MAIR + HEALTH

A review to support the re-commissioning of Healthwatch Leicestershire

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FOREWORD

The review team are pleased to present this report, which gives recommendations to ensure an effective Healthwatch Leicestershire (HWL) in the future, building on the considerable progress made by the current service. Leicestershire County Council (LCC) is undergoing a procurement process to have a new Healthwatch Leicestershire service in place for 1st July 2017. We present findings and recommendations to ensure the new service learns from other areas, has listened to the views and ideas of key local stakeholders along with Healthwatch staff, volunteers and members.

In the current financial climate the challenge is to safeguard the Healthwatch resource, 'do more with less', deliver the core statutory functions and ensure the organisation continues to grow in reach and impact as a true independent consumer champion for health and social care services.

One key finding that emerged early on in the review (from analysis of national research and talking to a range of people) is the need for local Healthwatch organisations across Leicester, Leicestershire and Rutland (LLR) to work more closely together.

> *"If we do one thing we need to get the local Healthwatch services working together across the patch, this would be more efficient and allow them to do more with less."*
>
> (Stakeholder)

Along with this there is a growing need for Healthwatch Leicestershire to collaborate with people in roles in other organisations that perform similar functions (seeking views of service users, service co-production, patient and public involvement, consultation and engagement).

These ideas were explored and built on throughout the review; mechanisms to support changes to this effect are presented within.

One unexpected by-product achieved through undertaking the work was that many people reported their knowledge and understanding of the purpose of and ambition for Healthwatch Leicestershire has increased.

The review team would like to thank all of the people who gave their time to talk to us and gave their ideas so freely. We hope that this report will prove interesting and useful.

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September 2016

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INTRODUCTION

Mair Health Ltd was commissioned by Leicestershire County Council to undertake a review of Healthwatch Leicestershire throughout August and September 2016. The brief for this piece of work is presented in Appendix 3.

The overall aim of the review was to inform the re-commissioning of the service from 1st July 2017 onwards and provide information and advice to allow Leicestershire County Council to provide a high quality, future-proofed and flexible approach to future Healthwatch Leicestershire service delivery.

The review starts with some background to the development of Healthwatch England (HWE) and local Healthwatch organisations before outlining the methodology used by the review team. Findings based on desk-based research drawing from national and other areas are supported by local research with a large number of stakeholders.

Commissioners are provided with an assessment and analysis of options for the structure and delivery of a local Healthwatch organisation that is independent and has the necessary skills, efficacy and authority to deliver the service successfully and manage the contract effectively.

Recommendations are made in respect to aims and objectives, statutory responsibilities, options for governance, partnership working arrangements, performance management, contracting / procurement, funding and income generation.

Due to crosscutting themes there may be repetition between different sections of the report however we felt that each section needed to be readable in its own right.

A glossary of abbreviations is available in Appendix 2.

BACKGROUND

Giving people a greater say in how the health and care system works was a central pillar of the coalition Government's ambition and a key component of the Health and Social Care Act 2012. To achieve this the Government outlined a framework for a network of local Healthwatch organisations with the aim of creating a credible, representative and influential public voice in the system.

The Act imposed a duty on upper tier and unitary local authorities to contract with a local Healthwatch organisation overseen by national Healthwatch England, the national body established as a statutory committee within the Care Quality Commission (CQC), whose purpose is to be *"the local consumer champion for patients, service users and the public"*.

Local Healthwatch organisations, whilst not statutory bodies, have statutory duties and powers similar to those of their predecessor – Local Involvement Networks (LINks). They represent the latest in a long line of attempts to give patients and wider communities an effective collective voice. Community Health Councils, Patient and Public Involvement Forums and LINks laid the groundwork for giving people a greater say in the local buying, planning and the running of services. More information on these predecessor organisations can be found in Appendix 4.

The Act also makes provision for contractual arrangement between local authorities and their local Healthwatch organisation, which must be a corporate body and a social enterprise. The Act allowed flexibility for councils to choose the commissioning route that offered the best value for money in their communities.

Through the legislature, Healthwatch England was empowered to:

- *"Provide leadership, advice and support to local Healthwatch, and will be able to provide advocacy services on their behalf if the local authority wishes;*
- *Provide advice to the Health and Social Care Information Centre on the information which would be of most use to patients to facilitate their choices about their care;*
- *Provide advice to the NHS Commissioning Board, Monitor and the Secretary of State; and*
- *Based on information received from local Healthwatch and other sources, HWE will have powers to propose CQC investigations of poor services."*

(Department of Health, 2010)

Summarising this, Dr Katherine Rake, former director of Healthwatch England, is quoted as saying:

> *"Healthwatch England has two principle roles. One to lead the Healthwatch network, supporting local Healthwatch organisations to be as successful as they can be. The other is as national consumer champion, speaking in our own voice and influencing health and social care providers, commissioners and regulators."*

Local Healthwatch organisations meanwhile were empowered to undertake those activities formally delivered by LINks as contained in 221(2) of the Local Government and Public Involvement in Health Act 2007:

> *"The activities for a local authority's area are—*
>
> *(a) promoting, and supporting, the involvement of people in the commissioning, provision and scrutiny of local care services;*
>
> *(b) enabling people to monitor for the purposes of their consideration of matters mentioned in subsection (3), and to review for those purposes, the commissioning and provision of local care services;*
>
> *(c) obtaining the views of people about their needs for, and their experiences of, local care services; and*
>
> *(d) making—*
>
> *(i) views such as are mentioned in paragraph (c) known, and*
>
> *(ii) reports and recommendations about how local care services could or ought to be improved, to persons responsible for commissioning, providing, managing or scrutinising local care services."*

The matters referred to in subsection (2)(b) are:

> *a) "the standard of provision of local care services*
>
> *b) whether, and how, local care services could be improved*
>
> *c) whether, and how, local care services ought to be improved."*

Additional functions introduced for local Healthwatch organisations included:

- *"Provide advice and information about access to local care services and about choices that may be made with respect to aspects of those services.*

- *Reach views on the standard of provision of local care services, and whether, and how, local care services could or ought to be improved.*

- *Make those views known to Healthwatch England.*

- *Make recommendations to Healthwatch England to advise the Care Quality Commission about special reviews or investigations to conduct (or, where the circumstances justify doing so, make such recommendations direct to the Care Quality Commission).*

- *Make recommendations to Healthwatch England that it should publish a report on a particular health or social care matter.*

- *Give Healthwatch England such assistance as it may require to enable it to carry out its functions effectively, efficiently and economically."*

(LGA, 2012a)

In addition, the Health and Social Care Act 2012 set out a requirement for councils to commission an NHS complaints advocacy service from an appropriate provider. In some localities this is undertaken through local Healthwatch organisations.

Regional Voices – a voluntary sector strategic partner of the Department of Health, NHS England and Public Health England – in association with the Local Government Association and the NHS Institute for Innovation and Improvement produced a report (2012a) on the challenges and supports needs for local Healthwatch pathfinders following a series of surveys, the development of detailed case studies and a national learning seminar.

The report identified two critical areas of uncertainty for commissioners. The first, organisational form, stemmed from the different interpretations of the legislation and the terms corporate body and social enterprise. The second, finance, stemmed from a lack of transparency and early information about the resources available for local Healthwatch organisations including the level of funding available and how this would be distributed and prioritised.

The report also identified a number of risks to inclusive public engagement:

> *"Lack of publicity and public awareness of Healthwatch, has repeatedly been identified as a barrier to broader public engagement and more inclusive volunteer involvement. Several people have highlighted this as something that prevented LINks from being better known and*

able to engage a wider range of people. There are particular concerns about this with regard to young people and the extent to which they will have a voice in local Healthwatch."

"Lack of engagement of the voluntary and community sector (VCS) in the design and development of local Healthwatch is a concern in some areas where these groups could be: helping to avoid duplication in community engagement and representative roles and assisting local Healthwatch to reach different parts of the community. As well as being potential providers of local Healthwatch, some parts of the voluntary and community sector also has considerable expertise in volunteer management and organisational governance."

(Regional Voices, 2012)

Importantly, each local Healthwatch organisation has a seat on the local Health and Wellbeing Board. In practice this represents a dual role, strategic partner, but also critic (they seek to be independent and hold other organisations to account as the independent voice of the public). They rely on good strategic relationships as well as community engagement.

There is no prescribed model under which local Healthwatch organisations are required to function, although nationally they do share a common brand and identity. Initially it was intended that they would become independent organisations in their own right.

The challenge for any local Healthwatch organisation is to be truly representative of their local populations. This requires good engagement with communities, effective strategic relationships to feed in views and a full understanding of the role of local Healthwatch organisations by their local partners.

National Progress

The Department of Health clarified in their publication A strong voice for people – the policy explained (2012c) that the Local Government Association (LGA) – a politically-led, cross-party organisation that works on behalf of councils to ensure local government has a strong, credible voice with national government

"Has a key role to play in helping local authorities determine what an effective and user-centred local Healthwatch should look like, to identify any barriers to successful implementation and commissioning strategies and to support the cascade of learning across all local authorities"

In line with this role, the Local Government Association produced a series of briefings to support with the commissioning, setting up and early development of local Healthwatch organisations. In addition, they also produced a number of commissioning support materials and oversee an online

forum for commissioners known as Knowledge Hub Healthwatch Commissioning Group (https://www.khub.net/web/healthwatchimplementationgroup) the aim of which is to:

> *"Provide an enabling and collaborative environment for council officers to share ideas, examples of practice and explore new ways of working."*

Whilst the documents have not been updated since January 2015 and the forum is not particularly active, they have provided a useful overview of local Healthwatch and its functions. Local Government Association materials reviewed in support of this project are listed in the Bibliography (Appendix 1) and the full suite of materials can be found online at www.local.gov.uk/health.

In 2015, The King's Fund, following a commission by the Department of Health, examined the progress made in the first 18 to 21 months of local Healthwatch organisations with findings presented in the report Local Healthwatch: progress, promise and power**.** This report states that broadly speaking local Healthwatch organisations were positive about the progress they were making in gathering views and influencing providers and commissioners. They also found that the organisations varied widely in how they are organised and how effective they are. Their activities are wide-ranging and capacity is often very limited. In November 2014, 108 surveys were returned, representing 71% of all local Healthwatch organisations. A total of 56 responses were received (from 362 sent out) to an equivalent survey sent to Clinical Commissioning Group (CCG) chairs and Health and Wellbeing Board leaders.

The report outlines the following headline findings:

- Healthwatch organisations are finding it difficult to strike the balance between being strategic partner and critic. Getting this right must be an area for focus.
- Each local Healthwatch organisation needs to consider where they sit in the system and how they engage with that system.
- Strong governance is needed to back up local decisions about how strategic relationships are made.
- Roles, responsibilities, lines of accountability for a broad transparent decision-making process need to be clearly outlined.
- People in local Healthwatch organisations require a mix of skills and expertise at both board and community development level.
- Local Healthwatch organisations work in many different ways.

- Local Healthwatch organisations have flexibility over how they conduct their day-to-day business, some are individual charities, some are Community Interest Companies (CICs), some are hosted or contracted out to an existing Voluntary and Community Sector (VCS) organisation. These arrangements often play a key role in defining the balance that each take between influencing and independence.

- A clear direction and purpose for the organisation must be defined.

- An organisation can choose to act or not to act on public generated evidence, there is still some way to go to transform the rhetoric around involving the public decision making into reality.

The Local Healthwatch Quality Statements (Healthwatch England, 2016) were developed to enable local Healthwatch organisations to understand how they are doing and identify areas for improvement. Healthwatch Leicestershire took part in the development of these statements and piloted the 360-degree survey. The pilot invited over 50 key stakeholders in local and health and social care systems to give their views about their experience of working with Healthwatch Leicestershire. 15 stakeholders responded and a report (Quality Statements: Internal Staff and Board Member Feedback Report) was prepared. The Quality Statements provide a framework for discussion with commissioners and key stakeholders about impact and effectiveness. The Quality Statements fall into five groups:

- Strategic context and relationships

- Community voice and influence

- Making a difference locally

- Informing people

- Relationship with Healthwatch England

The review team used these five areas to inform the development of the interview schedule / surveys and have presented findings and recommendations under these headings in the statutory functions section of this report.

Local Healthwatch across Leicester, Leicestershire & Rutland

In order to prepare for the establishment of Healthwatch from April 2012, the Department of Health invited proposals from local authorities in partnership with their Local Involvement Networks (LINks) to become a Healthwatch pathfinder, to test and challenge emerging models with and alongside

other local authorities and LINks, through a network of action learning sets. Limited resource was available to support the successful pathfinder proposals that:

> *"Collectively offer a range of operational models and provide learning about particularly testing or challenging circumstances from their: geographical spread, demographic spread, different local authority types, enabling LINks to strengthen their existing functions in preparation for local Healthwatch."*

(Department of Health, 2011a)

Leicestershire and Leicester City were chosen as two of the 75 Healthwatch pathfinders based on their proposals.

Leicestershire: To develop the signposting role of local Healthwatch e.g. in supporting local care services and promoting choice ensuring that comprehensive information is accessible to all. This pathfinder will focus on engaging hard to reach and seldom heard groups including children and young people and the organisational transformation of the LINk.

Leicester City: To explore how local Healthwatch can work at the local and strategic level by testing how it will provide advice and advocacy services, have meaningful representation on the local Health and Wellbeing Board to strengthen the collective voice. This pathfinder will focus on the operational and accountability arrangements for a local Healthwatch.

(Department of Health, 2011b)

In Leicestershire following an open, public procurement process, Voluntary Action LeicesterShire (VAL) were awarded the contract to deliver the statutory functions of a local Healthwatch organisation (this did not include the NHS complaints advocacy service) for three years from 1st April 2013 until 31st March 2016, with the option of a further extension. At the same time, Rutland County Council and Leicester City Council also awarded the Leicester Healthwatch contract to VAL to provide a one-year contract to establish their local Healthwatch organisations. Healthwatch Rutland became a freestanding organisation on 1st April 2014 and Healthwatch Leicester City became freestanding on May 1st 2015 following negation from Voluntary Action LeicesterShire.

METHODOLOGY

During August and September 2016 the Mair Health team conducted primary and secondary research using a mixed methods approach to ensure adequate coverage.

Secondary Research

The review team undertook desk-based research on a number of existing documents and research for the purposes of summary, collation and / or synthesis within this report including:

- National policy and guidance i.e. Department of Health (DH), Local Government Association (LGA) and Local Government Information Unit (LGIU) publications
- National research / reports on Healthwatch England and local Healthwatch organisations
- Materials from other local authority areas
    - In lieu of participating in an interview a local Healthwatch commissioner from another area supplied a series of documents including executive terms of reference, suggested structure and governance, current service specification and monitoring information
    - Service specifications sourced online.
    - Service specifications provided by the current Healthwatch Leicestershire commissioner for the purposes of the review.
- Materials provided by Leicestershire County Council i.e. service specification, performance reporting
- Materials provided by / sourced from Healthwatch Leicestershire i.e. annual reports, minutes of meetings

A full reference list is provided in Appendix 1.

Primary Research

Two main primary qualitative research methods were used, interview and surveys. The aim was to explore the subject area and allow a wide range of views and ideas to be collected. This then led to understanding people's interpretation of Healthwatch now and allowed the team to gather and share ideas for improvements in the future. As a relatively small number of participants were involved, statistical analysis is limited.

Interviews

Key questions for the local interview framework were developed from two key documents – The King's Fund (2015) Local Healthwatch: progress, promise and power and Healthwatch England (2016) Local Healthwatch Quality Statements. Additional topics / questions were added following discussion with the review commissioner. This interview framework can be found in Appendix 6.

Interviewees were informed that individual comments and views would be treated confidentially, so that any comments used in the report would not be directly attributable. They were also informed that if it was obvious where comments had come from and / or sensitive these would be shared with commissioners outside of the report and treated confidentially. This was to allow an honest range of views to be voiced.

Key questions for the local Healthwatch commissioners from other area's interview framework were based on the commissioning outputs of the review brief. This interview framework was also made available in the format of an online survey in order to encourage responses.

Interviews were in-depth and lasted between 30 and 120 minutes. The methods used were flexible and iterative, with views and ideas gathered, explored, built-on and checked out in subsequent interviews.

All interviews were transcribed and key comments collated on the review team's consultation log (an Excel spreadsheet used internally to track the progress of consultation between team members) that will be shared with the review commissioners only (Appendix 5).

The total unique number of people interviewed (i.e. excluding multiple interviews with the same person) is 50, made up of the following:

- Healthwatch Leicestershire staff 4
- Healthwatch Leicestershire board members 7
- Healthwatch Leicestershire volunteers 1

- Key stakeholders 33

  This group is made up of a range of stakeholders including Health and Wellbeing Board members and local health and social care commissioner / provider leads.

- Healthwatch England 3

- Local Healthwatch commissioners from other areas 5

Of the 67 commissioners contacted by email, 11 responded that led to 5 interviews and 1 completed survey. The commissioners for Healthwatch Leicester City and Healthwatch Rutland are counted within the key local stakeholders figure above.

Surveys

A number of surveys were developed and circulated to a range of groups. A mix of multiple choice, rating, and scaling questions were used, with open comments actively encouraged.

- Views on Healthwatch Leicestershire for members

This survey was developed by the research team and shared / refined in the development phase following input from the Healthwatch Leicestershire manager, review commissioner and Leicestershire County Council research team.

Healthwatch Leicestershire circulated a hyperlink to the survey to 1,800 of its members. 50 surveys were completed (2.78% response rate).

208 postal surveys were sent out to those members that preferred this method of contact. 35 surveys were returned and inputted manually onto the review team's online survey development cloud-based software to ensure inclusion in the overall findings (16.8% rate).

Overall, there were 49 comments in response to the request for ideas about how Healthwatch Leicestershire could make a more powerful contribution in the future and 32 general comments or concerns provided.

The template and unabridged responses from this survey will be shared with the review commissioners only (Appendix 7) although it is the review team's opinion that this should then be shared directly with Healthwatch Leicestershire to support current service improvement.

- Views on Healthwatch Leicestershire for volunteers

4 surveys were completed.

- Views on Healthwatch Leicestershire for chairs of meetings attended by a Healthwatch Leicestershire representative

2 surveys were completed.

- Survey for local Healthwatch commissioners

Of the 4 local Healthwatch commissioners that requested the survey link only 1 survey was returned.

Quotes from interviews and surveys have been included throughout this report where they illustrate a theme.

Strengths and Limitations of Approach

The combined methodology used provided a rich source of views and ideas.

The review team came together weekly to discuss emerging ideas and analyse interview content. The content of interviews was discussed, summarised and further summarised (recursive abstraction), to be distilled into key themes. This interviewer corroboration and triangulation enabled the validity of ideas to be tested and helped the review team to increase their understanding of the area. Findings will be credible and recommendations useful for future commissioning of Healthwatch Leicestershire.

The review team met bi-weekly with the review commissioner and produced a highlight report prior to the meeting. These meetings were a place where progress and barriers to progress were discussed and ideas and emerging findings shared. The review team and review commissioner had email and telephone contact in between the more formal meeting that proved useful for sharing information and ensuring the review delivered the products required in the given timescale.

During an early meeting it was agreed with the review commissioners that this would be an action review, as findings were discovered and explored they would be reported and acted upon where appropriate. An idea could become a recommendation that would lead to change whilst the review was still taking place. For example, the idea of considering joint commissioning with other local Healthwatch commissioners was explored early on in the review.

Because of the tight timescale for the review (9 weeks from the contract being awarded to presentation of the first draft final review report) both primary (interviews and surveys) and

secondary research (desk-based reviews) took place concurrently. Had more time been available, the desk-based research would have taken place at the start to further inform and develop the interview frameworks and survey templates.

The review team did not gather views from the wider general public or other community groups about Healthwatch Leicestershire. This was outside of the scope of this review, however it is something the review team think should be undertaken (refer to co-production below). Understanding the reach of Healthwatch Leicestershire and awareness of it by the general public would go some way to support the promotion, and effectiveness, of Healthwatch Leicestershire.

The sample size was open-ended and focused on key groups as requested by the review commissioner. One finding during the interviews was that stakeholders often had suggestions about other key people to talk to. Overall, people were keen to share their views of Healthwatch Leicestershire and engaged fully with the review process.

Several commissioners from other areas provided information to inform the review, although more views about what is working well in other areas would have been beneficial. During the review it became known to the review team that an event for local Healthwatch commissioners is being planned by Healthwatch England to take place in October 2016.

Of the other local Healthwatch commissioners and members of Healthwatch England who were interviewed, several reported they would like an update about the Healthwatch Leicestershire review following publication and to see resulting documents, such as the new service specification. This could be an opportunity for the existing commissioners to make contact and share findings and to continue to learn from other areas. Although a local review, many of the findings will be relevant to other areas.

Co-production

The aim of local Healthwatch is to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality. One mechanism to ensure this happens is through service co-production.

Co-production of services means tapping into the talents of service users in order to improve services. It is a step on from seeking the views of service users and involves:

- Listening to service users and professionals as equals and sharing good and bad experiences.
- Understanding that some patients have the ability to help not only themselves but others too.

- Understanding that it is much more challenging than just listening to service users and making use of their talents, as it means sitting down and working out how services should be delivered. This may involve the professional relinquishing control and letting go of the role of 'fixer'.

During the establishment of local Healthwatch organisations, Patient and Public Involvement Solutions (2012) highlighted the importance of co-production in the following statement:

> *"It was considered that good management and organisation of local Healthwatch will be immeasurably affected by the commissioning process and contract specification adopted by the local authority in their role as commissioners. Involve stakeholders (individuals, groups and communities) in the development of the service from the earliest opportunity and reflect their input in an effective contract and contracting process."*

This sentiment was echoed by the New Economics Foundation (2013 in their report to the Local Government Association by stating that local Healthwatch organisations must go beyond consultation and participation, using more innovative and effective ways of engaging local people in the design and delivery of services including the local Healthwatch organisation itself.

There are several good practice guidance documents and policy available on co-production, such as:

- The King's Fund (2013 Experience-based co-design toolkit

  This toolkit outlines a powerful and proven way of improving patients' experience of services.

- The King's Fund (2014) People in control of their own health and care

  This report examines how we can advance the cause of making person centred care the core of health and care reform.

- NICE (2013) Patient and public involvement policy

  This policy describes the National Institute for Health and Care Excellence's approach to patient and public involvement.

During this work we became aware of the growing awareness of the concept and practice of the co-production of services. We consider that this review and the work of Healthwatch Leicestershire would be strengthened by further engagement with the public, to understand their views about how to work with them in meaningful ways to improve local services.

FINDINGS AND RECOMMENDATIONS

Findings and recommendations are clustered into three headings:

1. **National Steer and Other Areas**

   Comes from a desk-based review of key national documents, as well as from talking to Healthwatch England representatives and other local Healthwatch commissioners.

2. **Local Findings**

   Comes from local documents (supplied by / sourced from Leicestershire County Council and Healthwatch Leicestershire), interviews and survey responses, as well as a small amount from the 360-degree pilot work.

3. **Recommendations**

   Comes from the consolidation of findings and balancing what is working well currently, with ideas for the future.

The findings in this section of the report broadly match the areas requested for focus by the review commissioners the five areas of focus for the Local Healthwatch Quality Statements,.

FINDINGS / COMMISSIONING

Organisational Form

National Steer and Other Areas

Legislature and subsequent guidance documents dictate that local Healthwatch organisations must be a body corporate (i.e. a legal entity) and social enterprise independent from the local authority able to employ its own staff and involve volunteers subject to the public sector equality duty under the Equality Act 2010 and Freedom of Information Act.

Whilst the Department of Health provided specific examples of acceptable legal structure – company limited by guarantee, charity or community interest group that has a social purpose i.e. a business with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community – there was limited guidance on organisational form and, as such, local authorities interpreted the mandate in a number of ways.

A review of nationally available materials and conversations with other local Healthwatch commissioners revealed local Healthwatch organisations that were:

- Procured
- Developed as a new social enterprise with input from the authority and partners;
- Evolved from the precursor LINk organisation with support from the authority to become a corporate body; and
- Grown from an existing organisation or network.

During the Healthwatch pathfinder stage, Kent were exploring options around a distributed model whereby each function of their local Healthwatch would be embedded into existing organisations that housed a Healthwatch champion who networked through a core body (in essence, a hub and spoke model). Similarly one of the local Healthwatch commissioners from another area spoken to as part of this review were considering the combination of a number of their voluntary and community sector contracts via an alliance-based or prime provider approach to cover the statutory functions and the advocacy function; a network of networks to avoid duplication.

Local Healthwatch organisations can also be either:

- Freestanding (an independent company operating under the local Healthwatch name / brand);

- Hosted (an independent company operating under the local Healthwatch name / brand whose workplace is not within their employing organisation); or

- Commissioned as a function within an existing organisation (a subsidiary of a larger organisation that licenses the use of the Healthwatch registered trademark from the Care Quality Commission, in line with section 45D of the Health and Social Care Act 2008, in order to indicate the carrying-on of local Healthwatch activities).

Whilst certain organisational forms might infer certain advantages and disadvantages (refer to the table below) they are heavily dependent on the operational expertise of the provider and oversight of the commissioner.

Organisational Form	Advantage	Disadvantage
Freestanding	• Truly independent	• Incur high costs for central functions
Hosted	• Strategic independence • Access to host central functions (for cost) • Able to leverage (some) skills, resources and linkages of host organisation	• Operational dependence on host organisation (dependent on functions provided)
Commissioned function	• Can broaden reach and take advantage of pre-existing relationships (if provider operates in a similar health and social care sphere to local Healthwatch) • Able to leverage skills, resources and linkages of provider organisation • Can take advantage of economies of scale	• Local Healthwatch funding contributes to central overheads irrespective of return • Strategic and operational dependence on provider organisation (can reallocate funding / capacity in line with wider organisational requirements) • Income generation activities do not align i.e. provider would benefit, not local Healthwatch • Potential conflict where provider or provider's customers are also subject to local Healthwatch scrutiny

When asked, Healthwatch England did not report any preferred organisational form. There is considerable opportunity for flexibility in the type of organisations that are commissioned and, in their opinion, what makes the most difference in terms of effectiveness is good local relationships and effective engagement with partner organisations and the public. If the local Healthwatch is to be part of another organisation, they recommend an arms-length local Healthwatch with a separate board that has the appropriate powers to listen, reflect what people say and provide evidence-based advice.

On this basis, it is important that the procurement process does not exclude specific organisational forms, but rather that the commissioners encourage applications from a variety of providers in a variety of forms which can then be judged based on tender proposals.

Whilst some other areas raised concerns about the subcontracting of local Healthwatch functions and its impact on quality of service, the Department of Health (2012d) confirmed that the functions to be delivered by a local Healthwatch organisation in section 221 of the 2012 Act (i.e. not the mandatory seat on the Health and Wellbeing Board that is overseen by other legislature) can be authorised to be subcontracted with no restrictions and that overall accountability remains with the local Healthwatch organisation.

Local Findings

At the outset of the review, Healthwatch Leicestershire had been referred to as a hosted organisation; the host organisation being Voluntary Action LeicesterShire, charity no. 509300, "whose objects are to promote any charitable purposes for the benefit of the community in the city of Leicester, county of Leicestershire, and county of Rutland, and to promote and organise co-operation in the achievement of this purpose" (Charity Commission, 2016).

It is the opinion of the review team that Healthwatch Leicestershire is not a hosted organisation but instead a procured function delivered by an organisation (alongside their other commissions and grants). It is not a separate business entity and Voluntary Action LeicesterShire is both their employing organisation and workplace organisation. This is also borne out by the current agreement between Leicestershire County Council and Voluntary Action LeicesterShire for the provision of local Healthwatch statutory functions in which the meaning assigned to 'Healthwatch Leicestershire' within the definitions. Whilst this is a minor point, the choice of terminology is important as it enables people to have clear conversations and shared understanding.

There is no consensus from Healthwatch Leicestershire staff, board members or volunteers about whether the current or alternate organisational forms would be beneficial. The review team were provided with examples of advantages of the current situation including the sharing of skills and office functions. The review team were also given possible disadvantages such as lack of clarity about the financial management.

The current agreement with Healthwatch Leicestershire states:

> *"Healthwatch Leicestershire shall not sub-contract any part of the Service, except for the hiring of agency staff, without the prior written consent of the Council."*

Initially provided by Voluntary Action LeicesterShire, Healthwatch Leicester City has been independent and based within Age Concern (i.e. hosted) since May 2015. This arrangement provides them with an office, IT and salary support. Both the Executive Officer and Chair of Healthwatch

Leicester City Board believe that this change has brought many benefits and better value for money. The Healthwatch Leicester City Board are now in control of their own budget and this informs their strategic plan, which over the last year was focussed on increasing their visibility and on public engagement. The policy steer in Leicester City is that Healthwatch organisations should be independent organisations, not a subsidiary function of another organisation.

Healthwatch Rutland has been an independent organisation based in Voluntary Action Rutland (i.e. hosted) since April 2014. This arrangement provides them with an office with IT support bought in at additional cost. The Healthwatch Rutland Board are committed to remaining independent, as they believe that this best serves the people of Rutland. They think that budgetary and strategic controls are fundamental to achieving this.

Unless greater clarity from the Government on commissioning options is forthcoming, an event unlikely given the passage of time, the key driver for an authority is to choose whichever organisational form best enables their local Healthwatch to operate independently, be accountable – to both the commissioning authority and directly to the population it serves – and offer value for money.

Recommendations

- There is no one-size-fits all solution to organisational form, and as such, the procurement process should not exclude certain organisational forms.

- Consider inviting tenders for separate local Healthwatch functions. For example, one tender for community voice and influence and one tender for signposting and information as a single provider. In theory, this would enable functions to be delivered by existing specialist providers and reduce duplication in the sector albeit, potentially, at the expense of efficiencies / synergy from integrated provision.

- Consider inviting tenders from a consortia arrangement (put together by suppliers) to fulfil the different functions. In theory, this would enable functions to be delivered by existing specialist providers and reduce duplication in the sector with an onus on the consortia to ensure efficiencies / synergy from integrated provision.

- Explore authorising the use of sub-contracts with existing voluntary and community sector organisations to help assist the lead provider in their activities i.e. by leveraging subcontractor expertise or relationships.

Procurement

National Steer and Other Areas

During the initial setup period *"councils took different approaches to commissioning local Healthwatch, which variously involved tendering processes, or a grant-funded route"* (LGA, 2012a). Heading into the second round of commissioning, local Healthwatch commissioners are expected to undertake a competitive tendering process in order to ensure they receive the best service at the best price (value for money) – although some local authorities may seek an exception from procurement in order to award their contract to the existing provider or another preferred supplier subject to meeting the appropriate legislative requirements.

It is understood by the review team that the procurement of local Healthwatch services are subject to the light touch regime set out in Section 7 of The Public Contracts Regulations 2015 and that due to the proposed value of the new contract and threshold for application, procurement should follow the general duty to comply with the principles of fair competition, equal treatment and non-discrimination.

A competitive tendering process of this nature has a number of benefits including its ability to test the market driving down prices and enabling creativity and innovation whilst providing an opportunity for the existing provider to further develop its competitive credentials. This process would also be in line with one of the guiding principles of the Localism Act 2011 by ensuring that local social enterprises and community groups with local solutions for local changes have the opportunity to be heard.

In order to stimulate the market and ensure a range of delivery models are explored, national best practice is to hold well-publicised information events for potential providers.

Grants are not subject to contract law, cannot be readily recouped, only have broad objectives to be achieved and are not monitored as closely as a contract; on this basis it is good practice to award a contract to deliver statutory obligations.

Procurement should be led by the local authority officer lead for Healthwatch Leicestershire. In their recommendations of best practice, Regional Voices (2012a, 2012b) state that the base of the lead officer within the local authority does not matter so long as it does not lead to a potential conflict of interest. For example, you should not base the lead officer within the adult social care directorate as these services are under the scrutiny of the local Healthwatch organisation.

The local Healthwatch commissioners in other areas that the review team spoke to are based in a number of departments including:

- Adult Social Care
- Children, Families and Wellbeing
- Commissioning and Contracting
- Communities Services
- Customer Services
- Governance Services
- Partnerships, People and Housing

If an option for joint commissioning with neighbouring local Healthwatch organisations is to be taken, there is a need to align commissioning timescales.

Local Findings

Following an open, public procurement process, Voluntary Action LeicesterShire were awarded Leicestershire's original contract for three years from 1st April 2013 until 31st March 2016, with the option of a further extension.

Leicester City Council commissioned a service from Healthwatch Leicester City and plan to re-procure, to have a new service in place April 2018. Rutland County Council award a grant to Healthwatch Rutland, with annual work plan agreed at outset.

Recommendations

- In line with procurement rules and to ensure an open and transparent approach to re-commissioning that achieves the best results, the local authority should undertake market testing followed by a competitive or a competitive negotiated tender process to award a contract.
- Undertake an information event to stimulate the market prior to publication of the Request for Quotation (RfQ).
- Maintain lead officer responsibility within the Chief Executive's department for the duration of procurement and the new contract to maintain clear accountabilities and a strong communication channel whilst preventing any potential conflict of interests.

- Explore the appetite for the joint commissioning of a single local Healthwatch organisation across Leicestershire, Leicester City and Rutland.

Contracting

National Steer and Other Areas

In Local Healthwatch: A strong voice for people – the policy explained (2012c) the Department of Health clarified that:

> *"Whilst a crucial function of Healthwatch England will be providing leadership and support for local Healthwatch by issuing guidance on best practice in a number of areas, including leadership and governance, this leadership and support does not extend to local authorities in the commissioning or performance management of a local Healthwatch."*

Rather, that the Local Government Association:

> *"Has a key role to play in helping local authorities determine what an effective and user-centred local Healthwatch should look like, to identify any barriers to successful implementation and commissioning strategies and to support the cascade of learning across all local authorities"*

In line with this role, the Local Government Association produced a series of briefings and commissioning support materials to support with the establishment and early development of local Healthwatch organisations.

Presently, other local Healthwatch commissioners and best placed to offer leadership and support to their peers in the commissioning or performance management of a local Healthwatch, sharing good practice and lessons learned through delivery.

Whilst only a small number of other local Healthwatch commissioners engaged with this review, the information and insight gained is invaluable and the commissioners of Healthwatch Leicestershire would benefit from developing relationships with their peers in the neighbouring areas and across the nation.

<u>Service Specification</u>

The Department of Health (2012d) suggests that:

> *"Transparency is critical for social enterprises in general, and will be crucial for local Healthwatch in particular […] a local authority must include in their contract certain*

requirements that ensure that a local Healthwatch must act in an open and transparent manner."

Whilst at a national simulation event, convened in March 2012, the Department of Health went on to state that, at a minimum, a local Healthwatch service specification should cover purpose, membership, job roles and responsibilities (including skills and competencies), functions, governance structures, methods of accountability, outcomes, milestones and outputs so that Healthwatch could participate effectively with authority and credibility.

In a subsequent publication, the Local Government Association (2012a) highlights a number of features of an effective local Healthwatch organisation, of which the following could be written into a service specification:

- Is proactively engaged in the development and operation of working partnerships and networks, to maximise the complementary relationship with the wider community engagement mechanisms and activities in the local area.

- Works collaboratively with other local groups and organisations as part of local community networks.

- Draws upon knowledge and experience that already exists and to maximise its reach across the diversity of the local community, with a particular focus on understanding the views and experiences of seldom heard groups.

In their report Shaping Local Healthwatch: The Actions and Findings of 9 Local Authorities in England, Patient and Public Involvement Solutions (2012) states that in order to fulfil the real opportunity of bringing existing providers of community engagement, information, signposting and advocacy services together, local authorities have to create a service specification *"in such a way as to encourage creative partnerships, collaborations and creativity"*.

Service specifications from other areas are varied as they are guided by local authority contracting requirements (i.e. use of local authority template, headings and pro forma text) and not around the needs of the service being contracted.

Other local Healthwatch commissioners spoken to as part of this review felt that a national service specification (that could be tailored for local use) would prove valuable. Whilst this sit within Healthwatch England's remit, and the Local Government Association have moved onto other topics following the publication of their 'Establishing Local Healthwatch' series of materials, this was discussed at a recent national Healthwatch England meeting attended by the Healthwatch Leicestershire commissioner.

Service specifications from other areas should be used as a reference guide when drafting the new Healthwatch Leicestershire service specification, lifting suitable wording and phrasing where possible to ensure a consistency in approach and language. The local Healthwatch commissioner for East Sussex had a wealth of experience (from Healthwatch establishment to date) and shared good ideas during the interview. Whilst their new service specification was not publicly available during the period of review (as they were in pre-procurement) it should be in the public domain by the time this report is published.

Contract Duration

The majority of local Healthwatch commissioners asked about re-commissioning and contract duration as part of this review, stated an intention to award based on an initial term of either 2 or 3 years with options to extend by up to 2 years. The rationale behind their choice was twofold. Firstly, an initial term of 2 to 3 years would provide both stability and security to the commissioner and provider, potentially encouraging more applicants during the tender process. Secondly, the options to extend would take the contract to the date of the next general election (May 2020); this would limit the risk to the commissioning authority in the case of a change in legislature and / or the abolishment of Healthwatch in a similar vein to its short lived predecessor arrangements – Patient and Public Involvement Forums from 2002 to 2008 and Local Involvement Networks from 2008 to 2013. Healthwatch England also endorsed 2+2 and 3+2 as ideal in an interview with a member of the review team.

Joint Commissioning / Partnership Working

The points below provide a summary of our findings from other areas on the topic of joint commissioning / partnership working:

- At present there are limited joint commissioning arrangement in place, but many commissioners are keen to explore opportunities for cross-area / organisation commissioning (i.e. with health or social care commissioner or across boundaries) to improve both quality and value for money.

- In general, local Healthwatch commissioners support the development of close working relationships with its neighbouring local Healthwatch entities. Partnerships are being explored with a view to better value for money, greater efficiency and the exploitation of economies of scale.

- East Sussex received a commendation for cross-border working. They have continued local Healthwatch commissioner development meetings to look at joint work and overlap. In addition, a quarterly Healthwatch Advisory Group is held by Healthwatch East Sussex in collaboration with Healthwatch West Sussex and Healthwatch Kent and attended by key health and social care partners for the purpose of horizon scanning and ensuring that

information and intelligence is shared at an early stage to enable the local Healthwatch organisations to better undertake their duties.

- Trafford are part of a Greater Manchester group (10 members) that meet for consideration of joint commissioning and partnership working. A Memorandum of Association (MoA) is in place to establish boundaries and agree who will compete for specific tenders.

Local Findings

The current Agreement for the provision of local Healthwatch statutory functions in Leicestershire can be found in *AGREEMENT NO CO doc 15 03 13 doc 20 06 13*.

This is a comprehensive document that includes:

Schedule 1 Service specification

Schedule 2 Pricing document

Schedule 3 Payment of contract price

Schedule 4 Contract management and monitoring arrangements

Schedule 5 Notices

Schedule 6 Performance indicators / outcomes

Schedule 7 Invitation to tender and response to the invitation to tender

Section 2 of the Agreement states that:

"2.1 The Agreement shall commence on 1st April 2013 and shall expire at midnight on 31st March 2016 (Initial Term) unless terminated earlier in accordance with clause 24 (or otherwise lawfully terminated) (or extended under clause 2.2).

2.2 The Council may extend this Agreement beyond the Initial Term by a further period or periods not exceeding 2 years (Extension Period).

2.3 If the Council wishes to extend this Agreement, it shall give Healthwatch Leicestershire at least 3 months written notice of such intention before the expiry of the Initial Term or Extension Period in which case this Agreement shall remain in force on the same terms set out herein …"

In summary, the current Agreement is operating on 3+1¼ with an option for a further extension until March 2018 that the local authority does not currently intend to pursue; instead procuring a new service for the delivery of local Healthwatch statutory functions to commence on 1st July 2017.

During the review process there have been initial discussions with Leicester City and Rutland local Healthwatch organisation commissioners and contract leads. All expressed an interest to meet as a group of local Healthwatch commissioners. The purpose meeting would be to discuss opportunities for the local Healthwatch organisations to work more closely together. This may include exploring joint commissioning / joint working / lead roles opportunities and aligning and standardising functions through shared policies and procedures.

Recommendations

- Commissioners from other areas are best placed to offer information and insight around commissioning and performance management of local Healthwatch organisations. Relationships with local authority peers should be developed particularly in neighbouring areas.

- Seek guidance from the appropriate local authority directorate on TUPE (Transfer of Undertakings, Protection of Employment) and 'second generation' transfers prior to commencing procurement.

Service Specification

- Follow the small amount of Department of Health guidance on local Healthwatch service specifications. Build on this using the best practice as detailed in the Local Government Association materials and examples of good practice as detailed in peer service specifications.

Contract Duration

- Re-commission based on an initial term of either 2 or 3 years with an option to extend by a further period or periods not exceeding 2 years.

Joint Commissioning / Partnership Working

- Local Healthwatch commissioners for Leicestershire, Leicester City and Rutland should meet to explore joint commissioning and partnership working in detail. A Memorandum of Understanding (MoU) could be developed with input from the respective local Healthwatch organisations to define the relationship between organisations and clarify working arrangements.

Performance Management

National Steer and Other Areas

In Local Healthwatch: A strong voice for people – the policy explained (2012c) the Department of Health clarified that:

> *"Whilst a crucial function of Healthwatch England will be providing leadership and support for local Healthwatch by issuing guidance on best practice in a number of areas, including leadership and governance, this leadership and support does not extend to local authorities in the commissioning or performance management of a local Healthwatch."*

Rather, that the Local Government Association:

> *"Has a key role to play in helping local authorities determine what an effective and user-centred local Healthwatch should look like, to identify any barriers to successful implementation and commissioning strategies and to support the cascade of learning across all local authorities"*

In line with this role, the Local Government Association produced a series of briefings to support with the performance management of a local Healthwatch organisation. Relevant extracts from these briefings are included below:

- Local Government Association (2012a) Delivering effective local Healthwatch: Key success features

  "Council commissioners are responsible for providing local leadership, managing the contracts with their local Healthwatch and ensuring effective delivery in line with the legislation – represented and supported by the Local Government Association."

- Local Government Association (2012h) Establishing Local Healthwatch: Introduction and the local authority role

  "Local authorities will have an on-going role in monitoring the work of LHS and in holding it to account for the fulfilment of the contract."

- Local Government Association (2012g) Establishing Local Healthwatch: Governance

  "In producing service specification to invite bidders for the local Healthwatch contract, a number of local authorities in consultation with stakeholders have gone into some detail about

specific objectives they expect the organisation to set and outcomes they expect to deliver in the first year of existence and in the longer-term."

This is referred to as an outcomes-focused strategy. Pages 16 and 17 of this document provide a number of output examples from Devon County Council and a number of general headings / cross-cutting themes identified by Kirklees Council.

In addition, the Local Government Association also developed a number of commissioning support materials. The two documents related to performance management are detailed below. Use of these documents is encouraged, as they are a national standard providing a level of consistency in expectations across local Healthwatch organisations and should allow for some level of peer comparison.

- Local Government Association (2014a) Local Healthwatch outcomes and impact development tool

  Jointly produced by the Local Government Association and Healthwatch England. Shaped and tested in a range of local Healthwatch areas and based on a number of local authority protocols, outcomes, performance frameworks and success measures.

  It presents a menu of outcomes and impacts that can be adopted and adapted by council commissioners and local Healthwatch organisations. The focus is to move beyond outputs such as the number of meetings held / attended and move to the outcomes that a local Healthwatch seeks to achieve i.e. specific improvements to health and social care services based on the views of people who use the services. There are sections including governance, finance, operations, relationships, resources and wicked issues. Each section is presented separately but with crosscutting themes.

  This document can be found in Appendix 9.

- Local Government Association (2014b) Local Healthwatch Reflective Audit

  Produced by the Local Government Association this local Healthwatch reflective audit was developed to help council commissioners and local Healthwatch organisations to understand how well local Healthwatch is working in their area. It also helps them to understand whether other organisations are introducing changes as a result of working with local Healthwatch.

  This document should be used to guide local Healthwatch annual reviews in pursuit of:

  - Identification of the development needs.
  - Understanding the blocks and barriers to the system.

- Understanding enablers in the system and how partners could support local Healthwatch to be as effective as possible.

- Information to support judgements about value for money.

This document can be found in Appendix 10.

When questioned about performance management, commissioners from other areas had the following to say:

- Where the local Healthwatch has good relationships with its partners in health and social care the commissioner can step back from the contract creating a positive space for the organisation to move in (a fluid approach to performance management).

- We use the Local Government Association's outcomes and impact development tool, as do our neighbouring local Healthwatch organisations (the same organisations that we undertake partnership working with). We undertake an annual peer review in addition to reflective audit.

- We use a local authority mandated service impact toolkit focused on outputs and outcomes with additional information on safeguarding.

- Having only just picked up the responsibility from another department for local Healthwatch commissioning we are only just starting to look at contract management and our local priorities

- Performance reporting is supported by quarterly progress meetings focusing on trends and anomalies alongside any ad-hoc meetings / contacts as necessary.

Local Findings

Performance indicators / outcomes for the current agreement can be found in Schedule 6 of *AGREEMENT NO CO doc 15 03 13 doc 20 06 13*. This document has clearly labelled headings, outcomes, indicators, frequency and evidence (types) as proposed in good practice guidance.

In addition, to the performance framework the current commissioners also undertake a quarterly monitoring meeting where the provider reports on progress against an annual work plan. Detailed notes are captured at the meeting for the purposes of reference and action.

The current iteration of Healthwatch Leicester City is relatively new (approximately one year old). Now that the organisation is established the commissioner intends to use the remainder of the contract (ends March 2018) to focus on activity and outputs.

The commissioner of Healthwatch Rutland has regular monitoring meetings to appraise progress against their annual work plan, itself agreed at the outset of each year. As a grant agreement, and not a contract, the commissioner may only set out broad objectives to be achieved.

Recommendations

- Performance management (and the subsequent framework) is a significant part of the local authority's duty in managing their local Healthwatch contract and ensuring effective delivery in line with the legislation. However, care must be to balance the amount and intensity of output and outcome reporting against the practicalities and capacity requirements for reporting by the local Healthwatch organisation (i.e. performance reporting should not be too onerous). Performance elements must be measureable, understandable, verifiable, equitable and achievable but also flexible so they can be adjusted during the contract period to reflect a change in priorities and work requirements. The local Healthwatch commissioner must use these outputs and outcomes to provide on-going feedback to the provider on progress and recognise the behaviours / practices that result in a good job. Whilst rewards for good performance are unlikely in the current financial climate, penalties for poor performance against target are not encouraged; instead a collaborative approach to understanding issues and developing remedial actions should be taken.

- Use the Local Government Association local Healthwatch outcomes and impact development tool adapted by the local authority and health and social care partners.

- Use the Local Government Association annual reflective audit to guide the development of the Healthwatch Leicestershire annual review.

- Continue form and function of quarterly monitoring meetings with the Healthwatch Leicestershire provider:

    - Provider-led annual work plan (developed into a more formal annual business case).

    - Preparation of a quarterly performance report by the provider against the outcomes and impact development tool and business case.

    - Clear meeting notes and actions for subsequent period.

- Undertake peer review in addition to self-assessment i.e. HWE Quality Statements and 360-degree as necessary.

- Short and long-term outcomes to inform the development of the new Healthwatch Leicestershire business case including: highlighted throughout this review including statutory

activities, general public awareness, development and use of volunteers, value for money and social value etc.

- Open conversations with the commissioner of Healthwatch Leicester City to look at aligning output, outcomes and targets.

- Consider amending targets in line with the new funding level.

Funding

National Steer and Other Areas

In 2012/13 the Department of Health allocated local authorities with £3.2 million under the Learning Disability and Health Reform grant to cover the set-up costs of local Healthwatch organisations. This funding was subsequently rolled into the Department of Communities and Local Government (DCLG) Business Rates Retention Scheme (BRRS) and is now provided to local authorities as part of their general funding (DH, 2013) although it should be noted that local authority funding has been cut by 32% since 2012/13, with future reductions expected to accumulate to 47% by 2019/20.

From 2013/14 onwards the Department of Health has provided specific local Healthwatch through a Local Reform and Community Voices (LRCV) grant that is comprised of the following funding streams.

- Funding for Deprivation of Liberty Safeguards (DOLS) in Hospitals;

- Funding for local Healthwatch organisations; and

- Funding for Independent NHS Complaints Advocacy Services (ICAS).

In total, through the LRCV grant, the Department of Health made around £42 million available in 2013/14, £43 million in 2014/15, £32 million in 2015/16 and £32 million in 2016/17. In 2013/14 this allocation was based on the Adult Social Care Relative Needs Formula and since then allocations have been frozen.

No details on future allocations have been published as at the time of writing.

Whilst local authorities have a duty to deliver *"an effective local Healthwatch"*, the funding provided through the DCLG BBRS and LRCV grant is not ring-fenced. Decisions about funding should *"be made by each local authority as part of its overall responsibilities to fund services to meet the needs of local people and communities"* (DH, 2012a).

In a challenging economy with an ambitious deficit reduction plan reliant on spending cuts, further reductions to the Local Reform and Community Voices grant allocation at a Government level or at a local Healthwatch contract level would not be unexpected.

The traditional response to achieving a cost reduction is through a competitive procurement process that favours price instead of value for money. Strong-arming providers into reluctant compliance might offer a short-term fix but with inevitable long-term consequences to the effectiveness of the service and relationships between parties.

The Department of Health (2012) states that a *"lack of funding can jeopardise the ability of a local Healthwatch to demonstrate to the local authority that it is providing effective services"* whilst Anna Bradley, former Chair of Healthwatch England said in 2014, before subsequent year-on-year funding cuts in over one-third of local authorities:

> *"Less than 4p out of every £10,000 spent on health and social care was allocated to champion the cause of consumers in the first place. The tragedies of Mid-Staffs, Morecambe Bay and Winterbourne View all highlight what happens when the system fails to listen. As a result, there is an even greater need for Healthwatch to speak up for consumers and users and challenge those who provide services to listen and respond."*

Alongside some desk-based research into private sector methods, interviews with other local Healthwatch commissioners identified a number of potential options to improve value for money including the elimination of waste (i.e. all reports available electronically with an at-cost charge to the recipient for hardcopy versions), better use of technology (i.e. in collecting feedback and views), increased use of volunteers (i.e. to improve skills and expertise available to the organisation), partnership working (i.e. to draw upon existing knowledge and exploit economies of scale), income generation (i.e. undertaking additional profit-making business for a third party) and the use of a strengths-based approach to work.

Research (Mount Royal, 2011) shows that strengths-based approaches are sustainable. The focus should be on the assets in an organisation and releasing value in the community by looking for opportunities on the common good and investing in citizens to develop capacity and supporting individuals, communities and organisations to develop their potential. In contrast, a deficit-based approach identifies the deficiencies in individuals, communities and organisations, has a reactionary response to problems and works will illness as opposed to wellness.

The local Healthwatch commissioner for East Sussex stated that their success in reducing costs by more than 5% was borne out by the proactivity of the provider who proffered up a savings plan; it should be noted that the service had matured and developed enough to free up resources to achieve this.

Local Findings

In 2012/13 the Department of Health allocated local authorities with £3.2 million under the Learning Disability and Health Reform grant to cover the set-up costs of local Healthwatch organisations. For Leicestershire this amounted to approximately £26K.

The following table provides a summary of the local authority funding position in relation to Healthwatch Leicestershire for each year since inception:

Financial Year	LRCV Grant[1]	Local HW funding[2]	Contract value[3]	Council top up[4]
2013/14	£422,834	£132,504 (31%)	£325,014	£192,510
2014/15	£436,033	£133,731 (31%)	£227,391	£93,660
2015/16	£325,299	£133,711 (41%)	£187,391	£53,680
2016/17	£330,058	£135,723 (41%)	£187,391	£51,668

1 Local Reform and Community Voices grant for DOLS, ICAS and local Healthwatch. Leicestershire County Council receives 0.0101% of the national LRCV grant allocation each financial year.

2 Amount of LRCV grant that is supplied in pursuit of (but not ring-fenced for) the delivery of local Healthwatch statutory functions. Figure in brackets is percentage of LRCV grant this amount represents.

3 Figures confirmed by Leicestershire County Council as part of this review. It should be noted that these figures differ to those contained in Schedule 2 of the Agreement due to the outcome of a 2013/14 public consultation carried out by the local authority on its overall budget position focused on the need to make substantial savings. Figures also differ to those stated in the Management Accounts supplied by the provider.

4 Contract value minus the amount received from the Department of Health for local Healthwatch funding. Funding for local Healthwatch is also provided for in the Local Government Finance Settlement.

The spreadsheet at Appendix 8 compares Leicestershire against other local authorities (of the 146 authority areas with a population of more than 10,000) on income received by each local Healthwatch to deliver their statutory activities. Raw data presented comes from a number of Healthwatch England publications (2013, 2014b, 2015). Figures for 2016/17 are not available at the time of writing.

Whilst Leicestershire was comparable to its CIPFA nearest neighbours (generated using a wide range of socio-economic factors and as used by Public Health England when undertaking peer comparative and benchmarking exercises) in 2013/14; year-on-year cuts in 2014/15 and 2015/16 has meant the local authority spent significantly less per head than other areas and its peers.

Healthwatch England said they were using their statutory powers to contact Leicestershire, as one of the ten councils who oversaw one of the most disproportionate reductions in their Healthwatch budget in 2015/16, asking them to explain their contingency plans to ensure investment in public engagement would be maintained. It is understood from the local authority that this was prompted

by a misunderstanding that not all of the LRCV had been spent as allocated (even though the LRCV grant is not ring fenced). The local authority responded to Healthwatch England to clarify that there was no disproportionate reduction in funding and that the LRVC grant allocation is spent on the local Healthwatch in addition to a supplement as indicated in the table above.

Whilst this information provides a useful at-a-glance comparison, please bear the following the following into consideration:

- Income figures were provided to Healthwatch England by local Healthwatch organisations not by local authorities. In respect to Healthwatch Leicestershire the figures reported are:
    - £325,000 in 2013/14 (against £325,014 as reported by the Council and £325,000 as reported on the Healthwatch Leicestershire management accounts);
    - £275,000 in 2014/15 (against £227,391 as reported by the Council and £254,392 as reported on the Healthwatch Leicestershire management accounts); and
    - £187,391 in 2015/16 (against £187,391 as reported by the Council and £216,551 as reported on the Healthwatch Leicestershire management accounts that includes £8,000 from income generation).
- Some of the income figures presented by local Healthwatch organisations were not to solely deliver statutory functions but also additional funding or supplementary grants. For example, to deliver an advocacy service, set up as a Community Interest Group or additional payments relating to TUPE.
- Healthwatch England only publish '£ per head' in their report for 2013/14. No source was identified within this publication for their population estimates. No justification was provided as to why they chose to forego the '£ per head' measure in subsequent years. '£ per head' figures for subsequent years are therefore based on Healthwatch England's 2013/14 population figure to enable a comparison.
- Healthwatch England presents the income received by each local Healthwatch in isolation. Other more suitable comparators might include:
    (1) Spend as a proportion of the LRCV grant received from central government.
    (2) Spend as a proportion of total local authority spend (itself dictated by local spending and sustainability plans).
    (3) Spend as a proportion of total health and social care spend on local authority population.

(4) Spend relative to total demand for health and social care services within local authority population.

Whilst a comparison of funding between local authorities is a useful exercise, in isolation it does little to inform the commissioner of their local Healthwatch organisation's value for money and effectiveness in delivering the required statutory functions (the two requirements for a local Healthwatch commissioner mandated by the Department of Health).

As stated above, local authorities are entitled to commission their ICAS through their local Healthwatch organisation. Whilst Voluntary Action LeicesterShire submitted a tender for this service, the current contract is provided by POhWER and has been extended to March 2018. It is currently proposed that this service will be incorporated into a wider Leicestershire advocacy services contract and not form part of the local Healthwatch contract.

A review of the Healthwatch Leicestershire management accounts for the initial term (2013/16) raises some areas for further examination and discussion with the Voluntary Action LeicesterShire finance lead:

- Figures are presented in a different manner in the management accounts to the original tender proposal; this makes an analysis of proposed versus actual difficult.

- Definitions are unclear.

- Income does not match the contract value as provided by the local authority or the figures provided to Healthwatch England for their annual local Healthwatch income reports. Income from 'external contract for delivery' is not clearly listed.

Some Healthwatch Leicestershire Board members voiced concerns about the lack of transparency and control that the Board have over the Healthwatch Leicestershire budget. As a subsidiary within a larger organisation, the Voluntary Action LeicesterShire Board is ultimately responsible for the Healthwatch Leicestershire budget. Board members reported that this two-tier governance structure provides challenges for the Healthwatch Leicestershire Board in terms of planning and maintaining the strategic direction of Healthwatch Leicestershire and could be seen as a barrier to independence by-proxy.

A number of key stakeholder interviewees raised questions about the high costs of a city centre location and the management costs of VAL.

Healthwatch Leicester City reported more control of their finances and better value for money following a move from being a commissioned function within an existing organisation to a freestanding organisation.

Rutland County Council spend considerably more than their grant allocation on their local Healthwatch organisation (ranked first in Healthwatch England's local Healthwatch spend documents from 2013/14 to 2015/16).

Recommendations

- Whilst further cuts to provision might be necessary (for example, as a result of reduction in central Government LRCV grant allocation or local authority spending and sustainability reviews) the focus should be on improving value through efficiencies and effectiveness (listed throughout this review).

- Focus on a strengths-based approach to service delivery by ensuring the public are part of the process in terms of managing their own health and care rather than being a passive voice guided by professionals (refer to section on co-production).

- Request more detailed Healthwatch Leicestershire accounts from Voluntary Action LeicesterShire in order to undertake a proper analysis of overheads.

- Open conversations with Healthwatch Leicester City commissioners to understand in more detail the cost implications following re-commissioning of their local Healthwatch.

Income Generation

National Steer and Other Areas

Whilst there is no reference to income generation within national Healthwatch legislation it can be inferred from the requirements related to organisational form – body corporate and social enterprise – that profit making activities outside of the core local Healthwatch functions are encouraged as social enterprises aim to fund their social mission through 'trading activities' (as opposed to a registered charity that traditionally aim to fund their social mission through grants and donations) and reinvest the majority of their profits in doing social good (Social Enterprise UK, 2016).

In conversation with the review team, Healthwatch England reported that they are producing guidance on income generation that will be available in the near future. It will include recommendations that:

- The local Healthwatch organisation must ensure that delivery of the core statutory duties remains the priority for the organisation. This means that additional work will probably result in the need for extra capacity in the team and with full awareness of any possible conflict of interest.

- The quality of the work must be high and improve the status and standing of Healthwatch.

- Findings must be presented to Healthwatch England and not solely shared with commissioner of the work.

Across the nation, income generation activities are seen as a way to stem the loss of funding incurred by local Healthwatch organisations in recent years as a result of national and local cuts, although the level of reliance on this varies greatly. There is consensus amongst the other local Healthwatch commissioners spoken to as part of this review, in that:

- Income generation activities are encouraged but must support the main objectives of the local Healthwatch organisations and add value to the wider health and social care system.

- Income generation activities must improve reputation and reach.

- Funding from income generation activities must allow for additional capacity to deliver the activity in addition to a worthwhile amount of profit (whether this be financial, reputational or in the realm of skills development and expertise).

Examples of income generation activities undertaken by local Healthwatch organisations in other areas include:

- Delivery of training

- Seeking views of specific groups

- Research projects (including formal research with local universities)

Those areas that are successful in attracting additional funding tend to be those local Healthwatch organisations with strong relationships that are seen as experts in their field.

Whilst the benefits of widening activity are that the organisation will have more certainty over several income streams, and therefore a more sustainable future, two potential conflicts were identified through our conversation with other local Healthwatch commissioners including:

1. Where the activity is commissioned by a health and social care provider clear lines must be drawn between the role of a local Healthwatch organisation as a consumer champion (relationship: a critical friend) and that of a supplier of traded services (relationship: supplier and customer); and

2. Where a local Healthwatch organisation is a procured function within an existing organisation, it is the overarching provider that would undertake the additional activity, allocate workforce to deliver the project accordingly and earn the profit – unless the local Healthwatch is managed at arms-length and therefore responsible for its own workforce and accounts.

Local Findings

As per the current Agreement (AGREEMENT NO CO doc 15 03 13 doc 20 06 13):

> *"5.2 In addition to the DH grant for Healthwatch Leicestershire functions, Healthwatch Leicestershire will be able to generate income and spot purchase additional work from other sources in return for payment."*

During 2015/16 Healthwatch Leicestershire received £8,000 from the Better Care Fund for the Stimulation to Evaluate Great Care collaboration project with Loughborough University and the local authority.

Healthwatch Leicester City may be considering developing a trading arm to deliver services to private companies.

Recommendations

- As with the current contract the service specification should encourage income generation activities that support the main objectives of the local Healthwatch organisations and add value to the wider health and social care system, improve reputation and reach, and allow for additional capacity to deliver the activity in addition to a worthwhile amount of profit.

- Where income generation is considered by the local authority to be a necessary supplement to core funding, the local Healthwatch organisation will need to ensure its business plan contains robust and proactive aims to explore opportunities with health and social care partners, local priority settings and local universities. Partnership working with other local Healthwatch organisations, to leverage expertise and present a more attractive offer to customers, should also be explored.

- In order to benefit from income generation activities, Healthwatch Leicestershire must be a freestanding organisation or an arms-length subsidiary within a larger organisation that controls its own workforce / capacity and accounts.

FINDINGS / ORGANISATIONAL

Governance

National Steer and Other Areas

The type of body corporate Healthwatch is will dictate to a certain extent how it sets up its governance structures. In order to be independent, accountable (to the commissioning authority and general public) and credible, the right balance of representation and skills is critical.

A national event convened in March 2012 by the Department of Health demonstrated that it is essential that all key players understand the role of Healthwatch and its independence. The need to ensure robust governance arrangements are put into place early to allow Healthwatch to participate effectively with authority and credibility was highlighted as a key deliverable for local authorities responsible for setting up Healthwatch. A clear skills and competency framework for Healthwatch was identified as one method for demonstrating a credible organisation fit-for-purpose.

The Local Government Association (2012g) outlined the minimum governance structures that a local Healthwatch organisation, as a corporate body, must have. This included:

- A membership (which owns the organisation either as shareholders or as members)
- A governing body or board or management committee (the actual name does not matter)
- A chair of the governing body or board (who is normally a non-executive director)
- Additional directors, both executive and non-executive (in the case of charities, trustees are (non-executive) trustee directors)
- An audit committee chaired by a director other than the chairperson, at least one member of which should have relevant and recent financial experience
- An annual report (which the HSC Act 2012 requires to be sent to the NHS Commissioning Board, relevant Clinical Commissioning Groups and Healthwatch England)
- Annual accounts audited and sent to members

- Any other requirements laid down in forthcoming regulations from the Department of Health (e.g. a requirement to obtain a licence from the Care Quality Commission to use Healthwatch branding).

Local Healthwatch Organisation's governing bodies will also be expected to conform to the Nolan principles of standards in public life. As they provide public functions, they will have duties under the Equality Act 2010 and the Freedom of Information Act and safeguarding responsibilities when they come into contact with vulnerable adults and children.

The Local Government Association states, in their document on effective local Healthwatch organisations (2012a), that:

> *"Good governance and management arrangements are required to be in place, including processes to maintain robust accounts of how local Healthwatch has used its funds."*

Nationally there is a wide variation in how local Healthwatch organisations are governed and how roles and responsibilities are carried out. Some of the transitional arrangements (from being part of another organisation to being independent) resulted in lack of clarity and disagreement about roles. Local Healthwatch organisations need to be representative of the public, not dominated by individual voices and retain independence as a core value. Some governance arrangements can pose a risk to independence e.g. when there is indistinct delineation between the board of local Healthwatch organisations and its specific responsibilities and that of any hosting organisation, or lack of clarity about the process of work planning, with undue influence from certain partners.

Governance is a formal role and board members require the skills and expertise relative to the duties of the board to ensure due diligence. Some local authorities have decided that the commitment involved for members of local Healthwatch organisation governing bodies requires remuneration, others have decided that being a member of a local Healthwatch organisation governing body is analogous to being (and in some case will actually be) a trustee of a charity and should not, therefore be remunerated, except for expenses or with the consent of the Charity Commission. The Local Government Association (2012g) states that:

> *"A remuneration structure for key board members attracts high calibre people, recognises the importance of new arrangements and drives performance."*

Local Healthwatch organisations appear to have benefited from aligning work plans and allocating clear roles. Sharing learning across local Healthwatch organisations is important in order to prevent constantly reinventing the wheel.

Local Healthwatch organisations rely on building partnerships with local stakeholders, with close relationships with providers, commissioners and third sector organisations, which may be involved in varying degrees to disseminate materials, undertake engagement work or facilitate scrutiny. In

some areas local Healthwatch organisations have been commissioned by local stakeholders to undertaken pieces of work. Some organisations expressed concern about undue influence over the focus of findings of work that local Healthwatch organisations are contracted to do by others.

Very few local Healthwatch organisations have active participation of the public at board level. Some did not publish board minutes or allow for independent scrutiny of the operation and activities of the local Healthwatch organisations. One expectation of social enterprise organisations is that they have appropriate representation from key stakeholders e.g. the public and provide mechanisms for those with specific interests and views to contribute.

Local Findings

The Healthwatch Leicestershire Board is a recommendation-making board (with representation from Voluntary Action LeicesterShire) that reports to the Voluntary Action LeicesterShire trustee Quality Subgroup. The Healthwatch Leicestershire Board – which consists of 12 members, some elected, some co-opted – focuses on running Healthwatch Leicestershire whilst Voluntary Action LeicesterShire maintains budgetary control and final decision-making. Some Healthwatch Leicestershire Board members voiced concerns to the lack of control that they have over the budget as this provides challenges in terms of planning and maintaining the strategic direction.

The feedback we received from staff, board members and stakeholders was very positive in relation to the current Chair of the Healthwatch Leicestershire Board, in particular his high profile and effectiveness in the role. Numerous people stated that the Chair should be financially rewarded to reflect the level of responsibility and time the role requires. Interviewees also suggested that should there be a change of Chair in the future, the role would need to be remunerated to attract the right calibre of candidate. The role of chair of the Healthwatch Leicester City Board currently receives £7,500 per annum.

Recommendations

- Where Healthwatch Leicestershire is commissioned as a function within an organisation (as opposed to a freestanding or hosted organisation):
    - Healthwatch Leicestershire would benefit from increased clarity and transparency about board arrangements with clear water between the local Healthwatch organisation and the organisation that holds the contract;
    - The Healthwatch Leicestershire Board should be fully accountable for the governance of Healthwatch Leicestershire with financial control and strategic management.
- To ensure effectiveness Healthwatch Leicestershire must have an effective governing board, with members with diverse interests and experience who have the right skills and time to

invest (including in legal and financial management) and who become connected to local key stakeholder groups to ensure they engage and influence organisations.

- The roles and responsibilities of the board members and officers should be clearly defined, with a clear process in place for decision-making and reporting.

- The membership, skills and engagement of the Healthwatch Leicestershire Board membership, should be reviewed (internally) on a regular basis.

- Reviewing if representing public views and independence are compromised should be on going. This can be achieved in part by assessing how priorities are determined and how impact is achieved.

- Any conflict of interest should be declared and discussed, with policies and procedures outlining how to deal with emerging issues and tackle the cause of conflict in place.

- The Chair of the Healthwatch Leicestershire Board should receive remuneration for their role at a similar level to that of the Chair of the Healthwatch Leicester City Board.

Increasing Capacity and Prioritising Work

National Steer and Other Areas

Local Healthwatch organisations are small in comparison to the potential scope of their statutory activities, with staffing being the greatest limiting factor on activity. Building networks and establishing agreements with other local voluntary and community sector organisations, to extend their reach and piggy backing on to activities other organisation, can increase capacity. All local Healthwatch organisations in the King's Fund (2015) study had to prioritise their operational activity.

Volunteering is an important way to increase the effectiveness of local Healthwatch organisations at a board and operational activity level. Board members can represent Healthwatch at other board meetings, where a level of seniority is required. Board members may also steer operational activities of the team. Volunteers can support delivery of outreach work, for example carry out 'Enter and View' visits to settings. They need support and training to undertake specific task and skills and to ensure they deliver with impartiality. Local Healthwatch organisations report that often general volunteers and board members are willing to be involved in an area they have particular interest in, but are less willing to support general work of the organisation (for example engagement) as a whole.

Prioritisation of work is an important area to get right. A range factors determine which service a local Healthwatch organisations focuses on such as:

- Analysing public feedback to identify common issues of concern;
- Specific consultation with members of the public about priorities;
- Internal organisation discussions to focus on particular groups;
- Assessing key local strategic documents to identify gaps and opportunities;
- Choosing to influence existing work streams of local system partners;
- Being directly asked or commissioned to do pieces of work;
- National concerns including those raised by HWE.

The Local Government Association (2012i) suggest that local Healthwatch Organisations will want work plans to reflect, to some extent, the priorities identified in the Joint Health and Wellbeing Strategy and in the Clinical Commissioning Groups' and local authority's commissioning plans. A local Healthwatch organisation can use its own intelligence networks to feed into the direction of travel of these plans and influence future developments. In addition, having a formal local Healthwatch communications and engagement strategy, that links in with the Health and Wellbeing Board and other Boards' relevant strategies is of benefit to local health and social care planners.

With such a range of potential work, explicit conversations about priority setting are important. One criteria should be to define the unique contribution that local Healthwatch organisations can make. This may be to focus on areas not covered by other organisations. National research showed that local Healthwatch organisations are seen to be more effective by partners if they feel they understand why Healthwatch has chosen the priorities it has.

Local Findings

Volunteering and Membership

Overall volunteering in Healthwatch Leicestershire is used in a limited way, with the key activates for volunteers being Board member and to undertake Enter and View activities.

Healthwatch Leicestershire's website states:

> *"Anyone who has an interest in local health and social care services, and who wants to make sure the needs of their community are listened to, can join and get involved.*

Subscribe to our Monthly E-Newsletter, take part in online consultations and surveys and submit your questions for our quarterly meetings with Chief Executives of Health & Social Care Services.

Becoming a member of Healthwatch Leicestershire means having a stronger voice to influence and challenge how health and social care services are provided locally.

Our members are kept up to date with the latest health and social care news, events and consultations as well as representing local people at health and social care meetings."

Depending on the level of membership you choose, Healthwatch Leicestershire members are able to:

- Receive information about health and social care services, events and activities;
- Give views and opinions on health and social care services;
- Raise awareness of Healthwatch Leicestershire in the local area;
- Represent the public voice on boards and at meeting;
- Enter and view health and social care services.

The Director of Healthwatch Leicestershire states that there are around 2,700 Healthwatch Leicestershire members. During this review we asked 2,008 members to complete a survey online and via mail – 85 people completed the survey.

When asked, "What do you understand the purpose of Healthwatch Leicestershire to be?" only 18 responses mentioned social care, the remainder of the responses focusing on health issues.

This finding aligns itself with the national position where the Local Government Information Unit (2012) noted in their May 2012 Briefing: Update on Healthwatch that:

"It is unfortunate, therefore that the name of Healthwatch does not reflect its responsibilities locally and nationally in relation to social care. It is clear from a number of reports on LINks that these organisations have struggled to maintain an interest among members in social care issues, despite the fact that many such members are among the older section of the population whose social care needs are most in need of an urgent response and who would most benefit from prioritisation, locally and nationally, of social care issues. It is hard to believe that people not already familiar with the system would turn to an organisation called "Healthwatch" for information on social care. Local authorities will have their work cut out to

support local Healthwatch in giving weight to the social care aspects of their work, particularly in light of the potential conflict of interests in this area. It may be that the on-going cuts to social services will galvanise the newly-formed local Healthwatch organisations, but it is unfortunately more likely that, like their predecessors, they will focus on more visible NHS services."

One Healthwatch commissioner from another area singled a lack of focus on social care services as a particular issue with their current provider and had subsequently revised their service specification accordingly to ensure the right balance of activity moving forward.

When asked, "What level of involvement do you have as a Member of Healthwatch Leicestershire?" 83% said their involvement was information only (receive eNews, take part in online surveys). 13% said their involvement was occasional (1-2 hours per month, attendance at consultation events, supporting engagement and signposting). 5% said their involvement was regular (significant time commitment, interested in representative / leadership role). A number of members shared that they would like to be more involved with Healthwatch Leicestershire i.e. "would like more, but no-one from Healthwatch had ever contacted me or asked if I would be interested".

When asked, "Why did you become a member of Healthwatch Leicestershire? Please tick as many boxes as are relevant." 72% of respondents chose "To ensure the voice of local people influences local service planning and delivery".

When asked, "What involvement have you had with Healthwatch Leicestershire? Please tick as many boxes as are relevant." 91% said they "Received updates about health and social care news". 62% said they had "Given views and opinions about health and social care services". 16% said they "Raised awareness of Healthwatch Leicestershire in the local areas" for example:

"Taken leaflets to local GP surgeries in my area on Healthwatch items, and also given details to GPs in my own practice"

When asked, "Do you think that you are kept up-to-date about Healthwatch Leicestershire's plans and activities?" 64% of respondents answered "Yes". 18% of respondents answered "No". 18% of respondents answered "Don't know". A number of people suggested that they would like more information, for example one person commented:

"Yes to some extent but newsletters are infrequent and quite light on content"

When asked, "What messages would you give Healthwatch Leicestershire in order to ensure that it makes a more powerful contribution in the future?" We received a wide range of responses, some of which are included below:

"Talk to more patients – do not see anything about it in GP surgeries."

"More seminars with proof of changes in NHS and GP surgeries, hospitals."

"Improve communications with members. More transparency about how Healthwatch operates and what they are doing."

"Keep listening, and try to reach out more in the communities, by other means! (Free Papers & Local Free Publication of an area)."

"More specific issues, less generalised health strategies etc."

"Get yourself known in the area, my guess is that not many people have heard of Healthwatch or what it does."

"Continue to collect evidence and present to commissioners, ensure providers involve patients and public in planning delivery, continue to provide scrutiny, recruit more able volunteers, seek an increase in funding."

"Get a facebook page. Put more articles in the local newspapers. Always respond to questions submitted via email rather than ignore them."

"Be seen to work with other Healthwatchs."

"Involve users and help them present their views. Don't do work for the CCGs and Health Trusts. Don't become part of a complaints process."

"It needs to be more visible – many of my colleagues are not aware of its existence, let alone what it does – and I work in the health sector!"

Under 8% of responders of the online survey were younger than 45, 39% were over 65, suggesting that the Healthwatch Leicestershire membership does not represent the younger population. Less than 11% of responses were from people from minority ethnic communities.

Based on the responses received it can be inferred that members are unclear of Healthwatch Leicestershire's remit (especially in relation to social care) and that more should be done around awareness and marketing both with members and the wider public.

<u>Collaboration</u>

Collaboration between local Healthwatch organisations and voluntary and community sector organisations is essential in maximising capacity and engaging the public. This is a sentiment echoed throughout our interviews with Healthwatch England leads as well as key stakeholders.

Very few examples were received of effective joint working between Healthwatch Leicestershire and neighbouring local Healthwatch organisations. Examples of difficult relationships between key people in local Healthwatch organisations across Leicester, Leicestershire and Rutland were provided to the review team.

Some good examples of joint planning and implementation of work between Healthwatch Leicestershire and local authority officers / Clinical Commissioning Group leads.

Healthwatch Leicester City and Healthwatch Rutland commissioner leads were approached as part of this review and are keen to meet and plan future provision. This is an important opportunity as each areas population are often talking about the same services (notably University Hospitals of Leicester NHS Trust and Leicestershire Partnership NHS Trust).

> *"I talk to people all of the time who complain about Healthwatch Leicestershire… the people at the top not talking to each other and the three Healthwatches not exchanging information because one can't work with the other."*

Partnerships working needs to be at strategic and operational levels.

Prioritising Work

Healthwatch Leicestershire use most of the mechanisms listed above (in National Steer and Other Areas) to determine local focus.

There is a question from partners and stakeholders about how Healthwatch Leicestershire prioritises their work or how to get Healthwatch Leicestershire to contribute or lead on a piece of work locally. If this is always prioritised by local independent feedback from the public, partners are not aware of this and it seems like there are some examples where this is not the case.

The Healthwatch Leicestershire 2015/16 Annual Report (pg.6) echoes this view and reports that:

> *"Not everyone understood the rationale behind Healthwatch Leicestershire priorities and in order to overcome this we need to be clearer on how we develop and communicate this."*

To determine priorities for 2016/17 Healthwatch Leicestershire undertook a survey to look at which area of health wellbeing and social care their members and the wider public consider a priority. Of the feedback received, 189 came from members and 212 came from the general public. Survey findings were cross-referenced with previous evidence and insights. The issues to emerge from the survey were the need for GP practices to inform patients about their appointment service and how to access care, the need for patients, families and carers to be equipped with information about the type of support available to them, better promotion of healthcare services with better informed

patient, carers and families, and targeted work around specific vulnerable groups to ensure healthcare is accessible for all.

Recommendations

Volunteering and Membership

- Increase the volunteering function and have a clear volunteering programme that will add skills and capacity to the organisation.

- Undertake local systematic mapping to identify voluntary and community sector organisations and other statutory organisations that provide services that overlap with the statutory functions of local Healthwatch i.e. signposting, information and advice.

- Work in partnership with the identified organisations to support the collection of views / experiences from a wider range of people (including hard to reach groups).

- Healthwatch Leicestershire to send out information to members clarifying their role and remit as independent consumer champion for health and social care.

- Healthwatch Leicestershire to review how they communicate with members (frequency and content).

- Healthwatch Leicestershire to consider ways to increase their public profile with limited cost e.g. information in GP surgeries, hospitals, in free magazines / newspapers.

Collaboration

- Joint work with neighbouring local Healthwatch organisations would ensure better value for money and greater efficiency / effectiveness across Leicester, Leicestershire and Rutland. This could happen in a variety of ways, either through joint commissioning or partnership working so that backroom functions, delivery methods, work themes etc. are aligned.

- There are existing mechanisms and duties for involvement elsewhere in the system, and other systems for consultation, monitoring, peer review and inspection. A Memorandum of Understanding between Healthwatch Leicestershire, Healthwatch Leicester City, Healthwatch Rutland, and health and social care commissioners / providers can help to clarify roles and allow for the combination of efforts and avoidance of duplication.

- A planning / communication meeting should take place with other local commissioners and contract leads.

Prioritising Work

- Create a policy describing how Healthwatch Leicestershire priorities are decided on. Circulate this to partner organisations in health and social care with wider availability on the Healthwatch Leicestershire website and social media accounts.

- Develop a Healthwatch Leicestershire Communications and Engagement Strategy that links in with the Health and Wellbeing Board, and other key partner, strategies. The Local Government Association documents Establishing Local Healthwatch: Engaging with the widest range of local people (2012f), Establishing Local Healthwatch: Engaging with children and young people (2012e) and Local Healthwatch: Engaging service users and the public – the role of local authority executive members (2012l) provide guidance on what an effective engagement strategy must include.

FINDINGS / STATUTORY FUNCTIONS

Strategic Context and Relationships

National Steer and Other Areas

The King's Fund report (2015) outlines that balancing the 'critic' and 'friend' role is an on going challenge for local Healthwatch organisations. Different organisations adopted different models of operation, favouring either an independent public voice rooted in the community or strategic local partner working in the system.

In its series of briefings on establishing local Healthwatch, the Local Government Association provides a series of considerations on strategic context:

The role of the local Healthwatch representative on the Health and Wellbeing Board is to provide an effective, authoritative, credible and influential voice for service users, the general public and the community and voluntary sector. Local Healthwatch will be a position both to present evidence-based views on services (rather than the individual views of the local Healthwatch representative) to the Health and Wellbeing Board and to present and explain the Health and Wellbeing Board's views to service users, the public and the community and voluntary sector (LGA, 2012k).

It is important for local Healthwatch organisations and Safeguarding Boards to understand each other's role and how they can support each other, for example through the provision of statistical information by local Healthwatch organisations aggregated from experiences of members of the public to assist the preventative work of Safeguarding Boards (LGA 2012d).

The Enter and View function is not the only way in which local Healthwatch can have an influence on the quality of care. Nevertheless it is seen as an important way of gathering information and developing experience in how care is delivered in different settings. Any representative of local Healthwatch who is undertaking enter and view visits or representing local Healthwatch at the Safeguarding Adults Board must have good awareness of the Council's (multi-agency) safeguarding procedures and how to use these procedures and protocols to make referrals and seek information (LGA, 2012d).

It is important to ensure that people coming to local Healthwatch with a complaint or needing someone to advocate on their behalf are referred to advocacy and complaints services in a supportive and timely way. Statistical information about the pattern and number of complaints will also need to be shared so as to feed into discussions about how services could be improved (LGA, 2012d).

Local Healthwatch organisations should be involved in the on-going development of Joint Strategic Needs Assessments which should draw on evidence gathered by local Healthwatch organisations and provided by public about the personal experiences of patients, service users, their families and carers (LGA, 2012d).

Relationships and trust are said to underpin the success of many local Healthwatch organisations and should not be underestimated (Regional Voices, 2012a and interviews with local Healthwatch commissioners). Building relationships takes considerable time and effort but is achievable through open, honest and timely dialogues.

> *"Strong relationships with statutory partners, other departments within the local authority, elected members, the health and wellbeing board, clinical commissioning groups, the third sector and voluntary organisations are equally important if Healthwatch is to be connected and provide a collective user voice."*
>
> (Regional Voices, 2012b)

Good relationships with Clinical Commissioning Groups, at both a strategic and an operational level are absolutely essential for local Healthwatch to do their job effectively as Clinical Commissioning Groups have control of most of the budget for NHS services (80 per cent) and therefore have the greatest opportunity to redesign services in a person-centred way for the benefit of patients and communities (LGA, 2012i).

Involvement with Patient Participation Groups or Patient Reference Groups at GP practice level will be an important source of intelligence for Local Healthwatch Organisations on the quality of primary care services. As primary care is commissioned by NHS England, influencing commissioning of primary care will require developing a good relationship with NHS England (LGA, 2012i).

The Local Government Association indicated that local Healthwatch organisations need to build relationships with district councils. This is to ensure mutual support in community engagement, as district councils have their own strategies and networks for engaging with local residents. This includes links with third tier local government and neighbourhood / community structures and parish councils. Local Healthwatch organisations are required to "work closely with democratically elected district and parish councils and other regional Healthwatch organisations to ensure high quality feedback and research" (LGA, 2012j).

Borough councillors can use their neighbourhood structures and their knowledge of communities at a very local level to support the work of Local Healthwatch. They can also draw on the work of Local Healthwatch as an additional source of intelligence about the concerns of their residents, ensuring that these are fed back to health and social care commissioners and providers and that action is taken, thus enhancing their role as community leaders (LGA, 2012n).

It will be helpful for health and social care commissioners and local Healthwatch organisations to consider how they will formalise their relationship so that all stakeholders understand it. This could be by a written Memorandum of Understanding (MoU), partnership agreement or protocol, which could include a common understanding of how the local Healthwatch organisation will respond to proposed substantial variations in services (LGA, 2012i).

The commissioner of Healthwatch East Sussex was clear that their local Healthwatch organisation's success as an adversary and agitator within the system is due to the strong and mature relationships they have with their partners. These key relationship must be in place to ensure scrutiny is seen as a deliberate not as an adversarial process (a 'critical friend'). Healthwatch East Sussex's strong relationships are maintained in part through delivery of a well-received and well-functioning Healthwatch Advisory Group that enables the commissioner to step back from the contract, creating a positive space for the local Healthwatch to move in. The Healthwatch Advisory Group is a quarterly meeting attended by the key players in their health and social care sector, for example directors of commissioning / provider organisations and neighbouring local Healthwatch organisations (West Sussex and Kent in this instance). Attendees use the meeting for the purposes of horizon scanning and ensuring that information and intelligence is shared at an early stage enabling Healthwatch to undertake its duties effectively. This reduces the amount of individual meetings attended by a local Healthwatch representative and the key health and social care players, freeing up capacity to deliver other functions.

Local Findings

Overall, stakeholders reported that Healthwatch Leicestershire staff and representatives have good strategic relationships, however there was less certainly about the impact of those relationships, with a range of views shared. The Healthwatch Annual Report 2015/16 outlines that Healthwatch Leicestershire representatives sit on many groups and boards as well as taking their statutory place on the Health and Wellbeing Board. Strategic leads valued the challenge role of Healthwatch Leicestershire and saw the importance of a relationship of independence to feed in the views of communities and acting as a critical friend.

So far, Healthwatch Leicestershire has focussed on developing relationships with the Clinical Commissioning Groups (CCGs) along with the University Hospitals of Leicester NHS Trust (UHL) and Leicestershire Partnership Trust (LPT). Healthwatch Leicestershire staff reported they have yet to develop strong relationships with the appropriate Voluntary and Community Sector organisations i.e. those representing seldom-heard user groups.

Some Healthwatch Leicestershire members and partners posed a question about how effective Healthwatch Leicestershire can be in changing plans and making a difference strategically.

Some stakeholders find the quarterly meetings with the Healthwatch Leicestershire Director very useful, however some found it less useful, with the focus being on individual cases rather than key themes.

The quotes below outline a range of views obtained:

> *"CCGs are big beneficiaries from Healthwatch"*
>
> *"Healthwatch (Leicestershire) are excellent partners and are definitely 'round the table'"*
>
> *"There is too much focus on people going to meetings"*
>
> *"Reps at our strategic meetings are sometimes too corporate"*
>
> *"It would be great if the local Healthwatch organisations could do more work together at a strategic level"*

Recommendations

- Effective strategic relationships between Healthwatch Leicestershire and service commissioners, providers, other local Healthwatch organisations and the voluntary and community sector must continue to develop. Healthwatch Leicestershire require skills at board level to ensure focus on this area. If the public know these relationships are in place it will help them to understand that giving views to Healthwatch Leicestershire is one mechanism to shape local services.

- Healthwatch Leicestershire are required to maintain effective relationships with key partners including local health and social care commissioners, safeguarding boards, NHS England and district and borough councils. This can be through formal and informal communication.

- The critical friend role is important and needs to continue, which may at time be uncomfortable and lead to interpersonal and professional tensions. Board members may require training and support to ensure they have skills to manage these tensions whilst maintaining relationships.

- Policies and operating procedures should be available to ensure Healthwatch Leicestershire representatives have consistent approaches to managing strategic relationships and understand their roles, responsibility and accountability. It would be helpful if these were shared across neighbouring local Healthwatch organisations (Leicester City and Rutland) to ensure a consistent approach.

- Mechanisms such as memorandum of understanding, partnership agreements or protocols can help increase understanding or roles and responsibilities and improve partnership working.

- Consider developing a Healthwatch Advisory Group in a similar form to that of East Sussex. These could be regular meetings attended and led by local Healthwatch leads from Leicestershire, Leicester City and Rutland, with participation from directors of partner organisations. The purpose is not to advise local Healthwatch organisations on what projects to undertake but for horizon scanning – an examination of provider intelligence and information to identify potential or emerging issues and opportunities within the health and social care sectors.

- To ensure maximum impact partners must consider involving Healthwatch Leicestershire in strategic decision-making at an early stage in any project or process.

- Enhanced strategic collaboration between the three local Healthwatch Leicestershire organisations is required.

Community Voice

National Steer and Other Areas

The King's Fund report (2015) outlines that this activity focuses on enabling local people to directly monitor the standard of provision in local health and social care services and bringing together the views of local people into an evidence-based position and making reports and recommendations about how services could or should be improved.

Four approaches predominate:

- Proactively seeking views through a range of activities including attending community events, conduction surveys, focus groups.

- Providing reactive mechanisms for people to provide their views, such as drop in sessions, feedback forms, comment cards.

- Incorporating intelligence gathered from local VCS organisations, including those who act as host organisations.

- Accessing other data that already exists, such as published survey results and local and national stories.

The New Economics Foundation (NEF) was commissioned by the Local Government Association to support the development of practical guidance and learning materials. In their report How can local Healthwatch tackle health inequalities (2013), they state that residents say they want engagement with local Healthwatch to be:

- Local: led by people who come from the area.
- Broad and proactive: involving many people in a range of different ways
- Communal and accessible: so people want to take part
- Meaningful and empowering: about interesting, important topics and providing avenues for action
- Reciprocal and supportive: drawing on and investing in volunteer skills
- Challenging: transforming the way service providers think about their work and people they serve

In their report on Shaping Local Healthwatch, Patient Public Involvement Solutions Ltd (2012) state that there was a view that local Healthwatch organisations should develop into a hub of community engagement and a centre of excellence for community engagement helping to reduce the duplication of effort by health and social care of consultation and engagement activity, by co-ordinating local intelligence and preventing 'consultation overload'. Additionally, that engagement with local people needs to underpin everything local Healthwatch organisations do:

> *"It needs to be reflected in the founding principles and stated values, the governance and membership, the organisational culture, the voice of those who speak for local Healthwatch, the accountability of local Healthwatch, its objectives, strategies and priorities, the way it measures and evaluates its own performance and the way it evaluates the performance of others."*

The Local Government Association (2012f) outlines that:

> *"Local Healthwatch will only be effective in improving services from the point of view of service users and the communities it serves, if it is embedded in and engages with those individuals and communities at different levels and in different ways."*

In recognition of the specialist / specific framework under which children's social care services are provided and monitored, and the sensitive environments in which such services often operate e.g. for children in care, Healthwatch does not use its powers of entry to visit premises that provide social care to children and young people such as children's homes or foster care. In light of this, local

Healthwatch *"needs to develop [other] strategies for effectively involving children and young people, particularly those who are most disadvantaged"* (LGA, 2012e).

The Local Government Association (2012e) is clear that children and young people should be involved in the development of their local Healthwatch priorities and plan to ensure adult issues do not dominate the agenda. They should be well represented in Local Healthwatch membership, governance, representative roles, seeking views and providing advice and information. In addition, all spokespeople should be sufficiently knowledgeable to speak on their behalf.

The Local Government Association document Establishing Local Healthwatch: Engaging with children and young people (2012e) provides a number of options on how to involve children and young people.

The Healthwatch England team suggest there is confusion about some elements of seeking views. For example the aim of Enter and View is not an inspection but to seek the views of patients and carers when they cannot be seen in their own home. Some areas do not provide this function, and some do not follow-up the Enter and View following the publication of their findings report and recommendations. Healthwatch England reported that if done badly, this area could damage the reputation of the local Healthwatch organisations.

Views can be gathered opportunistically, about provision in general or through more proactive approaches, for example as part of an explicit research project. Some local Healthwatch organisations provide support and influence others to ensure that their processes for consulting and engaging the public are working well. Activities that involve reaching out and engaging directly with the community were seen to be particularly effective. This approach was seen to be valued in ensuring collection of a wide range of views that were not influenced by a particular perspective. Surveys and focus groups were also noted for being able to guide information collection. Some local Healthwatch organisations focus on supporting seldom-heard groups to share views on services.

Information gained can be ratified and presented in several ways. The most common approaches are to either collate individual feedback into summary statistics, with some scanning of feedback for themes. Some local Healthwatch organisations report all feedback to providers. Views and experiences may also be shared through discrete projects focussed on particular issues. Some local Healthwatch organisations use evidence from multiple sources to build a volume of evidence and some present evidence but not recommendations in reports. Some local Healthwatch organisations acknowledged that they collect too many disparate views on an issue to create evidence, and systematically identifying trends and collecting corroborating data was an on-going challenge. Some local Healthwatch organisations reported frequently facing challenge and criticism for having small and unrepresentative sample sizes or using anecdotal information. There was a wide range of views on what constitutes evidence.

Nationally reports were often presented as evidence of impact, without evidence of commitment to actions as a result of the report. Reports only have real value if listened to and acted upon.

One key message from national documents and interviews with other Healthwatch commissioners is that, in general, the population are unaware of Healthwatch, its functions and the value it can offer as an independent consumer champion. Regional Voices (2012a) reports that more needs to be done both nationally and locally around brand awareness albeit with limited marketing budget or resources to achieve widespread success and truly reflect the community voice. A number of recommendations and suggestions were made to improve awareness, and therefore enable broader public engagement with a wider range of people, that included:

- Improve linkages with local voluntary and community sector organisations particularly those that work with and represent seldom-heard groups or those that provide functions similar to those of local Healthwatch i.e. the provision of advice and support around health and social care. Local systematic mapping might need to be undertaken to identify the appropriate organisations.

- Undertake a communications and public relations drive with the support of partner organisations assisting in the distribution of materials and collection of data. Communications from a local Healthwatch need to consider the language they use, both in the traditional sense given the diversity of Leicestershire's population and in the broader sense. Both the health and social care sectors (and sub-areas of those sectors) have their own languages that are not readily accessible to each other or the general population.

Local Findings

Healthwatch Leicestershire support people to share views and present findings in a range of ways including:

- Enter and View
- Community conversations
- Road shows
- Campaigns (healthy you happy you)
- Surveys

They use thematic reports and share individual feedback with providers through regular (quarterly) meetings. In addition, the 2015/16 Annual Report outlines that six other Healthwatch Leicestershire

reports were produced to provide insight into the patient perspective of the particular service they were scrutinising.

Healthwatch Leicestershire undertook five Enter and View projects in 2015/16.

A small number of stakeholders question the benefit and purpose of Healthwatch Leicestershire carrying out Enter and Views, one quote given was

> *"I don't mind if they come but what authority do they have? The CQC is the inspectorate."*

One Healthwatch Leicestershire staff member and several stakeholders commented that they have not been so successful in seeking the views of some groups, such as children. There seems to have been additional focus on this area recently with the Enter and View undertaken on the Child and Adolescent Mental Health Service (CAMHS) unit, the quick poll for under 18s on health services (where 55 Leicestershire residents responded) and the Listen to Me report, focussing on the views of 420 young people across Leicester and Leicestershire and delivered in June 2016.

We received a range of views about how well Healthwatch Leicestershire performs the function of gathering views from the public on health and social care services and use this information to influence service planning and delivery. There is a viewpoint that in relation to providing the public's voice they do this well and in a way it can be listened to. However on the other hand there is a view that not enough of this is done.

We received several plaudits for the quality of Healthwatch Leicestershire reports, which are easy to read and attractive. There is a view they add value to service development through feeding in the views of the communities they service in their work.

A range of comments are presented below.

> *"We need to move away from the 'you moan we react' approach (to gathering views)."*

> *"Health need to increase the involvement of members, limit the use of jargon, improve communications to members of the public, re-develop the website so that it is easier to navigate."*

> *"Healthwatch need follow up reports and recommendations to ensure impact."*

> *"Healthwatch need to listen and act on the thoughts of volunteers and the man in the street."*

> *"Healthwatch are doing a good job."*

"They could do more to make sure they get to people, don't see anything about them in GP surgeries."

"Need to make people more aware of your existence and work."

"Be clear about what you are going to focus on in the next 2 years."

"They keep saying hard to reach, seldom heard I would say, they're not hard to reach, they're not living on Mars. You can reach anybody. It's just getting into the community and getting to know them."

Recommendations

- Supporting people to share views and shape health and social care services needs to remain a priority for the organisation.
- Healthwatch Leicestershire need to be explicit about the process for seeking views and how it influences the prioritisation of work.
- Views must be collected and presented using established research methodology.
- There needs to be a clearly laid out planned programme of supporting people to share views, especially in rural areas and with seldom-heard groups. A range of innovative methods to seek views could be developed (social media, mobile units and pop-ups, developing links with e.g. community workers, community policing, locality area coordinators, elected members). These methods could then be promoted to ensure people are aware they can get involved and feed in their views to design services with maximum impact.
- Healthwatch Leicestershire must ensure it is representative of the communities it serves. One way to do this would be to review the membership demographics and actively seek involvement from under-represented groups.
- Healthwatch Leicestershire must ensure it is part of a strong and active network of community organisations, including the statutory sector, formal voluntary sector organisations and less formal community groups.
- Ensure children and young people are directly and indirectly engaged with Healthwatch Leicestershire and inform and shape services. There are a number of good practice guidance documents available from organisations including the National Children's Bureau on how to involve children and young people.

- One priority for the next contract is increasing the involvement of children and young people in the running and delivery of Healthwatch Leicestershire's core functions.

- There is an opportunity to use spaces to promote this function, e.g. reception at county hall, in newsletters that are developed by the local authority and district councils and in all health and social care settings.

- Developments need to be thought through alongside other mechanisms used to seek views, such as the Friends and Family test. Joined up thinking and planning will ensure that patients and the public are not confused and do not duplicate effort.

- Healthwatch Leicestershire could link with other health, local authority and local voluntary sector organisations to recruit and support young volunteers. They could then become the expert support to gather the views of young people through a range of innovative means.

- It would help local service planners and deliverers if Healthwatch Leicestershire were explicit about how they select locations for Enter and View, what the purpose is and to what extent recommendations will be followed up. If this is clearly agreed with providers it may relieve some capacity In the Healthwatch Leicestershire team.

- Healthwatch Leicestershire need to continue to market their vision, aims and objectives, and information about their statutory functions / remit to the general public. Partners must play a full and active role in the promotion of Healthwatch Leicestershire.

- Consider undertaking an audit of general population awareness of Healthwatch at the outset of the new contract to establish a baseline figure from which growth targets can be set throughout the duration of the new contract.

Influencing the Provision and Commissioning of Services

Making a difference locally

National Steer and Other Areas

As one of their 10 recommendations for successful local Healthwatch, Regional Voices (2012a) states that:

> *"Buy-in from NHS and social care commissioners and providers on the Healthwatch vision will help ensure Healthwatch is seen as an equal player around the Health and Wellbeing Board. It is essential that all board members value and recognise the role Healthwatch can play so it is not perceived as the 'junior partner'.*

This connection has been recognised [through Regional Voices own Supporting Healthwatch pathfinders: summary of snap survey findings 2012] as being critical to the accountability of Healthwatch and its ability to influence effectively."

The aim is that through membership on the Health and Wellbeing Boards, local Healthwatch organisations will be an integral part of the preparation of Joint Health and Wellbeing Strategies and Joint Strategic Needs Assessments, which form the basis of future local commissioning decisions.

The King's Fund (2015) suggest this activity includes:

- Influencing local health and social care providers.
- Influencing the commissioning of services through Clinical Commissioning Groups, Local Authorities and NHS England.
- Operating as a member of a health and wellbeing board.
- Sharing information with, and escalating concerns to, the Care Quality Commission.
- Sharing information and intelligence with Healthwatch England.

Local Healthwatch organisations do this in a number of ways:

- Ensuring the public voice counts during service change.
- Ensuring local providers demonstrate and justify that service provision meets local need.
- Providing feedback, raising concerns and holding providers to account for service delivery and accessibility.

Nationally, local Healthwatch organisations reported problems with influencing local decision-making because their evidence and work feeds into pre-existing organisations with the ultimate power to act or not act on evidence from local Healthwatch organisations. In general local Healthwatch organisations reported having more impact on influencing providers than commissioners. The practice of local public and community involvement in strategic decision-making continues to lag behind policy aspirations.

Nationally, the role that local Healthwatch organisations play in raising specific issues is said to be useful.

Taking part in committees and groups run by commissioners and providers is seen by local Healthwatch organisations as an important way to influence service improvement. They can do this through meetings or by commenting on provider consultations or quality accounts.

Sharing data and information is another way local HW organisations aim to influence providers. This may be on a case-by-case or through thematic insight reports. Some local Healthwatch organisations had information sharing and escalation protocols in place.

Overall, having good relationships was seen to be the best way to influence change. This was said by some to be easier with larger providers rather than small independent providers.

Local Findings

Overall, commissioning and provider stakeholders were positive about the potential for Healthwatch Leicestershire to influence service buying, planning and provision.

Healthwatch Leicestershire does appear to be making some impact locally. As well as examples provided in the 2015/16 Annual Report, partners gave several examples of work that had been informed, hastened and improved by the contribution of Healthwatch Leicestershire. Often this work will not be just down to Healthwatch Leicestershire, but a partnership response to the public's views, which may be fed to organisations through a range of means. For example in relation to the ophthalmology work, UHL upgraded this as a piece of work and it became a priority:

> "*Healthwatch are involved in the changes to A&E, with their perspective being useful*."

The timeliness of reporting was presented as an issue that affected the impact and influence of local Healthwatch organisations on the commissioning and provision of services. One commissioner commented that:

> *"The time lag of the work meant that by the time Healthwatch reported, we knew about the issue and had addressed the problem anyway."*

Some stakeholders reported respecting recommendations made in Healthwatch Leicestershire reports.

Healthwatch Leicestershire provided examples of where they have influenced the provision of local health and care providers in the 2015/16 Annual Report. Healthwatch Leicestershire does share information with the Healthwatch England and the Care Quality Commission, although evidence of this was anecdotal.

Several stakeholders commented that Healthwatch Leicestershire's thematic / insight reports are attractive and easy to read. Some reported problem with the way statistical data is presented (i.e.

the use of percentages on a small sample size), which at times can undermine the quality of reports and the impact they may have on influencing commissioning.

> *"They produce some really useful focussed bits of work."*

> *"They present information brilliantly with simple text and good use of infographics, these have an impact."*

Recommendations

- Increased joint work and collaboration with other local Healthwatch and voluntary and community sector organisations would ensure that influencing the commissioning and provision of services was more likely to happen.

- The council could support the work of Healthwatch Leicestershire, including the development of priority areas and increasing influence, by facilitating discussions about the statutory functions at council and the Health and Wellbeing Board.

- Healthwatch Leicestershire need consistency and rigor in the way they present information. This will mean reports have more impact and are more likely to influence the commissioning and therefore the provision of health and social care services.

- Partners need to include Healthwatch Leicestershire early in the planning cycle, e.g. in the commissioning intentions round and as key partners in Better Care Together and Sustainability and Transformation planning.

Informing People

Providing information and advice to people accessing services

National Steer and Other Areas

One function of a local Healthwatch organisation created by the Health and Social Care Act 2012 was the provision of an advice and information service to the public about accessing and choice in relation to health and social care services. Later policy documents also referred to a signposting service so the function should be described as advice, information and signposting.

> *"Enabling people to make informed choices is an important part of tackling inequalities in access to and provision of services […] There is always a danger that, where there are choices to be made, people who have had greater educational opportunities and / or experience of dealing with complex public services and finding their way round information systems will be*

at an unfair advantage over those with less access to information (for example because of the language they speak or lack of access to information).”

(LGA, 202b)

There is little national clarity of what the core offer of advice, information and signposting looks like, or the mechanisms by which it can be delivered. The Local Government Association (2012b) is clear that discussions with Clinical Commissioning Groups and the local authority (who both have a duty to provide information and signposting to residents) and voluntary and community sector services (that operate in a similar sphere) is hugely important in reaching a shared understanding of exiting information and signposting services to avoid duplication.

Guidance states that local Healthwatch organisations have an opportunity in explaining:

- How the system works.
- How different parts of the system relate to each other.
- Where people can get additional independent information and advice (for example specialist voluntary and community sector organisations).
- How they can take up issues both formally and informally if they are not happy with the services they receive (point the way to complaints and advocacy services)

During the establishment of local Healthwatch, the Department of Health Healthwatch Programme Advisory Group (DH, 2012b) made some practical recommendations that included:

“Make sure people can get information in different formats e.g. electronic, hard copy, Braille, preferred language translations.”

“Make full use of social networking tools to reach communities that are otherwise under-represented.”

The New Economics Foundation (NEF) was commissioned by the Local Government Association to support the development of practical guidance and learning materials. In their report How can local Healthwatch tackle health inequalities (2013), they state that information produced for residents should be:

- About people: based on peoples’ experiences not brushing over the heterogeneity of our area.
- Real: related to local places and services that we know about.

- ‘Top line’: tell us the main points and where we can get more information if we want it.
- Inspiring: tell us how to change situations for the better.
- Empowering: so we can work with the local authority to improve the situation.
- Plain speaking: taken out of public health jargon, into words that make sense to “my mum”.
- Memorable: information we can retell.

Few of the other areas spoken to as part of this review focused on signposting as part of their remit. Rather, their local Healthwatch organisations signposted other organisations that were better placed to signpost.

Local Findings

In the recent 360-degree feedback, of the competing statutory functions delivered by Healthwatch Leicestershire, this was the area least well delivered. As a result of this, the service has been focussing on this area. Healthwatch Leicestershire is a partner in the provision of the signposting directory of services. Overall stakeholders told us that informing people about local services is the area they think is least important, as other services provide this function.

The Healthwatch Leicestershire 2015/16 Annual Report states that (pg.19) there is a helpline / phone line. The service is open Monday to Friday 9-5pm, with a voice mail service 24/7 and an expectation that calls will be dealt with within 24 hours (not including weekends). In 2015/16 there were 325 enquiries. This function is not advertised because of budgetary constraints. 65% of contacts on the phone line were to do with accessing NHS dentists.

There had been some work with the adult Safeguarding Effectiveness Group about adult social care referrals that had come via Healthwatch Leicestershire – with a request for information from Healthwatch Leicestershire for information about what had happened to these referrals.

Recommendations

- Clarify the responsibility of local authorities in giving information and advice about social care services following the Care Act (2014). This is in order to make best use of resources and avoid duplication.

- Healthwatch Leicestershire is best placed to inform people about where to get up-to-date information and advice rather than to give direct information and advice. There are many other organisations providing this function.

- Healthwatch Leicestershire should direct people to make referrals to services (e.g. adult social care) rather than take referrals.

- Use existing directories of services, NHS Choices and link with Citizens Advice Bureau.

Relationship with Healthwatch England

National Steer and Other Areas

Healthwatch England is the overarching independent consumer champion for health and social care services.

There are several key aims of developing links between local Healthwatch organisations and Healthwatch England including:

- To learn from and share learning with other local Healthwatch organisations.

- To consistently share the views of local people at a national level.

- To become involved in national pieces of work including policy development.

Evidence and insight gathered by local Healthwatch is fed into Healthwatch England, using the Information Hub, enabling it to advise on the national picture and ensure that local views influence national policy, advice and guidance.

For local partners, the aim is that if an issue is escalated to Healthwatch England then this has helped the local health and social care system improve; local concerns are placed in a national policy context and the development of good practice is enhanced within both the local Healthwatch organisations and health and social care system.

Healthwatch England is an arms-length part of the Care Quality Commission, the national independent regulator of health and social care services. Recently there have been changes in the structure, management and leadership at Healthwatch England.

During our research we spoke to three members of the national team.

The Healthwatch Information Sharing Agreement can be found in Appendix 11. This document outlines working arrangements between Healthwatch England, local Healthwatch organisations and the Care Quality Commission, with the aim of identifying common themes, to improve joint working between local Healthwatch organisations and for the general sharing of intelligence, expertise, training and advice. Reports and information are accessible through the Healthwatch Hub, the database system where reports and information are deposited and accessible to enhance the sharing of fully anonymised and non-personal data and information.

Local Findings

Healthwatch Leicestershire report a good relationship with Healthwatch England They attend national conferences and are active members of the local network.

Healthwatch Leicestershire have taken part in national policy development, notably the development of the Local Healthwatch Quality Statements and using the quality statements for a 360-degree stakeholder review.

In August, Healthwatch England were planning to complete a new round of data gathering to enrich the understanding of local issues at a national level. Healthwatch England are promoting the use of Customer Relationship Management (CRM) by local Healthwatch organisations as CRM allows a full summary of the client story to be saved and stored, including experiences, problems, outcomes, any safeguarding issues. The benefits of local Healthwatch organisations using CRM is that themes from local feedback can be easily identified and contribute to the national picture.

Healthwatch Leicestershire reported that they do not use Healthwatch England's CRM software to record patient stories related to health and social care, instead they use their own reporting system using the in-house resources of Voluntary Action LeicesterShire's IT support. Healthwatch Leicestershire supplied the following rationale:

> *"Once HWE was established, they set up a CRM system and had a number of 'false starts' with the roll out and glitches in the centralised system. In the absence of a fully functional centralised system that all local HW had confidence in, many local HW procured off the shelf reporting system or designed their own with external specialist companies.*
>
> *HWL were involved a CRM pilot but by the time HWE had addressed all the problems with their system HWL were 'too far along' with our own signposting database, membership database and reporting systems.*
>
> *At this stage (May 2015) we did not have the capacity or resources to export all the data into the CRM system.*

We use our own systems to report centrally to data requests to HWE and also share our reports and findings to HWE directly and to the relevant HWE Yammer Groups."

Most stakeholders were not aware of the requirement for a relationship with Healthwatch England as one of the key statutory functions. One commented it would be useful if good practice from local Healthwatch organisations in other areas could be fed into local practice.

Recommendations

- Healthwatch Leicestershire should continue to be an active member of the local network of local Healthwatch organisations, with strong links to Healthwatch England.

- It would be beneficial if Healthwatch Leicestershire shared best practice from other areas with stakeholders. This could be done through development workshops or the suggested Healthwatch Advisory Group.

- Healthwatch Leicestershire should use the CRM system to ensure timely passing of information to the Care Quality Commission.

COMMENTARY AND DISCUSSION

Having analysed national guidance, best practice from other areas and spoken to local Healthwatch commissioners, staff, board members, other volunteers, members, and stakeholders, our recommendations for the new Healthwatch Leicestershire model are summarised below:

- Healthwatch Leicestershire will **listen to, support and empower** local people to design and improve local health and social care services. People and groups will be encouraged and supported to share their views about services.

- Through effective Healthwatch Leicestershire service delivery, local people and communities will have a **strong voice** to influence and challenge how health and social care services are provided.

- Healthwatch Leicestershire may be a **freestanding organisation, hosted organisation or commissioned function within an organisation,** regardless it must be **independent,** with control of its finances and strategic direction / working practices.

- **Continuity of commissioner** for the duration of the procurement process and new contact will maintain clear accountabilities and establish a clear communication channel and supportive relationship with the provider.

- The right **performance measures will be developed** that evidence the impact that Healthwatch Leicestershire is making.

- **Income generation will be encouraged** but not at the expense of delivering the core statutory functions or where potential conflicts might arise.

- **Strong and effective leadership** is required to ensure the statutory requirements at board and managerial level are delivered effectively.

- Clarity and transparency about Healthwatch Leicestershire **roles, responsibility, working practices, expectations and priorities** should be communicated in effective and wide reaching ways.

- Healthwatch Leicestershire will have the skills to involve service users and the public as equal partners in **service co-production**, with a move away from just seeking their views.

- Healthwatch Leicestershire will be open and transparent about how they **prioritise and plan** their work. This will include short term and longer term projects. **Effective partnerships** with

commissioning, provider and voluntary and community sector organisations also involving the public will ensure joined up planning and best use of resources. One mechanism to achieve this is to develop a joint **Leicester, Leicestershire and Rutland Healthwatch Advisory Group.**

- A Healthwatch Leicestershire **communication and engagement strategy**, that links to other key strategies will support joint planning and work. Working with seldom heard groups and children and young people should be key priorities in the strategy.

- Healthwatch Leicestershire must **balance spend and resource** on developing and maintaining strategic relationships with seeking views on local services and ideas for improvements, in a range of innovative ways. This balance is difficult to get right and may involve streamlining contact with key partners. Establishing an LLR Healthwatch Advisory Group may help this.

- **Effective collaboration and partnership working with other local Healthwatch organisations** will enhance the impact and reach of Healthwatch Leicestershire**.** A range of means will be used to achieve this which may include joint commissioning and provision, shared backroom functions and / or developing leads for discrete work projects. Aligning provision will ensure consistency and standardisation of delivery of the functions that are delivered.

- It would be helpful if all local Healthwatch organisations across Leicester, Leicestershire and Rutland worked to the same **standards**. Documents like the Enter and View delivery guidance and income generation guidance (for publication by Healthwatch England later this year) will be useful in ensuring a standard and consistent approach is used.

- Developing the **volunteering function** to deliver the core functions will add capacity to the organisation. To do this effectively Healthwatch Leicestershire staff and board members must have the appropriate skills to support and grow the volunteering function.

- Additional focus on the work of Healthwatch Leicestershire with **fewer workstreams** delivered to a high standard will benefit the local health and social care economy.

- Close **joint work with other partner leads** in service co-production and seeking views will allow gaps and overlaps in provision to be identified and mitigated against.

- All of the **Healthwatch statutory functions** will be delivered to a high standard and with the correct balance for the local area.

- To feed in the independent voice of the public, effective **strategic relationships** are required. Healthwatch Leicestershire will have an active role as a member of Leicestershire's Health and Wellbeing Board.

- Healthwatch Leicestershire will work closely with, but be **independent** of other key partners in the health and social care system. It must retain a role of challenge and be seen as a 'critical friend'.

- Healthwatch Leicestershire will present information and evidence accurately. Views and ideas will be collected and collated using **evidence-based approaches** and will include seldom-heard voices.

- **Marketing** of the key purpose and functions of Healthwatch Leicestershire will raise the profile so that local people know how they can engage with Healthwatch Leicestershire and make a difference. This can be done through a range of low cost mechanisms (use of posters, systems to link with key contacts such as elected members who have regular contact with constituents).

- Effective **signposting** will help people make choices about health and social care services.

- Healthwatch Leicestershire is required to be **flexible and dynamic** and to link in with emerging and changing local and national policy. This may include taking part in campaigns relating to use of local services and / or health improvement.

CONCLUSION

Local authorities have a duty to commission the statutory functions of a local Healthwatch organisation, ensuring they are effective and offer value for money. Leicestershire County Council are undertaking a procurement exercise to secure Healthwatch Leicestershire for the next 3 to five years.

Having been established in 2013, Healthwatch is an unseasoned body with local Healthwatch organisations continuing to find their feet and attempting to build on the foundations laid by their predecessors (PPIFs and LINks).

The existing Healthwatch Leicestershire has made a good start in delivering the core functions required of a local Healthwatch organisation. They are credible strategic partners with representation on many boards and groups, and are seeking the views of local people about health and social care services.

Moving forward, Healthwatch Leicestershire needs to prioritise its focus and ensure effective partnership working. They need to continue to share learning with Healthwatch England and also ensure learning from other areas is included in working practices and shared with partners. They need good local accountability to ensure the work they do is consistent and of a high standard. In order to be successful they require effective leadership to ensure a move to joint working, increased volunteering and communities that are empowered and heard.

Having to offer such a diverse range of functions, from developing and maintaining strategic relationships, to seeking the views of the public and communities in a meaningful way, is going to be a challenge, but is manageable with the right approach.

Over time, and as the profile of Healthwatch Leicestershire increases, the views of the general public on Healthwatch should be sought, in order to determine the true level of reach and engagement. Seeking views and involving local people in service development (in an evidence-based way) and increasing membership and volunteering are to key ensuring the impact of Healthwatch Leicestershire increases.

APPENDICES

Appendix 1	Bibliography (included below)
Appendix 2	Glossary of Abbreviations (included below)
Appendix 3	Brief for Consultancy Support (separate document)
Appendix 4	Predecessor Organisations
Appendix 5	Consultation Log
Appendix 6	Local Interview Framework
Appendix 7	Survey for Healthwatch Leicestershire members template and responses
Appendix 8	Local Healthwatch Spend comparison spreadsheet
Appendix 9	Local Healthwatch outcomes and impact development tool – version 2
Appendix 10	Local Healthwatch Reflective Audit
Appendix 11	Healthwatch Information Sharing Agreement

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APPENDIX 2 / GLOSSARY OF ABBREVIATIONS

A&E	Accident and Emergency
BCT	Better Care Together
BRRS	Business Rates Retention Scheme
CAB	Citizens Advice Bureau
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
CIC	Community Interest Company
CQC	Care Quality Commission
DCLG	Department of Communities and Local Government
DH	Department of Health
HSC	Health and Social Care
HWB	Health and Wellbeing Board
HWE	Healthwatch England
HWL	Healthwatch Leicestershire
ICAS	Independent Complaints Advocacy Service
LCC	Leicestershire County Council
LGA	Local Government Association
LGIU	Local Government Information Unit

LINk	Local Involvement Network
LLR	Leicester, Leicestershire and Rutland
LPT	Leicestershire Partnership NHS Trust
LRCV	Local Reform and Community Voice
MoA	Memorandum of Association
MoU	Memorandum of Understanding
NHS	National Health Service
NHSE	NHS England
PALS	Patient Advice and Liaison Service
PPIF	Patient and Public Involvement Forum
STP	Sustainability and Transformation Planning
TUPE	Transfer of Undertakings (Protection of Employment)
UHL	University Hospitals of Leicester
VAL	Voluntary Action LeicesterShire
VCS	Voluntary and Community Sector