience of citizens. The WAG is leading a process aimed at establishing a concordat between the bodies regulating, inspecting and auditing health and social care services in Wales, involving the adoption of a set of common principles that will allow similar inspection strategies, sharing of information and joint working.[321] This is fully in line with the Welsh strategy to develop a more integrated public sector with better mechanisms for internal co-ordination, collaboration and working across boundaries, which may provide an alternative model to economic regulation in small country governance situations.

The one area where parallel change may well occur is in the strengthening in Wales of the duty to 'consult and involve' under section 11 of the 2001 Act. It would be entirely compatible with existing engagement policies if Welsh policy makers opted to introduce a duty for commissioners and service planners to consult the public and explain decisions, along the lines of the English model. However, there are several reasons why even in this relatively restricted field, the Welsh approach is likely to be different. The baseline for change is the different institutional framework created by the decision to retain CHCs and establish LHBs corresponding with Local Authorities. This established forms of public representation and local democratic accountability that had no counterpart in England. The Beecham proposals to create local service boards aimed at increasing co-ordination between local service-providing agencies may open up another path for strengthening and integrating consultation processes, for example, at the interface between health and social care or in respect of community regeneration initiatives which have multiple dimensions.

A possible example of cognitive reframing in the Welsh context refers to an approach long advocated by some students of the policy implementation process, but rarely applied to date in real world situations, is 'forward mapping'.[322] This rests on the proposition that policy makers need to be more active in anticipating and supporting conditions for successful roll-out of policies, including matters such as identifying the actors who will be implicated, the local capacities required, and viable ways to offer support from a distance. In practice, against the background of the major organisational upheavals associated with devolution, the WAG had little opportunity to prepare actors and build capacities in advance in this sense. Local adaptation and learning appears to have followed implementation of PPI policies, rather than occurring in some prior phase of preparation for change. A more reflexive approach to implementation and 'forward mapping' may be one way in which the WAG government can support bottom-up community developments without throwing them off course.

9. Conclusions

We draw two main conclusions from the foregoing analysis.

(1) First, the question of how to increase patient and public involvement through PPI in the United Kingdom should be conceptualized as a problem of regulation within a system of multi-level governance. European and North American scholars have accorded much attention recently to the phenomenon of 'new governance' in policy

321 *Making the Connections*, pp. 25-26.

322 R. F. Elmore, 'Forward and Backward Mapping', in K. Hanf and T.A.J. Toonen (eds), *Policy Implementation in Federal and Unitary Systems* (Dordrecht: Martinus Nijhoff, 1985) pp. 33-70.

fields such as employment, health and education, focusing on a range of soft law mechanisms such as the Open Method of Coordination, democratic experimentalism, and the 'new approach to standardization'. The new governance is commonly characterized by a 'shift in emphasis away from command-and-control in favour of "regulatory" approaches which are less rigid, less prescriptive, less committed to uniform outcomes, and less hierarchical in nature.'[323] Furthermore:

> The idea of new or experimental governance approaches places considerable emphasis on the accommodation and promotion of diversity, on the importance of provisionality and revisability – in terms of both problem definition and anticipated solutions – and on the goal of policy learning. New governance processes generally encourage or involve the participation of affected actors (stakeholders) rather than merely representative actors, and emphasise transparency (openness as a means to information-sharing and learning), as well as ongoing evaluation and review. Rather than operating through a hierarchical structure of governmental authority, the 'centre' (of a network, a regime, or other governance arrangement) may be charged with facilitating the emergence of the governance infrastructure, and with ensuring coordination or exchange as between constituent parts.[324]

However, while there has been much discussion of new governance relationships in terms of interactions between EU, transnational and national institutions,[325] the national and sub-national levels have remained relatively unexplored. It is precisely this gap that the present study seeks to fill.

The new institutional and organizational landscape of PPI in England may be analyzed as a regulatory space comprising a range of actors and stakeholders engaging in processes of standard setting, monitoring and enforcement, exercising powers and subject to duties of various kinds, in complex and interlocking relationships of control and accountability within an economic system driven by choice and competition.[326] By contrast, the Welsh approach to small-country governance has created a regulatory field in which a central core of bureaucratic governance of public services coexists with a periphery of bottom-up community programmes subject to a lighter regulatory touch, and with a reduced emphasis on economic incentives and competition. In the context of PPI, programmes like *Communities First* and *SHARPs* are regulated mainly via the conditions attached to funding streams and the internal governance arrangements of the participating organisations and groups. This unusual split in the regulatory field reflects the belief, which runs through both the general public sector strategy and PPI policies in the NHS, that integrated public services still have a major role to play, but that this role is only viable in the modern era if they embrace new forms of public engagement.[327]

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323 G. de Burca and J. Scott, 'New Governance, Law and Constitutionalism', in G. de Burca and J. Scott (eds.), *Law and Governance in the EU and US* (Oxford: Hart Publishing, 2006), p.2.

324 Ibid, p.3.

325 T. Hervey, 'Europe: Governance of Health Care', in G. de Burca and J. Scott (eds.)

326 This conception differs markedly from the narrow definition of regulation presented in the recent *Future Regulation* White Paper: 'The control of a particular market or industry though a system of rulemaking and adjudication, often managed by an independent organisation within a framework set by Government, interpreted into clear rules by the regulator. Its purpose is to assure the public that providers of services are fit for the purpose' (*The Future Regulation*, Annex 1, p 69).

327 Thus *Making the Connections* sets out a pact in which, in return for WAG investment in the core public services, those services play their full part in public participation and more flexible joint working with cognate services: 'We will provide the structures, resources and incentives to see that the goals set out in this document are achieved. In return, we will ask our partners in the public service to engage actively in delivering the changes that are necessary to deliver the high-quality, citizen-centred services that Wales needs' (*Making the Connections*, p. 39).

(2) Second, policy makers should give explicit recognition to the importance of social learning in the institutional structures and processes contributing to service improvement. There is no necessary connection between patient and public involvement and social learning. Social learning should be adopted as a goal of regulation, and policy then directed at helping to establish the conditions of social learning in its various forms. What precisely this task entails may be thought of in terms of systemic or 'dynamic' efficiency, connoting the successful creation of 'incentives for permanent adaptation and innovation through processes of social learning and normative change.'[328] In the present context, systemic efficiency should be seen as a property not only of individual organizations but also of healthcare networks. Regulators, government bodies, health authorities, commissioners, patients and citizens, and public and independent sector providers are members of such networks by virtue of their performance of healthcare functions or their consumption of, or interest in, healthcare services. Social learning may occur, or fail to occur, at a number of levels: within particular organizations (for example, regulators, purchasers and providers, NGOs), in the relationships between these bodies, and in healthcare networks as a whole.[329] A paradigm shift in government thinking is needed in order to secure the regulatory conditions and to support institutions and processes in which social learning may develop within and across these domains.

Assuming that the different approaches to PPI that are emerging in England and Wales may be considered to meet some of these basic conditions of soft law or new governance,[330] the question for REFGOV theory is what other conditions (triggers, checking mechanisms, other regulatory devices) are necessary for the social learning potential in such networks to be realized? In Wales there has been a pragmatic emphasis on learning by doing, combining a limited degree of top-down direction with community empowerment and loose regulatory oversight of the periphery. In England, the more top-down reform agenda has resulted in the development of new structures

[328] T. Dedeurwaerdere, 'Building Resilience through Dynamic Institutional Efficiency: The Case of Forest Biodiversity', Amsterdam Conference on Human Dimensions of Global Environmental Change, 25th May 2007. In the organizational learning literature, whereas static efficiency is widely recognized as a powerful force for increasing consumer welfare through competition within existing technologies leading to decreased production costs, dynamic efficiency refers to gains to be achieved from constantly seeking and experimenting with entirely new ways of doing business – C. Agyris and D. Schon, *Organizational Learning: A Theory of Action Perspective* (Reading: Addison Wesley, 1978). Other writers in this tradition have depicted dynamic efficiency as compatible with an 'opportunistic' rather than 'passive' model of organizational adaptation 'characterized by search for, and exploration of, a wide variety of alternative goals, activities, and modes of operation'. Rather than simply attempt to perform current activities more efficiently, this orientation seeks 'to discover new purposes, new technologies, and new ways of achieving goals' – D. Miller, T. Lant, and F. Milliken, 'The Evolution of Strategic Simplicity: Exploring Two Models of Organizational Adaptation' (1996) 22 *Journal of Management* 863-887, 865. This model is said to be appropriate in environments of instability or turbulence, requiring organizations to experiment with new strategies to stay successful. The current healthcare environment may be considered precisely to exemplify such (deliberately induced) turbulence and instability.

[329] For example, a proposed extension and deepening of the current research will explore the 'transformative' role of NGOs in twin senses referring to both their capacities for internal adaptation, and their potential external impact in helping secure transformations in the networks in which they operate.

[330] 'Guidelines, benchmarks and standards that have no formal sanctions are important elements in new governance. There is also a development of informal processes to resolve grievances and disputes, including negotiation and multi-stepped procedures' – see L. Trubek, 'New Governance and Soft Law in Health Care Reform', manuscript, p 13. 'Soft law allows for learning and feedback. It allows actors to take on multiple roles, and creates alliances between traditional adversaries. Further, soft law incorporates economic incentives into the governance framework while allowing diversity and experimentation. It allows public and private domains, and different regulatory clients, to interact more easily', p 14.

and processes in the attempt to create a learning environment through more complex regulation, monitoring and checking mechanisms. Both sets of governance arrangements may be interpreted or 'read' in terms of social learning – as attempts to facilitate deliberation, to encourage experimentation, and to achieve capacitation of social actors.

In both England and Wales, our analysis of the (in)adequacy of current PPI initiatives focuses mainly on the deficiencies of current PPI arrangements in securing the conditions of social learning at the economic, deliberative, and experimentalist 'levels' – corresponding respectively to the neo-institutional economic, collaborative/relational, and pragmatic (democratic experimentalist) approaches outlined in the second synthesis report. At this stage we can only speculate as to the potential for social learning in the pragmatist (Schönian) and genetic senses. It is not clear in either country whether, and if so to what extent, conditions of social learning have been established involving the development of capacities for cognitive reframing and re-representation. In England, the major focus of ongoing research in these terms is the role of LINks in the context of new duties to involve, consult and report, and the associated role of the new Care Quality Commission in social regulation.

As regards Wales, it is important at this stage to understand that the approach to governance and regulation has emerged from a period of fundamental and wide-ranging constitutional changes which are still settling and throwing up many operational problems. The character of the devolution settlement, the transition from a corporate body with single legal personality to a formal division between legislature and executive, and the range of devices used to give Ministers policy making powers in areas where the Assembly does not presently have legislative competence, mean that many of the existing institutions have been erected on somewhat inelegant legal foundations which will inevitably be subject to further reform. The widespread use of delegated powers to allow Ministers to take forward policy in Wales under the umbrella of Westminster legislation may lead to pressure in future to set out the duties and powers of certain bodies such as Health Inspectorate Wales more explicitly in Assembly Measures. Initially, we had anticipated that changes in the next few years would take the form of incremental consolidation of existing Welsh policies, as opposed to convergence with England. However, the recent Consultation Paper proposals may result in a round of more radical, non-incremental reform, driven by wider political considerations concerning the overall shape of the Welsh NHS, that cut across past evolutionary developments in the area of PPI policies. It is too early at present to say whether such changes will derail the distinctive Welsh policy agenda of localism and PPI within a small country governance model. However, such a vision of integrated yet responsive public services is clearly worthy of further study as a rival to the English provider market model.

We suggest that some of the regulatory preconditions of social learning through public and patient involvement were identified in the prescient Kennedy Report, which outlined three key stages in an effective regulatory process.[331] (1) It is necessary to establish the views of patients, public, professionals, and other bodies in healthcare networks as to what is important in various domains. (2) The views of stakeholders should be sought as to what would promote improvement in regard to the particular matter identified as important. (3) Finally, it is necessary to decide how best to measure progress in the achievement of improvement, through the development of indicators and data on performance in relation to those indicators. Indicators and measures of

[331] I. Kennedy, 'Of Regulation', in *Learning from Bristol: Are We?* (2006)

improvement are necessary since the cultural changes within and between healthcare organizations that are preconditions of effective social learning can only occur gradually. 'Any new organisation, created to carry out a range of complex tasks, will need time to learn and develop … and will need subtle measurement.'[332]

In REFGOV terms, however, the inherent limitations of such a purely regulatory approach are evident in Kennedy's subsequent analysis:

> Once it was *known* what the regulator was seeking to measure, because it was regarded as constituting good performance, those managing organisations would *direct their efforts so as to comply with what was called for*. In doing so, they would be doing the very things which those involved in providing and receiving care regarded as designed to promote improvement in care. Thus, the regulatory system creates a virtuous circle, listening to what promotes improvement, reflecting it in what is asked of organisations, measuring compliance, and thereby entrenching improvement.'[333]

This account is correct in stressing the need for the regulatory process to be 'owned by those within the system … grown from the bottom up.' What is measured is not imposed from outside as in command and control regulation. But the analysis omits to specify *how* improvement is to occur beyond the regulatory process itself. Improvement is supposed to result from *incentives* on regulated entities to improve, yet incentives are not enough in the absence of other conditions of social learning. Learning may occur to some degree simply as a result of the communication of information (e.g. 'listening' to patients), but this presumes that both the problem and its solution are obvious. In reality, fully reflexive governance is likely to be dependent on deliberation and openness to alternative possibilities in the framing of problems and the suggestion of solutions, and on other conditions of capacitation as suggested by the pragmatic and genetic approaches to social learning.

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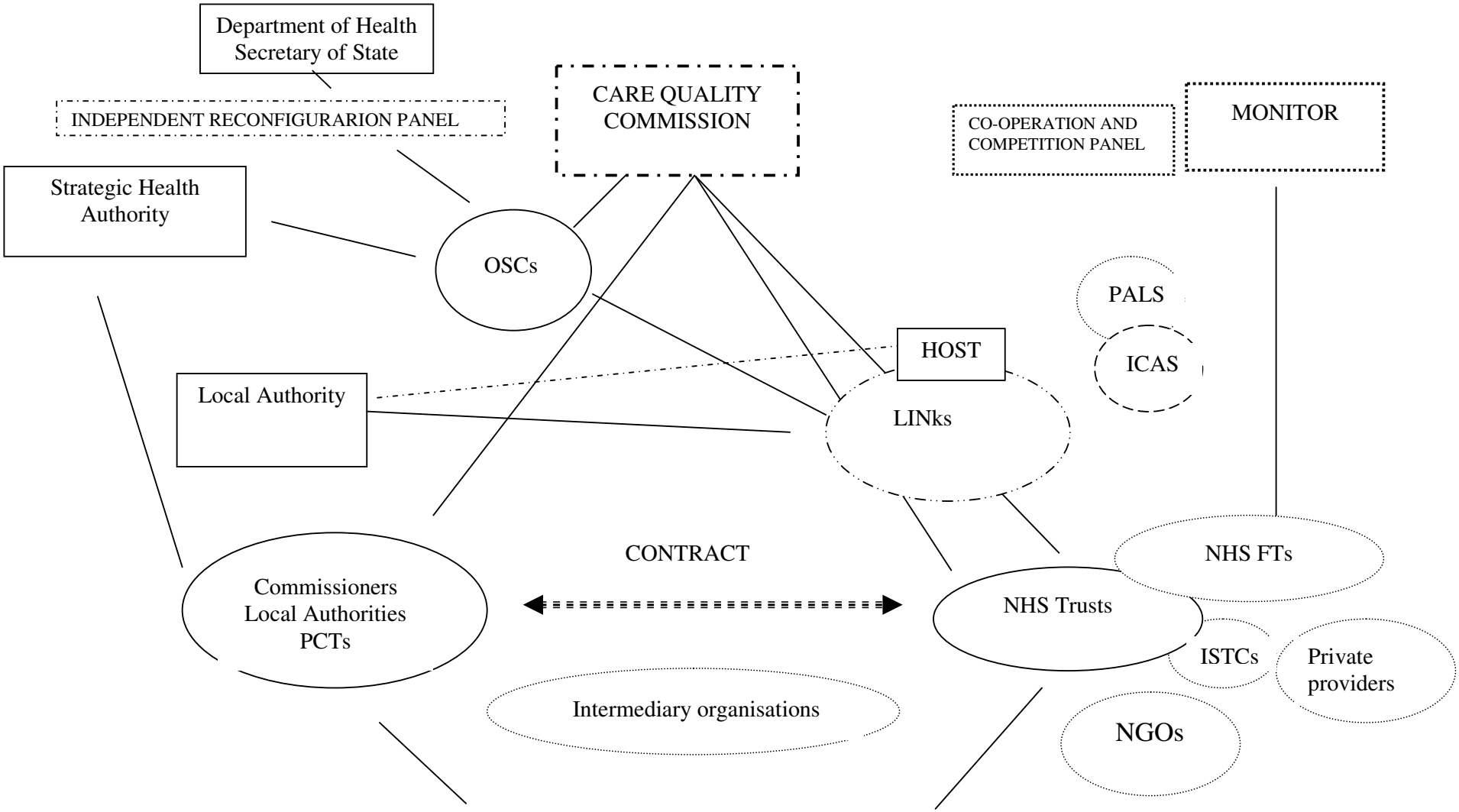
[332] ibid, 67. 'The indicators of success may take a myriad of forms and be hard to discern … the tools have to be designed.'

[333] ibid, p 63 (emphasis supplied).

Annex A, *Health and Social Care Network (England)*



Patients – Citizens – Stakeholders – Public

Abbreviations

CCP	Cooperation and Competition Panel
CHAI	Commission for Healthcare Audit and Improvement (Healthcare Commission)
CHC	Community Health Council
CPPIH	Commission for Patient and Public Involvement in Health
CSCI	Commission for Social Care and Inspection
CQC	Care Quality Commission
DH	Department of Health
FT	Foundation Trust
HCHC	House of Commons Health Committee
HIW	Health Inspectorate Wales
HRG	Health Resource Group
ICAS	Independent Complaints and Advisory Service
IRP	Independent Reconfiguration Panel
ISTC	Independent Sector Treatment Centre
LCO	Legislative Competence Order
LHB	Local Health Board
LINk	Local Involvement Network
MHAC	Mental Health Act Commission
NHS	National Health Service
NGO	Non Governmental Organization
OSC	Oversight and Scrutiny Committee
PALS	Patient and Advisory Liaison Service
PCT	Primary Care Trust
PPI	Patient and Public Involvement
PPIF	Patient and Public Involvement Forum
REFGOV	Reflexive Governance in the Public Interest
SDO	Service and Delivery Organisation
SHARP	Sustainable Health Action Research Programme
WAG	Welsh Assembly Government