



PART A

The transition to Local Healthwatch in the East Midlands

Reflections from LINKs members

April 2012

Written by Meghan Rainsberry

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This report should be read in conjunction with:

- PART B The transition to Local Healthwatch in the East Midlands: Reflections from commissioners
- APPENDIX A LINKs to Local Healthwatch Transition Planning Checklist
- APPENDIX B Questions on Healthwatch England from the East Midlands

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1 Introduction

1.1 About Local Healthwatch in the East Midlands

In anticipation of the changes coming under the Health and Social Care Act 2012, local authorities and Local Involvement Networks (LINKs) are preparing for considerable reform. In a new health and social care landscape, powers will be significantly redistributed in favour of local level decision makers – be they local authorities, clinical commissioning groups (CCGs) or patients themselves. All of these key players will depend on better access to quality information, strong representation from service users and the public, and assurance that their choices will ensure value for money. Central to the success of these reforms is Healthwatch – the independent consumer champion for health and social care.

Made up of two tiers – a network of Local Healthwatch organisations at the local level and Healthwatch England at the national level – Healthwatch will represent patient and public interests, locally and nationally. The responsibilities of other health and social care stakeholders depend on robust patient and public involvement mechanisms. Local Healthwatch will provide the evidence-base for decisions at all levels, and will inform the improvement of health and social care services. But Local Healthwatch will also facilitate the flow of information in the opposite direction, signposting patients and the public to information that will help them make choices about their care.

The formation of Local Healthwatch organisations is not happening from scratch. Since their creation, LINKs have done considerable work building valuable relationships and expertise that need to be transferred to Local Healthwatch organisations. From October 2011 to March 2012, members of the ten East Midlands LINKs participated in a programme of support for the transition from LINKs to Local Healthwatch. LINKs members entered into this programme with the intention of sharing learning, preserving strengths, addressing weaknesses and creating solid foundations for credible, independent Local Healthwatch organisations.

1.2 About the East Midlands LINKs to Healthwatch Transition Programme

The Community Development Foundation and Locally Made were commissioned to deliver a regional programme of support for LINKs members and local authority commissioners in the East Midlands. The programme was funded by the East Midlands Department of Health, Public Health and Social Care Directorate.

The programme consisted of a series of four workshops for LINKs and five sessions for commissioners themed around different challenges facing them in the transition

to Local Healthwatch. To encourage greater collaboration between the two groups, LINKs members were invited to one of the commissioners' sessions, and commissioners were invited to two of the LINKs' workshops.

1.2.1 Participating LINKs

Derby City LINK

Derbyshire LINK

Leicester City LINK

Leicestershire LINK

Lincolnshire LINK

Milton Keynes LINK

Northamptonshire LINK

Nottingham City LINK

Nottinghamshire LINK

Rutland LINK

1.3 About this report

This report serves as a record of the perspectives of the majority of LINKs members on a variety of issues raised over the course of the programme. It has been organised into six sections:

- **The organisational values, model and governance of Local Healthwatch:** Considerations on what will provide strong foundations for Local Healthwatch
- **The functions of Local Healthwatch:** Thoughts on LINK practice applicable to Local Healthwatch
- **Existing staff and volunteers – Motivations and retention:** Suggestions for motivating and retaining existing staff and volunteers during the transition period
- **Solidifying relationships with health and social care stakeholders:** Considerations on the relationships that need to be established in the run-up to Healthwatch
- **Relationship with Healthwatch England:** Questions raised about the role of Healthwatch England in relation to Local Healthwatch
- **Smoothing the transition from LINKs to Local Healthwatch:** Thoughts on potential challenges in the transition process and how to overcome them

1.3.1 Note on the representativeness of the report

Please note that this report represents the perspectives of the *majority* of LINKs participants, and therefore does not necessarily reflect the thoughts and feelings of every individual participant on every issue. Any errors, omissions or misrepresentations remain the fault of the author.

2 The organisational values, model and governance of Local Healthwatch

Many of the participants in the East Midlands LINKs to Healthwatch Transition Programme have volunteered for years in patient and public involvement. Their journeys have been evolutionary ones, with many current LINKs members having been involved in one or more of the preceding involvement mechanisms. As the region gears up to implement Local Healthwatch, LINKs members can foresee both the value of an “independent consumer champion for health and social care” and the challenges with realising this policy ambition locally.

Over the course of the programme, LINKs participants expressed several key points concerning the values, model and governance that would underpin a successful Local Healthwatch organisation.

2.1 The values

2.1.1 Accountability to the public

All Local Healthwatch activities should be carried out with patients and citizens at the core. Regardless of its place within the wider health and social care system, Local Healthwatch must remain accountable to the public first and foremost.

2.1.2 Challenging health inequalities

Challenging health inequalities ought to be central to the work of Local Healthwatch. However, overcoming such inequalities should not be seen as something one agency can achieve alone – Local Healthwatch should always be seen as part of a wider system working towards solutions.

2.1.3 Engagement and representation

All the work of Local Healthwatch should be underpinned by strong community engagement and representation.

2.1.4 Volunteering

The notion of volunteering is important to the ethos of Local Healthwatch. Regardless of the model chosen in each area, volunteers will be the ones who will create the identity, recognition and commitment for others to latch on to.

2.1.5 Informed decision making

Local Healthwatch will be a crucial source of information to the health and social care system’s decision making. In fulfilling this function, and in its own decision

making, Local Healthwatch must have a strong respect for robust research and facts in decision making.

2.1.6 Independent and user-led

Part of Local Healthwatch's effectiveness will depend on its independence. A lesson to take from the work of LINKs is the trust that can be gained when these functions are carried out by individuals who are not employed by health or social care professional bodies. Local Healthwatch should preserve the role of users in governance.

2.2 The model

2.2.1 Body corporate

The organisational model for Local Healthwatch remained a point of contention throughout the course of discussions, in particular the requirement for Local Healthwatch to be a 'body corporate'.

A key difference between LINKs and Local Healthwatch is the role of the host. The LINK model was two-fold: an autonomous volunteer network, supported by a host organisation (that was contracted by the local authority). Local Healthwatch will not have a host – it will be its own legal entity.

While many remained unconvinced of the benefits of the body corporate model, there were some strong arguments made in favour. Table 1 lists the pros and cons that emerged from the discussions. In areas where the host/LINK relationship is working well, the transition to a body

What is a body corporate?

A "body corporate" is an organisation that has a legal status separate from that of its owners or members, and that will continue to exist despite any change in those owner or members. This includes companies with limited or unlimited liability, companies limited by guarantee, charter companies and bodies created by statute.

Under the Health and Social Care Act 2012, the local authority must make its Local Healthwatch arrangements with a body corporate which:

- is a social enterprise, and
- satisfies any additional criteria prescribed by regulations (secondary legislation).

In this context, a social enterprise is defined as an organisation that acts for the benefit of a community or a section of a community in England.

Sub-contractors

The Act allows Local Healthwatch organisations to sub-contract others to assist it to carry out its activities or to carry out activities on its behalf.

More to come

The Secretary of State will provide further guidance in the regulations on:

- the types of social enterprise appropriate for Local Healthwatch
- activities that may reasonably be considered to be or not be for the benefit of a community or section of a community in England.

corporate is seen as disruptive to an already productive set-up. However where the host/LINK relationship is not working, the alternative of a body corporate could offer new opportunities.

Table 1: Pros and cons of the body corporate model

Pros	Cons
<ul style="list-style-type: none"> • Potential to diversify income strands, earn money from sources other than the council, maintain independence • More freedom to manage budget (in current LINK model, budget is split between host budget and programme budget) • Legal structure offered by body corporate does provide some defence in the case of disagreements with clients • Potential to be more adaptable and offer a space for volunteers to pursue their interests 	<ul style="list-style-type: none"> • Concern that Local Healthwatch management will be more focused on managing the business than looking after the interests of the population • There will be an additional cost to providing support to management committee members who may not have the right skills for running a business • Volunteers could be put off by having to take on responsibility for: <ul style="list-style-type: none"> - HR - Insurance - Indemnity - Money - Data protection - Training • Risk that if it fails, organisation is stuck with wind-up costs • Major organisational change takes considerable time • If all East Midlands LINKs became bodies corporate and pursued other income streams, potential for them to be in competition with each other

2.2.2 Alternative options

For those considering setting up a new social enterprise, there are several practical barriers that arise in contracting a newly formed body corporate to deliver Local Healthwatch (such as insurance, capacity, track record, etc.). Delivering Local Healthwatch via a **consortium** was seen to avoid such problems, as well as collect skills and expertise, and share risk and responsibility.

Nottinghamshire LINK and County Council are pursuing an **‘independent collaborator’** option for LINKs members to continue in Local Healthwatch. The contracted organisation would be required to work with the existing membership. This model allows volunteers to continue without taking on corporate responsibility, however they would lose their autonomy under the new arrangements.

2.2.3 The roles of volunteers in any model

Under the current LINKs model, volunteer members take on a variety of roles both in governance and management, and in delivery. East Midlands LINKs participants believe Local Healthwatch should retain this two-tiered approach to using volunteers. Many LINKs participants felt that administrative functions (communications, policy, finance, etc.) should be the only paid roles in Local Healthwatch.

Participants saw Local Healthwatch's challenge as creating a wider range of types of volunteering – to include some opportunities with less bureaucracy, some for varying time commitments, task-based roles and providers of occasional opinions. Some felt that the current LINK volunteer opportunity was only attractive to existing patients.

However in transitioning to Local Healthwatch, it is important to remember certain realities of working with volunteers:

- It is important to identify the skills of volunteers and use them appropriately to retain their involvement.
- Volunteer time is limited and they can be unpredictable.
- Retaining skills and reflecting the demographic mix of the population is a constant challenge.
- Volunteers need to be self-motivated.

2.3 Governance

Good governance is vital to ensuring both the independence of Local Healthwatch, and its accountability to the public. It was generally agreed that a strong, streamlined and strategic executive team would be crucial to the success of any body corporate model. Many felt this should include a member-elected Chair.

However discussion around roles within the governance structure highlighted some difference in opinion. While some felt that an all-volunteer Board would help secure Local Healthwatch's independence, others felt that a much more mixed Board would be needed, with volunteer members of the public, executive members and representatives from the voluntary sector. Some LINKs have suffered from the transient membership of an all-volunteer Board. The suggestion was made that a Local Healthwatch Board should have a paid core (to secure a commitment) with a mixture of other people (building out from the secure commitment).

2.3.1 Outcomes

LINKs participants stressed the need for clear outcomes guiding Local Healthwatch. However, how these outcomes might be set and measured uncovered some clear challenges. LINKs participants recognised the value of shared outcomes and measurements across the region, in an effort to provide a more consistent and uniform service. One suggestion was to use the Department of Health outcomes framework as a basis for all Local Healthwatch organisations in the East Midlands.

It was noted that the budgets for Local Healthwatch will likely be very different across the region, and it may not be realistic to hold a Local Healthwatch organisation with a limited budget to the same outcomes as one with a much larger budget.

It was also noted that Local Healthwatch organisations in the East Midlands will need to be able to work with Local Healthwatch organisations in neighbouring counties outside the East Midlands with whom they might share patient flows. If bordering counties outside the East Midlands do not share the same outcomes, this may pose problems for joint working and a seamless user experience. This is an argument for Local Healthwatch to have broadly the same outcomes nationally.

3 The functions of Local Healthwatch

According to the Health and Social Care Act 2012, Local Healthwatch will be responsible for:

- a) promoting and supporting the involvement of local people in the commissioning, provision and scrutiny of local care services
- b) enabling local people to monitor for the purposes of their consideration the standard of local care service provision, and whether and how these services could and ought to be improved, and to review for those purposes, the commissioning and provision of local care services
- c) obtaining the views of local people about their needs for, and their experiences of, local care services
- d) making —
 - i. the views of local people 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.
- e) providing advice and information about access to local care services and about choices that may be made with respect to aspects of those services
- f) reaching views on the standard of local care service provision, and whether and how these services could and ought to be improved and making those views known to the Healthwatch England
- g) making recommendations to Healthwatch England to advise the CQC about special reviews or investigations to conduct (or, where the circumstances justify doing so, making such recommendations direct to the CQC)
- h) making recommendations to Healthwatch England to publish reports under section 45C(3) of the Health and Social Care Act 2008 about particular matters; and
- i) giving Healthwatch England such assistance as it may require to enable it to carry out its functions effectively, efficiently and economically.¹

While there are differences between the functions of LINKs and the functions of Local Healthwatch, some of the East Midlands LINKs' current practices can help to ensure that the functions of Local Healthwatch are delivered effectively. Where examples of good practice exist, they can be adopted across the region.

In other cases, practices may be at risk of being lost or will need to be improved in the transition to Local Healthwatch.

¹ Health and Social Care Act 2012 p.5 c.1 s.182(4).

3.1 Communication (reach)

Local Healthwatch has significant responsibilities for collecting evidence of patient and public views on and use of local services. Gathering this information will require strong communication and sufficient reach within local communities. Several East Midlands LINKs have developed good and regular communication practices, which have resulted in high response rates to surveys and consultations. Such examples of good two-way communication will be valuable in fulfilling the functions of Local Healthwatch. However, it will be equally important (and often difficult) for Local Healthwatch to demonstrate to respondents how their feedback has been used so people do not develop consultation fatigue.

Local Healthwatch will also be responsible for communicating the evidence it collects to a wide range of health and social care stakeholders, including Health & Wellbeing Boards. These stakeholders will depend on Local Healthwatch as a vital source of information for their decision making and work planning. Establishing working relationships early on will help ensure good information flows in the future.

3.1.1 AT RISK: Local communication

Healthwatch England will have responsibilities for national communication and branding. However there is also valuable communication work at the local level. Funding for maintaining local dialogue between agencies, providers, patients and the public could be lost if communications is seen as solely the responsibility of Healthwatch England. Greater clarity is needed on the division of responsibilities between Local Healthwatch and Healthwatch England, particularly within broad functions such as communication.

3.2 Engagement and representativeness

Local Healthwatch will have responsibilities for working directly with patients and the public, as well as representing them to other agencies within the health and social care system. Fulfilling these responsibilities will require Local Healthwatch to have representative memberships and strong engagement practices.

East Midlands LINKs have had both successes and struggles with engagement and representation. Where LINKs have managed to build trust and understanding with sections of the community, it has been a slow process. Recruiting champions from minority groups has been particularly difficult. While one solution is to go through the voluntary sector, some noted this may only reach the self-appointed leaders.

Working with other agencies can be equally challenging. While being centres of excellence in health and social care, many other agencies do not necessarily understand genuine engagement, making joint working harder. East Midlands LINKs see addressing this lack of understanding as a crucial point for Local Healthwatch, as a wider pool of stakeholders will use Local Healthwatch for engagement work.

3.2.1 Case study: Milton Keynes LINK *Communications*

When you've asked for people's views, it's important that they know how that information is being used. This value underpins communications at Milton Keynes LINK.

How does the LINK communicate with members?

The LINK's main communications tools include:

- Website (and database)
- Electronic and print newsletters and alerts
- Booklets and factsheets
- Visits and presentations

Members can contact the LINK office by phone, email or freepost. The communications strategy and work plan is set by the LINK executive, and carried out by LINK staff.

Accessibility

It's not just about feeding back, it's about providing information in a way that's accessible to LINK members and the wider public. Some of the steps the LINK takes to ensure information is accessible to all include:

- materials are written in plain English
- all electronic materials are also provided in print
- interpreters are provided for deaf members
- large print and audio copies of materials are available upon request
- all materials are translated into Tamil, and are available in other foreign languages upon request

What's the benefit of this work?

The LINK has a wide reach, with 1,600 members (area population 240,000) and 240 affiliated health and social care organisations. They recently received one of the highest response rates to a consultation on Any Qualified Provider requested by the PCT. And they can mobilise their members quickly. When a leading consumer guide asked for help recruiting participants to a review of domiciliary care with only a few days' notice, the LINK was able to provide the number of people needed on time.

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3.2.2 AT RISK: Engaging seldom heard communities

Many participants worried that when funds are limited, outreach to seldom heard groups will be at significant risk of being cut. If Local Healthwatch is unable to build and maintain these connections directly, relationships to the voluntary sector become crucial, but these organisations are also losing their own funding and infrastructure.

It should be noted that the definition of “seldom heard communities” varied quite widely from area to area. For example, in Leicestershire the seldom heard groups are rural communities, children and young people. They have had success in reaching these communities (350 of 1,700 members are young people) by having connections to universities. In Rutland, rural communities, Travellers and service families are seldom heard. Travellers are unconnected to health services and the wider community as a whole, and service families come in and out of the area, sometimes using local health services and sometimes using self-contained health services.

3.3 Enter & Views

Local Healthwatch will work with local authorities and the Care Quality Commission (CQC) to monitor and scrutinise health and social care services. Several LINKs in the East Midlands have successfully conducted Enter & Views to evaluate services in their local areas. LINKs members identified Enter & View work as an example of good practice with robust evidence of impact (in the take-up of recommendations). They also felt Enter & Views fitted with many councils’ priorities – to improve care and enhance the dignity of patients in treatment.

However, it was also noted that it takes six to nine months to develop robust ways of doing Enter & View work. There is a lack of direction from existing policy regarding the need for full-time staff to be present in visits or not. Some noted that it is most useful when full-time staff, local authority staff and volunteers can partner up to visit. It was also noted that Enter & Views can be strong or weak depending on the council’s priorities. Where a local authority does not want Enter & View work carried out, efforts can get lost.

3.3.1 Case study: Derby City LINK *Care home visits*

A LINK survey of public perceptions of supported housing found that people were particularly concerned about care homes. They worried about the quality of care they would receive, and wanted more support to stay at home and recommendations from someone they could trust. The LINK decided to conduct visits into all the residential and nursing homes in the city to determine what it is like to live, work and visit these facilities. They have visited 38 of 57 homes in Derby so far.

How does the LINK conduct care home visits?

The process begins with a pre-visit to inform the home manager of the LINK, explain the purpose of the project and arrange a date for the visit. Posters are displayed at the homes to let people know when the visit is taking place, and visitor and staff surveys are left at reception.

The visits are usually conducted jointly by LINK employees and volunteers and last an average of two hours. The team observes the facilities and the interaction between staff and residents. They help residents, staff and visitors complete a short survey about their experiences of the home, their involvement in decisions about care, and their recommendations for improvements.

Any safeguarding issues are immediately passed on to the home manager and reported to the Safeguarding Vulnerable Adults Board. Other findings and recommendations are included in a report, to which the home may respond. The final report is then made available on the LINK website and shared with the CQC and other relevant statutory bodies. When specific recommendations are made, the LINK follows up with the home at a later date.

In order to carry out these visits, staff and volunteers undergo Authorised Representative Training, LINKs Enter And View Training and Safeguarding Vulnerable Adults Training, and complete a CRB check.

What's the benefit of this work?

First and foremost, these visits help to improve the quality of care provided. The LINK also hopes the reports will be a useful source of information for people considering a care home for themselves or a relative.

What's next?

The LINK is now adapting their approach to visit homes serving those with mental health and learning difficulties.

Derby City LINK

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3.3.2 Case study: Nottinghamshire LINK

Enter & Views

Over the past year, Nottinghamshire LINK has been developing an Enter & View practice across a range of services in the county. Their primary objective is to capture examples of good practice that can then be shared across all health and social care providers.

How does the LINK conduct Enter & Views?

So far the visits have been arranged with the provider in advance. Each visit is conducted by two LINKs volunteers, who carry out interviews with patients and staff and observe the facilities and how care is provided.

Volunteers allow at least two hours to conduct an Enter & View, but the time can vary. The volunteers write a report within 24 hours, which is given first to the provider so they have the right to instant reply. Once the report has been shared with the provider, the LINK shares it with the CQC and the local authority. At the end of the series of visits, the LINK puts together a final report of good practices and recommendations.

The LINK follows up on its visits six months later as a standard part of its case management. Providers tell them what changes they've made, and give reasons if a recommendation has not been implemented.

The LINK has six volunteers who are able to do Enter & Views. Each volunteer had to be trained in safeguarding and how to conduct a visit, as well as complete a CRB check.

What results does the LINK see from this work?

Some of the concrete results from the LINK's Enter & View work include reduced waiting times for dental surgery under anaesthetic for people with learning disabilities (down from 30 days to 17).

The LINK also conducted Enter & View visits to look at dignity and respect in care homes as part of a pilot scheme on improving care in the field of dementia. The LINKs recommendations were implemented during the course of the pilot scheme.

What's next?

Next year the LINK will be looking at the issue of dignity within a private ambulance service responsible for transporting NHS patients. The provider is keen to look at this issue in more depth, and approached the LINK for support at one of its information sessions.

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3.4 Coordination between agencies

Local Healthwatch will be one of the few health and social care organisations responsible for engaging directly with all levels of stakeholders: local strategic level stakeholders, local delivery stakeholders and service providers, national stakeholders, other Local Healthwatch organisations in the region, and of course patients and the public. These responsibilities position Local Healthwatch as a central hub in the complex web of the health and social care system.

LINKs' experience acting as coordinators across a range of agencies and service providers will be valuable. However, the impact of this activity is not always easily evidenced, and as LINKs were seen as primarily delivery rather than strategic organisations, it was not always readily financed. East Midlands LINKs are concerned that this coordinating function may become vulnerable under Local Healthwatch.

3.4.1 Case study: Northamptonshire LINK *Coordinating engagement practices*

When consultation is done differently by different organisations, it can be unclear to patients and the public what their role is. They don't necessarily understand what part of the system they're engaging with, and why they're being consulted on the same issues repeatedly. If they aren't told how their feedback has been used, they can feel used, devalued or apathetic. Northamptonshire LINK saw a need for a common model for engagement in the county and has taken a leading role in its development.

How does the LINK help to coordinate engagement work?

The LINK is facilitating discussions with engagement leads in the county on how to better share resources and develop a common model for engagement. The LINK also advises health and social care stakeholders on how to engage with their communities effectively.

What's the benefit of this work?

The LINK is increasingly seen as a resource by stakeholders. There is a more regular exchange of information and patients and the public have a mechanism for seeing how their feedback has been used (via the LINK).

What's next?

Coordination is a growing role for the LINK. It will continue to pursue a common model for engagement in an effort to improve the experience for patients and the public.

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4 Existing staff and volunteers: Motivation and retention

Periods of uncertainty can make it difficult to motivate and retain staff and volunteers. At the same time, LINKs need all hands on deck to deliver existing work, gear up for Local Healthwatch, and in some cases deliver pathfinder projects. There is a risk of losing capacity and knowledge as volunteers and staff move on, which could also hurt the ability of others to pick the work back up.

East Midlands LINKs felt that identifying ways to motivate and engage their members is an important part of the transition process. Suggestions include:

- find a defined project or focus to keep LINK members and staff enthusiastic about continuing LINK work for an extended period
- hold local workshops and engagement events
- provide training and inductions to the roles that volunteers will play, and to the health and social care system (with the help of all key organisations)
- use LINK members as the core base for consultation on Local Healthwatch
- use LINK members as ambassadors for wider change in health and social care
- tell volunteers the impact they have made and the value they have added.

4.1 Case study: Leicester City LINK

Motivating and informing the LINK membership

In an effort to inform and engage the LINK membership in the transition to Local Healthwatch, Leicester City LINK recently held a Healthwatch engagement event for existing and potential members, with workshops on signposting, governance, and communication and engagement.

The LINK has also held away-days for Board members to discuss successes, issues and barriers in the transition. The local authority commissioner attends the sessions, and has facilitated discussions on governance and commissioning.

Leicester City LINK

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5 Solidifying relationships with health and social care stakeholders

The reforms laid out in the Health and Social Care Act 2012 create an intricate array of local and national relationships, in which Local Healthwatch organisations must find their place and voice. Networking and relationship building will be crucial skills, as Local Healthwatch organisations will need to be seen as credible, reliable voices in the local interactions of councils, Health & Wellbeing Boards and clinical commissioning groups (CCGs) among others. Local Healthwatch organisations must also be tightly knitted into the local voluntary and community sector (VCS) fabric, as the Health and Social Care Act 2012 allows for greater involvement from VCS organisations in a much wider and diverse pool of health and social care providers.

In some cases, these relationships already exist in LINKs. In others, these relationships need significant work if Local Healthwatch is to be successful. An essential part of the transition process will be solidifying stakeholder relationships and integrating Local Healthwatch into the health and social care system. LINKs participants want to improve their understanding stakeholders' priorities, as well as national and local policy drivers, as they see this as important in building relationships.

Some East Midlands LINKs participants were of the opinion that formal written protocols were needed to properly establish relationships with different stakeholders, while others felt that they had built strong working protocols informally. Similarly, some suggested that protocols were something that could be written into the specification (i.e. set in advance), while others felt it should be up to Local Healthwatch to determine what the protocols should be.

Regardless of whether they are formally or informally established, productive working relationships take hard work and time to develop. In most cases, the success of these relationships is down to the people involved rather than formal processes or agreements for collaboration. Working relationships depend on the drive, interest and in some cases prior knowledge and relationships of the individuals involved.

5.1 Key health and social care stakeholders

5.1.1 Local authorities

Local authorities will be responsible for commissioning Local Healthwatch, determining its levels of funding, and ensuring it delivers against its target outcomes. While the central relationship for Local Healthwatch must always be with patients and the public, the relationship with the local authority is in many ways equally valuable to the operations and development of Local Healthwatch.

East Midlands LINKs participants value open communication with local authority commissioners. With a clear understanding of what commissioners are thinking, and importantly what constraints they are dealing with, LINKs members can contribute more effectively to the transition process.

LINKs participants also stressed that those who end up managing Local Healthwatch contracts need to understand the context and tasks of the organisations. It is about having the right people in the local authority, as well as in Local Healthwatch.

5.1.2 Health & Wellbeing Boards

Local Healthwatch will have a statutory seat on the local Health & Wellbeing Board. This will be the primary platform for Local Healthwatch to promote the needs and views of patients and the public. Health & Wellbeing Boards will also have a role in determining the work plan for Local Healthwatch, as they will be responsible for producing the Joint Strategic Needs Assessment (JSNA) which Local Healthwatch will need to work towards. This input into the JSNA was seen by LINKs participants as particularly important to keeping the work of Local Healthwatch focused on patient and public interests.

The Local Healthwatch representative on the Health & Wellbeing Board was a key concern when considering which posts should be paid and which should be filled by a volunteer. It was generally agreed that there needs to be some recognition of the commitment and contribution the person is making to the Health & Wellbeing Board, however not everyone felt this recognition needed to be in the form of a salary.

5.1.3 Clinical commissioning groups (CCGs)

The transfer of decision making power and responsibility for commissioning directly into the hands of GPs is one of the most significant reforms to be introduced by the Health and Social Care Act 2012. It also has a major impact on Local Healthwatch.

As a crucial source of information on patient and public perspectives, Local Healthwatch will have a responsibility for ensuring health and social care decision makers like CCGs are taking this information into account in commissioning processes. While the expectation is that CCGs will give due regard to the needs and views of patients and the public, how they exercise this responsibility in conjunction with Local Healthwatch will depend on the nature of the working relationships between the organisations.

East Midlands LINKs participants see establishing relationships with local CCGs and GPs as a priority. Local Healthwatch will need to ensure that a) local CCGs are aware of Local Healthwatch and its role within the health and social care system, and b) Local Healthwatch is seen as a credible and reliable resource to CCGs in their decision making.

At the time of writing, there is a concern among LINKs participants that GPs:

- do not know that Local Healthwatch organisations will exist
- are unaware of what LINKs currently do
- do not understand the concept of patient and public involvement.

LINKs participants stressed the importance of increasing the visibility of Healthwatch and finding an effective way of describing Healthwatch to different stakeholders (see Section 6.2 for more detail on national awareness campaigns). In terms of building working relationships with CCGs, LINKs members felt that having CCG representatives on Local Healthwatch Boards would be an important first step. LINKs members recognise that unlike Health & Wellbeing Boards, Local Healthwatch does not have a statutory right to be on CCG Boards. Where there is LINK / Local Healthwatch representation on CCG Boards, the representative is a non-voting member.

There is a strong sense of urgency in establishing relationships with CCGs, as some LINKs participants reported that CCGs in their areas were setting up their own 'mini-LINKs' as they do not know of the existing LINK and its work.

5.1.4 Voluntary and community sector

The Health and Social Care Act 2012 opens up service provision to a wider pool of stakeholders, including voluntary and community sector (VCS) organisations. VCS organisations also provide a valuable gateway to sub-sections of the community which may otherwise be hard to reach. Local Healthwatch will need to act now (at the planning stage) to establish strong relationships with VCS organisations, both as providers and as representatives of patients and the public.

In many areas of the East Midlands, LINKs have established relationships with VCS organisations. LINKs participants see it as important not to throw away these connections, which have taken a long time to establish. It was also noted that in some cases, working relationships with VCS organisations exist primarily with the host. If the host organisation were to no longer be involved, Local Healthwatch may not be able to legitimately claim the same connections to the VCS from the outset.

5.1.5 Other Local Healthwatch organisations

While there is a political barrier to formal regional working, LINKs participants valued the notion of informal regional working. Suggestions included sharing learning about how to capture volunteer commitment, sharing offices, and a regular coming together of Local Healthwatch organisations for mutual support.

The current structure of Healthwatch suggests that learning and best practice from Local Healthwatch organisations will be gathered by Healthwatch England, turned into guidance, and distributed back to the local organisations. There will be times,

however, when learning from other local areas will be needed sooner rather than later. One such example is the learning from Local Healthwatch pathfinders during the transition period. In these cases having established relationships and communication channels between Local Healthwatch organisations can allow for informal and interim sharing of knowledge, support and best practice.

6 Relationship with Healthwatch England

East Midlands LINKs participants welcome the direct connection to the national level provided by Healthwatch England. While their interactions with national partners such as the CQC and the Department of Health have slowly improved in recent months, instances of good relations between the local and national levels are still too few and far between. It was generally felt that messages from the top (whether from the Department of Health or the CQC) take too long to reach the local level, and are often distorted along the way. Healthwatch England can potentially smooth communication and act as a powerful connection for local voices to national partners.

6.1 The functions of Healthwatch England

While it does have potentially valuable contributions, Healthwatch England is also an additional player in an already complex system. LINKs participants urgently need to know the exact division of responsibilities between Local Healthwatch, Healthwatch England and the CQC. Crucially, LINKs participants also want to know how those different responsibilities will be coordinated. This is especially important for broader functions such as monitoring (Enter & Views), communications, and data collection and analysis, which seem to lie within the remit of both Local Healthwatch and Healthwatch England.

This message also needs to be transmitted to patients, the public and other health and social care stakeholders. LINKs participants see national communications as a top priority for a newly-formed Healthwatch England, and a central part of the “leadership and support” it will provide.

6.2 National communications

A primary concern for LINKs participants was a national awareness campaign for Healthwatch, which they see as the responsibility of Healthwatch England to lead. LINKs participants recognise that the demand for Local Healthwatch’s services will not necessarily turn on like a tap from April 2013 – growing that demand will require public awareness. But it will also require health and social care stakeholders to have a strong understanding of the responsibilities and purpose of Local Healthwatch, and the expectations on stakeholders to engage with Local Healthwatch and prioritise patient and public involvement in service development. Healthwatch England can play a valuable role in ensuring there is a consistency of message and shared understanding across the country.

6.3 The nature of the relationship between Local Healthwatch and Healthwatch England

There have been some mixed messages on what is the exact nature of the relationship between Local Healthwatch and Healthwatch England, and how other agencies like local authorities and the CQC fit in. LINKs participants stressed the need for clarity, but insisted there should be direct lines of communication (but not direct accountability) between Local Healthwatch and Healthwatch England. Reporting requirements for Local Healthwatch to Healthwatch England will also need to be clarified as reporting can use significant financial and human resources.

6.4 Timetable for Healthwatch England

LINKs participants were pleased to see that the changes in the timeline will mean Healthwatch England will be established before Local Healthwatch is launched. However, the primary advantage of setting up Healthwatch England first is to have guidance and pathfinder learning distributed in time to feed into Local Healthwatch plans. LINKs participants are concerned that despite the delayed launch of Local Healthwatch, this information will still not be ready in time.

There is also scepticism from many LINKs participants that the guidance on leadership and governance promised by Healthwatch England will come in advance of local authorities having to finalise their specifications and go out to tender.

6.4.1 Lack of guidance on pathfinder reporting

Pathfinder areas reported that they have not been given any guidance on when and how to report on their work. LINKs participants are concerned that if pathfinder reporting is not clarified, then the learning from these projects may a) not be taken into account in setting up Healthwatch England, and b) not be made available to non-pathfinder areas to assist in the set-up of Local Healthwatch.

6.5 Existing relations with the CQC

East Midlands LINKs have had inconsistent relationships with the CQC. Some areas have done individual pieces of work with the CQC that have proven useful, but the change-over of CQC staff has been highly disruptive in establishing ongoing working relationships. Several LINKs also reported that CQC regional representatives have seemed unclear how to work with LINKs and lack understanding of LINKs' capacity to respond to CQC requests. LINKs participants would like the CQC to be more visible in the future, and to have clear working protocols with Local Healthwatch (including protocols for sharing information).

There is a significant concern among LINKs participants that monitoring be better coordinated between Local Healthwatch, local authorities and the CQC. In particular more joined up inspections will be important so providers are not over-burdened with monitoring requirements, distracting them from providing a quality service to patients. Milton Keynes was the only area to report an improved relationship with the CQC in recent months. They have recently begun conversations between the LINK, local authority and CQC regional rep to better coordinate Enter & Views in the area. Other areas indicated this would be a useful approach for determining what information each organisation is collecting, in what form, and how that information is being used and shared.

For a more detailed list of questions raised by commissioners and LINKs participants about Healthwatch England, see Appendix B: Questions on Healthwatch England from the East Midlands.

7 Smoothing the transition from LINKs to Local Healthwatch

The transition process is complex, unpredictable and subject to countless influences. However this does not mean that all obstacles are unavoidable. In the course of discussions, East Midlands LINKs participants have identified potential problems, and in some cases solutions, at four different stages of the transition to Local Healthwatch:

1. Continuation and completion of LINK work
2. Implementation of pathfinder programmes
3. Commissioning of Local Healthwatch
4. Handover from LINK to Local Healthwatch

7.1 Continuation and completion of LINK work

East Midlands LINKs participants repeatedly stressed the need to make decisions (and/or revisions) on the work plan, budget and hosting arrangements for LINKs between now and the launch of Local Healthwatch in April 2013. LINKs participants were concerned they may have to prioritise and reduce activity during the transition period because resources will be redirected to setting up Local Healthwatch, there could potentially be less money over all, and staff and volunteer numbers may fluctuate during periods of uncertainty.

These decisions were seen as the responsibility of local authorities, in discussion with LINKs Boards and hosts. Setting up a shadow Local Healthwatch board quickly was seen as important so the LINK could continue to deliver LINK work and the shadow board could handle Local Healthwatch.

7.2 Implementation of pathfinder programmes

Five of the ten LINKs participating in the programme are Local Healthwatch pathfinders: Derby City, Leicester City, Leicestershire, Lincolnshire and Northamptonshire. Pathfinder programmes aim to test the plans and functions of Local Healthwatch in advance of their launch in April 2013. The pathfinder work must be delivered in addition to the work they are mandated to complete as LINKs.

There were complaints from pathfinder areas that they have no learning sets or other information sharing mechanisms, that they have not been told what other

pathfinders are working on the same issues, and that they have not been given any national direction on how to report on their work. Both pathfinder and non-pathfinder areas question how useful, relevant and timely the information from the pathfinders will be to others.

LINKs participants asked that Healthwatch England or the Department of Health clarify the reporting requirements for pathfinders and say when the learning would be made available to others. In the meantime, LINKs members suggested that there is an opportunity for East Midlands pathfinders to informally share work in progress in future regional sessions.

7.3 Commissioning Local Healthwatch

The primary concern for LINKs participants in the commissioning of Local Healthwatch was the genuine involvement of members of the public in that process. This was seen as vital in setting the expectation of patients and the public as the central focus of Local Healthwatch.

7.4 Handover from LINKs to Local Healthwatch

If there is going to be a transfer of responsibility from one provider to another, an effective handover needs to be planned. For LINKs with good host relationships, changing providers was seen as an unnecessary disruption of productive local working relationships and infrastructure. For other areas, a change in provider raised concerns that intelligence, databases and other resources be transferred to a new organisation. LINKs participants felt that the timeline should include some parallel running time between LINKs and Local Healthwatch, particularly if there was going to be a change in provider (host).

LINKs participants recommended that TUPEing staff and building a transition or launch period into the Local Healthwatch contract could smooth the transition and prevent a vacuum created by loss of knowledge and capacity.