Department of Health

Getting ready for LINks

Planning your Local Involvement Network

DH INFORMATION READER BOX

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For recipient's use	

Foreword

Health and social care services exist for the benefit of every citizen – that's why everyone of us should be given the opportunity to help shape the care they provide.

I know from working as a nurse and as an MP, if you give people the confidence to say what they want from local services, and the ability to influence how they are run, this ultimately results in a better system.

We are committed to creating a stronger local voice. As our Prime Minister clearly set out when he announced a review of the NHS, "we need to listen to patients' experience and expectations to forge a new partnership with doctors, nurses and other practitioners and together produce a way forward that will lead to an NHS that is changing to be truly patient-led and ever more responsive to their needs."

The establishment of Local Involvement Networks (LINks) is key to this vision. LINks will bring real accountability to the whole system, from commissioning to front-line care. LINks will give communities the chance to influence all health and social care services – whether they are run by councils or the NHS. LINks will give citizens the chance to have their say in a much wider range of ways. And, LINks will enable a broader spectrum of people to have their say.

Although the Local Government and Public Involvement in Health Bill – which will enable LINks to be established – is yet to be passed by Parliament, it is important that local communities start to get ready.

To help with this task, we have established a network of LINk 'early adopter' projects and have held a series of regional events to identify how LINks might work in practice and the issues that communities need to think about. This document reflects much of this work and, one year on from *A stronger local voice*, sets out in more detail the vision for LINks.

I would like to thank all the Patient Forums, patient participation groups and other networks who have contributed to this work. I know that a lot of time and effort already goes into improving services. I hope that through LINks and by engaging those who find it hard to give their views, we can build on this work.

Health services belong to all of us, and by getting involved, we can make them better for ourselves and our communities. I look forward to working with all of you to make this new system a reality.

Ann Keen MP, Parliamentary Under-Secretary of State for Health Services

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1. Definitions and explanations

1.0 The terms used in this document are intended to help to explain LINks. Those terms used to describe methods of involvement in LINks aim to identify the different levels of involvement that there might be and how they might be implemented to enable inclusivity. The terms used are not definitive and we recognise that different terms may be used locally in different ways to explain the various roles within LINks.

1.1 **Early Adopter Programme (EAP).** Seven EAPs were established by the Commission for Patient and Public Involvement in Health (CPPIH) at the end of 2006. The EAPs aim to identify learning about different models and approaches that LINks might apply based on the local issues. The EAPs were established in the following areas:

- Doncaster
- Dorset
- Durham
- Hertfordshire
- Kensington and Chelsea
- Manchester
- Medway

The EAPs are being evaluated by the NHS Centre for Involvement.

1.2 **Healthcare Commission test sites as early adopters.** In 2005 the Healthcare Commission established two test sites to look at how to widen engagement in their annual health check and the Healthcare Commission regulation process. The sites are based in Leeds/Bradford and the South West. The test sites are being rigorously evaluated and they have been incorporated into the EAPs.

1.3 **Local care services.** This term is used to describe both health services commissioned and provided by the NHS and social care services commissioned and/or provided by local authority social services departments. Increasingly health and social care services are commissioned jointly. The roles of LINks apply to both health and social care services.

1.4 **Patient and public involvement (PPI).** PPI is defined by the Department of Health as involving the public in shaping a care system's development, and keeping patients well informed of clinical processes and decisions.[1] There is no formal structure for involvement in social care, but since 1992 councils have been expected to have mechanisms for consulting and involving people in the area of community care services.

1.5 A number of key principles of effective PPI and user involvement have been identified:[2]

- Be clear about what *involvement* means.
- Focus on *improvement*.
- Be clear about why individuals and groups are involved.
- Identify and understand the stakeholders.
- Involve individuals and groups at all stages of decision-making in relation to the commissioning and provision of services.
- Be inclusive – working to involve as broad a group of people as possible.
- Give people a choice of how and when to get involved.
- Provide feedback on involvement and use the outcomes of involvement to shape commissioning and service development.

1.6 **Consultation.** This is defined as the dynamic process of dialogue between individuals or groups, based upon a genuine exchange of views, and with the objective of influencing decisions, policies or programmes of action.[3]

1 Department of Health, 'Glossary', June 2007, Department of Health website, www.dh.gov.uk/en/Help/Generaltemplate/DH_076163

2 The NHS Centre for Involvement, 'Key principles for effective patient and public involvement', as amended by the Commission for Social Care Inspection, www.nhscentreforinvolvement.nhs.uk

3 Consultation Institute, www.consultationinstitute.org

1.7 **LINk member.** This is a person or group that makes a commitment to take part on a regular basis in the development and implementation of the roles of the LINk, and to provide information to and collect information from a local community or a specific group within a community. LINks will decide themselves how members will be chosen. For example, this may be through election from the wider LINk.

1.8 **LINk participant.** This is a person, group or organisation that wants to influence the bigger picture through the roles of the LINk, even though they may not be in a position to participate on a regular basis. A participant may be interested in a single issue, may take an active role in specific pieces of work that relate to their areas of interest, or they may take a less active role by answering surveys or providing information or a view on behalf of an interest group. A participant may make use of the power to enter and view health and social care premises.

1.9 **Scrutiny.** Public scrutiny is the ability to critically examine the activities of those exercising power on behalf of the wider populace, in order to hold them accountable for it.[4] The Centre for Public Scrutiny[5] has developed four principles of effective scrutiny that it considers should be the basis for any scrutiny of public services. Such scrutiny should:

- provide a 'critical friend challenge' to executive policy-makers and decision-makers
- enable the voice and concerns of the public to be heard
- be carried out by 'independent-minded governors' who lead and own the scrutiny role
- drive improvement in public services.

4 Centre for Public Scrutiny, *Scrutiny map*, 2003, p.3
5 Centre for Public Scrutiny information can be accessed at www.cfps.org.uk

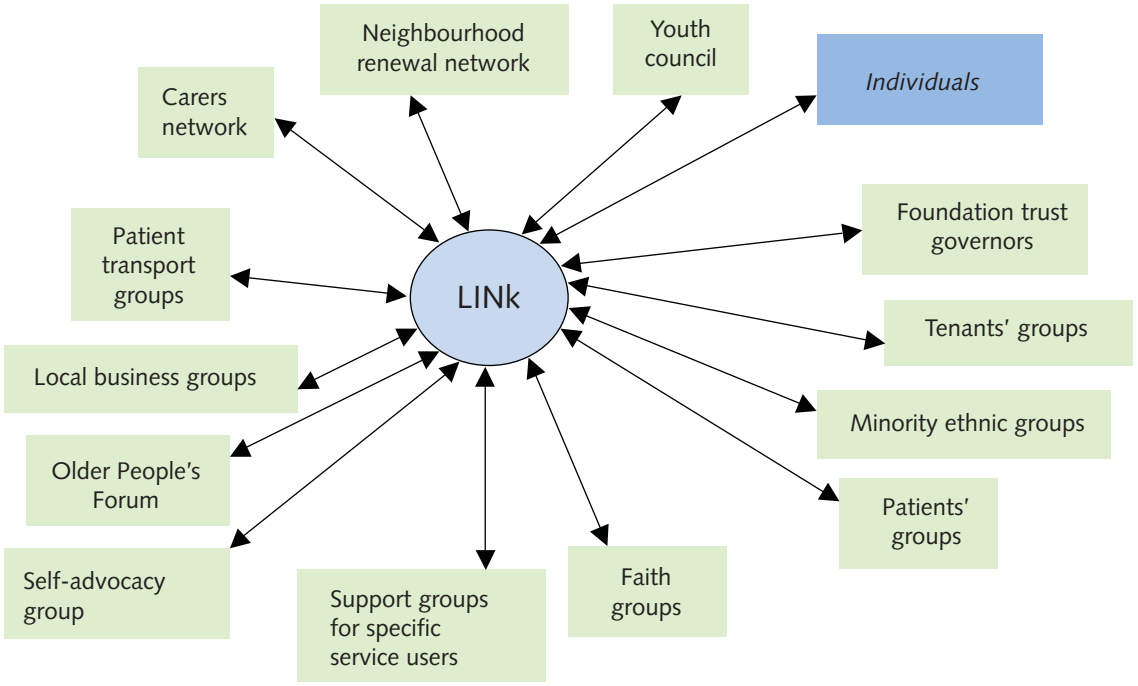
2. Introduction

2.0 This document provides an introduction to what an established and effective Local Involvement Network (LINk) might look like. It builds on the details set out in *The Government's Response to 'A stronger local' voice* published in December 2006, and makes use of existing experience of involving individuals, groups and communities in shaping local services. The document explains some of the actions that need to be considered when setting up a LINk and how they impact on its effective working. It includes some examples of the experiences of participants involved in the LINks Early Adopter Programme (EAP) and the Healthcare Commission's patient and public engagement test sites, as well as examples from other community-based initiatives. It has also been informed by nine Getting Ready for LINks regional events that were held in the spring of 2007. These were attended by a variety of people from national and local voluntary organisations, Patient Forums and local authorities.

2.1 LINks will be established within each area that is served by a local authority with responsibility for social services. This means that there will be 150 LINks, each covering a county, unitary, metropolitan or London borough council, including the Common Council for the City of London, and also the Council for the Isles of Scilly. Their roles will be set out in legislation and their primary role is to enable local individuals and groups to actively influence local care services, from planning and commissioning to delivery.

2.2 Each LINk will be made up of members and participants, including individuals, groups and organisations, with an interest in their local care services. As the members and participants will be volunteers, every LINk should be established in a way that is inclusive and enables involvement from all sections of the local community, especially those who are difficult to involve or seldom heard. It is important to remember that LINks are not merely groups of individuals, but are primarily networks that will bring together diverse groups in the area, and representatives of other networks. For example, a LINk might include all of the people and groups shown in Figure 1.

Figure 1: Membership of a LINk



2.3 The transition to the LINk system is likely to be evolutionary, building on the achievements of existing patient, public and service user involvement but broadening statutory involvement to include, not only NHS services but also social care services. This should enable more people to get involved in helping to shape services and strengthen their ability to hold services to account.

2.4 The sooner LINks can be established, the sooner they can build on the work of existing forums and enable users to have a stronger voice across the health and social care system. There is no reason why members of existing forums who become part of a LINk cannot continue to build on the often positive relationships they have formed with specific NHS trusts. Specifically, LINk members will be able to form specialist sub-groups focusing on areas such as hospital trusts or mental health trusts. They will also be able to focus on LINk-wide commissioning issues at a primary care trust (PCT) and local authority level.

2.5 The flexibility of the new system will enable the best practice developed by some Patient Forums to continue but to extend into social care services, while enabling other LINk participants and members to focus on different roles and functions.

2.6 Each LINk will be supported and guided by a host organisation that is contracted to undertake this role by the relevant local authority. To understand the relationship between the LINk, host and local authority, it is recommended that this document is read in conjunction with the Department of Health document *Getting ready for LINks – Contracting a host organisation for your Local Involvement Network*. LINks will have a role in:

- promoting and supporting the involvement of people in the commissioning, provision and scrutiny of local health and social care services
- obtaining the views of people about their need for, and experiences of, local health and social care services
- enabling people to monitor and review the commissioning and provision of care services
- raising the concerns of local people with those responsible for commissioning, providing, managing and scrutinising services.

2.7 This will be achieved by establishing a flexible organisational framework, which can be tailored in each area to take advantage of the work that is already taking place and fit with local circumstances.

2.8 **A LINk is not:**

- a group of volunteers who are solely responsible for inspecting NHS and social care premises and services
- a method of performance managing health and social care services
- a method of dealing with individual complaints about local care services
- a network that duplicates other networks and initiatives
- a group of self-appointed people who are unaccountable
- a group of professional workers
- a bureaucracy based on political issues.

2.9 The details of the powers of LINks will be provided in future regulations. These are likely to be consulted on shortly.

2.10 The Department of Health will publish full guidance on LINks after the legislation has received Royal Assent. We expect local authorities to start the procurement of host organisations upon Royal Assent.

3. Role of a LINk and its relationship with the host organisation and local authority

3.0 The primary role of a LINk is to provide a stronger voice for local people in the planning, design or redesign, commissioning, and provision of health and social care services. The Government has not prescribed how a LINk should be structured because we believe that LINks should develop flexibly, taking into account local groups and communities and their priorities, and particular geographical issues and culture.

3.1 Although LINks have flexibility about how they undertake their roles, there are a number of principles that should be common to all. These include:

- being open and inclusive
- being accessible to all, including those with full-time jobs, those who feel excluded and those who might need support to participate
- reaching out to all communities, looking for and collecting evidence of their views
- recognising that tackling health inequalities, looking at public health issues and addressing the wider determinants of health are central to their role
- a commitment to communicating the information they receive in a constructive way to service planners, commissioners and providers
- always feeding back responses and outcomes to the wider community.

3.2 Some Patient Forums are already looking at LINk styles of working and have made the development and inclusion of wider networks part of their work plans. For example, the Lancashire Care Patient and Public Involvement (PPI) Forum, which relates to a mental health trust, has committed to establishing a network, with locally based user and carer groups being its main focus for 2007–2008.

3.3 There are a variety of methods of involvement that LINks can use, each of which provides a different type of influence and outcome, and which may require different levels of involvement and time commitment. These include the following:

- *Information*, for example publicity, holding public meetings, undertaking opinion surveys. This method is often seen as 'one way' (i.e. not an interactive method) and the least influential, but it may be helpful in gathering data and raising awareness.
- *Consultation*, for example consulting people during the planning stage as well as involvement in formal consultations on plans or decisions to make changes to services. Often this involves asking individuals and groups to provide ideas or to comment, using a variety of methods, on a series of options. The LINks system will be a key resource when statutory partners want to consult within their communities.
- *Participation*, for example working in partnerships, undertaking outreach, helping to shape proposals. This includes taking a direct role in influencing commissioning decisions. This approach relies on consistent input from the same people when an issue is being examined.
- *Delegation*, i.e. asking other networks, groups or individuals to undertake work on their behalf. For example, an overview and scrutiny committee (OSC) may commission a LINk to undertake research on an issue that it plans to review as a method of collecting evidence.
- *Co-production*, i.e. some groups may want to become involved in designing and delivering services on a user-led model; the 'expert patient' approach is one example of co-production, peer support for independent living is another. LINks might be a route to facilitating this engagement and encouraging groups to take part.

3.4 The Healthcare Commission is evaluating methods of engagement as part of the assessment of its test sites. LINks will need to use and promote different methods of involvement when they seem most appropriate and effective in order to be accessible to all. There are many creative and innovative examples of methods within the community development field that LINks might use and that will enable those who currently don't get involved to participate.

3.5 Role of the host organisation

3.6 A host organisation is contracted to provide support to the LINk. It is the responsibility of the local authority to procure the host, and funding will be provided to the local authority by the Department of Health in the form of a specific grant. Each host will be contracted to provide support for an initial period of three years. Although it is accountable to the LINk for ensuring that the support provided is appropriate and that it meets the needs of participants, the host will be performance managed against the contract by the local authority. To ensure that this dual accountability is carried out effectively and in a cost-efficient way, it is suggested that the LINk and local authority develop a process of joint performance management that includes reporting evidence of the effective influence of the LINk. The issue of accountability of the LINk is discussed in more detail in the accountability section of this document (see Chapter 9).

3.7 As the procurement and contracting process for the host will take time to complete, it is recommended that local authorities and interested stakeholders begin to engage with local groups and interested individuals now, and that they begin to identify a working model for the LINk at the same time as preparing for the procurement process. This will encourage people already engaged in influencing local care services to help to shape the LINk and to begin the process of change that will be necessary to be effective in the new involvement system. Early work should include the widest range of people in discussions and use a variety of methods to encourage involvement. It will also be a step towards establishing the LINk and thus minimising any gaps in involvement that might exist when Patient Forums are abolished and LINks established. The outcomes of preparatory work can be handed over to the host when it is in place.

3.8 As the accompanying resource *Getting ready for LINks – Contracting a host organisation for your Local Involvement Network* makes clear, the role of the host organisation is to establish, maintain and support the LINk. The role of the host may be considerably different during the set-up period when it will have a responsibility for engaging with individuals and organisations in recruiting a diverse and representative group to establish the LINk. In order to get things started, the host will need to focus on outreach and be

innovative, to draw in potential participants, suggest options for structures and help to identify priorities. Following the establishment of the LINk the relationship between the LINk and host needs to be defined clearly in its local context, reflecting the methods of working that the LINk has adopted.

3.9 The core roles of the host organisation, such as informing and supporting the LINk, will need to be supplemented by the LINk itself setting priorities and developing its sense of direction.

3.10 The relationship between the host and the LINk

3.11 The relationship between the host and the LINk should be complementary and build upon the skills and expertise that each brings to their role.

3.12 The host's role is to provide support that enables LINk members and participants to maximise their involvement. This may include seeking out models of best practice for LINks, for example models for supporting volunteers, capacity-building and training. LINks, however, need to focus on the experience of local people and organisations who receive or have an interest in local care services.

3.13 The LINk role is therefore primarily facilitative – enabling and encouraging the process of involvement and participation as a method of influencing future services.

3.14 Both LINks and the host organisations will need to have their own forms of performance management, and each will have a role in participating in the evaluation of the effectiveness of the other.

3.15 Role of the local authority

3.16 Local authorities have a number of roles in relation to the establishment, implementation and ongoing development of LINks and will need to develop a working relationship with the LINk. In particular, local authorities should consider the following points.

> Prior to their establishment, local authority officers and councillors should undertake work to stimulate interest in LINks, with both potential members and participants and with potential host organisations. This may be undertaken through workshops, meetings, information on council websites

or in council newsletters, and through discussion with interested groups and organisations. Local authorities may find it helpful to make use of processes developed through the compact to achieve this.

- Local authorities are responsible for contracting with a host organisation, initially for three years, for effective support for the LINk within the budget allocated. This will involve developing a contract specification, making use of the document *Getting ready for LINks – Contracting a host organisation for your Local Involvement Network*, tendering and letting the contract, and performance managing the contract against the specification.
- The overview and scrutiny committee (OSC) within the local authority has a role in scrutinising how the contracting process was undertaken, and ensuring that best value is achieved.
- The OSC may commission a LINk to undertake work on its behalf, for example to consult people on their views on an issue that it plans to scrutinise and review in the future.
- Local authority departments and a LINk may agree to pool information or work together to gather the views and experiences of local people and groups regarding particular health and social care services.

4. Establishing a LINk

4.0 There are many local networks and groups that can provide useful lessons for establishing a LINk, and we are aware that in many parts of the country work has already begun to start this process of sharing information. Learning from Patient Forums, the Early Adopter Programme (EAP), Healthcare Commission test sites, and from other community-based initiatives, may be helpful for those areas that are beginning their preparation.

4.1 The first step in establishing a LINk may be to set up a working group of interested stakeholders. The aim of the group would be twofold: to identify existing engagement activity, and to ensure that the group is able to reflect the needs of all interested and diverse communities, not just those with the loudest voice. Membership of a group should be determined locally, but may include interest from:

- representatives from local voluntary and community sector organisations, including neighbourhood forums, Councils for Voluntary Organisations, self-advocacy groups, black and minority ethnic community groups, local support groups, and youth councils or parliaments – special attention should be paid to involving marginalised and disadvantaged groups from the start
- representatives from Patient Forums and Forum Support Organisations
- social care users and user groups
- representatives of local networks, for example Community Empowerment Networks, homelessness networks, and gay and lesbian networks
- local representatives of national charities, for example the British Heart Foundation
- local authority officers and members
- representatives from NHS commissioners and providers
- representatives of social care commissioners and providers.

4.2 Each of the EAPs established a project group involving a variety of participants. The work of these groups was evaluated and a number of lessons were identified for some types of representative.

Representative	Learning
Local authority	Need to ensure that the right officer or councillor attends when discussing specific issues. Officers responsible for commissioning social care services need to commit time to discussions. Larger local authorities need to identify the different types of input that will be helpful in developing the LINk, e.g. commissioning, partnership working, community development, adult and children's services, overview and scrutiny, and procurement expertise may be appropriate at different times.
NHS organisation	Need to recognise the impact of organisational change and commit time to discussions. Involvement and engagement experience can highlight existing networks and evidence of what works or doesn't work.
Patient Forum	Forum experiences can influence some of the LINk development, but need to stay focused on the new role of LINks and not attempt to recreate forums. Have demonstrated the importance of some of the ground rules that exist for forums, such as a code of conduct and governance arrangements.
Voluntary and community sector	Helpful in mapping local organisations, developing communication strategies and identifying how to access and engage with 'seldom heard' groups.
Input from individuals	It is important to reach beyond those people that are already engaged in patient and public involvement and service user involvement. LINk project groups need to use accessible language and refrain from using jargon, acronyms and abbreviations.

4.3 One of the challenges for the EAPs has been to involve individuals who are not currently involved in patient or service user initiatives. They have tried a number of approaches, but they recognise that this is likely to take time.

4.4 While there may be a large number of diverse local organisations with an interest in LINks, it is important to ensure that a project group process is manageable and able to develop an effective plan for implementation. If a group is too large it may struggle to stay focused, and there is a risk of it becoming bureaucratic as each interest group tries to assert its voice. However, too small a group may be limiting and may exclude helpful experience. It is important that those participating in an initial project group recognise that individuals and groups who want to become involved later must not be excluded. Communication both within the group and to external stakeholders is therefore essential at every stage.

Importance of communication

Communication during the process of establishing a LINk is important. For example, the EAP in Medway established an interactive website to provide regular information to participants and anyone else with an interest.

4.5 A project group should be clear about its role and responsibilities, both to its own membership and to the task of establishing the LINk. It needs to recognise that it is not the LINk, nor is it the host, but that some of the participants in the project group may form part of the LINk when the host is in place and the LINk has been established.

4.6 The initial tasks for a project group are likely to include:

> mapping information about the locality to identify the diversity of the population and its needs

> starting to develop a model of working for the LINk that reflects the various communities, the geographical area, and the health and social care needs of local people, especially those who are most vulnerable and whose voices are least likely to be heard

> identifying the principles for involvement that LINk participants will need to embrace

- looking at how people and groups will participate and whether there should be different models of membership or participation
- identifing other networks and groups who may have a role in participating in, supporting or being influenced by the LINk.

Learning from other organisations

In the London Borough of Camden the primary care trust (PCT) and Adult Services Team from the local authority have undertaken an audit of involvement across the range of health and social care services. The audit identified the following issues:

- mechanism of involvement
- type of involvement
- purpose of involvement and influence
- who was involved
- how participants were selected
- strengths and weaknesses of the process
- examples of the impact the involvement had.

Camden Community Empowerment Network, which facilitates networking across the area, has also agreed to act as a channel for communication on LINk development.

This information will be helpful to inform the establishment of the LINk.

It is likely that many local authorities will have undertaken similar audits that may be useful for LINks.

4.7 Most of the EAP project groups have used various methods of involvement to publicise their LINk and to invite individuals and organisations to begin to engage with the process of establishment. These range from holding open public events, and developing 'easy read' materials, to targeting work with communities in particular geographical areas. For example, Durham EAP has worked extensively with local communities, involving over 150 different

groups and individuals at one event, and targeting the involvement of children and young people using a variety of methods. In Doncaster, a stakeholder engagement strategy has been developed. In addition to raising the profile of LINks, such outreach activities help the project group to start to identify how people may want to become engaged in the roles of the LINk, and these discussions will help to identify the most appropriate LINk structure for the community.

4.8 An example of wider participation in the current system may be the work of the Patient Forums in Manchester, Salford and Trafford who established a Health Reference Panel in 2006. The panel has a few dozen members, including some members of Patient Forums who could not make an extensive time commitment. Members are sent a copy of the monthly newsletter and invited to submit views and comments or obtain more information. Since January 2007 they have requested over 50 documents from the newsletter on issues such as mental health, older people, dentistry and sexual health. These have been used to inform reviews and other initiatives. Most panel members responded to a Department of Health consultation on hospital travel costs with Manchester Patient Forum and completed a questionnaire for the School of Pharmacy at the University of Manchester about information to patients. Using this example in a LINk context, the LINk would reach out to a diverse range of people including social care users, individual carers and support groups and special interest social care groups. The methods used might be focused more on outreach, with LINk members and participants going out to groups to discuss the documents and consultations, running workshops or coffee mornings, and using information technology to collect views.

Learning from the Healthcare Commission test sites

The test sites have identified the following factors that might help the effective establishment of a LINk.

Clarity of purpose – *ask "What's our role?"*

> Establish a mechanism, at the earliest possible opportunity, to enable stakeholders to develop a *shared understanding* of purpose, objectives and milestones.

> An incremental or phased approach may avoid over-committing.

Capacity and resources – *"No one told us we'd need that much!"*

> Plan early for 'effective' resource allocation, so that this can be dovetailed into existing, traditional budget planning processes that may be being used within stakeholder organisations such as local authorities.

Defining concepts – *"I didn't realise that was what you meant when you said that."*

> Define all concepts early.

> Develop a shared understanding of expectations and what is required around these, in order to avoid future misunderstanding or confusion.

Roles and responsibilities – *"When did we agree I'd do that? Isn't that something you're leading on? How can I get that done? Who do I need to get agreement from for that?"*

> Clarify roles, responsibilities and governance arrangements as early as possible.

Ownership and buy-in – *"What's in it for me? It's not worth it unless I can see I'm making a real difference."*

> Early focus on achieving 'buy-in' from *all* stakeholders is critical.

4.9 When a LINk has been established for a year it should be able to effectively address the above issues and demonstrate how engaging with the LINk can make a difference for local people and organisations. It should also be able to offer a variety of ways in which people can participate, recognising that membership and participation are different but that both are of equal value and have equal influence or impact on the voice of the LINk.

4.10 All the EAPs, including the Healthcare Commission test sites, have focused on involving seldom-heard groups through a variety of outreach initiatives including small workshops and focus groups. In most cases this has resulted in the compilation of databases of contacts with an interest in becoming involved in work on specific topics. However, learning from the Healthcare Commission's Northern test site suggests that there are some challenges for community groups where their core business is the delivery of services such as information and advice and where involvement is likely to entail additional work that is not currently funded and may detract from their primary work.

5. Implementing an effective LINk model

5.0 Developing a model

5.1 The legislation to establish LINks is designed to enable each LINk to develop its own methods of working according to the needs of the local area. An established LINk is likely to have sufficient flexibility within its structure to encourage individuals and groups to participate as and when they want.

5.2 Experience already exists of developing participative and inclusive 'networks of networks' that enable people, already active on one issue within their communities, to link into new initiatives without duplicating their efforts. For example, Community Empowerment Networks in many areas act as co-ordinating groups to link together existing networks based on specific topics or communities of interest. The Community Network for Manchester has established a health inequalities theme – drawing together voluntary and community sector organisations to comment and feedback on health and social care issues – and a LINk could expand this. Where such 'networks of networks' already exist, a LINk should seek to build on their work.

5.3 The Healthcare Commission test sites and the other Early Adopter Programmes (EAPs) have identified learning about the impact of other local factors on the approach and speed of progress in setting up their projects. Both have identified particular challenges relating to involving diverse participants in rural areas, especially those with less developed voluntary and community sector networks. This suggests that in rural areas the communities are more likely to be dispersed, and that there may be less developed voluntary sector infrastructures that can be built on, whereas in the more urban areas there appear to be more established structures that can more readily become part of the LINk approach. It is important that these challenges are recognised and that the planning and implementation phases are allocated enough time to develop effectively. It is likely that LINks will develop over a period of time and that in some areas a LINk may be established quickly, whereas in other areas it may take longer to engage with local individuals and groups and begin to have the level of influence that the participants and partners would aim for.

5.4 To develop an effective model of working, it may be helpful for the project group, or for those people who are keen to start the work of the LINk, to identify the types of participation that local people may look for through the LINk. For example, some people may have the time and interest for regular

involvement. They may enjoy a particular type of activity, such as strategic planning, monitoring, developing and undertaking research, carrying out publicity, or reaching out into specific communities. Others may not have the time or capacity to participate in an ongoing way, preferring to receive and comment on information, respond to questionnaires or surveys or participate actively in relation to a single issue. Many people who have volunteered in previous patient and public involvement systems have taken up specific roles within the groups that they have participated in and have developed skills associated with these roles.

5.5 LINks differ from previous systems as they are based on broad networks rather than on small specialist groups, involving representatives from organisations as well as individuals, and addressing issues across health and social care rather than focusing on individual organisations or services. However, there will be a need for some of the roles and skills used in previous systems in addition to the new outwardly focused and outreach roles. The development process may require a fine balance, and it is likely that a LINk may initially apply one model of working and develop into another over time. This may be particularly challenging for people who have participated in previous systems and who are more comfortable with structured and formal working. Some may need to develop their skills and understanding to take up new, less formal roles.

Questions to think about

The following questions may help those engaged in developing a model for the LINk to identify some of the issues that will need to be addressed.

- What do we know about the area, the organisations, perspectives and priorities, and the needs of local people?
- What are the particular challenges that the area provides (for example rurality, poor transport, variety of ethnic groups, inequalities)?
- What networks already exist and how do they relate to one another?
- What don't we know?
- How can we find out more?

- How can we provide a balance between involvement from individual participants and input from representatives of groups?
- What do we need to do to communicate and engage with the diverse range of people who live in the community?
- How do we undertake our planning and decision-making?
- How do we achieve a balance between meetings and outreach?
- What skills are we going to need, and how are they going to be used?

5.6 The legislation and the service specification for the host organisation identify that it is the role of the LINk itself to develop its own methods of working, and thus its own model. This may be a particular challenge during the initial establishment phase. It is important for a host organisation to have a clear understanding of these challenges, and for both the local authority that is procuring a host and the potential host organisations to be aware of models and approaches that may be adapted or applied by the first LINk participants. Learning from the EAPs demonstrates that time is needed for early participants to discuss how they should work and to plan if they are to be successful. By building capacity and addressing such issues as how engagement can be undertaken in different ways, and how a broad network such as a LINk can maintain standards of work and conduct by its participants, there is more likelihood of building trust and influence both with the commissioners and providers of services, with individuals and communities, and with other networks.

5.7 The diagrams on the following pages show different models, developed by some of the EAPs, which LINks might use to organise their work and to structure themselves. They may be helpful during the initial set-up of the LINk and as it develops over the first year or so. However, in the longer term there may be other models that LINks may wish to pursue. It is the LINk's role, supported by the host, to decide how it can work most effectively.

Diagram 1: Amended from a model developed by the Kensington and Chelsea EAP

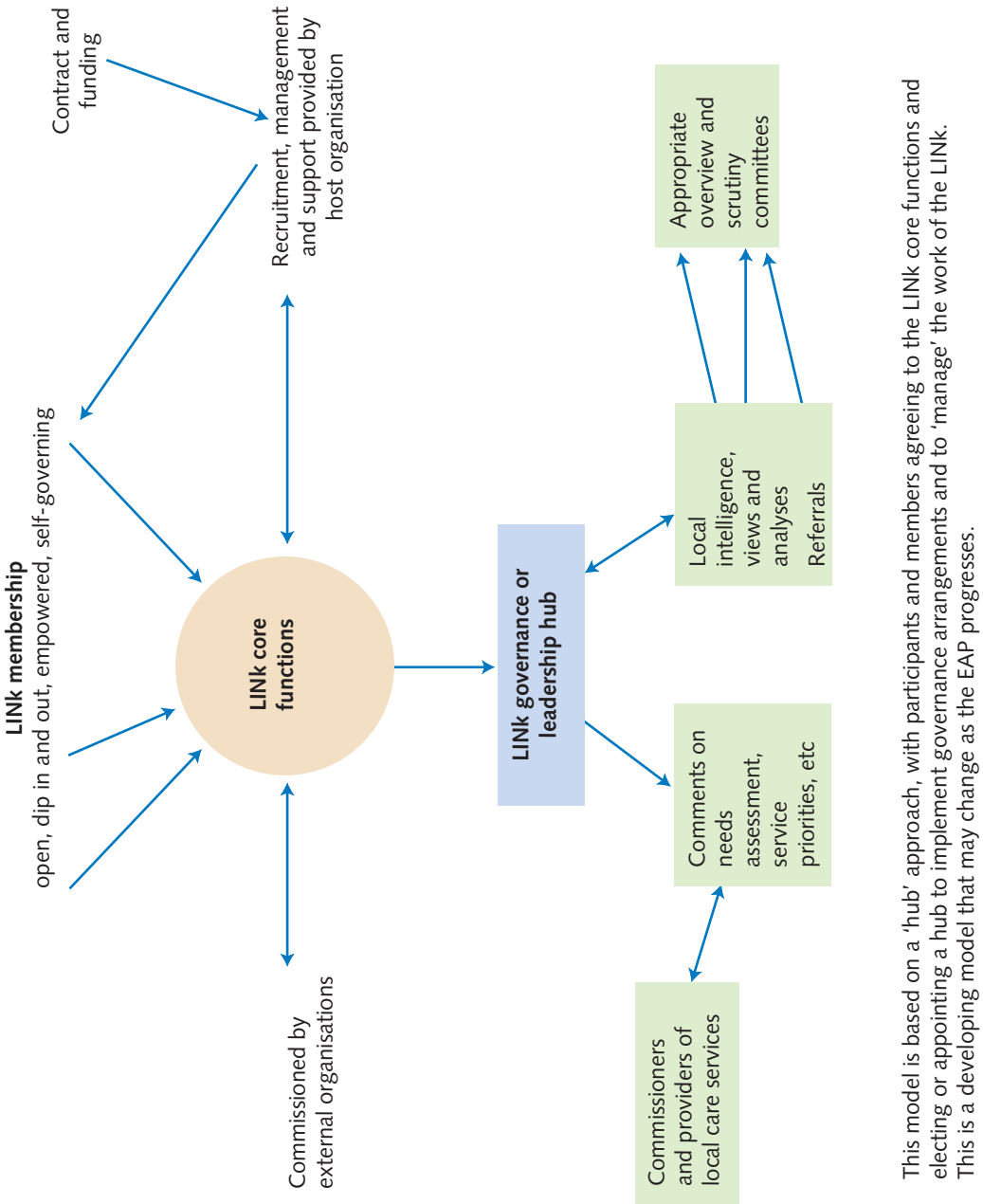
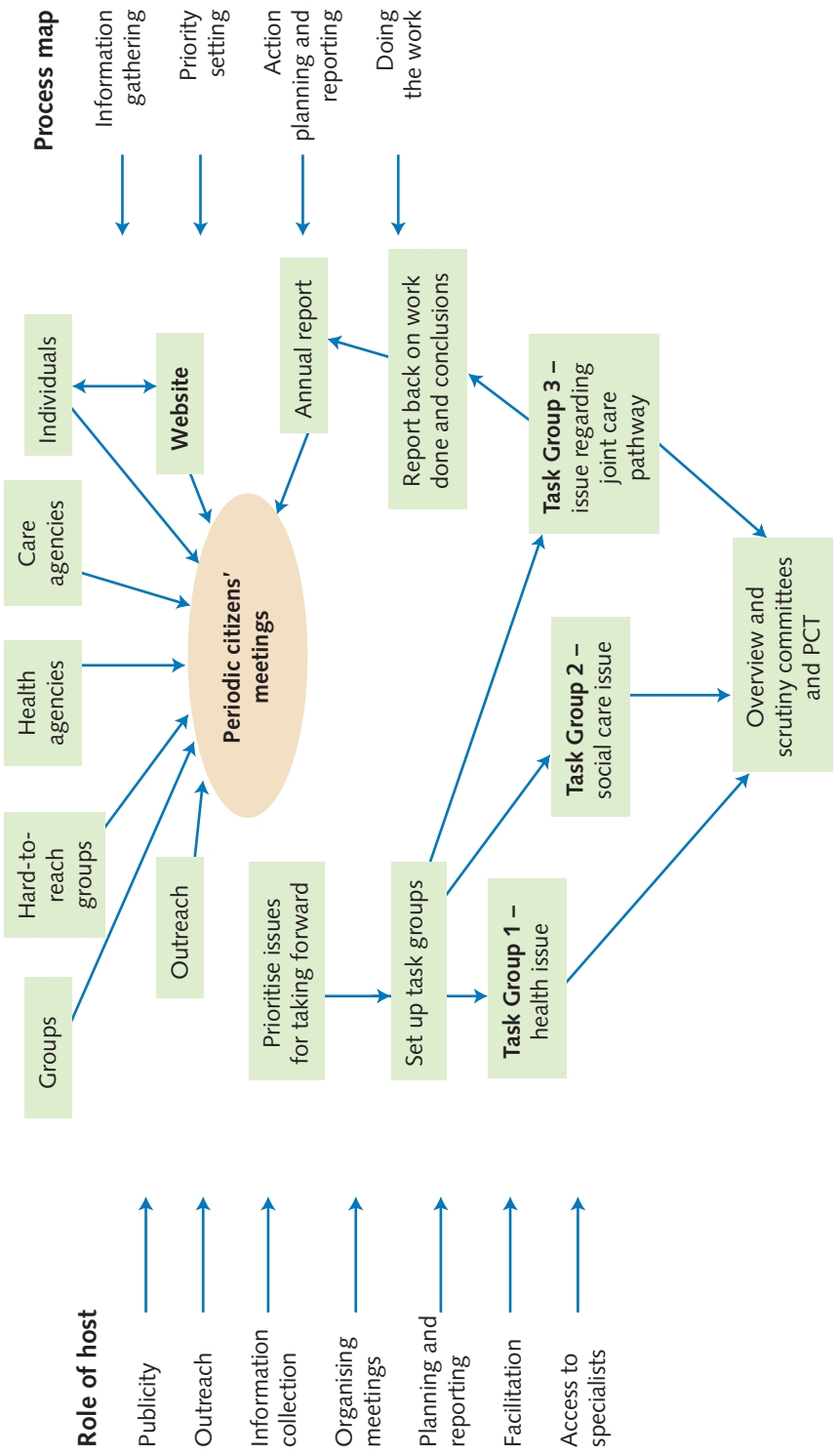


Diagram 1 proposes a model where participants can choose to participate as and when they want, but where the governance or leadership of the LINk is driven by a 'membership hub'. The broader group of members and participants feeds views and information into the work led by the hub.

Diagram 2: Amended from a model developed by the Kensington and Chelsea EAP



This model is based on a flexible structure where the host organisation co-ordinates the work that comes out of periodic citizens' meetings and there is no central hub of members. LINk participants and members take part in task groups that end when the task ends. The model is still in development by the EAP.

Diagram 2 proposes a model where the host organisation acts as facilitator for periodic citizens' meetings where priority issues are identified and decisions taken. Task groups are established as a result of the citizens' meetings to review, consult or consider the priority issues. The task groups report back to citizens' meetings, and report to the local PCT and Overview and Scrutiny Committees as appropriate. An annual report is collated from the outcomes.

Diagram 3: This model is currently being developed by the County of Durham EAP

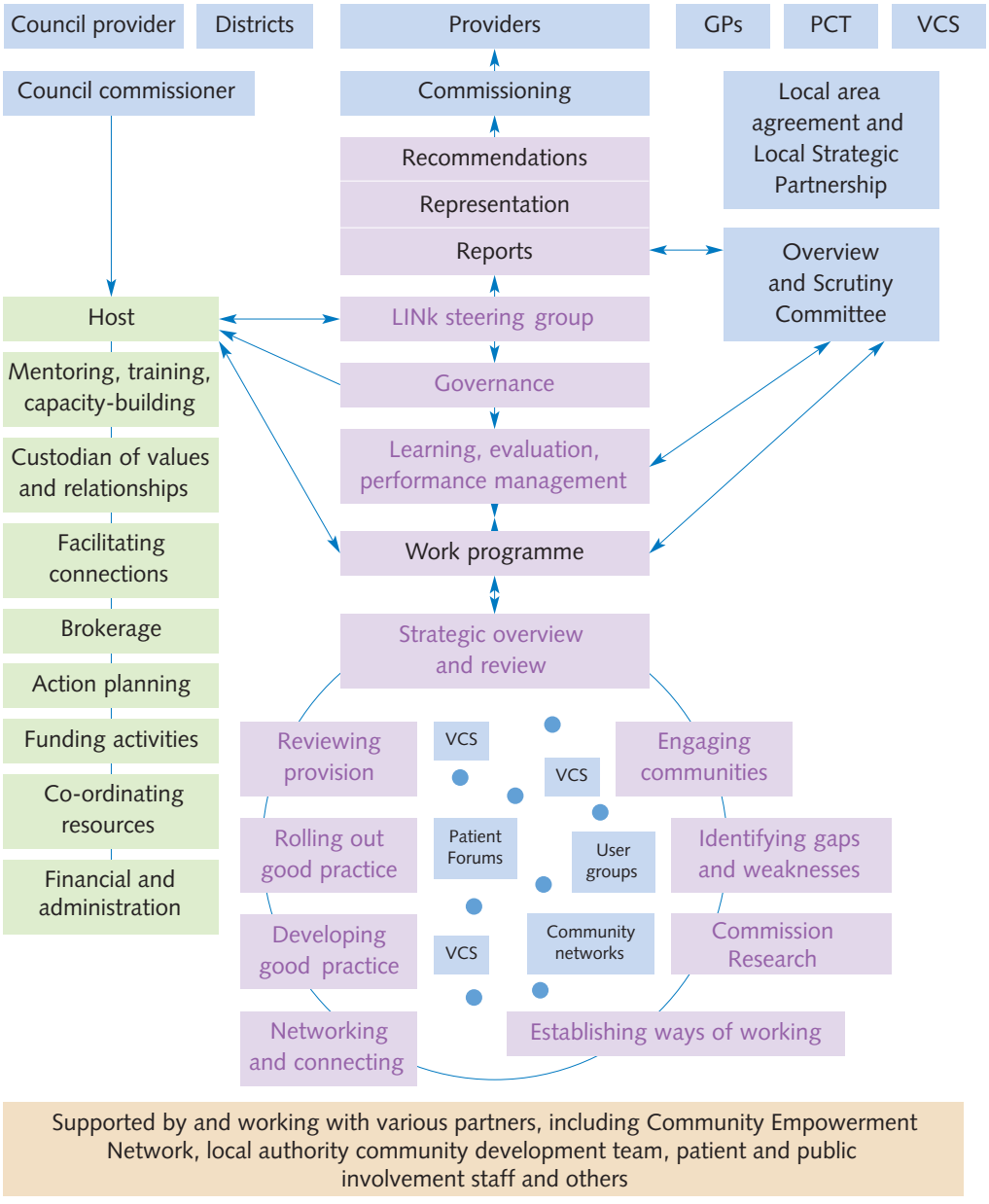


Diagram 3 proposes a model that is also based on a LINk steering group. The diagram illustrates a cyclical approach to developing the work programme and to developing and learning from good practice, based on input from voluntary and community sector (VCS) and other groups. This model illustrates the process of developing the work programme using a cycle that starts with taking a strategic overview; engaging with individuals, groups and communities including VCS groups; and developing good practice.

5.8 Some local organisations, Patient Forums and interested participants are already considering the possibility of LINks developing into social enterprises, co-operatives or other types of stand-alone organisations over time. For example, the principles and values of the co-operative movement may have resonance in some areas and for some LINks.

Values and principles

> Led by agreed principles, the co-operative movement works with its members to make changes for the better.

> Members show their values by working together for everyone's benefit.

> Members act responsibly and play a full part in their community.

Co-operative values

> Self-help – we help people to help themselves.

> Self-responsibility – we take responsibility and answer for our actions.

> Democracy – we give our members a say in the way we do business.

> Equity – we carry out our business in a way that is fair and unbiased.

> Solidarity – we share interests and common purposes with our members and other co-operatives.

Our ethical values

> Openness – nobody's perfect, and we won't hide it when we're not.

> Honesty – we are honest about what we do and the way we do it.

Social responsibility

> We encourage people to take responsibility for their own community and work together to improve it.

Caring for others

> We work to support local charities and community groups.

Our principles and the way we put our values into action

> Voluntary and open membership – membership is open to everyone.

> Democratic member control – all members have an equal voice in making policies and electing representatives.

- Economic participation – all resources are controlled democratically by members for their benefit.
- Autonomy and independence – co-operatives are always independent, even when they enter into agreements with the Government and other organisations.
- Education, training and information – co-operatives educate and develop their members as well as their staff.
- Co-operation among co-operatives – co-operatives work together with other co-operatives to strengthen the co-operative movement as a whole.

5.9 The 'social justice' type model aims to use statutory powers and rights for the public good in a fair, equitable and transparent manner. It is likely to have a flat or non-hierarchical structure that is dynamic and self-correcting.

5.10 A similar set of principles has been developed by the Healthcare Commission's Northern test site, which involves Leeds Involvement Project (LIP) and Bradford Alliance on Community Care (BACC). The principles are as follows:

i) To use a **barriers-based approach** to issues of health inequality, for example the social model of disability, and to remove barriers to participation in the way that we work in the project, for example meeting people's access requirements.

ii) To ensure that a **diverse range of service users, patients and carers are involved**, prioritising those who face additional discrimination or disadvantage such as:

- black and minority ethnic people
- people with disabilities, including mental health service users, people with learning difficulties, people with hearing impairments and people with physical and sensory impairments
- lesbian, gay and bisexual people
- refugees and asylum seekers
- women

- young people
- older people
- unemployed people and people on low incomes.

iii) To use **community development approaches** to the work. This involves:

- collective working:
  - working together towards common goals
  - forming networks and making connections to help people collaborate and come together in groups
- equality and justice:
  - challenging discrimination and working alongside those who are powerless
  - raising awareness about inequality and how things can be changed
- learning and reflecting:
  - recognising that everyone has skills and knowledge
  - learning from mistakes as well as successes
- participation:
  - helping individuals to get involved and sharing power through communities
  - increasing people's influence over decisions that affect their lives
- political awareness:
  - raising awareness of communities' concerns
  - linking local concerns to the bigger picture
- sustainability:
  - working with and investing in the capacity of people and groups so that change lasts
  - using environmental resources responsibly.

iv) To develop **innovative approaches** to involvement work, for example by trying out new methods of working.

v) To regard any views gathered in the project as an 'additional stream of information' about healthcare from '**experts by experience**' rather than as 'representative views'.

vi) To recognise that this is phase one of a project and a main aim in this phase is to get the **engagement processes and tools** with the Healthcare Commission right, before expanding the project to reach out widely to new groups of people with whom LIP and BACC do not currently have contact.

vii) To evaluate the project against this set of principles, as well as against other outcomes.

5.11 It should be remembered that the establishment of the LINk is not an end in itself but only one small part of the process, and that it is the effective implementation of the LINk roles that is important. Over time, the LINk may develop its roles, for example to take on work commissioned by other organisations, and as a result of this it may reorganise how it works and the methods that it uses.

6. Governance arrangements

6.0 The role of governance is sometimes confused with that of accountability. The two concepts are related, but in the context of LINks we are using the term 'governance' to describe the processes and systems by which a LINk operates and governs itself. These need to be clear to LINk participants and also to be shared with external stakeholders, including commissioners and providers of local care services.

6.1 The form of the governance structure will be for the membership to decide, supported by the host organisation and by Department of Health guidance that sets out examples of best practice. This might be achieved, for example, by the participants electing a board or steering group, or the participants might choose to take a co-operative approach. The LINk should ensure that it has a governance structure that will:

- agree the overall priorities and work plan of the LINk in consultation with the wider LINk participants
- establish principles for LINk participation, including being the arbiter of membership decisions within the governance framework
- create, review and make recommendations on the governance arrangements
- decide where, when, how and by whom the LINk's powers should be used, for example to enter and view specified health and social care premises
- sign off external reports
- ensure that the LINk operates within the agreed governance framework
- promote the LINk and report on its activities, including via its annual report
- contribute to the performance management of the host by the local authority
- ensure that equality and human rights principles are integral to the LINk's work.

6.2 While LINks will be responsible for establishing their own governance frameworks, the experience of the Early Adopter Programmes (EAPs) and Patient Forums, and that gained within the community and voluntary sector, identifies the need for a number of core issues to be addressed, such as:

- a code of conduct for participants, especially those who take up roles relating to outreach, and use of the power to enter and view premises, and who represent LINk in working with other groups and organisations
- a process for implementing of the power to enter and view health and social care premises
- dealing with complaints (internal and external)
- dealing with potential conflicts of interest
- the use of resources, including the allocation of financial resources
- the use of influence in working with stakeholders
- communication (between participants, between participants and the host, and between the LINk and the outside world)
- achieving an equitable balance between individuals and organisational participants
- dealing with Criminal Records Bureau (CRB) checks for those members and participants with an interest in taking up the power to enter and view premises.

6.3 Many of the participating groups and organisations in the set-up phase of a LINk are likely to have experience of dealing with some of these issues and should be able to share good practice and learning. They will recognise that good governance is crucial to ensuring that networks operate effectively.

6.4 It will be the responsibility of the LINk itself to decide how it is established and to identify whether any groups of people or types of representative should be excluded from the LINk as a whole or from roles within the LINk. These decisions will need to be communicated widely and will form part of the governance arrangements.

6.5 An established LINk that is working effectively to achieve its roles will have clear governance arrangements that demonstrate the following:

- The method of appointment to any 'stewardship' or governance steering group. One model of achieving this would be for all people who register an interest in a LINk to have the opportunity to stand as a member of a

group and to be able to vote for members. This would be a similar approach to that used in NHS foundation trusts to elect a board of governors and, if this model is applied, learning could be taken from the development of foundation trusts.

- A method of identifying any individuals or groups that the LINk considers should be excluded from taking a leadership/governance role. For example, a LINk might consider it appropriate to exclude elected councillors, or that a participant who work for a provider of care services should be able to participate and lead work on one type of issue but not on another that relates more closely to their commissioner.
- Consideration who must be included in order to achieve suitably diverse and inclusive governance arrangements.
- A strategy for renewal of participants involved in the governance arrangements, or other specified roles, that takes into account drop-out rates and end of term of involvement. It should be recognised that there will be drop-out from engagement in the LINk as individuals' and groups' circumstances and priorities change. It is important that an established LINk has an agreed process with the host organisation to recruit and engage more participants on an ongoing basis rather than waiting until there are gaps in governance or leadership roles. This is also important to ensure that over time a LINk does not become dominated by one view or one priority, creating a risk of becoming exclusive.
- The balance between individuals and group/organisation representatives. There are risks and benefits to involving both individuals and group representatives in LINks. It is important that an established LINk is clear that both have an equal but different role. Ensuring equity of influence will be a challenge during the establishment phase, but this may be helped if the culture of the LINk recognises the value of both. In other contexts, networks of individuals and groups usually allow all participants to have one vote (if voting is required), even when the participant represents a large organisation.

- The balance between the LINk's role in representation and that of other representative bodies such as Older People's Forums and Centres for Independent Living. LINks will need to develop good working relationships with these bodies so that they feel their voice is being amplified, not duplicated or replaced.
- How particular roles will be carried out, for example chairing meetings, representation to the host or local authority, outreach to groups, discussions with commissioners, providers or regulators of services, or the power to enter and view premises.
- Length of tenure in a role.
- Terms of reference or a constitution for the LINk. Guidance on setting terms of reference or constitutions for voluntary and community groups is available through a number of national voluntary organisations and support structures.
- A method for ensuring that the decisions taken, for example on setting standards for participation or agreeing a code of conduct, are representative of the wider LINk membership.
- How conflicts of interest of members or participants will be addressed. It is common practice to develop a policy that defines what a conflict of interest is and states when and how the policy should be applied. This may be of particular importance where there are participants or members from NHS foundation trusts or voluntary organisations that also provide local care services.
- How complaints will be dealt with. This should include:
  - complaints by individual LINk participants, external bodies or individuals about LINk representatives when they are undertaking LINk functions
  - complaints about the content of work undertaken by the LINk
  - complaints about the LINk as a whole.

The host organisation will be able to provide advice and guidance on these issues, but individual LINks may wish to work with other LINks in order to develop effective and consistent approaches. For example, two LINks might

consider sharing their practice on individual complaints and acting as a support process, advising and arbitrating for each other.

- Processes for approving the budget and accounts and how financial matters are discussed with LINk participants and the host organisation.
- How a framework of delegation (if needed) will be established.
- The process for monitoring the LINk's performance (see Accountability, in Chapter 9).
- How it will be ensured, with advice from the host where appropriate, that the LINk's affairs are conducted lawfully and in accordance with accepted standards of best practice and probity.
- How the processes of decision-making and communication within and external to the LINk will be agreed, for example the use of 'authorised representatives' to liaise with stakeholders on particular issues.
- How a process of review for the governance/leadership group will be agreed and how LINk participants will take part in this.
- How the power to enter and view premises will be implemented, for example who will undertake the role, what training they will be given, and what processes they will use to feedback their findings to the LINk, to commissioners and to service providers.
- How information that has been collected is stored, and how Freedom of Information Act requests will be dealt with.
- How the LINk relates to the host.

6.6 It has been suggested that there will be some roles within a LINk that will need to be clarified through more rigorous governance processes than others. For example, those LINk participants who form a governing body, those who undertake a regular and active outreach role, or those who take up the power to enter and view premises should sign up to the Nolan Principles of public life and should be subject to CRB checks. This would help to ensure that the risk of inappropriate behaviour related to a LINk is reduced. More information on these issues will be provided in the formal guidance to be

published when the Local Government and Public Involvement in Health Bill receives Royal Assent.

6.7 As the service specification for the host organisation suggests, an effective host will be able to demonstrate that it has good governance structures in place. This should enable the host to provide guidance and support to the LINk as it develops its own approach to governance.

7. Carrying out LINk roles

7.0 While it is important to invest sufficient time in developing ways of working, the primary focus of LINks should be on how the initial set-up and development will ensure that they are able to make a difference and have influence when carrying out their roles. To help to demonstrate this, LINks may want to set priorities in the first year that are highly visible or relatively easy to bring to a conclusion, aimed at raising their profile; building credibility with the local community, commissioners and providers; and encouraging participation; as well as making a difference.

7.1 The Manchester Early Adopter Programme (EAP) is looking at access to services for people at risk of experiencing stroke. This will be developed with a network of organisations and will consider prevention, emergency and acute care, primary care and social care support.

7.2 In identifying priorities, a LINk will need to be networked with other groups and organisations, sharing information and work programmes. How a priority area is identified may be influenced by the organisational model that the LINk has developed, but should include a number of core elements, as follows.

> The topic should be relevant to local people and raised by local people or groups, and local people should be able to be involved in the work.

> Work undertaken by the LINk should not duplicate a review or scrutiny process by other stakeholders, but may complement and add value to it.

> The work can be undertaken within existing financial and participant resources.

> The LINk can add value to the topic.

> The topic is not over-ambitious and can realistically achieve a result that is going to have an impact on health services and health inequalities.

> The topic is timely.

7.3 When an issue has been identified and there is evidence that it is of importance to local people, the LINk should initially contact the commissioner of the service to discuss the issue and the LINk's proposed action. This will provide an opportunity for the service commissioner(s) to discuss their knowledge of the issue, to provide any information about complaints or

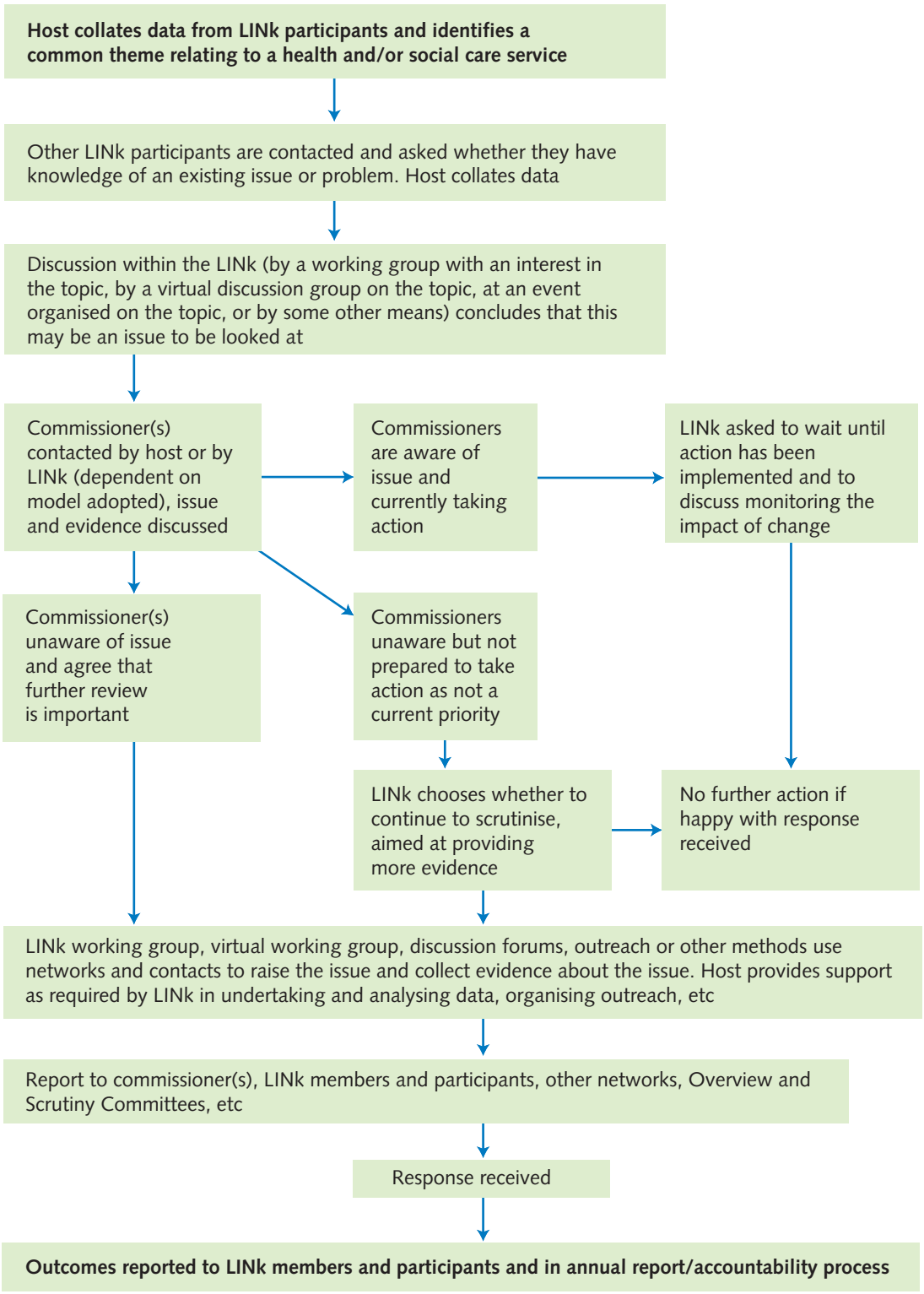
comments that they are aware of, and also to give details of any planned action that might influence the timing of the LINk review. For example, if a problem has been identified and is in the process of being rectified, it may be inappropriate for a LINk to undertake any work until the commissioner has made the proposed changes. It will also be good practice for the LINk to check with other networks and stakeholders whether the issue has been identified as being important, and whether they are already looking at it. This will prevent the risk of duplication and will provide an opportunity for networks and groups to share the intelligence that they collect.

7.4 The flowchart (Figure 2 overleaf) explains how an issue might be identified and considered by a LINk.

7.5 For a LINk to be effective in its role it will need good support from the host, and this will include effective information technology. The Department of Health is currently scoping the needs of an IT infrastructure for LINks. It is also essential that LINks are adequately supported by the host in making use of the intelligence that they gather.

7.6 The host should have a significant role in helping the LINk to communicate with other participants and networks, to make effective use of the media and to account to the local community on how it is using the resources invested in LINks. Work in the Healthcare Commission northern test site has highlighted the need to be very clear about the different sets of skills needed by a host and a LINk. The skills required to do good, creative engagement work with a broad range of communities, are not the same skills as those required to distil, analyse and translate views and experiences into feedback that is useful to health and social care providers, commissioners and regulators. For involvement to be effective and make an impact, it needs to be deployed so that the input from service users and patients has some influence on those who make decisions about local care services.

Figure 2: How a LINk might identify and consider an issue



8. LINks within the wider community context

8.0 LINks will be established within and across communities where many other networks also exist. A core part of their role will therefore be to develop relationships with other networks, to ensure that duplication is avoided and to help to link other networks together. The primary relationships that LINks develop may vary across areas, but are likely to include:

- local people, community engagement networks, user groups and community initiatives
- commissioners and providers of local care services
- foundation trust members and governors
- overview and scrutiny committees
- health and social care regulators
- strategic health authorities
- other LINks, especially neighbouring LINks and those receiving the same services, for example mental health or ambulance services
- voluntary and community sector organisations involved in providing services, supporting or representing users and carers
- local media, local politicians
- Local Strategic Partnerships (LSPs) and the implementation of local area agreements (LAAs)
- local authority officers and members leading on the Community Call for Action
- in two-tier local authority areas, both officers and councillors.

8.1 The more formal existing initiatives that LINks will encounter are LSPs and LAAs. Specifically, LSPs are made up of diverse local organisations that set the strategic direction within which services are developed locally. LAAs set out the local public service priorities that have been agreed between central government, the local authority (as the accountable body of the LSP) and other key partners at the local level. Local area agreements simplify some central funding, help to join up public services more effectively and allow greater flexibility for local solutions to local circumstances. Through these

means, LAAs are helping to devolve decision-making, move away from a 'Whitehall knows best' philosophy and reduce bureaucracy. An effective LINk will be in a good position to provide data and evidence to LSPs about whether the LAA targets relating to health and social care are being met. This will help to verify strategic development locally, and may highlight areas of best practice as well as areas for improvement.

8.2 The Local Government and Public Involvement in Health Bill proposes a number of new local arrangements that LINks may add value to or develop relationships with. For example, the Bill introduces Health and Well-being Partnerships, which should enable local partners to achieve a truly integrated approach to delivering local government and NHS priorities. The Bill will require local authorities and primary care trusts (PCTs) to produce a joint strategic needs assessment. This will ensure that local partners have a shared understanding of the needs of their locality, enabling them to agree more effective long-term health and well-being priorities. The intelligence that LINks collect and collate from within their areas may be very useful in informing the needs assessment and vice versa.

8.3 It is a relatively small but nonetheless powerful change that will help the PCT and local authority to work in partnership to deliver care that is more responsive to the needs of individuals and the community that they serve. It would be for the local authority and PCT to encourage involvement of the LINk in their area in the Health and Well-being Partnership and the strategic needs assessment that it produces. We would encourage them to engage with their local LINk as an important voice to be included among the LSP partners.

8.4 In addition to local working, there will be times when LINks need to work with each other across more than one local authority boundary, although their focus will remain on the needs of their local populations. For example, this would be the case if one LINk has concluded that it should scrutinise issues relating to mental health services that include NHS and social care provision commissioned for local people but provided across a region, or if LINk participants across more than one LINk identify concerns relating to emergency ambulance provision. An established LINk will be aware that such issues may arise, and will have developed processes to enable joint work to take place with its neighbouring LINks. This may be undertaken in a number of ways, including:

- the nomination of a 'lead' LINk member within each LINk, with a remit for collecting data, leading discussions and outreach for a particular topic of interest, and liaising with other 'leads' within a specified geographical area
- the establishment of a 'network of interest' across a number of LINks, communicating with each other (possibly electronically) with one host collecting and collating data on behalf of the partnership of LINks
- the establishment of a joint working group including representatives from each LINk within a region or geographical area of interest
- the organisation of regular workshops or stakeholder events across a number of LINks to discuss one or more common areas of interest.

8.5 There may be other models of working that LINks will wish to develop jointly. These will rely on good working relationships with the host organisations and between host organisations, and on the facilities being available for hosts to support larger areas for targeted work. This may require the LINks and hosts to establish processes for 'payment in kind', pooling budgets or sharing resources across more than one LINk to ensure that working across areas is adequately funded and on supported. Joint working of this nature will lead to additional benefits such as avoiding duplication and sharing the expertise of both LINks and host organisations with their neighbours.

9. Accountability and measuring performance

9.0 Accountability

9.1 Being accountable can mean different things to different people. 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. LINks are responsible for deciding their priorities and actions, and they should be able to account for those actions, decisions and achievements to local people and organisations.

9.2 Accountability needs to be demonstrated:

- by the host to the local authority
- by the host to the LINk
- by the LINk to local people and organisations
- by LINks to the Secretary of State for Health.

9.3 Each LINk therefore needs to be clear about *what* it is accountable for and *how* it will account for its actions. This is not a difficult task if the LINk considers accountability in conjunction with the following:

Transparency: ensuring that it is open about its methods, processes and performance.

Liability: taking into account the consequences of the actions, decisions and views that it takes and communicates.

Responsibility: making sure that it follows the methods of working that have been agreed by the LINk as a whole, including codes of conduct for participants and working groups.

Responsiveness: listening to and involving interested individuals and organisations, and responding to their information and priorities based on evidence of need.

9.4 **Host accountability to the local authority**
This should focus on performance monitoring arrangements. The host will need to account for how it fulfils its contract, including how the money that it receives is spent, and how it engages with organisations and individuals within the community.

9.5 **Host accountability to the LINk**

It is important that the host and the LINk are clear about which roles the host is accountable for in relation to the LINk. For example, in the Getting Ready for LINks regional workshops, it was identified that the host should be accountable for demonstrating that there are robust ways of ensuring that issues that emerge from LINk participants and contributors are managed effectively. The host and the LINk will need to clarify expectations about accountability early on in their relationship to enable the host to undertake, for example, any data collection that the LINk might ask for.

9.6 **LINk accountability to the community**

A number of different methods of accountability are used by voluntary and community organisations, public bodies and private companies, including:

- production and dissemination of an annual report, explaining how the roles have been undertaken, how broad, diverse and equitable involvement has been maintained, and how outcomes have been achieved
- publication of materials using different methods to suit a diverse audience, for example a website, text messaging, outreach presentations, or a proactive relationship with the local media
- holding meetings or events in public where the LINk presents its achievements, is open to questions and debate, and demonstrates its inclusivity.

9.7 An established LINk that is confident and influential is likely to use these methods and collect annual feedback from stakeholders and partners to identify how it is perceived by groups and organisations within the community. This is often called '360-degree feedback'. The process might include asking for feedback from commissioners and providers of care services, as well as from a selection of groups, organisations and individuals within the locality. The collated feedback can be incorporated into the annual report and shared with LINk members and participants as well as with stakeholders, enabling the LINk to demonstrate transparency and accountability.

9.8 **LINk accountability to the Secretary of State for Health and Parliament**

LINks will be required to produce an annual report with the support of the host organisation. This report will be a method of accounting to the Secretary of State and ultimately to Parliament.

9.9 It will be important for the LINk to develop an accountability process that enables people and organisations who are not engaged in its work to ask questions, challenge priorities and be given an opportunity to shape the way in which it works for the future.

9.10 Measuring performance

9.11 In addition to being accountable to local communities, LINks need to be able 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. We believe a LINk will be a success if it can demonstrate the following achievements:

- People know of its existence and what its role is, and perceive it as a credible local organisation.
- People are able to gain access to it through the avenues and opportunities that suit them (within a reasonable cost).
- People know what it is doing and why, and are able to comment on its work.
- It has reached out widely and deeply into the community and can show evidence of the effectiveness of this.
- It works in inclusive and non-discriminatory ways and is able to show a diverse range of participation in its activities.
- It knows what people's needs are for health and social care services – it should have an evidence base which encompasses views from an appropriate section of the local population.
- It has an evidence base of how people in its area perceive the health and social care services they have received.
- It has identified areas in which health and social care services can be improved in the eyes of the public or users of services – and has made recommendations to those bodies responsible for those services.
- It has established constructive and open relationships with health and social care commissioners and providers.

- It has a focus on partnership, outreach, networking, relationship-building and making common cause.
- It has a constructive and open relationship with its host organisation.
- It has a constructive and open relationship with relevant overview and scrutiny committees, with health and social care regulators, with strategic health authorities and with local voluntary and community sector organisations.
- It is rated by key local organisations as a credible partner, adding value and providing effective insight.
- It is able to account (via the host) for the money that has been made available to it to fulfil its activities.
- It can identify the impact the involvement of the LINk and recommendations it has made have had on services.

9.12 It is important that these performance indicators focus on the qualitative aspects, such as quality of interaction, the building of relationships, influence and achievements, as well as quantitative indicators such as the number of people reached and reports made. Outcomes and indicators will need to be negotiated locally to ensure that they are appropriate to local circumstances and informed by the knowledge and experience of the local partners.

9.13 It will be up to local authorities to decide, in conjunction with local people, stakeholders and prospective host organisations, what the appropriate indicators are to demonstrate that a host organisation has enabled, supported and guided the LINk successfully in its activities.

9.14 To support both LINks and host organisations to undertake their roles in relation to accountability and performance management, we 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. This will be published when Royal Assent has been received for the Local Government and Public Involvement in Health Bill.

10. Further guidance and information

10.1 As the development phase of LINks progresses, more learning from the Early Adopter Programme (EAP) will become available. This will be published on the Commission for Patient and Public Involvement in Health's Knowledge Management System, which can be accessed by visiting the website www.cppih.org and following the references to LINks.

10.2 Information is also available on the NHS Centre for Involvement website at www.nhscentreforinvolvement.nhs.uk

10.3 The Social Care Institute for Excellence publishes best practice guidance on user involvement which can be found at www.scie.org.uk

10.4 The Care Services Improvement Partnership (CSIP) was created in 2005 by the integration of a number of initiatives supporting the development of services to help improve people's lives. CSIP's overall purpose is to support improvements in health and well-being. For more information visit www.csip.org.uk

10.5 The Centre for Public Scrutiny also provides information that may be helpful for LINks. Its website can be found at www.cfps.org.uk

10.6 Information about government policy regarding health and social care is available on the Department of Health's website at www.dh.gov.uk

10.7 The Commission for Social Care Inspection inspects and reports on care services and councils to improve social care and stamp out bad practice. Find out more about their work at www.csci.org.uk

10.8 The Healthcare Commission promotes improvement in the quality of the NHS and independent healthcare. For more information visit www.healthcarecommission.org.uk

10.9 We recognise that there are a number of details about the development of LINks that will need to be provided in more formal guidance from the Department of Health. Such guidance will be published when the Local Government and Public Involvement in Health Bill has received Royal Assent in the autumn of 2007. We currently expect guidance to include information about the following issues:

- expenses policy
- a LINk standard of conduct policy or code of conduct
- complaints procedure
- relationship between local authorities, primary care trusts and providers
- relationship between the governance structure and the host
- finance
- rights and powers (including referring to the NHS model contract for the independent sector)
- annual reports
- models of governance structures
- training/development
- recruitment/induction
- branding/communications
- the role of the NHS Centre for Involvement and the Social Care Institute for Excellence.

10.10 We are also working with the NHS Centre for Involvement to produce a compendium of resources for LINks collated from Patient Forums and existing initiatives that will help support the future role of LINks.

APPENDIX A
Action List

The following table contains a summary of actions for developing an effective LINk.

	Action
Establishing a LINk	> Clarify the LINk's roles – what it is and isn't – and ensure that all stakeholders involved in establishing the LINk have the same understanding of its roles. > Identify what information is already available within the LINk area on types of public and community involvement and how it is used. Identify what gaps there are and what needs to be done to 'map' existing activity. Identify how this can be done. > Identify what information already exists about the communities and groups within the area. Who is hard to involve and why? What needs to be in place to enable them to participate in the LINk? > Clarify how the LINk will complement existing networks, partnerships and user involvement groups and how they can share learning. > Be clear about the role of the host organisation and how it will support the establishment and ongoing work of the LINk. Look for ways in which the host organisation has additional expertise derived from its other roles that the LINk might benefit from. > Begin discussions with local voluntary and community organisations to identify the capacity for and interest in taking up the role of the host organisation. This might be on an individual or consortium basis.
Relationships with other stakeholders	> Build on the principles and agreements within local compacts to ensure that all involved work to compact principles, are valued and informed and are able to participate equitably.

- During the development of a LINk, identify who needs to be involved, in what and when. For example, which voluntary organisations are interested in the host role and which wish to be involved as participants or members of a LINk.

  Involve representatives from existing networks who may share good practice and identify potential conflicts of interest or risks of duplication before they arise.

  Identify the main communities of interest and place, and promote LINks to them to begin developing relationships and stimulating interest. The Early Adopter Programme (EAP) can provide examples of how this might be done.

  Involve commissioners, providers and regulators in discussions as the LINk is established, to help to find out how they work, how a LINk can add value and what their hopes and concerns are.

- Identify existing methods of communication that might be able to promote and share information about and with a LINk, such as local authority residents' newsletters, parish magazines, websites, noticeboards, community radio and area forums.

- Develop relationships with other local authorities across the region to enable the LINk to develop regional relationships and plan for joint work on issues that span larger areas.

- Identify important times for different groups and organisations, such as religious days, service planning timescales and performance management cycles, so that the LINk is clear about when to avoid activities and which times are good for maximising participation.

Ways of working	> Look at learning from the EAP about different ways of carrying out LINk roles. > Be creative in involving individuals and groups in ways that meet their needs. > Be inclusive and make use of best practice in involvement and community development from other contexts, such as neighbourhood renewal and social inclusion, to enable those who are seldom involved to participate.
Governance	> Clarify what is understood by the term governance and list areas within the LINk roles that need clear governance arrangements. > Identify relevant learning from Patient Forums, the EAP, local and national voluntary organisations, NHS foundation trusts and other groups that involve volunteers in their work. > Work to develop governance arrangements that are easy to understand and implement, not bureaucratic and exclusive.
Making a difference and identifying success	> Consider what success might mean locally, after one year, after three years and after five years. How can this be demonstrated to people not engaged in a LINk? > Identify what 'making a difference' might mean to different people participating in the LINk. It may be different for someone who is keen to take part in a regular and ongoing way than for someone representing a particular support group, or for an individual who has never been involved before. > Discuss success and making a difference with the commissioners of NHS and social care services and work towards a joint understanding.

Accounting to local people and groups

- Ensure that all stakeholders recognise the value of and need for accountability processes to be in place.
- Building on existing and new relationships, ask people how they would want the LINk to account to them and try to develop inclusive and transparent processes.
- Build a feedback process, such as a 360-degree review of the annual work programme, and report the outcomes openly in the annual report process.
- Look at how the host can collect and collate information about the achievements and work of the LINk that can be easily incorporated into an annual report.

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