Local Government Association

healthwatch

Health, adult social care and ageing

Making an impact with Healthwatch

A discussion paper by Mark Gamsu and Lorraine Denoris

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1. Introduction

Local authorities are commissioning new local Healthwatch organisations (LHWO) and existing and potential providers are formulating their ideas on what the shape of the new service should be.

This discussion paper considers the impact that Healthwatch should make and how it might need to work in order to succeed.

The paper is not a prescription but instead represents some of the ideas and debate that have emerged through pathfinder activity, feedback from LINk representatives, LA commissioners, Department of Health and Healthwatch England (through CQC).

2. Context

Funding

Although spending on local Healthwatch will be comparatively small compared to NHS and Social Care expenditure, the total investment in Healthwatch at a national level alongside local funding is significant. There is potentially £43 million made up of £16.5 million allocated specifically for Healthwatch plus the existing funding for LINks of £27million (2009/10 figures) available. This funding is not ring-fenced which means that local authorities will determine the final level and shape of investment.

While this figure is small compared to the total amount of funding invested in the Health and Social Care system it is a significant resource and it will be important to ensure that it has as great an impact as possible.

There are no comparable organisations to compare local Healthwatch investment against. However the scale of local Healthwatch can be understood when compared to other voluntary organisations with national coverage.

How local Healthwatch funding and use of volunteers compares with other organisations with national coverage - all figures 2010/11

Organisation	Turnover	Number of volunteers
Citizens Advice Service – national and local (10/11)	£198m	21,000
Age UK (2010/11)	£156m	2,000 physical activity 7,300 fundraising
Alzheimers Disease Society (10/11)	£61.6m	5,300

There is no national information available on the number of volunteers who are currently involved in Local Involvement Networks - one of the challenges will be to consider how to build on the existing LINk volunteer base.

The Department of Health has described local Healthwatch as being like a 'Citizens Advice Bureau for health and social care'[1]. Like a CAB, local Healthwatch will need to consider how it gets the right balance between:

- providing a direct service to individuals
- influencing local commissioning and provision to improve quality
- providing information to be used at a national level to inform policy and strategy.

Like Citizens Advice Bureaux, local Healthwatch face the same dilemmas as a small local organisation with a limited funding base, i.e. how to:

- provide a service that operates at system level - rather than just meeting the needs of the lucky few
- make a coherent impact strategically
- build actions from the views and concerns of the public
- involve the public in their services as users, stakeholders and volunteers.

Ambition

The ambition that the Department of Health has for Healthwatch is set out in Local Healthwatch: a strong voice for people - policy explained[2]:

"we will put patients at the heart of the NHS (. . . . .) we will strengthen the collective voice of patients and the public through arrangements led by local authorities, and at a national level through Healthwatch England."

"Healthwatch will strengthen the collective voice of local people across both health and social care, influencing Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies"

"Local Healthwatch will gather people's views on and experiences of, the health and social care system."

1 Local democratic legitimacy in health DH, CLG July 2010 p4

2 local Healthwatch Narrative- Department of Health 2 March 2012

In its Annual Report[3] 2011/12 the Care Quality Commission (CQC) notes that it is responsible for the regulation of 22,302 providers from NHS Healthcare, Independent Healthcare, Adult Social Care, Primary Dental Care and Independent Ambulance services (table 1 page 11)

Type of provision	Number of locations
NHS healthcare	2396
Independent healthcare	2764
Adult social care	25008
Independent ambulance	323
Primary dental care	10130
Total	40621

The challenge is actually much greater than this because many providers have more than one location[4].

If there were an equal distribution of services across England (which there is not) this would equate to 270 providers per local authority area.

These figures do not take into account the scale of some of these services - the number of hospital wards, provision of homecare services or assessment services.

3 Annual Report and Accounts 2011/12 Care Quality Commission p11

4 Ibid

3. What a good local Healthwatch needs to do

The Government's ambition is "to strengthen the collective voice of local people across health and social care in order to drive service improvement and quality."

Some of the mechanisms that government policy documents have described for achieving this are:

- ensuring access to information about health and social care provision
- providing clear access to support members of the public to give their views - including complaints - about the local health and social care system
- providing mechanisms to challenge service providers on the quality of their services with particular reference to Enter and View
- through a position on the Health and Wellbeing Board contribute to ensuring that the Joint Health and Wellbeing Strategy drives improvement across services and takes a balanced approach to health and wellbeing that recognises the importance of the social determinants of health.

While the above functions are helpful - the starting point when commissioning local Healthwatch can be summarised in two questions:

- How to strengthen the collective voice of local people?
- How to drive service improvement and quality?

The best LHWO's will be looking to establish and demonstrate the skills and competencies required to deliver these critical success factors very early on. Preliminary work on the Quality Framework begins to articulate "what good might look like". All partners - individual Local Healthwatch Organisations (LHWOs), Local Authorities, Local Government Association (LGA), Healthwatch England (HWE) and Department of Health have a part to play in co-producing appropriate interventions, development and support that can enable LHWOs to be the best they can possibly be. The Health and Wellbeing Board may be the place locally to bring these discussions together, define outcomes and allocate resources that will support this important aspiration.

4. Collective voice of local people

It is important to recognise from the outset that the notion of a single collective voice is not helpful - communities and interest groups may have very different ambitions and views about priorities. The challenge is to establish processes and systems that validate different perspectives and allow for new ideas to emerge from these.

In order to achieve this, LHWOs will need to develop strong relationships with the public. Key factors that will help this process are information and building capability.

Information about health and social care

"Local Healthwatch will provide information and advice to the public about accessing health and social care services and choice"[5]

Information about health and social care and other services that address health inequalities such as welfare rights, housing advice, youth and community work is already provided by many mainstream statutory and voluntary agencies. As well as local information provided by Hospitals, Primary Care Trusts (currently), Adult Social Care Departments etc, information is also available nationally through phone and internet channels - these include services such as NHS Direct, the Citizens Advice Website and through CQC, Public Health Observatories etc.

Rather than putting resources into what is an already crowded market LHWOs might be better focusing on how to ensure that there is a high quality, consistent approach to ensuring accessible provision and use of local information within a local authority area. This will need to be across agencies and sectors, with a particular focus on ensuring that there are clear pathways and channels for easily ignored communities and interests such as adults with a learning disability, people with

5 Local Healthwatch: A strong voice for people- the policy explained. DH 2nd March 2012 p14

long term conditions, those with terminal illnesses, communities where English is a second language etc.

This could mean using its position on the Health and Wellbeing Board to run the equivalent of a standing committee of local information leads to ensure that there is a strong focus on access to information and advice about health and social care services, choices, performance and need.

Active citizens

"promote and support the involvement of people in the monitoring, commissioning and provision of local care services"[6]

In addition to transitioning those existing LINk volunteers who wish to remain involved in the LHWOs, new providers will need to get the right balance between involving members of the public directly in Healthwatch and developing relationships with a much wider group of organisations in order to genuinely mobilise the public in improving the quality of their health and social care services.

"We want to see local Healthwatch organisations operating as part of existing local community networks ensuring they can have maximum reach across the diversity of the local community....they will be able to work with employed staff in addition to the many thousands of volunteers who continue to give of their time and energy to make sure local people can have their say"[7]

In order to achieve system level impact it will clearly not be sufficient to rely on a small group of Healthwatch volunteers. The challenge facing LHWOs will be to consider when is it appropriate to have dedicated 'Healthwatch volunteers' and when and how LHWOs should seek to connect with and engage other active citizens - carers, volunteers and potential volunteers.

One of the tests might be to consider how someone with an interest in health and wellbeing might be able to build their understanding, share their views and if they wish to become more involved. This is too large an area to address in detail here.

6 ibid p14

7 ibid p17

However, there is tremendous potential to engage and connect with the public for example:

- Health and Social Care organisations - hospital visitors, WRVS, volunteers in hospices, lunch clubs, community health champions, support groups, members of foundation trusts etc
- Community Organisations - welfare rights providers including Citizens Advice, Adult Education - including the Workers Education Association, local neighbourhood and voluntary organisations, tenants and residents associations etc.

A successful LHWO will identify formal and informal ways in which these people can contribute to the debate; continually reviewing communication channels and engagement possibilities so that existing and new communities of interest and individuals can have their say.

In order to be effective LHWOs will need to take a strategic view on how relationships with the public are managed at a system level and how the health and social care system will build capability and understanding to help members of the public engage effectively.

Relationships with the public

- Managing relationships with local organisations and networks.
- Clarity of brand.
- Ease of contact - using a wide range of media including twitter, email newsletters and facebook.
- Clear routes to enable people to move from accessing information, sharing their experiences to becoming more actively involved as volunteers in contributing ideas and challenging services.

Building capability and understanding among the public

- Working with partners in other organisations to build the capability of existing service users, volunteers and paid staff to help them champion high quality health and social care services - understanding their responsibility and how they can bring influence and challenge to bear in an appropriate way.
- Supporting the development of training that increases the capacity and capability of communities to contribute to the work of Healthwatch specifically - using models that have been developed through the Community Health Champion process pioneered by initiatives such as Altogether Better, HELP, Unlimited Potential and Well London. Potential delivery partners include the local colleges, the Workers Education Association and the trade union movement.

5. Driving service improvement and quality

The main tools described in Government policy are:

- complaints and concerns
- Enter and View
- contributions to the Health and Wellbeing Board.

This paper seeks to consider the relative power of these to drive service quality at a system level.

Complaints and concerns

Members of the public want an opportunity to share their experience and/or concerns and want action to be taken on the basis of these.

While Healthwatch will have a close relationship - and in some case deliver the Independent Complaint and Advocacy Service there are wide range of mechanisms for the public to use.

They include:

- using provider and commissioner complaints systems
- accessing the Independent Complaints and Advocacy Service and other advocacy services such as Independent Mental Health Advocates, Independent Mental Capacity Advocate and Deprivation of Liberty Safeguards services
- using mainstream welfare rights providers - such as Citizens Advice - who currently respond to over 100,000 health and social care issues a year.
- taking concerns to local councillors and MPs
- recording their experiences through 'Patient Opinion' the 'Trip Advisor' for the Health system
- raising issues with the Parliamentary and Health Services Ombudsman
- a wider range of stories and narratives from more qualitative work with the public.

LHWO will need to understand the relative scale and importance of these, and through working with the Health and Wellbeing Board (HWB) consider:

- Are mechanisms for the public to raise concerns and challenge accessible enough?
- Are they of good enough quality?
- Are mechanisms in place to share information and drive deeper investigations such as Enter and View when required?
- Do the views of members of the public drive commissioning when appropriate?

Local Health will need to take a balanced approach to capturing this evidence and presenting it in a way that is powerful and timely. The best LHWOs will find ways of accessing analytical expertise so that intelligence and data can be used most effectively, especially with service commissioners. There may be opportunities for LHWOs to collaborate and jointly resource this expertise; HWB's may want to support these initiatives to demonstrate commitment to ensuring robust citizen feedback is being reflected across its activities.

Enter and View

- There has been no systematic audit of Enter and View – so it is not possible to say what impact this has had on local systems. Some of the strengths of Enter and View include:
- bringing non-institutional expertise to question and challenge what are normally fairly closed environments
- placing local assessments of services into the public domain
- encouraging providers to engage with external challenge outside of more formal inspection regimes.

Some of the problems with Enter and View have been:

- it is very difficult to ensure system level coverage of all service providers
- the impact of Enter and View assessments is inconsistent and largely unproven.

While Enter and View is a worthwhile tool in the armoury of the local Healthwatch- the risk is that it is seen as the **main** mechanism for improving quality- there is little evidence that **on its own** Enter and View brings sufficient impact.

Open services

Rather than seeing Enter and View as the key mechanism through which Healthwatch brings informed consumer challenge to service quality it should instead be understood to be one of many tools and techniques that can be deployed.

It could be more powerful for a LHWO to use its positional authority in the local system to pull together quality leads across providers to develop, agree and implement local protocols and processes to ensure that a wide variety of mechanisms for constructive external challenge by informed members of the public are in place and that adherence of these and lessons learnt are regularly captured and fed back to the Health and Wellbeing Board. Such a grouping could have a permanent role at local authority level - driving forward a programme of peer review, development support and local standard development to ensure that services capitalise on the wide range of perspectives and views that people who deliver and rely on services have.

This approach is consistent with the Governments localism ambitions and with a sector led approach to improvement.

Such an approach would consider how all stakeholders involved in health and social care provision are able to bring challenge and are supported to do so.

Stakeholders include:

- people receiving health and social care support
- carers
- volunteers involved in service provision
- members of staff
- commissioners.

Health and Wellbeing Board

The fact that Healthwatch has a statutory place on the Health and Wellbeing board is a tremendous opportunity. One risk is that the LHWO will see this as the most important point of engagement and influence while it is in fact just one useful way to ensure leverage and connection with the local health and social care system.

The statutory place on the Health and Wellbeing board is important for what it signifies as much as the position itself.

It signifies that the authority of Healthwatch is equivalent to that of the other partners around the table. This means that local Healthwatch needs to make a thoughtful judgment about how to use its authority at the Health and Wellbeing Board and also how it utilises other levers in the local system.

In order to be powerful and credible voice local Healthwatch will need the capability to:

- capture data and analyse it
- conduct or commission reviews of areas of concern or deficit
- produce clear system level reports based on evidence and recommend actions that need to be taken.

A helpful model here is the idea of a local Healthwatch Observatory that emerged from work in Kent[8] – having capability in research methodology, able to capture and collate secondary research data; advise on and design data capture tools/techniques; analyse data; extrapolate trends and themes etc.

It is probable that such a resource would be too costly for individual local Healthwatch but could be something that is commissioned sub-regionally, or through a relationship with an academic institution, Public Health England or analytical resources in local organisations.

Without this capability local Healthwatch representatives will run the risk of being perceived as passionate and able advocates but lacking grounded contextual analysis.

Other issues that local Healthwatch might want to consider:

- What relationship does it want with other key points in the local system such as the Overview and Scrutiny Committee and the local press?
- Will it use the Health and Wellbeing Board to drive system level work on public involvement and open services - as we have described earlier?
- What role does the Healthwatch representative have for bringing seldom heard voices to the Health and Wellbeing Board?

8 Building successful Healthwatch organisations LGA, NHS Institute, Regional Voices, April 2012 p22

6. Public health

One of the tricky areas that all LHWOs and their commissioners will need to consider is the extent to which LHWOs will bring added value to the broader health and wellbeing agenda.

The resources available to LHWOs may mean that it will make more impact by focusing on the quality of health and social care provision and the implications that this has for commissioners.

The risk to this is that there is tremendous potential to improve health and wellbeing through focusing on the quality and allocation of services that impact on the social determinants of health such as welfare rights, housing and those that strengthen social mobility such as education, careers guidance and vocational training.

7. Improving quality a shared responsibility

One of the big risks with local Healthwatch is that the local authority and the Health and Wellbeing Board will see the Healthwatch role as something that sits 'out there'.

As the commissioners of Healthwatch local authorities will need to provide strong leadership to ensure that expectations of LHWOs is high and that they are given a strong mandate to lead and drive change. In this discussion paper we have suggested some areas where we believe LHWOs could provide important system level leadership.

Our proposition is that the replacement of LINKs with Healthwatch provides a real opportunity for existing providers and local authority commissioners to consider what added value LHWOs can bring to the new system. There is much talk about LHWO's moving into a new and different space but we must not forget that alongside this, LA's and HWB members will also need to take on new roles and responsibilities.

The best LA's, will already be considering how they can support and build robust and credible LHWOs going forward. For many this will require a real culture change and different supporting activities. The task begins rather than ends once the contracts have been signed in readiness for 1st April 2013 start date. This developmental responsibility is becoming increasingly recognised and there is increasing appetite for support around this from the LGA who are currently looking to design an ongoing 'offer' that can tie-in with other key LA health responsibilities such as public health.

An ambitious Health and Wellbeing Board will consider what its constituent members and provider organisations can do to ensure that the Healthwatch role is powerful.

This will include ensuring that Healthwatch has the positional authority in the local system to make an impact. This could be in the manner described above by leading on:

- developing consistent good practice across all local providers to ensure local services are open to challenge from stakeholders
- system level information planning around health and social care - pulling all health and social care organisations together
- gathering and analysing soft and hard information about service user experience.

As well as a clear mandate to lead much of this will require larger organisations to commit resources to support the work of Healthwatch in particular analytical and communications expertise.

National support

"LINks have struggled to involve a wide range of people of all ages and different sections of the community..... there has been unnecessary variation in ways of working and effectiveness, and little evidence of self-assessment or peer support"[9].

With the level of resources that are available at a local level it is clear that in addition to the support of local Health and Wellbeing partners that we have described, strong national support is also necessary.

This would include:

Building local capability with a focus on the development and implementation of coherent quality frameworks and skill sets and mechanism to assess and test these.

For example Citizens Advice operates a triennial Quality Assurance Programme which provides confidential feedback and challenge to member bureau looking at quality of advice and organisational governance.

Building Capacity- we have identified a number of areas such as analytical and intelligence functions where there is unlikely to be sufficient resource within most LHWO.

We would expect that the Local Government Association in partnership with the Department of Health and Healthwatch England will all take a lead role in addressing these issues in partnership with LHWOs.

9 Local Healthwatch: A strong voice for people-the policy explained DH March 2012 p6

However, there are a range of other national agencies who will also need to consider what the creation of LHWOs mean for them and the opportunities this presents. These include:

- statutory bodies such as Public Health England, the NHS Commissioning Board and MONITOR
- networks such as the NHS Confederation, the Association of Directors of Adult Social Services, Association of Directors of Children's Services
- voluntary organisations such as the Department of Health Strategic Partners.

8. In conclusion

For understandable reasons a considerable amount of energy to date has focused on the commissioning of LHWOs.

In writing this discussion paper, the authors are keen to encourage all those involved, to step up a gear and consider the real opportunities LHWOs present: - providing a strong local collective voice alongside improving choice and access to services may be the key to delivering real service improvement and better health and care outcomes – in other words making "no decision about me without me" a reality.

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