

Oldham

LINK

MAKE IT HAPPEN!

Local Involvement Network

Report of the

Oldham LINK Consultation Workshop:

Equity & Fairness: Liberating the NHS



Monday 27th September 2010

Supported by Gaddum Centre Host Support Organisation



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1 Introduction

1.1 In July 2010, the Department of Health released its proposals for transformations within the NHS - "Equity & Excellence: Liberating the NHS" – which set out a "bold vision" for its future, described as being based upon the coalition's core principles of freedom, fairness and responsibility (DofH, 2010, p1). Its ambition is to:

"...once again make the NHS the envy if the world. Liberating the NHS – a blend of Conservative and Liberal Democrat ideas – sets out our plans to do this." (DofH, 2010, p1).

1.2 Liberating the NHS sets out the government's plans to achieve its ambition, focusing upon:

- **Putting patients at the heart of everything the government does**, by increasing choice and control to make decisions about their care by having easy access to accurate, trustworthy and good quality information.
- **Clinical outcomes** – success is to be measured against patients having better health outcomes and seeing an improvement to their health (e.g. by improving cancer and stroke survival rates)
- **Placing clinicians and health professionals within the driving seat of healthcare**, so that professional judgement can determine patient treatment by giving front line staff more control.

1.3 The government's strategy for the NHS is detailed within the White Paper document against four key sections:

- Putting patients and the public first
- Improving healthcare outcomes
- Autonomy, accountability and democratic legitimacy
- Cutting bureaucracy and improving efficiency

Supplementary, more detailed consultation documents were subsequently published against each of these areas, in which there contained a series of consultation

questions regarding the government's proposals for an independent champion for health and social care 'consumers' called HealthWatch. The main proposals on HealthWatch were outlined in the main White Paper published on 12th July 2010.

- 1.4 Local Involvement Networks (LINKs) will become local HealthWatch organisations and, as such, will replace the current arrangements through each existing LINK to monitor and scrutinise services; gather views, opinions and experiences from patients, users and carers; and promote public, user and carer engagement within the decision making processes of the services that affect them so as to be able to influence the nature of the commissioning decisions taken about their care.



Alan Higgins, Director of Public Health for Oldham, addresses participants of the LINK consultation

- 1.5 With this in mind, it seemed appropriate for Oldham LINK to focus on the proposals for HealthWatch so that local people were able to inform and shape the development of their new local HealthWatch and to input into the plans for HealthWatch England. This also fits with Oldham LINK's objective of endeavouring to keep the local population informed of policy changes that affects it and to broaden participation within decision making processes that affect Oldham's communities.

2 Methodology

2.1 People living and working in Oldham were invited to attend a consultation workshop session, which took place on 27th September 2010 at the Link Centre, Union Street, Oldham. The purpose of this session was to:

- Provide an overview of the White Paper content and legislative process.
- Focus on the implications of the proposals for patients, service users and carers.
- Enable participation within the consultation process in order to influence the resulting legislation.



Ursula Hussain, Manager of Oldham LINK, presenting to participants the key aspects of the proposals.

2.2 The session was hosted by Gaddum Centre, Oldham LINK's the Host Support Organisation. The content of the White Paper was presented, with key note speeches from representatives of NHS Oldham/Oldham MBC regarding what patients should expect whilst the transition takes place to replace the commissioning functions of Primary Care Trusts; and what the implications of the proposals mean for the future of public health.

2.3 Whilst the presentation of content covered each aspect of the White Paper, the workshop placed a particular emphasis on the sections "Putting Patients and the Public First" and "Autonomy, Accountability & Democratic Legitimacy". In terms of the patient and public voice and enabling the participants to make informed comments on the HealthWatch proposals, these two areas were considered to be of the most relevance.

2.4 The final aspect of the day's event was structured using four facilitated discussion workshops to respond to the HealthWatch consultation questions. A number of key

issues were highlighted and selected for exploration, although not each and every question specified by the Department of Health within the HealthWatch consultation document were considered due to the availability of time.



Workshop discussion group facilitated by Oldham LINK Governors Nicola Shore (Age Concern Oldham) and Miranda Deblasio (Princess Royal Trust Oldham Carers Centre).

2.5 A total of 48 people attended and took part in the workshop, which comprised predominantly of members of the public and only a small proportion of professionals. The information detailed within Section 3 contains the responses and results from the discussion groups and constitutes Oldham LINK's formal response to the consultation.

3 Consultation Responses

Key themes emerging from across each discussion group have been surmised in most cases, with comment and observation added where further thought and analysis was prompted from the participants' contributions. Details of some the individual points raised have been included where they have been helpful to convey meaning and example.

Consultation Question 1:

3.1 What needs to happen for local HealthWatch to fulfil its new functions around health and complaints advocacy?

Participants felt that they needed firmer information beyond the proposals for them to be able to fully comment within this consultation.

Discussion however centred on firstly needing to make a distinction between two issues:

1. What needs to happen for complaints advocacy?
2. What needs to be done to enable choice?



Participants considering complaints advocacy, facilitated by LINK Development Worker, Laura Chidgey and Nayan Joshi, Voluntary Action Oldham (LINK partner organisation & Member).

3.1.1 Information, Promotion & Awareness Raising

3.1.1.1 Each group spent a significant proportion of time focusing on the need to promote the availability of the service and as such was a key emerging theme in terms of enabling HealthWatch to fulfil a health and complaints advocacy role. The importance of a need for a strong marketing role was highlighted several times.

3.1.1.2 A number of suggestions were made about how this could practically be done by local HealthWatch, such as making good use of community networks and local community and voluntary organisations. It was felt that the onus for ensuring that the people of Oldham were well informed about the advocacy service available should reside with the Local Authority.

3.1.1.3 It was suggested that communications sent out to households by the Council could be made use of, such as the census mailing for example, which would ensure that every household in Oldham could receive information about what is available to people in terms of health complaints advocacy.

3.1.1.4 A relevant point was raised in that people may be unaware of the new procedures surrounding HealthWatch, and that a "one-stop shop" or a single point of access for information may be the solution to this.

3.1.1.5 This issue of making it easy for people to get help and information and making this more straight-forward was also raised. Again, people reported that it should be the responsibility of the Local Authority to do this.

"What could HealthWatch do to make sure they [service providers/ commissioners] need to do the work?"

"The public would need to know what services are around in their local area".

3.1.1.6 An up-to-date distribution of information is needed, and should be made available in different formats (e.g. brail, large type etc) and every part of the community should be considered.

3.1.1.7 The language and format of the literature should also be easy to understand and devoid of any complex jargon.

3.1.2 Skills Set & Staff Attributes

3.1.2.1 Provision of an advocacy service would require a skills set beyond those required for public engagement. If LINKs are to develop into HealthWatch, contractual arrangements would need to ensure competency for advocacy provision in addition to the skills and knowledge base currently required by LINKs teams.



Participants were able to share their own experiences of their interactions with services to agree upon a useful set of attributes for HealthWatch staff.

3.1.2.2 Participants commented that the first things which come to mind when asked what the people working for local HealthWatch need to have were;

- the ability to do the job
- the proper training
- an appropriate level of experience
- “people person” attributes – the ability to empathise with people
- knowledge of the needs of people in the local area

3.1.2.3 The organisation supporting local HealthWatch must also be able to show a demonstrable track record in delivering not only the elements that LINKs currently provide, but also the new addition within local HealthWatch of information, advice and advocacy (should the Local Authority is to commission this strand from local HealthWatch).

3.1.3 Complaints Processes

Discussions around this consultation question also prompted a number comments, suggestions and questions about the nature of complaints and complaints management.

3.1.3.1 Change complaints system to truly independent review

3.1.3.2 Will this replace PALS?

3.1.3.3 Complaints should be run by patients.

3.1.3.4 Rules of engagement –how will complaints be used to improve standards of service?

3.1.3.5 Involve and keep complainants informed throughout the complaint investigation process.

3.1.4 Miscellaneous

3.1.4.1 Consultation within GP surgeries would be required to make service care effective.

3.1.4.2 We can only build service once we know how much funding we have.

3.1.4.3 Capacity – need more as casework will mean increased working with specific individuals.

Consultation Question 2:

3.2 What needs to happen for local HealthWatch to support people making choices, in particular to support people who do not have the means or capacity to make choices about their care?

3.2.1 Signposting, Promotion & Communication

- 3.2.1.1 Promotion, marketing and awareness raising activity was prioritised across all discussion groups, with all participants commenting on the importance of this. A number of ways to approach this were considered.
- 3.2.1.2 The benefit of frontline health and social care services/workers promoting HealthWatch and signposting clients/patients to it was considered, and deemed to be very important. This should primarily include GP's; Health Visitors; District Nurses; Social Workers/Care Managers; Occupational Therapists; Care Workers, hospital staff etc.
- 3.2.1.3 Clear information about how to access the HealthWatch service for information in order to make choices about care options must be provided by a variety of mechanisms. Venues accessed by a high volume of potential HealthWatch 'users' should be targeted, e.g. GP surgeries, dentists, hospitals etc. Promotion in more generic venues was also considered, such as libraries, shops etc.
- 3.2.1.4 Appreciating the need to recognise that the Internet is not the answer for everyone regarding appropriate communication methods was also raised.
- 3.2.1.5 Due consideration to people that may be 'housebound' should also to be given, who would of course not gain information via public places. The importance of front-line workers (e.g. domiciliary care workers, District Nurses, Social Workers etc) promoting HealthWatch would be particularly enhanced within this type of scenario.

3.2.1.6 Making use of networks developed via LINKs would also be useful to promote and raise awareness of HealthWatch (and to prepare people for the transition). It was however felt that the *onus* for ensuring that **every** Oldham resident was informed about HealthWatch should reside with the Local Authority.

3.2.2 Carers, Families & Independent Advocacy

3.2.2.1 Independent advocacy was discussed across the groups as being an important and necessary function of HealthWatch being successfully and ethically able to support people to make decisions about their care, where there were issues regarding vulnerability and compromised capacity.



Question & answer session during the event

3.2.2.2 A number of issues were discussed concerning the role that carers and families have to play in supporting service users with compromised capacity to make social care choices. Whilst the focus must of course be upon the user/patient themselves, to ensure that their needs and wishes are central to the decisions made about their care choices, recognition that carers and family

members often have a broader perspective to contribute should also be accounted for and that decisions taken should be located within the context. It was felt important for HealthWatch workers to work closely with carers and families in these circumstances.

3.2.2.3 HealthWatch providing independent advocacy however in such cases was one means discussed to manage any conflict of interest between carers' wishes and opinions and the user/patient's wishes and point of view. This would serve to manage the potential for abuse of a vulnerable person whose family/carers may be involved in determining the final decision or option taken, which would of course be

a possibility when involving a third party to engage in a person's decision-making should they have compromised capacity.

3.2.2.4 Comment was also made about adequate financial resource being allocated to the advocacy element of HealthWatch so that firstly, the positions will attract high caliber candidates to contribute to high quality case work and that secondly, the advocacy 'branch' had adequate capacity to be able to respond promptly to meet need and demand. It was felt that where lengthy waiting lists operate, clients often get 'missed' and that cases requiring urgent or timely attention are not accommodated. If this were to be the case, participants felt that HealthWatch would not be able to provide a service comprehensive enough for it to properly support people who lack the means or capacity to make choices about their care.

3.2.3 Staffing Issues

3.2.3.1 The comprehensive and complex undertaking of HealthWatch needs to be acknowledged in terms of salary grading of positions, so as to reflect the magnitude of the responsibility that HealthWatch must assume.

3.2.3.2 Participants had mixed views about whether advocates should be paid, professional or voluntary. Perhaps a mix of both may be appropriate, but patients/public would need suitable supporting and training. A distinction would need to be made however about which types of cases it would and would not be appropriate to allocate less experienced and less qualified advocates to. An overarching initial assessment by a senior advocate may mediate this.

3.2.3.3 HealthWatch may initially need a very high staffing level to be able to meet initial expectations and to meet demand.

3.2.4 Miscellaneous

- 3.2.4.1 Identify what support people with compromised capacity are getting now and what they will need in the future.
- 3.2.4.2 Use the Quality Outcomes Framework (QOF) to incentivise GPs.
- 3.2.4.3 Make it a statutory duty to inform patients and the public about HealthWatch.
- 3.2.4.4 PALS are already very helpful and well qualified – make use of their expertise.
- 3.2.4.5 Ensure there is 'transparency of purpose' communicated.

3.2.5 Supplementary Questions

A number of questions arose for people from their discussion of consultation question 2:

- 3.2.5.1 What will HealthWatch look like?
- 3.2.5.2 How many people will there be working for HealthWatch and what skills will they have?
- 3.2.5.3 What sort of 'power' will they have?
- 3.2.5.4 Will it be independent?
- 3.2.5.5 Can we base these people (HealthWatch workers) in GP surgeries? (Think about confidentiality).
- 3.2.5.6 Who will manage all this and scrutinise the procedure? (Think about having 'champions' in GP surgeries).
- 3.2.5.7 Are people really having a choice?

Consultation Question 3:

3.3 How should HealthWatch England and local HealthWatch relate to and work with other patient and community groups and structures, and what principles should underpin this relationship?

3.3.1 Relationships between HealthWatch and other Groups

3.3.1.1 HealthWatch should relate to other groups recognising that they are their own authority upon which HealthWatch can build and support. HealthWatch must build good 'personable' (whilst formalised) relationships with other groups so that the relevance of their work and the clientele they work with can feed into the HealthWatch service. The networks and relationships already established via LINKs should be the foundation from which HealthWatch should build.

3.3.1.2 HealthWatch England should have role to engage with key national interest organisations within the Third Sector to develop national alliances and relationships. Local HealthWatch should replicate this locally, extending this to smaller groups too.

3.3.1.3 HealthWatch should recognise the variety and breadth of work of existing groups and by developing a continual dialogue, to ensure that issues addressed or approaches used are not duplicated. Perhaps local HealthWatch may need to undertake an initial audit of activity, as a refresh of similar undertakings conducted by LINKs.

3.3.2 Working with other Groups

3.3.2.1 HealthWatch should be in continual contact with community and patient groups, ensuring that there is an effective communications strategy in place to provide 360 degree feedback and to ensure that communication mechanisms enable a collaborative approach from the 3rd sector to HealthWatch succeeding.

3.3.2.2 HealthWatch should act as an over-arching co-ordinator in feeding groups and their activity in to informing HealthWatch's work. The networking function of LINKs should not be lost when HealthWatch is introduced.

3.3.3 Underpinning Principles of Working with Other Groups

3.3.3.1 Clearly identified and commitment to a common cause – i.e. improving the patient experience of patients/service users and to enabling interactions with them to lead to improved service delivery.

3.3.3.2 There must be a clear distinction between the different roles of HealthWatch and other respective groups, with clear delineations of responsibility for HealthWatch and groups.

3.3.3.3 Working with HealthWatch should provide a benefit or advantage to local groups, either to strengthen, support or collaborate for mutual benefit, and should be the basis of working together.

3.3.3.4 Respect for the positions of HealthWatch and individual groups is important, and ensuring a confidence for groups to engage is vital.

3.3.3.5 Groups should be reassured around issues of confidentiality and that their integrity would not be compromised by working with HealthWatch.

Consultation Question 4:

3.4 How should local HealthWatch work with the local authority and GP consortia to influence commissioning decisions?

3.4.1 Building Relationships

3.4.1.1 The importance of HealthWatch building relationships with both bodies was recognised as being important, so as to develop close working practices. A spirit and openness and collaboration was discussed as being the best way forward, rather than purely taking a role to scrutinise and criticise services and commissioning arrangements.

"Be careful it doesn't become just a complaints processing body. It should be about sharing what's working well too."



LINK members and workshop participants finding ways forward to work together with GP Consortia to influence commissioning decisions within new commissioning arrangements. LINK Governor Paul Benedek, LINK Outreach & Engagement Worker, Jade Czuba, and NHS Oldham's Associate Director for Stakeholder Engagement, Mark Drury, support the discussion.

3.4.1.2 It would be useful for the public to be able to begin conversations ahead of the establishment of new arrangements, so as to be part of the development and shaping of structures. This would ensure that patient engagement mechanisms can be truly embedded from the start. This is not to deny the importance of clinical judgement and a focus on outcomes to predominantly determine the nature of services to be commissioned but rather to operate upon a principle of “co-production” between patients and commissioners to shape services to achieve the ‘best-fit’ possible for patients.

3.4.1.2 Comment was also made about the importance of the local authority and the GP Consortia themselves proactively seeking to develop relationships with HealthWatch. This would also be necessary for GP Consortia to be compliant with Section 242 of the NHS Act 2006 regarding their duty as a statutory body to consult and engage with patients and the public concerning issues of service change. Ongoing dialogue however rather than sporadic liaisons concerning only major service change examples would appear to bear more fruit in terms of achieving better health outcomes and to develop best practice approaches to putting patients and the public first.

3.4.2 “Co-Production”

3.4.2.1 The term “Co-production” within a public services context refers to the production of public services through the contribution of service users and communities, making use of their resources, expertise and willingness to provide legitimacy to services, together with professional service providers (Needham, 2009). Co-production in this sense is distinctively different from co-production between organisations, which amongst the sector is more often referred to as 'partnership working'. Within a social care setting, the model advocates that patients, users and their carers discuss with professionals which services are likely to be most appropriate in each particular case.

***“Don’t talk
about us, talk
to us.”***

- 3.4.2.2 The recent renewed interest in co-production, especially in the UK and Australia, has arisen from a combination of forces, including the realisation of the valuable contribution which it can make to public service improvement; the desire to find effective ways to achieve citizen empowerment; and the belief that the mobilisation of resources from service users and citizens can cut public sector costs.
- 3.4.2.3 More recently, the UK Cabinet Office (2009) has highlighted findings from an international study (Loeffler et al, 2008) within its report on co-production of public services, which suggested that there are a number of ways in which co-production might help the transformation of public services.
- 3.4.2.4 Current UK projects are being undertaken to set out the research agenda for co-production in relation to local government services (e.g. The Local Authorities Research Council Initiative), from which local work could build.
- 3.4.2.5 Co-production in this manner aligns with the coalition's principle of "shared decision-making" becoming the norm (NHS, 2010) and for the aspiration of making "no decision about me without me" to be realised. As the White Paper explains:
- "International evidence shows that involving patients in their care and treatment improves their health outcomes, boosts their satisfaction with services received, and increases not just their knowledge and understanding of their health status but also their adherence to a chosen treatment. It can also bring a significant reduction in cost...and improve the management of long-term conditions."* (NHS, 2010, p.13).

3.4.3 Aligning the Commissioning Cycle

- 3.4.3.1 For HealthWatch to be able to influence commissioning processes, it will indeed need to be part of the process itself. The model of co-production fits quite neatly to embed participation within each of the main quadrants, particularly if we consider Loeffler et al's address to the 2006 European Quality Conference in Public Administration, which emphasised the importance of the "4 Co's": Co-Design; Co-Decide; Co-Deliver; and Co-Assess (see Loeffler et al, 2008).

3.4.3.2 The most rudimentary elements of any commissioning cycle typically follow the sequence at Figure 1:

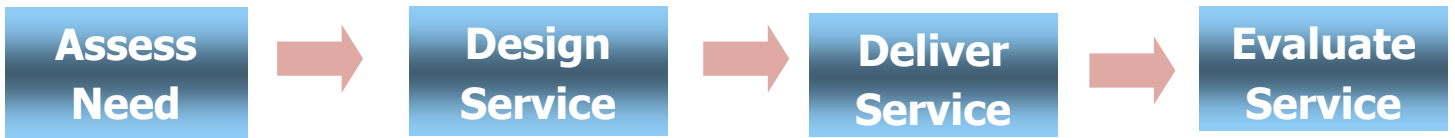


Figure 1

3.4.3.3 HealthWatch involvement within each quadrant element would be required for shared decision making (see NHS, 2010, p.13) - as a means of the coalition's strategic objective of putting patients and the public first – to be realised.

3.4.3.4 Figure 2 shows how patients engagement, using the principles of co-production could translate to each of the commissioning quadrants:

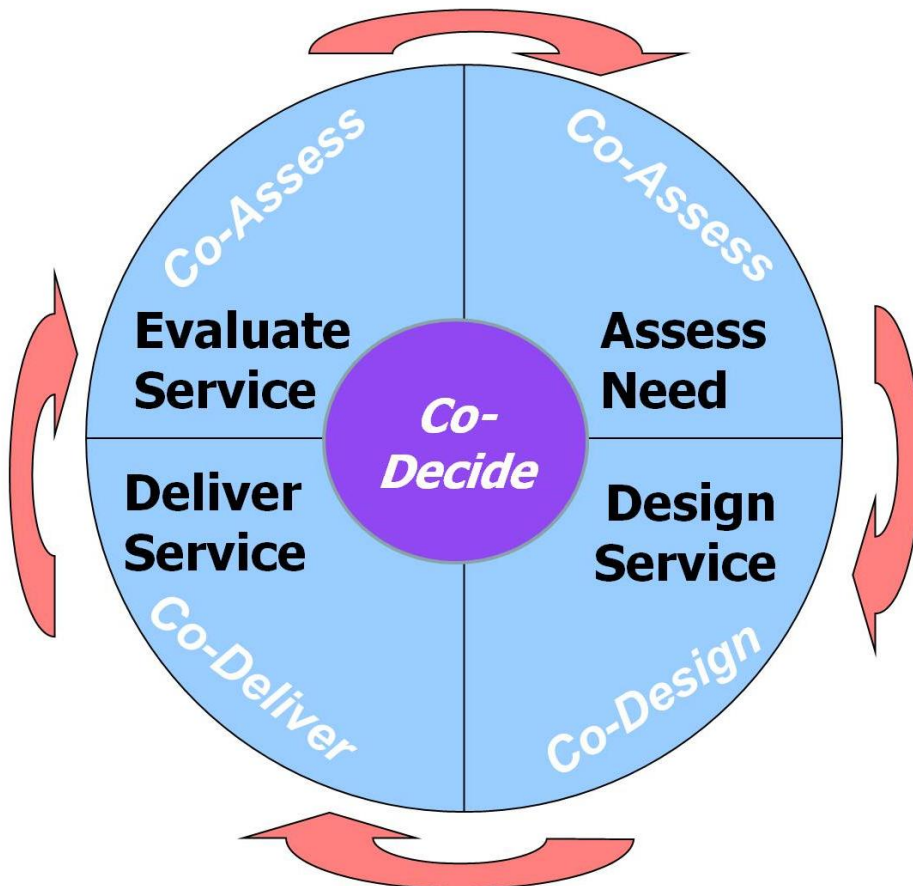


Figure 2

3.4.4 Existing Local Models of Practice

3.4.4.1 Building upon the foundations that the LINK programme in Oldham has embedded would be a useful starting point from which to formalise and develop these relationships, as well as looking to other engagement structures within the Borough that could also be expanded upon.

3.4.4.2 One particular area of practice - concerning engagement within commissioning practices by a method of public consultation and co-production - that has been well worked up is the Oldham Standing Conference. This is a mental health consultation event that has been embedded within a wider three-tier model to ensure: networking across the sector; issues of local priority can be determined; and that users, carers, patients and professionals as key stakeholders of services are engaged in a structured process to collaborate with local commissioners. This work has shown to have informed and influenced commissioning practices.

3.4.4.3 The conference is hosted by Oldham LINK, and received added capacity for its initial development from Tameside, Oldham and Glossop Mind. The conference is supported by NHS Oldham - as the current commissioning body - which is a key partner in embedding the event's public engagement element within local mental health commissioning practices. This activity has shown that having a close working relationship and a structured open dialogue between key mental health commissioning personnel and local people can and has supported

"HealthWatch needs to be a part of the GP consortia and local authority and involved in commissioning decisions."

commissioner's own practices. This model has achieved regional recognition by NHS North West, with another six Primary Care Trusts within the region looking to replicate it as an example of good practice.

3.4.4.4 Participants commented that it would be useful and mutually beneficial for a patient/public representative via HealthWatch to sit on the new Commissioning Board, as one way of working with the GP Clinical Commissioning Consortia. It is worth noting that a number of elected individual representatives of the Oldham Standing Conference have a role to input into the existing Programme Board commissioning structure as a means of streamlining and 'funnelling' the involvement of the public event element into commissioning decision-making processes. A similar form of representation could be developed with new commissioning arrangements to make it fit in a way appropriate to new arrangements, or indeed to support how these arrangements are framed, so as to allow for manageable public engagement at executive level. This would be one way of accommodating the perspective of individuals represented within this consultation.

3.4.4.5 This model could be applied to and replicated for any area of health and/or social care service and adapted to fit – or indeed used to help shape – emerging commissioning structures. It may prove to be a useful starting point for GP Clinical Commissioning Consortia to begin to consider the nature of its public engagement practices and for the local authority to consider how to develop its public engagement relationship via HealthWatch.

"It needs to be made up of local people who have the time and enthusiasm to make changes for their community and environment."

Consultation Question 5:

3.5 What needs to happen for local HealthWatch to support the needs of vulnerable people – such as older or very frail people?

- 3.5.1 Firstly, participants felt that the terms “vulnerable” and “frail” must be defined so that all parties could have a shared understanding. In addition to patients and service users, groups felt that carers should be included within this ‘vulnerable’ bracket. It was suggested that members of the public and other patient and interest groups could work with the GP Consortia to determine this from a perspective understood by particular communities that may be considered to be within these groups.
- 3.5.2 In communicating the availability of the HealthWatch service as described above, it must be acknowledged that electronic and on-line methods of communication will be largely inappropriate for these groups of people and that any communication strategy should account for this.
- "Remember that one size does not fit all".***
- 3.5.3 Suggestions to promote the service via frontline workers as detailed above were again made as a means of an alternative approach to promotion.
- 3.5.4 Identification of older, frail and other vulnerable people could be assisted via GP patient lists. Whilst it is acknowledged that patient details could not be disclosed for HealthWatch to directly make contact, GP surgeries themselves could circulate targeted information to this patient group.
- 3.5.5 Making good use of the contacts and networks local community groups and services have with more vulnerable members of the community could also be explored. Linking up with sheltered accommodation schemes and services that already support vulnerable groups would also be beneficial to identify and build relationships with this client group.

- 3.5.6 Census data could also be used to identify and target older people.
- 3.5.7 Local Authorities should take ownership for informing people, as discussed above.
- 3.5.8 A very personal one-to-one approach to working with vulnerable people would be needed and would perhaps require individual case work to enable people to make good use of the service. This would require additional resources in terms of staffing capacity, as it would take a great deal more time to provide the same information and support than it would for a person not within this category to access and make use of the service.

Consultation Question 6:

3.6 What needs to happen for HealthWatch to champion the rights of people who lack capacity to make decisions about their care?

- 3.6.1 Advocacy provision was considered to be an important topic across all discussion groups. It was not felt adequate for the HealthWatch service to simply be an information service, as this would not accommodate the needs certainly of people who lack capacity to make their own decisions but also of those vulnerable groups, such as carers for example, who are already under significant strain. This would be one way to champion people's rights on an individual basis.

"Need to be able to listen and fight for the parents/service users/carer's rights".

- 3.6.2 HealthWatch's own staffing compliment and service ethos must be framed within an understanding and commitment to promote the rights of people who lack capacity to make care-decisions themselves and to have clear organisational objectives

against which to perform. Staff must have a clear expertise of working with this client group. Championing the rights of people that are not able to advocate on their own behalf must be integral to the work of HealthWatch in its entirety.

"Should use lots of different methods rather than focussing on one or two."

3.6.3 Support at this level as an early intervention was considered to be a means of stopping the 'revolving door syndrome' and would prove to be cost-effective in the long term.

3.6.4 More broadly, HealthWatch could work with other existing campaigning/lobbying organisations that have a firm track record in campaigning for the rights of vulnerable people and/or for those with compromised capacity. This should be at both the national and local level. Participants provided examples, such as Shelter and the Salvation Army.

Local examples also exist, such as OPAL, Dementia Support Group, Mind, Princess Royal Trust Oldham Carers Centre, to name just a few.

3.6.5 Local HealthWatch should, as part of its networking and relationship building activity, seek to support and co-ordinate local campaigning activity and mobilise resources from within both voluntary groups and more established Third Sector organisations. This should be to recognise the value of long established local organisations and their roots within a local area.



Members of community support groups and local voluntary organisations were present to discuss the best ways to work together.

3.6.6 In so doing, participants reported that HealthWatch would need to undertake a level of preparatory work with such organisations to demonstrate the benefit of

their involvement with HealthWatch. This would be an important prerequisite to ensuring 'buy-in' and to ensure their formal commitment and involvement as partners of HealthWatch. This reflects a similar experience during the development work to establish LINKs, whereby demonstrating how the aim of an organisation could be furthered by becoming a LINK member needed to be communicated so as to build and strengthen the collective influence of the Network.

Consultation Question 7:

3.7 What role should HealthWatch England and local authorities play in assessing the effectiveness of local HealthWatch?

3.7.1 "Process" & "Content"

3.7.1.1 The experience of Local Involvement Networks has shown that when considering "effectiveness", a distinction must be made between *process* and *content*.

3.7.1.2 There is a role within contract compliance to assess the process by which the work of local HealthWatch is undertaken in relation to it performing against certain key performance indicators – i.e. the methods and means by which the support organisation seeks to achieve its objectives. The *content* however – or rather the outcomes that are achieved in relation to patient experience and service development – is somewhat beyond the control of the local HealthWatch organisation and relies more so upon the actions taken by service commissioners and providers. To measure local HealthWatch's *effectiveness* in terms of service change would be unfair. There is however a role for the effectiveness of 'content' to be assessed, although this must be considered within the wider external context.

3.7.2 Role of Local Authorities

3.7.2.1 Current proposals state that local authorities will be the contracting body of local HealthWatch organisations. From a contract management point of view, the local

authority will of course need to monitor how well its local HealthWatch is performing in terms of contract compliance. This should be distinguished from how *effective* the local HealthWatch is in terms of its outcomes relating to the nature of service design and development and the improvements to patient/user experience. What is meant by “effective” in this context must also be determined, although may be best determined by the public from their own perspective as ‘consumers’ of health and social care provision and how well HealthWatch is able to influence decisions that affect their care and their experience throughout their care pathway.

"If HealthWatch are advocating, they could be in effect fighting the local authority who are providing the service – which is a conflict in itself and may put people off approaching."

3.7.2.2 Local HealthWatch is to have a monitoring and scrutiny of local health and social care

services. Undoubtedly therefore, local HealthWatch will during some point of its life offer some critical challenge to the local authority as the provider/commissioner of social care services. Many participants considered that it would therefore be a significant conflict of interest for the effectiveness of local HealthWatch to be assessed by its own local authority.

3.7.2.3 One discussion group recorded concerns regarding how the political make-up of local authorities as a civic institution could potentially compromise providing a fair assessment of the effectiveness of local HealthWatch. As such, it was felt that this risk should be managed by completely removing the local authority as an assessor in determining how effective local HealthWatch is (with reference to measures beyond those of contract compliance).

3.7.3 HealthWatch England

3.7.3.1 HealthWatch England should have a role to assess the effectiveness of local HealthWatches. This is with a view to providing support to local HealthWatches to avoid inconsistency across levels of performance and to provide support to local HealthWatches that appear to be underperforming in comparison to the national average of activity. Of course, such an assessment tool developed by HealthWatch England would need to account for the variances between locales, although it would be useful to provide some consistent and comparable evaluation information on local HealthWatch performance.

3.7.3.2 The purpose of this should not be adversarial or negative but to simply identify gaps and provide guidance and support early, intervening so as to prevent the experience of the LINKs programme, which has shown that individual approaches of individual LINKs have yielded some very different results and differing levels of success to inform commissioning decisions.

3.7.3.3 This would also be useful to provide a standard measure of 'effectiveness', although, again, the nature of this should be determined in partnership with the patients and users that have the biggest stake in how effective their local HealthWatch is.

3.7.3.4 HealthWatch England assessments were also considered to reflect a possible conflict of interest in determining whether or not local HealthWatches are effective. HealthWatch England could neither be completely impartial nor disassociate its own interests in assessing local HealthWatches as 'good', regarding levels of effectiveness. For this reason – and those described at 7.1 – the consideration of a role for an independent scrutiniser/assessor of local HealthWatch was explored. It was felt that this may be the only mechanism to completely manage any conflict.

***"The community &
public should monitor
HealthWatch"***

3.7.4 Independent Assessment

3.7.4.1 Teachings can be drawn from existing models of 'customer' evaluation and assessment of services. *Peer Reviews* are currently used within cancer services to provide a role of independent scrutiny. The process is concerned not only with review of an organisation's compliance against a set of detailed measures as set out in the *Cancer Manual* care standards, but also with the qualitative assessment of a broad set of objectives for the delivery of services which will encompass the whole system of patient care and the patient and carer experience.

3.7.4.2 The Peer Review consists of the following key stages:

- **Pre-Assessment** - to include a self assessment of the degree of compliance against the quality measures (as set out in the Manual for Cancer Services 2004) and additional evidence particularly to support the implementation of Improving Outcomes Guidance (IOGs).
- **Peer Review Visit** - this is undertaken at a cancer network site which will provide opportunity for a more qualitative assessment
- **Action planning, implementation and follow up.**

3.7.4.3 This option would allow for independence within the role of assessment and provide 360 degree feedback from the stakeholders of the service. This would support the proposals of the White Paper to make "no decision about me without me" and promote patient participation to bring about a truly patient-led NHS. An assessment tool of this nature would complete the circle.

3.7.4.2 This approach would need to focus on the 'content' or outcome element regarding the effectiveness of local HealthWatch. Patients and the public could be used to develop the criteria against which to make their assessment. This is important because *how* assessment criteria are framed can result in a particular 'research bias', which if it is to exist, should be sympathetic to the stakeholders of the service. This should also be determined by patients to enable to results concerning HealthWatch's effectiveness are to be truly patient led.

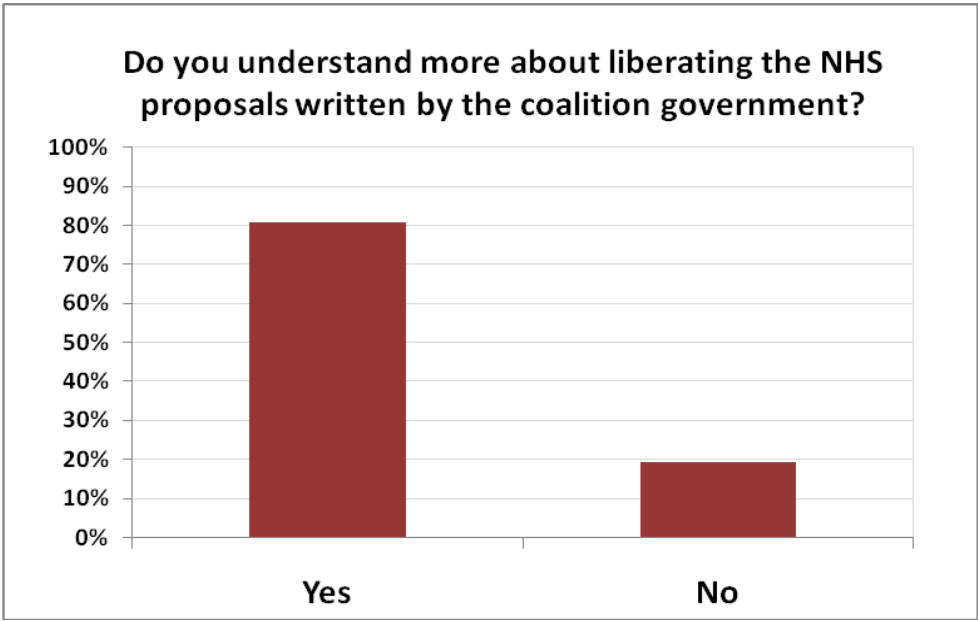
4 Participant Feedback & Evaluation

4.1 Liberating the NHS Consultation – Feedback from Delegates

The graphs in this section illustrate the responses gathered from the feedback forms given out at the Liberating the NHS Consultation which took place on Monday 27th September 2010.

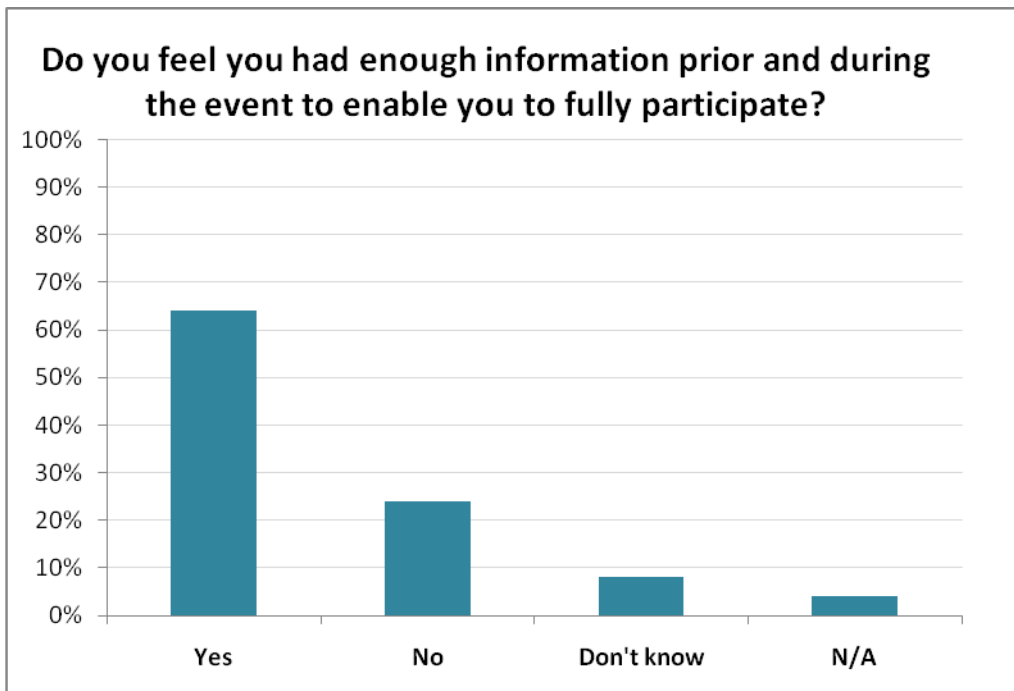
26 feedback forms were given out and collected at the end of the Consultation. The data has been collated and the results given in percentages which show the majority answers to the questions asked on the feedback forms.

Figure 3. Understanding of NHS proposals



4.2 The first question was “Do you understand more about the Liberating the NHS proposals written by the coalition government?” Figure 3 shows the response to this question; 80% of the participants stated that they did understand more about the NHS proposals after the consultation session, meaning that in this respect the workshop has been largely a success.

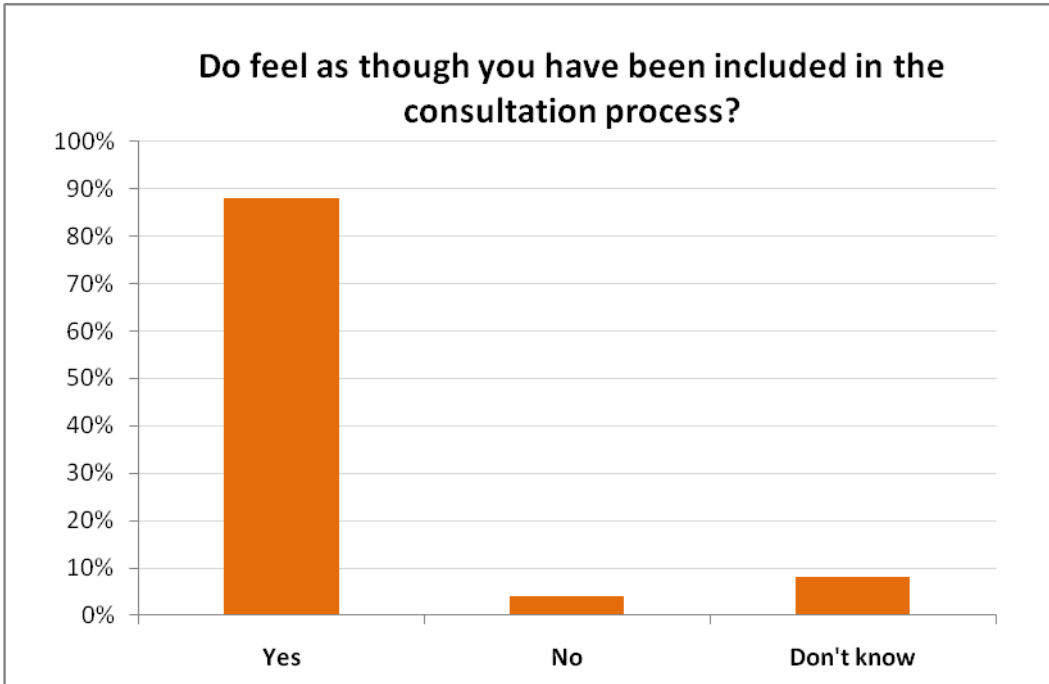
Figure 4. Enough information to participate



4.3 Figure 4 shows the response to the question "Do you feel you had enough information prior and during the event to enable you to fully participate?" The answers to this question reflect how well the Oldham LINK host team distributed information both prior and during the event.

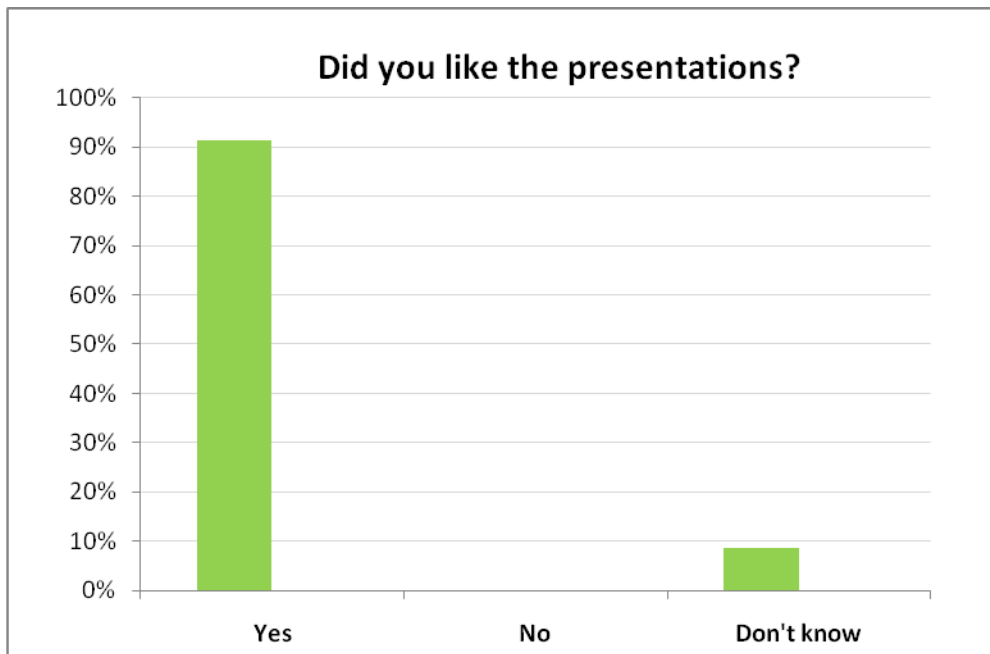
4.4 The response here was not so clear cut as the response to Question 1 (as shown in Figure 3), with 64% stating that they did and 24% saying that they did not. Although this is a favourable response it may be an area which could be improved upon for future conferences.

Figure 5. Inclusion in consultation process



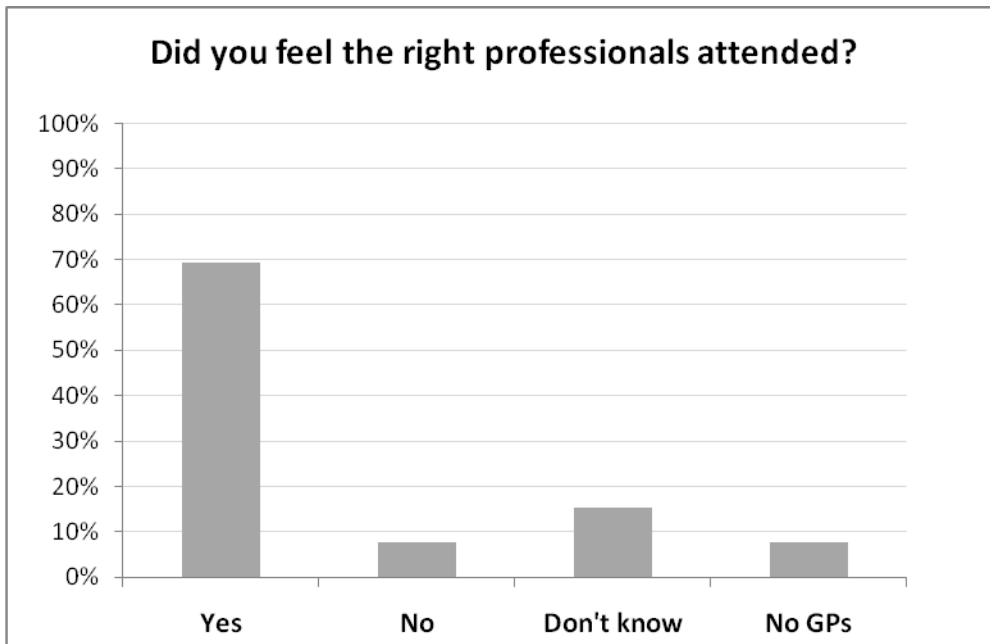
4.5 The next question that was asked regarded whether or not the delegate felt that they had been included in the consultation process. Figure 5 shows the response of a very large majority (88%) saying that they did feel they had been included, indicating that in this respect the event had been a strong success and the majority of the delegates did feel they had been properly included in the consultation process. This is very good as this aspect was one of the key focuses of the workshop.

Figure 6. Presentations



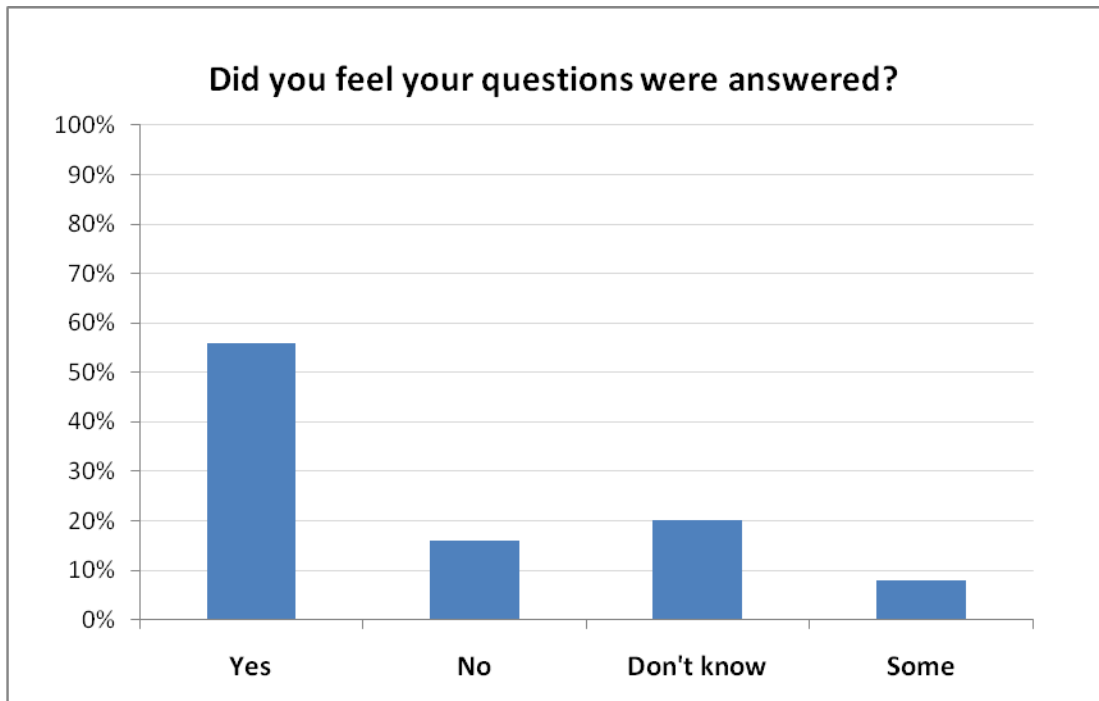
4.6 The next question which can be seen on Figure 6 asked whether or not the delegates liked the presentations at the consultation workshop (the presenters being Ursula Hussain (Oldham LINK), Mark Drury (NHS Oldham) and Alan Higgins (NHS Oldham/Oldham Metropolitan Borough Council)). Figure 6 illustrates an emphatic 91% 'yes' response from the delegates who participated, indicating that the delegates thought that the presentations were of a very high standard.

Figure 7. Professionals attending



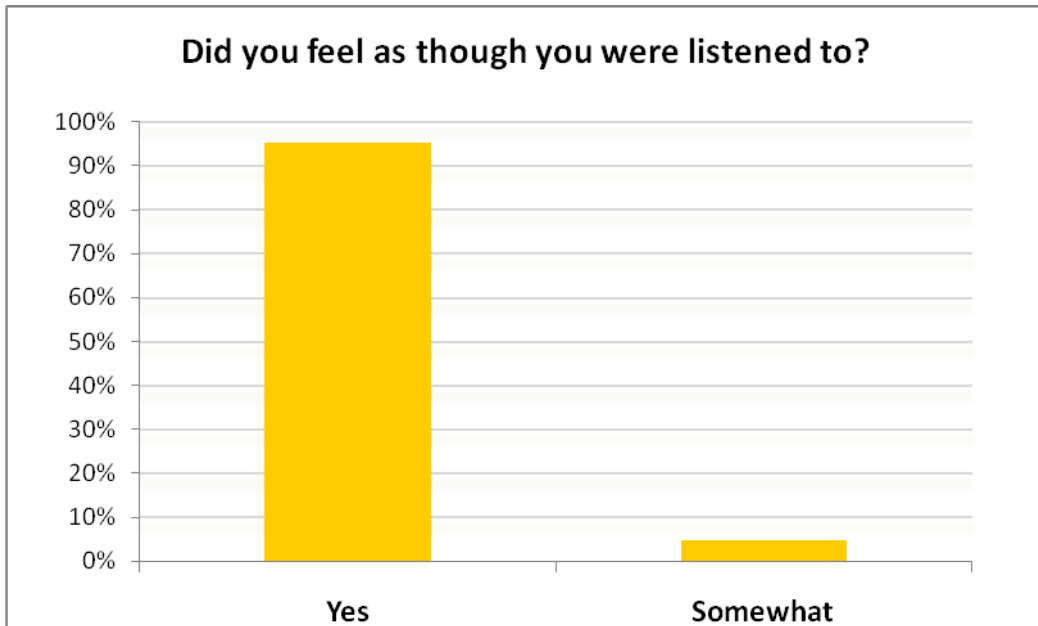
4.7 Question 5 (as illustrated in Figure 7 above) asked the delegates whether or not they felt the right professionals attended the consultation session. Figure 7 shows a majority response of Yes (69%) which shows a success, but also some brought up the point that no GPs attended the event (8%).

Figure 8. Answering of questions



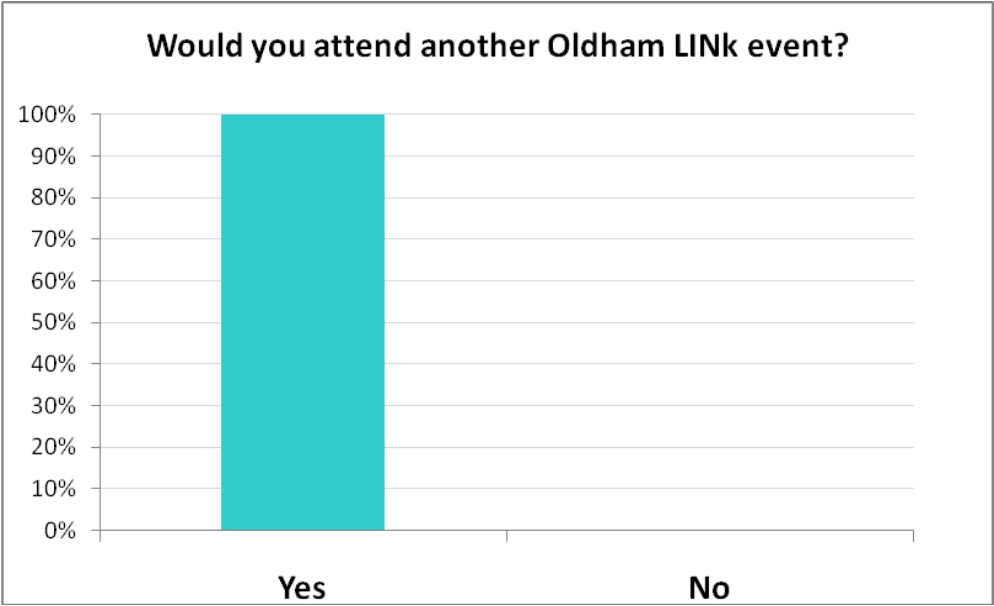
4.8 Question 6 asked whether or not delegates felt their questions had been answered. 56% stated that they did, while 20% stated that they didn't know. A further 16% stated that they did not feel their questions had been answered. This may perhaps reflect the nature of the White Paper providing only a series of proposals, with the detail of which yet to be determined. Representatives of the NHS were not able to answer some questions not due to lack of preparation or knowledge but simply because this information had not yet been released by the Department of Health.

Figure 9. Listened to?



4.9 The next question (Question 7) asked the delegates whether or not they felt they had been listened to. Figure 9 (above) illustrates the answer to this question, which was a resounding Yes (95%), with 5% saying they didn't know and no one saying that they felt they had not been listened to.

Figure 10. Future attendance



4.10 Question 8 asked the delegates whether or not they would attend another Oldham LINK event. As can be seen on Figure 10 (above), 100% of the delegates asked this question say that they would attend another event hosted by Oldham LINK.

5 References

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Needham, C. (2009). Co-production: an emerging evidence base for adult social care transformation. *SCIE Research Briefing 31*. London: Social Care Institute for Excellence.

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