

**Evaluation  
of  
LINKs  
simulation  
event**



**22 October 2007**

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Artworks  
Creative  
Communities



Bradford and Airedale   
Teaching Primary Care Trust

City of Bradford Metropolitan District Council

[www.bradford.gov.uk](http://www.bradford.gov.uk)

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Evaluation of LINKs simulation event, Bradford 22 October

### Executive Summary

More than 100 people met at the Carlisle Business Centre, Bradford, on 22 October 2007, to discuss their Local Involvement Network, or LINK, as expected to become operational on April 1<sup>st</sup> 2008.

The event simulated the activity of a Local Involvement Network through an experiential set of discussions. Six morning workshops generated points that were then fed back to the assembled audience in the afternoon for consideration as LINK issues.

‘Essentially a community development project,’ the success of a LINK is contingent upon a sense of ownership that is claimed and shaped at grass-roots level. To this end the day was successful in attracting concerned individuals, members of existing PPI forums, and community activists, as well as representatives from the voluntary and the statutory sector.

Three broad categories of opinion emerged from data gathered on the day:

1. The view that the LINK should be as locally and organically rooted as possible, and that top-down national guidance should not be allowed to get in the way of bottom-up community engagement.
2. The view that operational procedures should be rendered in simple, uncomplicated systems and language such as all might understand and engage with.
3. The view that a pragmatic approach was necessary to get the LINK up and running, in order to retain the momentum established by PPI and other local initiatives.

Within each of the three areas there were both tensions and solutions.

The clearest challenge was how to bridge the gap between particular voices and general agendas. For the LINK to operate effectively requires parties to sign-up to a common agenda. At the same time, though, a strong emphasis upon individual experience sits at the heart of the LINKs initiative, and was clearly evident during the simulation exercise. An ethical commitment to subjective modes of knowledge and expression underpinned many contributions.

This tension, between particular ways of seeing things and general ways of addressing them, was expressed in various forms. Arguments for change, at every level, were challenged by cries to ‘not reinvent the wheel.’ Arguments to attend to the overlooked needs of a particular community were challenged by cries to find issues that arose across service provision.

The argument for strictly local, bottom-up, experiential issue-generation clearly resonates with the spirit of the legislation. At the same time, the issues generated must ultimately crystallise as a network-wide agenda, to include those stakeholders under a statutory obligation to partake and support the LINK. But many of them seem uncertain as to exactly what they are partaking of.

In part this uncertainty is due to the fact that LINKs are not yet up and running. But in part this uncertainty would seem to reflect a deeper challenge, as to how in fact it will cohere the various voices and formulate an entity that is more than the sum of its parts.

To make engagement with health and social care an active, community-wide process will require a firm hand on the LINKs tiller in order to establish an agenda to which all stakeholders can subscribe. An often passionate commitment to enabling particular and exceptional voices to be heard is an asset that will need careful and sensitive steerage if it is to result in a programme of activity commanding community-wide levels of support. The stated desire of most participants for more and better modes of engagement offers a clear opportunity for the LINK to establish itself as a new channel of communication. But to do this it must first of all develop an identity of its own.

The new LINK will need to move quickly, if the good will and energy of the simulation exercise of 22 October is not to be dissipated.

Uncertainties abound, but are eclipsed by an essential sympathy for the aims and values of the initiative, especially as they chime with experiential and subjective openings for otherwise hard to reach and seldom heard groups. No participants expressed dissatisfaction with the event. Of those who had problems with the LINKs initiative, there were none who were not seeking to be engaged at some level. In modelling that engagement the simulation exercise demonstrated both the difficulties and the opportunities of LINKs. As one participant said, ‘we just need to get on with it and make it work.’

## Introduction

This is an evaluation of a one-day event that brought more than 100 people to the Carlisle Business Centre, Bradford, on 22 October 2007, to discuss their Local Involvement Network, or LINK.

The Bradford LINK, like all other LINKs, has yet to assume operational functions. Only on April 1<sup>st</sup> 2008 is the LINK expected to go 'live.' Until then there is much room for interpretation on the part of stakeholders to shape the form and the focus of the network as it evolves.

To that end is this report directed, by capturing experiences and insights pertaining to the ongoing process, rather than measuring satisfaction rates for an event that has already passed. As a qualitative and prospective contribution to capacity building this evaluation draws out the key learning points such as might embed ownership of the LINKs initiative in Bradford.

The day aimed to simulate the activity of a Local Involvement Network through an experiential set of discussions. Six morning workshops generated points that were then fed back to the assembled audience in the afternoon for consideration as LINK issues. With a tight schedule and a wide array of opinion and emphasis, the event benefited from the facilitative framework of Artworks Bradford, who mediated the flow of information and expression through the day.

In simulating the activity of a LINK through workshops and discussion, the day aimed to foster a wider and clearer understanding of issues and methods, the better to engender ownership and participation in this still-formative period. An experimental approach allowed for a diversity of expression and style as part of a commitment to 'bottom up' capacity building. Contributions from the floor, and within groups, reflected this diversity, forcing all participants to begin to understand the complexity of dialogue in the context of such a variegated experiential setting.

Here we review the range of those experiences and assess their respective contributions to the establishment of the LINK. We also examine the extent to which those experiences might *not* contribute to that end. Success being contingent upon engagement, this report identifies the extent to which the LINK idea has filtered out into the community, and where it might yet need to make its presence felt.

## Methodology

This report is primarily concerned to capture the experiences of those attending a one-day simulation of LINKs. It is less concerned with empirical facts than it is with experiential values, and how they might be fed back into the ongoing construction of a new model of involvement in health and social care. In this respect, this report broadly follows the model adopted in the Interim Report (June 2007) from the NHS Centre for Involvement<sup>1</sup>, where an adapted Theories of Change framework is utilised.

‘The Theories of Change approach is fundamentally formative (focusing on learning from the past with a view to the future) rather than purely summative (an appraisal of whether or not an initiative has worked). It is therefore particularly well suited to the evaluation of the Early Adopter Programme which aims to gather the learning and experience of the EAP sites as they occur, with a view to informing the future implementation of Local Involvement Networks across England.’<sup>2</sup>

With roots in psychology, Theories of Change looks at the building blocks that together enable and confirm a given outcome – in this case, the LINK. Theories of Change presumes a dynamic process of development as each phase of change is negotiated and constructed, and looks to understand the story of change ‘from the inside,’ in ethnographic terms. At the same time, all parties to the process are presumed to be working toward the same end – the influencing of service design, enhancing accountability, and feeding in to the regulatory process.

Data gathering was limited to participants in the one-day simulation event, who were invited to complete a simple semi-structured questionnaire.<sup>3</sup> A number of participants were also interviewed, on the day. Only the names of key personnel are used here; all others are anonymised.

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1 ‘Learning from the early adopter programme’ (June 2007)

2 *ibid*, p.7

3 See Appendix 5

## LINKs explained<sup>4</sup>

A LINK will be a network of local people and organisations, funded by government and supported by an independent organisation to hold commissioners and providers of care services to account. There will be a LINK in every local authority area that has social services responsibility. LINKs will cover any health or social care service that is funded by the taxpayer. The role of a LINK will be to:

- give everyone the chance to say what they think about their local health and social care services – what is working well and what is not so good
- give people the chance to check how those services are planned and run
- provide feedback on what people have said about services, so that things can change for the better.

LINKs will have a range of powers, so that they can say how local services should improve. They will be able to:

- make reports and recommendations and get a reply within a set period of time
- ask for information and get a reply within a set period of time
- go into some types of health and social care premises to see what they do
- refer issues to the local overview and scrutiny committee (OSC) and get a response



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4 From Have your say – Consultation on the regulations for Local Involvement Networks (LINKs) (Health 2007b), p.2

## Background to LINKs

Public involvement in health, in its current form, has its policy origins in *The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995* (2001), where Sir Ian Kennedy identified the challenge ‘to find new ways of involving the public which will work and which are embedded in the fabric of the system.’

Whilst public involvement was already being explored in the Health Action Zones established by the Green Paper *Our Healthier Nation* (1998) and the subsequent White Paper *Saving Lives* (1999), it was not until *The NHS Plan* (2000) that the vision of a health service designed around the needs of the patient rather than the professional came to the fore as a clear policy objective. In this respect, *The NHS Plan* reflected and accelerated the decisive shift in mood that had crystallised in the run-up to the publication of the Kennedy report.

*The NHS Plan* triggered an ambitious programme of change in the structure and function of Britain’s health service. One small part of this wider agenda was a commitment to abolish the 26 year-old Community Health Councils in order to ‘modernise, deepen and broaden the way that patient views are represented within the NHS.’

From this flowed the establishment of the Commission for Patient and Public Involvement in Health (CPPIH) and the introduction of Patient and Public Involvement (PPI) forums in all NHS Trusts – almost 400 of them. CPPIH and the Forums were established at the end of 2003, launching a new era of involvement.

PPI forums were, however, only ‘fully operational for about six months before the abolition of CPPIH was announced in July 2004’ (Committee 2007:21), when Ministers announced the results of its review of Arm’s Length Bodies. Initial thinking, that ‘Patients’ Forums will remain the cornerstone of the arrangements’ (Health 2004:18), subject to change but essentially intact at a local level (Health 2005), soon gave way to the view that they were unsuited to an increasingly joined-up policy agenda, as constructed around patient pathways that traversed both health and social care.

Exactly what would replace them remained on-hold whilst the deliberative research exercise, *Your Health, Your Care, Your Say* (2006b), probed the parameters of public engagement. The subsequent White Paper *Our Health, Our Care, Our Say* (2006d:Ch.7) stated the

need for ‘more rigorous fulfilment of existing duties to involve and consult the public’, which ‘should be able to take a view of health and social care in the round’, but left the detail of PPI to an expert panel, which reported back in May 2006.

In its report, the expert panel (Health 2006a) emphasised the need for ‘more flexible and creative ways’ of developing and building public involvement through a ‘sustained effort to build capacity in voluntary and community organizations.’ The panel laid out the rationale for Local Involvement Networks (LINKs), encouraging a stronger voice for local communities, building on existing or developing involvement structures and strengthening the duty of commissioning organizations to involve and consult their communities.

The response to the expert panel was *A stronger local voice* (2006e), a consultation document setting out ‘plans for widening and strengthening patient, user and citizen engagement in health and social care.’ Alongside various associated reforms, the basic framework for Local Involvement Networks (LINKs) was articulated, and subsequently codified within the Local Authority and Public Involvement in Health Bill, published in December 2006 and expected to complete its journey through both Houses of Parliament and become law soon, confirming the abolition of the CPPIH on 31 March 2008, followed by the launch of LINKs on the following day.

In preparation for that day the LINKs initiative is being extensively and intensively trialled across the country in a range of settings, with an emphasis upon flexibility and innovation at the local level. Numerous documents inform and reflect this still-evolving initiative.<sup>5</sup> An interim report on the ‘early adopter programme’ (Health 2007c) informed the consultation process on the regulations for LINKs – *Have your say* (2007b) – that is still running (closes 21<sup>st</sup> December 2007). *Getting ready for LINKs: Planning your Local Involvement Network* (2007a) incorporates the findings from the nine LINKs ‘early adopter’ sites and provides advice on getting a network up and running.

A key theme throughout remains the development of local methods appropriate to local issues. In this spirit the simulation exercise hosted by Bradford Alliance on Community Care sought to foster the active participation of a range of stakeholders on terms that were, from the

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<sup>5</sup> See the Bibliography at the end of this document.

outset, agreed and constructed by all parties to the exercise, building support for the LINK from the ‘bottom-up.’

### Early Adopters

Nine early adopter projects (EAPs) have been set up around the country to ensure that the new local involvement networks (LINKs) will work well and that the learning and experience of the current system is not lost.

Seven of these projects are being run for the Department of Health by the Commission for Patient and Public Involvement in Health (CPPIH). These commenced in December 2006 and are located in:

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

In addition, the Healthcare Commission has, since October 2005, been working in conjunction with two projects; one in the South (Plymouth/Cornwall) and the other in the North – the collaboration between Leeds Involvement Project (LIP) and Bradford Alliance on Community Care (BACC) that is behind the simulation event with which this report is concerned.

A number of reports have been produced from some of the Early Adopter Projects identifying teething troubles and learning points as well as success stories and prospective models of work.<sup>6</sup> A common theme is the dynamic, evolutionary nature of the LINK initiative as it begins to assume coherence and momentum in a given area. Experience is expected to be its own reward, as facilitated through the construction of relationships that are specific to the context of a given area. Being ‘essentially a community development project looking at the structures required to empower and support community engagement in health and social care’ (Health 2006c:48) each LINK will necessarily reflect the social capital of its area as it seeks to cohere various parties and interests around a common agenda.

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<sup>6</sup> See the NHS Centre for Involvement website at <http://www.nhscentreforinvolvement.nhs.uk/>

The purpose of the Early Adopter Programme (EAP) has been identified as the need ‘to learn as much as possible, as quickly as possible,’<sup>7</sup> about the following:

- How the new public involvement system might work in that area, and what it needs to make it work.
- What the local issues in health and social care are.
- What opportunities there are for the LINK.
- What are the challenges and threats?
- Who needs to be involved in the LINK?
- How LINKs will improve on equality and diversity.
- The level of interest of potential stakeholders and partners.
- How the LINK might engage with the wider community and stakeholders.
- What is already happening so that the LINK adds value?
- What the governance arrangements might be. This may include addressing a number of issues including, membership, constitution and structures, the balance between individual and organisation membership, how will the LINK be held to account, how might non-members or contributors engage.
- What the LINK relationship with regulators might be, e.g., with regard to the annual health check.
- How will an issue become a LINK issue?
- What kind of support a LINK might need and how the LINK might regulate or manage the relationship.
- How the relationship with NHS and social care providers, PCTs and OSCs might work.
- What the relationship might be with the part of the Local Authority that procures support.
- How the community might be involved in procurement in advance of the LINK.

Whilst the Bradford simulation day was not able to furnish answers to every one of these questions it did aim to clarify some of them along the way. The challenge was to make the questions serve a sense of ownership and engagement, as opposed to merely probing opinion in the abstract.

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<sup>7</sup> Annex A (p.47) of the Government response to 'A stronger local voice'

## Bradford LINK

Recent guidance on establishing a local involvement network emphasises the need – and the opportunity – for hosts to develop an agenda from the bottom-up, taking their cues from those already established within the community: ‘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.’ (Health 2007a:20)

In support of this emphasis the Northern test site, as run by BACC, has been codifying principles that arise out of its experiences of working with a wide variety of groups and individuals in the community. Those principles have been identified in the following terms:<sup>8</sup>



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.

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<sup>8</sup> From Getting ready for LINKs: Planning your Local Involvement Network p.25-7

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
- 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.

BACC’s statement of values resonates clearly with a wider emphasis upon bottom-up, user-led inclusion in reflexively constructed agendas of health and social care. Turnout for the event of 22 October suggested a healthy relationship between BACC and the various parties to the LINK. In this it is in tune with national guidance on LINKs, where the development of ‘strong, credible relationships’ across communities, including ‘seldom heard groups and individuals’ who are enabled to be ‘not only heard but...also influential’ sits at the centre of the LINKs function.<sup>9</sup>



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<sup>9</sup> See Appendix 1

## The structure of the day

The day began with brief Introductions from Councillor Mike Kelly, Deputy Chair of Health Improvement Committee on Bradford Metropolitan and District Council, followed by Peter Marshall, officer of the council supporting the health improvement committee.

Having succinctly outlined what is currently known about LINKs – how they will work, with what powers and profile – Peter Marshall also stressed what is still to be determined: ‘We don’t know the criteria for success’ he said, and invited ‘suggestions on how to do this... What is your impact going to be? It’s hard to know.’ For the Local Authority, the impact of the local involvement network remains in the hands of those getting involved.

For BACC, Phil Cutler outlined the plan for the rest of the day, urging participants to apply themselves to what is on offer in the legislation, rather than what is not. To ‘try and avoid reinventing the wheel’ became a recurring theme, in various guises throughout the day.

A warm-up exercise followed, led by Annie Berrington and Emma Baylin from Artworks Bradford, on ‘what you want to get out of today.’ In this each table was asked to develop an answer that could be communicated to the front stage in a non-verbal manner.

From the ten tables (averaging ten persons on each) came a variety of messages:

1. ‘Listen and act’
2. Washing line with lots of messages on it – unscrambling a piece of scrambled wool: ‘get your act together’, ‘more podiatry needed’, ‘good start with today, 7/10.’
3. ‘Health, equality for all’ sign with attached labels representing different peoples baggage.
4. Extended (washing) line, with different messages, as linked one to the other and also to a common centre (= host).
5. Smiley face with message ‘hope for all’ on it.
6. All stood up, linked with bit of string and a question mark on page.
7. ‘Bradford First: keep it local’ on paper.
8. Banging tambourine, questions on page: how, when, why, etc.
9. A question mark on one, and an A on other, side of a page
10. Sheet of paper with large question mark and a hole in the middle with string feeding messages through the middle.

Participants then broke out to six workshops in which issues were discussed and codified, to be brought back to the general forum, where all could simulate the brokering process of a local involvement network. The workshops were as follows:

- “Let’s Get Involved” – Learning Disability needs: a training workshop led by People First.
- Mental Health & Communication – a workshop using alternative methods of support, led by Sharing Voices.
- What “evidence” – the Healthcare Commission – a training workshop for activists.
- Podiatry Services “Happy Feet” – a workshop led by Bradford Older People’s Alliance (BOPA).
- Language Services for LINKs – a workshop on solutions to language problems for LINKs.
- Disability & Getting a Job – a workshop showcasing learning from residential workshops of May & June.

Lunch offered an opportunity for informal discussion and contributions to be made to the ‘What do you think’ comment wall<sup>10</sup> before everyone reconvened for the afternoon session, in which each workshop fed back to the general forum. Key points from workshops were written up on card (shaped as chain links) and displayed.<sup>11</sup>

The aim of the afternoon was for participants to think and act like a LINK, weighing different issues in the scale of a common agenda to which all might subscribe. Discussion was lively and protean and also signposted along the way to questions raised in *Have your say* (Health 2007b), the Dept of Health consultation exercise that runs through to 21 December 2007.<sup>12</sup>

At 3pm Phil Cutler brought proceedings to a close, saying that ‘its clear that Bradford is on target to have a LINK by April 2008. Your contribution today is part of that process.’

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10 See Appendix 2

11 See Appendix 3

12 See Appendix 4

## Analysing opinion

Many issues and themes arose during the day. People gave voice to concerns ranging from the personal and particular to the policy focused and the political. Some spoke for large and relatively well-known community organisations, others for those who are more seldom heard. Some were keenly aware of the protocols of large meetings where complex and diverse interests are being discussed, whilst others were less comfortable with such a forum. Some were clearly supportive of the LINK initiative, whilst others are yet to be convinced.

To capture the range of views and experiences on the day a rolling series of interviews was conducted, notes taken during debates, and a semi-structured questionnaire given to all participants. A large amount of qualitative data was amassed, analysis of which reveals certain trends and themes. These are here aggregated in relation to three axes of opinion:<sup>13</sup>

- Local – National
- Utopian – Pragmatic
- Simple – Complex

### Local and National

Perhaps the most recurrent theme, expressed in various ways, was the idea that the LINK should be as locally and organically rooted as possible. This came through strongly in the written responses to the questionnaire.

In response to the question on how involvement in the LINK might be ‘extended to include those parts of the community that are seldom heard’ participants mentioned a plethora of local groups, campaigns and media such as might usefully bridge a gap between LINKs and the seldom heard. Media such as the Talking Telegraph, Sunrise Radio, Bradford Community Broadcasting, Bradford Talking Media and other radio and press outlets might usefully ‘get the message over.’ Also, through a ‘direct approach to groups, i.e. Macular Degenerate, Hard of Hearing, Deaf Groups’ and ‘through outreach visits.’ Many respondents specifically cited the benefits of direct, face-to-face communication.

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<sup>13</sup> In grouping the data thematically we impose order upon opinion. Where some methodologies admit of the ethical equivalence of all shades of opinion, this cannot apply here, for the simple reason that participation in the LINK is contingent upon acceptance of its legislatively defined parameters.

One respondent wrote of the need for the LINK to make itself known amongst ‘community organisations that on the face of it do not have a health remit’ such as community centres, Bradford and Keighley Young People’s Parliament, and local church groups. Another mentioned the opportunity provided by neighbourhood forums. Also mentioned was the Isis Centre for Women, the Cellar Project, LGB communities, Equity Partnership Bradford, Barnardo’s, and many others.

A concern raised by a number of respondents was the impression that a local involvement network might struggle to embed itself and be as inclusive as it should be ‘as they are expected to enjoy more limited resources than PPI...that is going to be a problem; the types of groups we want to be involved with need a great deal of support to be involved.’ This view, of the shift from PPI to LINKs as a cut in funding, was expressed by those who were sympathetic to LINKs, as well as those who were not.

Another interviewee, who had reservations about the move to LINKs, said that ‘PPI forums are seen as almost a professional body...not reaching out to the community.’ A LINK might ‘reach the community’ more effectively, not least of all because it was – or at least should be – more closely rooted in that community: ‘people don’t trust authority, people see the current arrangements working *for somebody else*, not for me.’ The legitimacy of the LINK, it was felt, resided in its distance from national norms and institutions, as evinced in its embeddedness in local, cultural context.

In a similar contribution, another person, representing a local community organization, expressed anxiety about ‘national priorities dominating the tendering process, which can clash with local concerns and methods.’ The national agenda ‘excludes us’ and this is a ‘recurring problem.’ If LINKs can ‘help raise local priorities at a higher level, then this would be a step in the right direction.’ There was thought to be ‘too much national criteria...there’s a need for local criteria to be established quickly, to get people’s attention.’

In this vein, Peter Marshall reported that the council routinely talks to people and asks them what it is that should top the priority list. This echoed a wider sentiment, for users of health and social care to be consulted in terms that were of their own making. Terms such as ‘dignity’ (of the user/patient), ‘non-patronising,’ ‘accessibility,’ and ‘listening’ attest to a desire for dialogue that is negotiated and shaped from both

ends of the care spectrum, rather than specified in national policy documents.

### Simplicity and Complexity

Another strong theme of the day was the demand to simplify modes of communication. The report back from ‘Let’s get involved,’ the training workshop led by People First, emphasized the need for ‘more accessible information’ with ‘one version of a document, rather than lots of versions... a version that all can understand’ – including the learning disabled. The use of pictures and diagrams, of people and body parts, was also recommended, as a tool to highlight and explain otherwise complex healthcare issues and as a part of information packs for those working with the learning disabled.

The demand for ‘plain English’ was expressed on more than one occasion, though calls for better provision for those for whom English was not a first language were also made. The workshop on Language services for LINKs raised the problem of assuming that a person’s first language was English. ‘Pictures can help in communication; but can be inappropriate in certain cultural contexts’ it was reported. One possible challenge for the LINK, it was suggested, might be to consider how receptionists engage with persons for whom English was not their main tongue.

Mohammed Shabir, from Sharing Voices Bradford argued that ‘Things have got really, really complicated... we need to simplify things.’ By this he meant the churn of policy, which throws up one priority after another. The solution is for the LINK to ‘engage with people quickly: we need local emphasis to encourage people in terms of things that they want and need.’

Pointedly, though, he also raised the concern that ‘You can simplify – but you can also dilute.’ Simplicity, in his view, was as much about purity of experience – allowing for the undiluted views of service users to be voiced – as grammatical or logical correctness. Allowing service users to articulate their concerns in their own voice, rather than obliging them to communicate in the language of national policy, was regarded as the most genuine of methods.

This question was also articulated in relation to the ownership of ‘expertise by experience.’ Again, the issue was rooted in a desire for an

authentic voice, speaking from experience, to be the defining identity of the LINK.

### Utopianism and Pragmatism

A recurrent theme of the day was that flagged at the very start, when Phil Cutler urged participants to address the legislation as it stands, rather than the legislation as they would like it to stand.

Most participants were keen to make LINKs work, and many understood the need for a pragmatic approach. One participant, frustrated at a lack of focus in the afternoon discussion, stated this in precise terms: ‘We need to clarify what exactly LINKs are going to do, because it sounds at the moment that you’re going to change the world, and that’s not going to happen.’

Another expressed concern that ‘the sheer speed of change means that senior management ended up...being tokenistic,’ but also welcomed the shift toward a more joined-up model, wherein health and social care were considered ‘in the round.’ This was seen as a more realistic reflection of ‘how it all works’, with care pathways traversing both clinical and social settings. For this participant, with a close relative receiving long-term daily care in the community, the LINKs model offered a chance to start with the experiences of the person ‘at the sharp end,’ an emphasis that was also explored in the workshop on Issue tracking.

Another wrote of the need for a ‘clear understanding of local issues in order to prioritise’ – a point made by others too. Many argued that ‘we mustn’t reinvent the wheel...we must start with things as they already are.’ The ‘Language Services’ workshop similarly argued that the LINK must ‘Try not to reinvent the wheel; find a system you like and share it.’ The new LINK should ‘allow itself time; get rid of all its difficulties before it starts; it shouldn’t reinvent the wheel – it should re-service the wheel, adapt what is already there, but needs fine-tuning.’

A good example of a pragmatic and reasoned approach came from the workshop on ‘Disability and getting a job.’ In an informed report-back to the afternoon session, the stubborn facts of disability among the unemployed were reviewed: ‘80% of disabled people are unemployed, but lots of them want to work...There is a lot of employment support schemes, as well as pressures from the Government, to enable the disabled to get back into work.’ Disabled unemployment remains high,

but so does an active determination to get disabled into work: ‘Why then do so many disabled people remain unemployed?’

Usefully, the answer to this question was posed in terms of three broad suggestions: ‘Firstly, statutory agencies should model good practice as an employer, by creating lots of opportunities for employment... Secondly, to develop a project to link the disabled in employment with other employers... Thirdly, to address concerns about the benefits system.’ Pragmatically, though, one summary point was also offered: a suggestion that the LINK ‘establish an employment and disability sub-group’ to begin to cohere a common approach across Bradford.

By contrast, some others articulated aims that might best be termed aspirational. The ‘Happy Feet’ workshop, for example, called for ‘more resources right now that were affordable and accessible.’ In answer to the question of ‘What local issues in health and social care should be at the top of your LINKs agenda’ some similarly ambitious suggestions were offered: ‘Clear and sustainable career paths leading to employment’ wrote one. ‘Affordable health care service for every member of the community’ wrote another. ‘Access to services that are as close to your home as possible’ was another. The call for disabled people ‘to receive real payment in order to promote positive images’ was similarly advanced.

Some individuals went further still and were sceptical about LINKs in general, saying that it was ‘One step forward, two steps back’ and ‘another way for the government to push us about.’ ‘We’re jumping from one place to another... a vast waste of time and money... jobs for the boys... another level of bureaucracy’, said another. ‘There’s no consolidation of what does work... PPI doing some good; rather than scrapping that it would be better to consolidate what is there... Shift to LINKs will lose lots of people... they’re going to go.’

When questioned, though, such views were found to be less negative than they initially appeared. Beneath the many expressions of discontent about policy reform in patient and public involvement, some of which stretched right back to Community Health Councils, lay a desire for more and better modes of inclusion. Notably, none of the completed questionnaires were negative about the general thrust of the LINK initiative.

Peter Marshall usefully reminded the afternoon session that you’re ‘not necessarily set up to fail, so long as you prioritise... we looked at obesity, and people said ‘huh, you’re not going to do anything about that... but we

did...I'm optimistic that you can make an impact....it will be a credible organisation and it can happen.'

## Discussion

Within each of the three areas identified above exist both tensions and solutions.

Perhaps the most obvious tension is between particular and general. Particular issues do not always fit general agendas, such as a network requires if it is to establish its own identity. For the LINK to operate effectively requires all parties to sign-up to a common agenda.

At the same time, though, a strong emphasis upon individual experience sits at the heart of the LINKs initiative, and was clearly evident during the simulation exercise. An ethical commitment to subjective modes of knowledge and expression underpinned many contributions.

This tension, between particular ways of seeing things and general ways of addressing them, was expressed in various forms. Arguments for change, at every level, were echoed by cries to 'not reinvent the wheel.' Arguments to attend to the overlooked needs of a particular community were echoed by cries to find issues that arose across service provision.

The argument for strictly local, bottom-up, experiential issue-generation clearly resonates with the spirit of the legislation. At the same time, the issues generated must ultimately crystallise as a network-wide agenda, to include those stakeholders under a statutory obligation to partake and support the LINK. But many of them seem uncertain as to exactly what they are partaking of.

In part this uncertainty is surely due to the fact that LINKs are not yet up and running. But in part this uncertainty would seem to reflect a deeper challenge, as to how in fact it will cohere the various voices and formulate an entity that is more than the sum of its parts. One PCT worker explicitly acknowledged this point: 'for me the key thing is how local communities might work...this is a rather difficult concept...this network is a fairly radical move...I know the policy, I know the technical side...it's the local understanding that needs improving.'

Improving 'local understanding' will require a firm hand on the LINKs tiller in order to establish an agenda to which all stakeholders are equally committed. An often passionate commitment to enabling particular and

exceptional voices to be heard is a precious asset that will need careful and sensitive consideration if it is to result in a programme of activity commanding community-wide levels of support. The stated desire of most participants for more and better modes of engagement offers a clear opportunity for the LINK to establish itself as a new channel of communication. But to do this it must first of all develop an identity of its own.

One solution, from a senior figure in the VCO sector, was for the new LINK 'to address local communities in a more pro-active manner... a more active engagement of voluntary and community organisations to get them involved.' This person suggested that the LINK 'offers something positive to the VCO's,' but will need to approach them with ideas.

The new LINK will also need to move quickly, if the good will and energy of the simulation exercise of 22 October is not to be dissipated. One paid PPI worker specifically highlighted 'dentistry and mental health issues in Bradford' as offering an opportunity to capitalise on already existing experience. The same worker was at pains to stress the need for 'an understanding of what they (LINKs) are, and what they can achieve,' because 'lots of people don't really know.'

## Conclusion

To bring over 100 people together to discuss a community development programme that has yet to begin was itself a good indication of the degree of interest from the community. As one participant said: 'there is a good cross section here today... a range of people, by age, ethnic minority, disabilities; it wasn't just... the normal faces.'

A relatively short programme, running from 10.30am to 3pm, was successfully managed, concluding on time, and leaving everyone in a positive mood. Artworks Bradford added value to the proceedings, with a warm-up exercise that had everyone interacting and feeding back to the wider audience in a short space of time. Subsequent facilitation was no less professionally managed.

In terms of the stated aim of the day, to simulate the work of a local involvement network, this was a challenging ambition, given the inherently unstable nature of the initiative at this formative stage. Until such time as the LINK is formally established there can be no real sense of direction, pace, or style. Nonetheless, the exercise brought a broad cross-section of individuals and organisations together to begin to



## Appendix 1

### The function of LINKs

The ultimate goal of LINKs is the influencing of service design, enhancing accountability, and feeding in to the regulatory process. The primary function of LINKs have been described in various places, but the following is perhaps the clearest:<sup>14</sup>

*‘The primary function of LINKs is to gather the views and experiences of people using health and social care services in their area. They...will scrutinise the entire journey and experience rather than looking at individual organizations...They will help the new system of commissioning to evaluate its effectiveness, and are also likely to provide information about the implementation of patient choice...They will also need to act proactively with commissioners and undertake research and evidence collection on their behalf, where practicable, to be used in the development of commissioning plans.’*

*‘LINKs will be able to set their own priorities and agenda driven by the priorities for local communities. They will do this taking into account the plans developed by other organisations, networks and partnerships, including Local Delivery Plans, Local Area Agreements, Community Plans, and Children and Young People’s plans. This freedom will require LINKs to develop strong, credible networks and relationships across their communities, enabling them to involve seldom heard groups and individuals, and ensure that they are not only heard but are also influential. This will need to be demonstrated in their annual report to the Secretary of State for Health.’*

### **What will LINKs do?**

*Their functions will be:*

- *promoting and supporting the involvement of local groups and individuals from across the community to influence the commissioning, provision and scrutiny of health and social care services;*
- *obtaining the views of local groups and individuals about their health and social care needs;*
- *gathering the views of local groups and individuals about their experience of health and social care services;*

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14 From Dept of Health: Government response to 'A stronger local voice'

- *conveying those views to organisations responsible for commissioning, providing, managing and scrutinising health and social care services;*
- *enabling local groups and individuals to share their skills and experience in order to influence the development and improvement of local health services;*
- *supporting people within the community to make their voices heard, including people who find it hard to participate in traditional ways or do not choose to;*
- *supporting the commissioners and providers of health and social care services to engage with the local community, and in particular those groups and individuals who find the services they need difficult to access;*
- *act as a hub within a network of user-led and community based groups in the area covered by the host local authority, providing a channel for views and information between these groups and the local health and social care organisations;*
- *LINks will set their own agenda and focus on issues of concern to local people and seek to influence change; and,*
- *LINks will be required to report on their activities and expenditure to the public, to health and social care bodies, the relevant local authority, the Secretary of State for Health, and other interested organisations.*

*‘It must be remembered that the primary responsibility is to approach and hear from **all** groups and people within the area.’*

### ***How will LINks undertake their role?***

*‘There is no prescribed view about how LINks will undertake their role, although they will be required to demonstrate that they are fulfilling their statutory role, and in particular that they are maintaining their inclusivity, independence, and accountability.’*

## Appendix 2

### Notes on the 'What do you think?' comment wall

Freedom of Information: The Government believes that the Freedom of Information Act will give LINKS all the power they need to get information from providers. What do you think?

- *Commissioners, providers and LINKS etc need clear guidance about what information they can ask for/ should disclose. Freedom of Information not enough*
- *Need to have clear defined ways to ask for information. Many people will not know how to use the Freedom of Information Act*
- *What? Isn't there supposed to be a different sort of relationship between the LINKS and providers. Talking in terms of FIO sends all the wrong messages – Why is this needed?*
- *FOI process too long. Some core documents should be made available on request*
- *LINKS should have proper power not just have the 'freedom of Info Act' to access*

Do you think that is OK that LINKs cannot go into some services? Are these the right services? Should there be other services that LINKs cannot go into? Why?

- *'Access' to inspect services needs to be used with discretion but no health services should be excluded*

The Government believes that these proposals will help to make sure that the LINKs can do their job well, and will also make sue that people who uses services have their safety and dignity protected. What do you think?

- *The Regulations; re: reporting seem unnecessary and anticipate a confrontational relationship*

The Government thinks that these proposals will help to make sure that Overview and Scrutiny Committees will hear the views of local people so they can take action. What do you think?

- *Good that Overview and Scrutiny committee should be more responsible to the public. What is the penalty if they are not? What about a fine!*
- *Want the OSC to review Health Inequalities Agenda*

Do you think that providers should have extra duties to provide information to LINKs? What extra duties should they have?

- *Why are they needed?*
- *20 day feedback is fine but LINKS need more teeth otherwise the feedback will not result in any action*

General comments about LINKs

- *We all need to make LINKS work as effectively as possible*
- *It is important that LINKS concerns are translated into action and policy*
- *Ensure adequate resource to support LINKS*
- *What information can we access and contribute through LINKS?*
- *Why are we signing up for the 'LINKS' without knowing what the format is? Because LINKS' concept is not fully developed*
- *LINK to community networks and CVS'S*
- *How do we ensure that LINKS does reach the whole community and not just with the 'hobby horses' for the few?*
- *LINKS needs to review commissions decisions of PCT – No community input to this (or staff?) at present*
- *What is the means of accountability for LINKS?*
- *LINKS need to tap into existing good practice in consultancy and involvement and explain these clearly*
- *LINKS groups to have more 'teeth'*

- *How will LINKS committee prioritise issues that are feedback to it?*
- *How to prioritise this huge challenge re workload?*
- *Even if the target is huge – you can make an impact and will build credibility from it*
- *LINKS should pick up common strands across districts and prioritise them*
- *LINKS shouldn't focus on one issue or client group but look for common threads*
- *Need long-term plans but politicians are only interested in short-term*
- *Long term planning not short term fix!*
- *Not many know anything about how the Government works at least locally – some should know how health and social concerns as well as a lot more about LINKS*
- *Prevention and public health priority*
- *Patient stories need to be evidenced, dated, factual to fed into review systems*
- *Make health promotion central. Health inequalities need to be a dimension of everything - need to ask how a service is tackling Health Inequalities*
- *Social Care and Health Care do no mix! Reorganised NHS has become less effective. Try a bit of dignity. Do old or people matter?*
- *Do you live on the same planet? Have you used NHS all the time? Can you spell respect? Give young ones responsibility.*
- *Overloaded structures. Where is Public Health Agenda? How effective is monitoring and evaluation in VCS to commissioners? Or does it go in the drawers?*

- *Learn positives and negatives from PPI*
- *The first thing LINKS should do, which some forums have failed with, is to engage with the public they represent, to know what their concerns are, and not assume that members issues and concerns are those of the larger community, done in a professional and appropriate way, otherwise they will fail before they start!!!*
- *Local Involvement Not Knowing Specifics (LINKS)*
- *LINK – good idea in theory however the community, individuals, organisations (statutory, private, volunteer etc) need to see real life outcomes. Not just number of consultations and people attended. LINKS, PPI, Foundation Trusts – communication/wording used is very confusing to the general public. One outcome could be on understanding within the community etc. Regular updates – this is the issue, this is what LINKS is doing, this is the next step.*
- *We have heard this all before. What is different?*

#### Structure/Membership/Representation

- *How do we know who is a member of LINK?*
- *Do we need list of membership? Web-based? As it will be continually developing hopefully*
- *How does the individual membership idea work? Who is organising this?*
- *You will have difficulty with selecting an Executive or Managing Group. This equally needs to be satisfactorily and above suspicion or be accepted as the voice of hundreds*
- *Want local organisation involved in hosting*
- *LINKS should be run by a Bradford District organisation not an outside consultancy – this should be a condition of tendering*
- *Balance between current host role and representing other groups they may not know of*

- *Individual as well as group membership. Varied and interesting group of encouraging individuals and communities to engage*
- *How do we ensure appropriate and responsive representation of cultural sub-groups?*
- *Involvement of local people/communities/existing networks at all levels of LINKS, true representation, engagement and participation*
- *There needs to be an executive or something to be able to facilitate how issues can be discussed and looked at in detail and direct to organisations that can deal with issue*
- *Decision makers must act and deploy resources in response to people's wishes/needs*
- *How small VCFs organisation will be supported and represented by LINK/host e.g. groups in specific geographical area or with specific groups?*

## Communication

- *LINKS need to give timely and appropriate feedback to people*
- *Will the LINK in Bradford link into different areas of the country to see how they are running? People want to know that their voice is being heard, that something is being done. Keeping informed. Big word – communication. How will the message be put across to the community?*
- *Public needs reassuring that their voice will be heard and that concerns are addressed*
- *Keep information simple to be inclusive to all*
- *Simplicity please!!*
- *Communication and good marketing*
- *How to communicate with all of Bradford? Page in T & A*
- *Easy-read documents*

- *Any information to the LINKS be written in plain English*
- *Stop producing different document for different groups. Make one that is accessible to all*
- *LINKS need a good marketing strategy – the public need to know what the link is, how to access it and why they might want to access it*
- *Task group to ensure communication is inclusive and make recommendations to LINK committee on how to publicise LINKS, how to get involved in it and how to continue effective, inclusive communication throughout*
- *Task group to report back to LINK with recommendations e.g. media campaign, how to get involved*

#### Accessibility

- *Need to be accessible for everyone*
- *LINKS need to have easy access for ‘everyone’ to feed views into*
- *Access issues are clearly a problem for many groups. Time and resources need to be available to enable these groups to get involved*
- *Pictures used in hospitals to explain diagnosis etc for people with other languages*

#### People with disabilities

- *How do you inform people with learning difficulties?*
- *People with learning disabilities ask we keep it simple to ensure they can be included*
- *People with disabilities are best people to train on disabilities PAID!!!*

- *Find it very hard to access easy/read tapes and information about LINKS*
- *Not enough information about LINKS for visually impaired people!*

### Government Funding

- *If we invest money now on services we would save on services in long term. Need more services*
- *Central Government Funding (or lack of) is crucial to service users satisfaction*
- *More money needed now as issues not dealt with in past but money also needed on prevention so problem not big a lain in future*

### General Remarks

- *People are being kept in institutions longer than needed*
- *Special support to a great number of patients in each GP practice who are put on mini tranquilliser and sleeping pills for long term or until they die. Supposed to be given for 26 weeks – not years*
- *Look at lifestyle issues*
- *Social workers need to listen more*

### Feedback from event

- *Can feedback and any presentations from all workshops be shared via email please!!*
- *'The setting scene' which involved everyone was very good because it 'linked' everyone. A good 'Ice breaker'*

*Today's event does not give me much faith about how LINK will work in the future, very disorganised*

## Appendix 3

### Post-lunch feedback, from the workshops to the LINK

#### Workshops:

1. Language Services for LINKs
2. Disability and getting a job
3. 'Let's get involved'
4. What 'evidence'? (HealthCare Commission)
5. Mental Health and communication
6. Podiatry Services: 'Happy Feet'

Comments from workshops, written up on card and linked together as chain in the following order (numbering refers to workshops):

1. Build a system to communicate consistently with all groups and always consider language barriers.
3. People who can explain things to people with learning disabilities if they need help
4. Local Focus
  1. Training and support in language and communication for 'front line' staff (eg: receptionists)
  3. Simplicity
    1. Don't assume a first language
    4. From birth on, a high visibility campaign to reach everyone, inc. senior professionals, and everyone with feet!
  1. Accessible information
  5. Transparency
    4. It is important to make the collection of information flexible!
    2. Recommended that statutory agencies should model good practice and create opportunities for disabled people; and release disabled staff who are employed to talk to other employers + be a link.
  2. Develop a LINK connection between working disabled and employers.
  3. Conference run by voluntary group: experts in different disabilities
  5. Using existing networks
  4. How will LINKs get beyond those already involved in community groups?
    2. Co-ordination of support to employers of disabled people
    3. Hospital picture – body part

- 2. Research into revised benefits system so not afraid to take up work: help to claim benefits if no longer able to work.
- 1. Use pictorial language: Makaton
- 5. Marketing
- 3. Information packs
- 5. Feedback
- 4. Issues tracking forms could be used by LINKs for many purposes: i.e.: feeding into regulation, work planning, etc.
- 4. When LINKs finds out about local views: where does the information go and who is it used by?
- 4. When LINKs collect information from the regulator: who collects it? How are they trained?
- 4. LINKs need to know how to ask questions and how to listen to answers.
- 4. Issues tracking: how does the LINK distinguish a complaints process from collecting experiences of health care?
- 6. More resources for older people now affordable, accessible and across the board.
- 1. Find out about good practice in communication (in different language and/or with people with diverse first language) and share it!

## Appendix 4

### Questions raised in *Have your say* (Health 2007b)

Detailing proposed statutory instruments by which LINKs might be regulated, as part of 12-week consultation exercise (28 September to 21 December 2007).

1. Do you think that services-providers should have duties to provide information to LINKs that go beyond the obligations imposed in the FOI Act 2000? If so, what should they be and why are the duties needed?
2. Do you have any comments on these proposals? (Re: 'Responding to reports and recommendations made by a LINK', see p.11-12 of report)
3. Is the timescale of responding within 20 days appropriate?
4. Do you have any comments on these proposals? (Re: 'Duty of services-providers to allow entry by LINKs', see p.13-16)
5. Are the premises that are exempted from the duty to allow entry appropriate?
6. Are there any further premises that should be exempted?
7. Do you feel the safeguards in place are proportionate? If not, why not? What do you think should be altered and why?
8. Do you have any comments on these proposals? (Re: 'LINK referral to an overview and scrutiny committee', see p.17-18)
9. Is the timescale of responding within 20 days appropriate?

(Page numbers here refer to *Have your say*)

## Appendix 5

Bradford Alliance on Community Care: LINK simulation event: Monday 22 October 2007, Carlisle Business Centre, Bradford.

Please take time to complete this form, which will help in the development of best practice for the LINK. Personal details are not obligatory, but can help ascertain breadth of involvement.

NAME.....

ORGANISATION.....

Are you linked to, or do you represent, an organisation? If not, have you come as an interested individual?

AGE: Under 18 ; 18-29 ; 30-39 ; 40-49 ; 50-59 ; 60+  Prefer not to say

GENDER: Male  Female  Prefer not to say

ETHNIC BACKGROUND.....

How do you identify yourself, in ethnic terms (Eg: Pakistani, British Asian, Irish, White British, Black etc). Or do you prefer not to say?

DISABILITY: Are you Registered Disabled? Yes ; No ; Prefer not to say

1. How might involvement in the LINK be extended to include those parts of the community that are seldom heard?

2. What local issues in health and social care should be at the top of your LINKs agenda?

3. Engaging the community through existing groups makes good sense: are there community groups that are not here today that really should be involved?

4. What lessons might LINKs learn from patient and public involvement?

5. LINKs will have power of entry to health and social care facilities: how might this power be used in your area?

6. What level/kind of support might your LINK require from the host?

## Significant documents, by date and with URLs:

2006

July  
Dept of Health: *A stronger local voice: A framework for creating a stronger local voice in the development of health and social care services.*  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4137040](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4137040)

December  
Parliament: *Local Government and Public Involvement in Health Bill*  
[http://www.publications.parliament.uk/pa/pabills/200607/local\\_government\\_and\\_public\\_involvement\\_in\\_health.htm](http://www.publications.parliament.uk/pa/pabills/200607/local_government_and_public_involvement_in_health.htm)

Dept for Communities and Local Government: *Local Government And Public Involvement In Health Bill – Explanatory Notes for Bill as introduced in the House of Commons on 12th December 2006 [Bill 16], Part 11 - Patient and Public Involvement in Health and Social Care (p.56-61)*  
<http://www.publications.parliament.uk/pa/cm200607/cmbills/016/en/2007016en.pdf>

Dept for Communities and Local Government: *Regulatory Impact Assessment for the Local Government and Public Involvement in Health Bill*  
<http://www.communities.gov.uk/documents/localgovernment/pdf/153122>

Dept of Health: *Government response to 'A stronger local voice'*  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_062839](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_062839)

2007

January  
House of Commons Library Research Paper (07/01): *The Local Government and Public Involvement in Health Bill*; Ch.12 'Patient and Public Involvement in Health' (p.86-98)  
<http://www.parliament.uk/commons/lib/research/rp2007/rp07-001.pdf>

February  
House of Commons Health Committee: *Patient and Public Involvement in the NHS: Third Report of Session 2006–07: Oral and written evidence (HC 278-II)*  
<http://www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/278/278ii.pdf>

March  
House of Commons Library Research Paper (07/30): *The Local Government and Public Involvement in Health Bill, Committee Stage Report*  
<http://www.parliament.uk/commons/lib/research/rp2007/rp07-030.pdf>

Healthcare Commission: *Capturing Lessons from the Early Adopter Programme for the Local Involvement Networks: Evaluation Summary*  
<http://www.nhscentreforinvolvement.nhs.uk/docs/CAPTURING%20LESSONS%20FROM%20THE%20EARLY%20ADOPTER%20PROGRAMME.pdf>

Healthcare Commission: *Patient and Public Engagement (PPE) Test site: Reflections and Learning for Early Adopter Pilot (EAP) Programme.*

- <http://www.nhscentreforinvolvement.nhs.uk/docs/Learning%20from%20test%20sites%20March07v3.pdf>
- April Dept of Health/CPPIH: *Local Government and Public Involvement in Health Bill: Remaining Stages (17<sup>th</sup> and 22<sup>nd</sup> May 2007)*  
<http://www.epolitix.com/NR/rdonlyres/F5C5E331-26B6-48E0-BFFC-E34E15D5AC47/0/CPPIHReportStageBriefing.doc>
- House of Commons Health Committee: *Patient and Public Involvement in the NHS: Third Report of Session 2006–07: Report, together with formal minutes (HC 278-I)*  
<http://www.nhscentreforinvolvement.nhs.uk/docs/PPI%20Report%20HC%20278-I%2006-07.pdf>
- May Dept for Communities and Local Government: *Local Government And Public Involvement In Health Bill - Explanatory Notes for Bill as brought from the House of Commons on 23rd May 2007 [HL Bill 74]; Part 14 - Patient and Public Involvement in Health and Social Care (p.80-86)*  
<http://www.publications.parliament.uk/pa/ld200607/ldbills/074/en/2007074en.pdf>
- June Parliament: *Government Response to the Health Committee's Report on Patient and Public Involvement in the NHS' (Cm7128)*  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_075501](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_075501)
- NHS Centre for Involvement. *Learning from the early adopter programme: Interim Report June 2007*  
<http://www.nhscentreforinvolvement.nhs.uk/docs/EAPS%20interim%20report%20Final.pdf>
- August Dept of Health: *Getting ready for LINKs: Local Involvement Networks (LINKs) bulletin: Issue 5*  
[http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/PatientAndPublicinvolvement/DH\\_076482](http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/PatientAndPublicinvolvement/DH_076482)
- Dept of Health: *Getting ready for LINKs: Planning your Local Involvement Network*  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_077266](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_077266)
- Dept of Health: *Getting ready for LINKs: Contracting a host organization for your Local Involvement Network*  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_077266](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_077266)
- September Dept of Health: *Getting ready for LINKs: Local Involvement Networks (LINKs) bulletin: Issue 6*  
[http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/PatientAndPublicinvolvement/DH\\_076482](http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/PatientAndPublicinvolvement/DH_076482)
- Dept of Health: *Have your say – Consultation on the regulations for Local Involvement Networks (LINKs)*  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH\\_078788](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_078788)

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- . 2006a. "Concluding the review of patient and public involvement Recommendations to ministers from Expert Panel." Dept of Health.
- . 2006b. "Evaluation of Your Health, Your Care, Your Say: An independent report commissioned by the Department of Health. Final Report." Pp. 18. Dept of Health.
- . 2006c. "Government response to 'A Stronger Local Voice'." Pp. 48. Dept of Health.
- . 2006d. "Our health, our care, our say: a new direction for community services." Pp. 227. Department of Health.
- . 2006e. "A stronger local voice: A framework for creating a stronger local voice in the development of health and social care services." Dept of Health.
- . 2007a. "Getting ready for LINKs: Planning your Local Involvement Network." Pp. 49. Dept of Health.
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