The King's Fund

Ideas that change health care

Local Healthwatch: progress and promise

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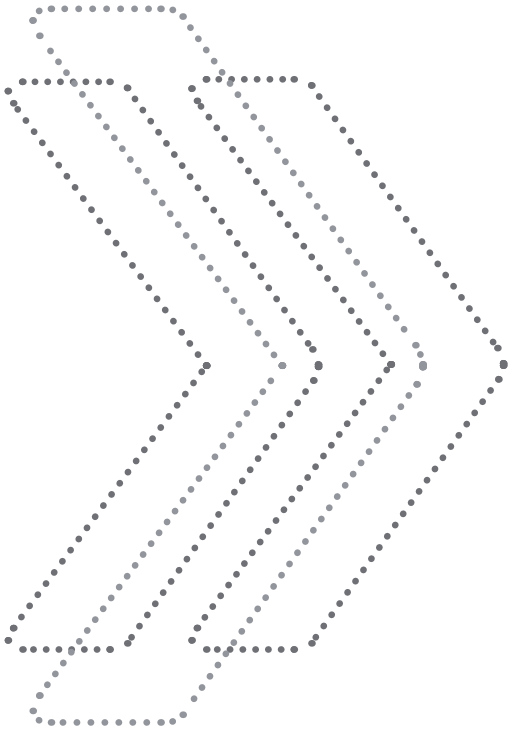

This report was commissioned by the **Department of Health.** However, it is based on independent research conducted by **The King's Fund** and the conclusions reached are those of the authors.

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Executive summary

- Established following the Health and Social Care Act 2012, local Healthwatch organisations are the local consumer champion for patients, service users and the public, covering both health and social care. Local authorities have a statutory duty to commission a local Healthwatch organisation, which in turn has a set of statutory activities to undertake, such as gathering local views and making these known to providers and commissioners, monitoring and scrutinising the quality of provision of local services, and a seat on the local health and wellbeing board.
- This report was commissioned by the Department of Health to examine the progress that had been made in the first 18-21 months of local Healthwatch and to identify the positive steps that could be taken across the system to enable a high-performing and effective local Healthwatch network.
- Broadly, local Healthwatch organisations are positive about the progress they are making, with particularly positive assessments of progress in gathering people's views and influencing providers and commissioners. Local Healthwatch organisations are in the process of shifting from setting up the organisation and developing local relationships to developing effective processes for carrying out their activities, and then in some cases beginning to achieve impact in terms of changes to services.
- Local Healthwatch organisations vary widely in how they are organised, how they conduct their activities and how effective they are in carrying out their statutory activities. Their activities are wide-ranging but their capacity is often very limited and so, in this context, local Healthwatch will only ever be effective through prioritising their focus and working effectively in partnership with others.
- Our case study sites highlighted a number of key factors that influence the effectiveness of local Healthwatch organisations. Some of the challenges that local Healthwatch face could be addressed through greater support, advice and shared learning on how to operate effectively. Good local accountability for governance and ways of operating (eg, related to the effective leadership of the organisations, how conflicts of interest are managed, and how the public are involved in activities) is essential to ensure the legitimacy and credibility of local Healthwatch organisations.
- Local Healthwatch organisations rely on building relationships with other local stakeholders in order to build legitimacy, influence and create impact. Their effectiveness in doing this is in part mediated by the receptiveness of local stakeholders to the involvement of local Healthwatch and to the value of public involvement more widely.

- Fundamentally, the role that local Healthwatch are expected to play in the health and social care system is a demanding one, with great potential for improving how responsive and inclusive the system is of local people's concerns and priorities, but also great challenges in defining a distinct local role and balancing being an independent voice with being part of decision-making processes as one of the local system leaders. As local Healthwatch organisations continue to mature and develop, addressing both the practical and these more deep-seated challenges will be crucial to maximising their effectiveness and impact.

1. Introduction

Established following the Health and Social Care Act 2012, local Healthwatch organisations replaced Local Involvement Networks (LINks) to become 'the local consumer champion for patients, service users and the public', covering both health and social care. Local Healthwatch organisations now cover every upper tier local authority in England (152) and have been in operation since 1 April 2013.

Local authorities have a statutory duty to commission a local Healthwatch organisation, and local Healthwatch in turn are contracted to undertake a series of statutory activities as set out in legislation, which defines their role. A number of these activities are similar to and carried over from LINks, such as gathering local views and making these known to providers and commissioners. Other functions, however, provide local Healthwatch with a more extensive role in influencing provision through local decision-making processes, reflected in their seat on the local health and wellbeing board.

Local Healthwatch organisations are required to be social enterprises, though there is no prescribed model under which they are required to function. In practice, this flexibility has resulted in a number of different models being employed, including community interest companies (CIC) and charities. Several organisations were originally hosted by other voluntary and community sector organisations with an expectation that local Healthwatch would eventually become an independent organisation in its own right.

It was intended that in setting up local Healthwatch, these new organisations would build on any existing LINks' successes but, in addition, would address some of the previous system's weaknesses, with a greater focus on being representative of local communities, building profile through a common brand and identity, and moving towards greater transparency and accountability.

Local authorities have a statutory duty to contract with a local Healthwatch organisation (rather than commissioning a 'service' as is perhaps the more usual approach for local government), and for re-commissioning if deemed necessary. The statutory activities of local Healthwatch provide mechanisms for them to escalate issues directly to Healthwatch England as appropriate (or, where justified, directly to the Care Quality Commission). Local Healthwatch organisations are also required to share information with and support the national remit of Healthwatch England. Although local Healthwatch organisations are accountable to a commissioner with the relevant local authority, emphasising

their role in meeting local needs and priorities, Healthwatch England has a role in developing the potential of the network by providing local Healthwatch organisations with support, guidance and advice.

Healthwatch England, the Department of Health and the Local Government Association have produced a number of guidance documents to support the set-up and development of local Healthwatch. These guidance documents have largely focused on purpose and function, with more recent documents providing a mechanism for local Healthwatch organisations to assess their own progress and outcomes.

Although each local Healthwatch organisation is required to publish an annual report and Healthwatch England has conducted its own surveys of local Healthwatch organisations, there seems to be little publicly available, aggregated intelligence available on the extent to which local Healthwatch organisations are carrying out their statutory activities, the diversity of their practice or, importantly, their effectiveness in influencing services as the independent voice of the public.

About this report

We were commissioned by the Department of Health to conduct a piece of research that would examine the progress that had been made in the first 18-21 months of local Healthwatch and identify the positive steps that could be taken across the system to ensure a high-performing and effective local Healthwatch network.

This report first sets out the methodology we used and then presents our findings in four sections, looking at the different activities of local Healthwatch and at the factors that underpin their effectiveness. From our own research, and drawing on evidence in the wider literature, we set out some of the key elements of an effective local Healthwatch. After some brief conclusions, we then present recommendations for ways to help maximise the impact and effectiveness of local Healthwatch organisations as they continue to develop.

2. Methods

We conducted our research between September 2014 and February 2015, using a mixed-methods approach combining national surveys with six in-depth local case studies and interviews with national stakeholders.

We did not gather views from the general public or other community groups about local Healthwatch organisations because of the relatively early stage of Healthwatch's development. In the longer term, however, as local Healthwatch organisations become more established and have conducted more work, it will be very important to understand how they are viewed by the local communities they seek to represent.

Local Healthwatch survey

We sent an online survey to lead officers of all local Healthwatch organisations in November 2014, after piloting the survey to test format, language and length. Respondents were asked to self-rate their organisation's progress in fulfilling each of its statutory activities. Respondents had the opportunity to answer according to the following scale: really progressing well; making good progress but lots more to do; challenging but some limited progress; really challenging, little progress. Respondents were then asked to describe their activities, and to outline any factors that they felt had helped or hindered them in achieving impact in this area.

A total of 116 responses were received from 108 local Healthwatch organisations, representing an approximate response rate of 71 per cent of all local Healthwatch organisations. Just less than 40 per cent of responses were from the CEO or equivalent role, followed by operational managers (21 per cent); 15 per cent of respondents did not report their role, with the remainder comprising smaller percentages in other roles.

Local stakeholder survey

An equivalent online survey was sent to all clinical commissioning group chairs (211) and health and wellbeing board leaders (151) via email, and to local authority commissioners via the Local Government Association (LGA).

Respondents were asked to rate how successful their local Healthwatch organisation had been at fulfilling the range of statutory activities, for any evidence to support this assessment, and for views on what might have influenced how effective their local Healthwatch organisation had been in fulfilling each function. Two reminders were issued, but the survey received only 56 responses.

Given the low response rate for this survey, the resulting data was not analysed for inclusion in the final report, but was used to validate other findings. This means that the survey data we have used in this report comes only from local Healthwatch organisations themselves, although the case studies include perspectives from local stakeholders as described below. Once local Healthwatch organisations have become more established and have conducted more work, it will be important for any future studies of their effectiveness and impact to gather data from local commissioners and other local stakeholders to build a full picture of how local Healthwatch organisations are performing.

Case studies

Six case study sites were selected non-randomly, drawing on intelligence from the Local Government Association and Healthwatch England. The set of criteria used ensured that the sites selected covered local Healthwatch organisations with varying levels of perceived organisational effectiveness, included representation of the different commissioning models being employed, were drawn from each of the four NHS England regions, and included examples from both urban and rural settings. Sites also had to meet the practical requirement of holding a board meeting within our research period. For each site we:

- conducted semi-structured interviews with the CEO and chair or board member from the local Healthwatch organisation
- conducted semi-structured interviews with local stakeholders (including – depending on availability in each case study site – CCG chairs/directors, health and wellbeing board leaders/board members, local authority commissioners and NHS England primary care commissioners)
- observed a local Healthwatch board meeting
- analysed six months' worth of board minutes from both the local Healthwatch organisation and the health and wellbeing board.

So whereas we were unable to gather sufficient numbers of wider stakeholder perspectives through the survey, we were able to gather some insights into how local authority commissioners and other local stakeholders were perceiving the work of local Healthwatch organisations through these case study interviews.

In the interviews, we discussed how the local Healthwatch organisation was set up, what role it played locally and how it operated, its key activities and impact to date, relationships with other local partners in the system and with national bodies, factors that have helped and hindered effectiveness and what needs it had for further support. We observed local Healthwatch board meetings to gain an understanding of how these meetings were run, how decisions were made and how those at the meetings interacted. In the review of health and wellbeing board minutes, we looked at local Healthwatch contributions at those meetings, and in the review of local Healthwatch board minutes we looked at attendance, public engagement, decisions being taken and records of activities undertaken and their impact.

National stakeholder interviews

Face-to-face interviews were carried out with national stakeholders, comprising representatives from the Department of Health, Healthwatch England, the Local Government Association, the Care Quality Commission and NHS England. These interviews were used to discuss our emerging findings and to understand the roles of national organisations in relation to local Healthwatch organisations. They did not explore the support that individual organisations were providing for local Healthwatch.

Use and presentation of data in this report

We have analysed our data sources (survey responses, interviews, board observations and board papers) thematically, and linked the data together to present our findings and analysis. We have included quotes from either the survey responses or our interviews where they illustrate a broader theme in our findings. The data collected from the local Healthwatch survey forms the basis of our intelligence on the activities that local Healthwatch organisations are undertaking, and on the factors that they feel enable or limit their effectiveness. The data from the case studies provided more in-depth insight into how local Healthwatch organisations are operating and how they are perceived by local stakeholders.

3. Findings

A. Providing information and advice to people about accessing services

What local Healthwatch organisations are doing

Most local Healthwatch organisations reported undertaking work in this area, although there was much variation in their focus and the activities carried out. Many responses described providing information related to the marketing and promotion of the local Healthwatch organisation itself and its work, as opposed to providing wider information about access to services.

Information and advice is provided by local Healthwatch organisations in a number of different ways, including through helplines, drop-in sessions, one-to-one appointments, in response to enquiries, and as part of wider engagement work with local people as part of their role in gathering local views. A small number reported providing a specific information and advice service with dedicated staff and contact points, but most organisations incorporated this activity into their wider work.

Local Healthwatch organisations reported using a number of existing resources, most commonly NHS Choices and existing directories of services developed by the local authority or for commissioners; some had developed their own information resources. Some had developed partnerships with other local organisations to support this work, and two reported that they had subcontracted this activity to Citizens Advice.

A few local Healthwatch organisations reported that many of their direct contacts came from people seeking advocacy and support after feeling that they had exhausted all other avenues. These people are described as having complex cases and high expectations that Healthwatch would solve their problem, leaving staff or volunteers in a difficult position, often unable to meet their needs.

Effectiveness in this area

Some 85 per cent of all Healthwatch survey respondents said that this work was either progressing really well or that they were making good progress with more still to do. The diversity and distinct nature of individual responses suggested

that how local Healthwatch organisations interpret this activity varied. Apart from dealing with a small number of individual issues, the majority of local Healthwatch organisations do not routinely provide advice and perceive their role as largely signposting. Local Healthwatch organisations provided little detail about what information they were disseminating and in many cases this appeared to be carried out in parallel with activities to promote local Healthwatch and collect intelligence from the public as opposed to a discrete activity.

Respondents reported that what worked best was employing a range of different methods that focus on maximising accessibility, with outreach work noted as a particularly effective means of reaching the public. Although electronic media was identified as effective for disseminating information, respondents reported continual demand for information in hard copy.

B. Gathering intelligence on people's views and experiences of health and social care services

This activity includes:

(i) gathering people's views and experiences of health and social care services

(ii) enabling local people to directly monitor the standard of provision in local health and social care services

(iii) bringing together the views of local people into an evidence-based position and making reports and recommendations about how services could or should be improved.

(i) Gathering people's views and experiences of health and social care services

What local Healthwatch organisations are doing

Four approaches predominate:

- proactively seeking views through attending community events, holding their own dedicated events, conducting surveys, focus groups, interviews, observations and workshops
- providing reactive mechanisms for people to provide their views, such as drop-in sessions, feedback forms, comment cards, social media and via websites
- incorporating intelligence gathered from local voluntary and community sector organisations, including those who act as the host organisation or are directly involved as formal partners in the local Healthwatch structure
- accessing other existing data, particularly that available online such as GP survey results, public feedback websites like Patient Opinion and NHS Choices, and local and national media stories.

Most of these activities focus on opportunistically gathering views and experiences of provision in general. When more proactive approaches are used, these are generally either to collect views and experiences on specific topics, or as part of an explicit 'research project', where surveys, interviews and focus groups are designed, carried out and analysed.

Alongside conducting their own engagement and data collection work, several local Healthwatch organisations also support and influence others to ensure that their processes for consulting and engaging the public are working well. They do this through:

- encouraging different, related local engagement efforts to be more joined-up
- promoting and supporting best practice in engagement
- developing standards for engagement activity and providing toolkits and training
- challenging the deadlines around local consultations and arguing for extensions to enable appropriate engagement with the public
- being contracted to provide engagement activity on behalf of other organisations, particularly local clinical commissioning groups (CCGs).

Effectiveness in this area

Respondents felt that, of all their activities, they were most effective at gathering people's views, with 91 per cent saying that this work was either progressing really well or that they were making good progress with more still to do. Local commissioners in our case study sites generally agreed that this activity was one of their local Healthwatch organisation's particular strengths.

Activities that involved local Healthwatch organisations reaching out and engaging directly with the community were highlighted as particularly effective. Outreach approaches were valued in ensuring collection of a wide range of views that were not unduly influenced by a particular perspective. Surveys and focus groups were also noted for being able to guide information collection and work with groups on a particular issue.

Some local Healthwatch organisations reported that they focused on gathering views from 'seldom heard' or 'hard-to-reach' groups. Local commissioners can find this particularly helpful in filling in gaps in their knowledge, but local Healthwatch organisations themselves inevitably reported challenges in gathering views from some groups of people; the hardest to reach groups were: children and young people; specific BME groups; people in work; people with sensory impairments; and older people in residential care, receiving domiciliary care or who were isolated.

(ii) Enabling local people to directly monitor the standard of provision in local health and social care services

What local Healthwatch organisations are doing

Local Healthwatch organisations often saw the routine collection of views and experiences as a core part of monitoring provision. However, they reported that they most commonly directly monitor provision by conducting 'enter and view' visits, or engaging in similar structured approaches such as PLACE assessments (patient-led assessments of the care environment) and 15-step challenge visits (a method for understanding the quality of care from patients' perspective).

Many of these activities are carried out with the prior agreement of the provider. A few Healthwatch organisations reported that they do not carry out any direct monitoring activity. One of our case study sites explained that they felt unclear about the criteria they should apply to justify an 'enter and view' visit, and so did not do any. Others varied in how they decided to conduct visits, with some seeing the use of 'enter and view' as appropriate only when serious or multiple concerns are raised, whereas others see this power as a more routine part of how they gather their intelligence.

Effectiveness in this area

Around two-thirds of local Healthwatch survey respondents felt this activity was progressing well, making this one of the areas that overall they felt to be progressing least well.

Several respondents reported tensions and difficulties with providers in carrying out monitoring activity, describing 'suspicion' and 'obstruction'. Providers were also reported to have raised questions about the legitimacy of local Healthwatch conducting these activities. From our survey, defensive responses were more often encountered in relation to social care services than NHS services.

Many local Healthwatch organisations rely on volunteers to carry out these visits, and several told us how important it is that these volunteers are trained well, with some expressing concern that poorly trained 'enter and view' volunteers risk damaging Healthwatch's local reputation and relationships if these visits are carried out badly. Our stakeholder interviews expressed additional concerns about the focus of 'enter and view' activities. Activities focused on the views and

experiences of patients were perceived as valuable, but where local Healthwatch were described as scrutinising services and in some cases commenting on areas such as clinical practice, this was seen as beyond their remit. Those local Healthwatch organisations who felt they have particularly successful monitoring activity tended to report that they had good relationships with both providers and commissioners, where the purpose of visits was clearly explained to providers and providers responded with a genuine interest to the insights that Healthwatch could offer.

Our case study and survey participants often pointed out how selective they needed to be in carrying out direct monitoring activity. As one put it, their remit covers '*six foundation trusts, 10 NHS hospitals, more than 50 care agencies, 90 dentists and hundreds of GPs'*, so this activity can only be carried out for a small proportion of providers in its area.

Two of our case study sites reported that this activity was key to achieving 'incremental' and direct impact on patient care, explaining that these visits had allowed them to raise specific issues with frontline staff and see those issues addressed quickly.

(iii) Bringing together the views of local people into an evidence-based position, and making reports and recommendations about how services could or should be improved

What local Healthwatch organisations are doing

Two approaches predominated in the survey. The most common approach described was to collate individual feedback into summary statistics or regular reports, with some explaining that they '*scan feedback for themes'*. A few local Healthwatch organisations reported '*everything we hear, however small'*, either directly to providers or in their regular reports. A second approach relates to the collation of views and experiences, often as part of a discrete project focused on a particular issue, into reports. Methods of forming evidence for reports often reflected those used in collating individual feedback. However, a few local Healthwatch organisations report collating evidence gathered from multiple sources in order to build a volume of evidence and corroborate perspectives.

How recommendations for action are generated seems to vary, with local Healthwatch boards sometimes discussing and refining the recommendations before the final report is completed. A few local Healthwatch organisations told us that they do not see it is their role to develop recommendations for stakeholders, arguing '*we present the evidence and it is up to them to decide what to do about it'.*

Effectiveness in this area

Four out of every five of our local Healthwatch survey respondents felt that this work was progressing well. In three of our case study sites the reports highlighted as important outputs by our Healthwatch interviewees were also identified by at least some of the other local stakeholders as having been useful.

Evidence from both our survey respondents and case study sites suggested that data collected on general views and experiences often reflected too many disparate issues to support the creation of evidence. Local Healthwatch organisations also reported that they had difficulty in systematically identifying trends and that collection of corroborating data was challenging.

Some local Healthwatch organisations, including from our case study sites, told us that they frequently faced challenge and criticism for having small sample

sizes, being *'unrepresentative'* of the wider population, or being *'anecdotal'* and therefore *'not robust'*. Qualitative research based on in-depth interviews with people, even when methodically rigorous and well-presented, can nevertheless be challenged by decision-makers more used to statistical evidence based on large numbers, and so these challenges are not unique to local Healthwatch organisations and their work. Examples from both the survey and case studies, however, demonstrated that local Healthwatch organisations themselves also hold diverse views on what constitutes evidence, ranging from individual comments to work produced through more formal research methods. It is evident that in some cases this results in information being presented as evidence inappropriately, for example when an individual comment alone is used as evidence for a much wider group of people's views or proof of a wider problem.

Some of our case study sites told us how difficult it could be to develop good recommendations. As one survey respondent put it, '*It is easier to say what is not working than to make a recommendation for change… Sometimes we feel there is much more we should know about the service before jumping to recommendations*.' Several local stakeholders across our case study sites also expressed frustration at '*poorly specified or targeted recommendations'*, although some acknowledged that the issues and experiences that people raised with local Healthwatch could be complex and did not lend themselves to simple recommendations. They also agreed that developing targeted recommendations demanded extensive knowledge of who is responsible for what in a local health and social care economy which has been particularly hard to understand in recent years given the '*constant state of flux'* local services and commissioning responsibilities have been in.

We were struck by how many local Healthwatch organisations cited producing a report as evidence of their impact, without any evidence for commitment to actions or actions taken as a result. This may reflect a feeling that these actions are the responsibility of others. This is understandable, but reports ultimately only have real value if they are listened to and acted upon. The local Healthwatch survey and case studies both demonstrated challenges between the process of creating evidence and then influencing change. This includes devising questions which produce evidence that local stakeholders find relevant and understanding the level of evidence required by different stakeholders and how it is used to make decisions. As one chief executive noted: '*They are quite formal reports we've presented but I think it's almost like gearing them up to match the language of the audience you're addressing them to. I think that's been really important to us.'*

The next section discusses how effective local Healthwatch organisations are in influencing local providers and commissioners.

C. Influencing the provision and commissioning of health and social care services

This activity includes:

(i) influencing health and social care providers
(ii) influencing health and social care commissioners
(iii) operating as a member of the health and wellbeing board
(iv) sharing information with, and escalating concerns to, the Care Quality Commission
(v) sharing information and intelligence with Healthwatch England.

(i) Influencing local health and social care providers

What local Healthwatch organisations are doing

Local Healthwatch organisations describe their role in relation to providers in a number of ways, including:

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

Taking part in committees and groups run by providers was seen by local Healthwatch organisations as an important element in being able to influence. Many contribute to providers' patient and public involvement groups, sit on provider committees and observe provider boards. Many local Healthwatch organisations also told us that they respond to providers' consultations and comment on their annual quality accounts.

Sharing data and reports is another key way in which local Healthwatch organisations aimed to influence providers. The data shared varies widely. Some local Healthwatch reported '*sending every comment we receive'*, others provide summaries, while a few only did so when they began to see a trend emerging or had higher numbers of comments. Reports produced by local Healthwatch,

including those from 'enter and view' visits, were also routinely shared with some organisations, highlighting feedback specific to individual services.

Information was often shared via email but in many cases this was followed up by a face-to-face meeting with individual providers. Some of these represented regular opportunities to meet, while others are scheduled when necessary. These meetings were used to '*go through all the comments'*, raise concerns, discuss performance and improvements, but also serve to follow up on progress in response to issues previously raised. The value of these meetings often included the opportunity to address issues at a senior executive level. Some organisations also used these opportunities to share work they were doing and discuss the potential for joint working.

There were a few examples of local Healthwatch organisations describing themselves as working in partnership with providers and facilitating the voice of local voluntary sector organisations as a means of influence. This work included supporting providers to implement improvements, and contributing to reviews of service provision.

Effectiveness in this area

Of all the different routes for influencing change, directly influencing providers was the route that local Healthwatch survey respondents felt that they were most effective at, with 78 per cent saying this work was either progressing really well or that good progress was being made with more still to do.

Respondents said that the most effective way of having influence was through having good relationships with providers. A combination of building relationships with individuals in strategic positions and engaging in provider-run committees and meetings enabled local Healthwatch organisations to raise issues at the appropriate level, and to ensure that they were '*at the table when actions and decisions are made'.* Participation also meant local Healthwatch organisations could be seen as playing a legitimate and credible role. As with the activity of developing evidence, a few respondents said they had insufficient knowledge and experience around which tactics and approaches to influencing would be most effective. A few respondents also said that having formal action plans or information-sharing and escalation protocols with providers ensured due process was followed for concerns and issues they raised.

However, as discussed above, many local Healthwatch organisations described their work here only in terms of submitting reports rather than being able to demonstrate that the providers had made changes as a result. Two local Healthwatch organisations told us that after sending a report they invoked their statutory powers and requested a response within 20 days, others reported asking the provider for information on what they proposed to do and for evidence that they had taken the feedback into consideration and had taken appropriate action. A few respondents noted the need for tenacity and persistence in influencing providers, with one respondent saying '*If we don't follow up, they don't do anything.'*

A few local Healthwatch organisations reported that influencing primary care and social care providers was harder than influencing NHS hospital trusts, '*due to the number of small and independent providers*'. This is partly due to the number of organisations to influence, but also because smaller providers seem to be less likely to have heard of Healthwatch and/or understand their role and powers.

(ii) Influencing commissioning of services through CCGs, local authorities and NHS England

What local Healthwatch organisations are doing

Most respondents to our survey reported having done work to influence their local clinical commissioning group(s), with a slightly lower proportion describing influencing local authority commissioners.

Most local Healthwatch organisations have some representatives on commissioning and other strategic groups, for example, on CCG boards and governing committees, the CCG patient and public involvement (PPI) forum, strategic boards and working groups, quality surveillance groups and safeguarding boards. Most also hold individual meetings with commissioners. These range from regular meetings with the council and CCG leads to specially scheduled meetings that also include specific commissioners. These meetings are used to feed back information, report on specific pieces of work and build relationships to gain strategic influence.

Key approaches to influencing commissioning include:

- sharing data and intelligence, for example, raising issues of concern and reporting on findings of 'enter and view' visits with the relevant local authority scrutiny body
- challenging commissioners on the improvements they are putting in place in relation to specific services and areas of care
- escalating issues to commissioners when Healthwatch feels the response of the provider has been inadequate (although the process, pathway and threshold for escalation varies)
- challenging commissioners on their engagement and consultation activities
- being involved in commissioners' tendering and contracting processes – several local Healthwatch organisations report being involved in procurement and interview panels as a representative of public voice.

As discussed above, several local Healthwatch organisations said they supported commissioners with their engagement activity, with a few reporting that they specifically recruited staff for this purpose. This work includes:

- providing advice on effective engagement
- reviewing documents to improve accessibility and readability

- offering volunteer training programmes
- training members of CCGs in engagement
- running public events on behalf of commissioners
- gathering views from the public on topics specifically requested by commissioners.

From the case study sites, it appears that some local Healthwatch organisations see these engagement activities as a core part of their role in facilitating the voice of patients and the public and carrying out statutory activities, while others approach it as additional, commissioned activity undertaken on behalf of a local partner. The approach to supporting the engagement activities of other stakeholders may be influenced by the degree to which individual Healthwatch organisations perceived their role as being a part of the system or outside of it. In the former facilitating effective engagement of the public on behalf of and by others was perceived as a legitimate means of delivering their statutory activities and creating influence. However, it may also be related to the limited definition between what falls within core statutory activity, and what should be classed as additional work that complements local Healthwatch's remit, but falls outside of this core role.

Very few of our survey respondents referred to having influence with NHS England and its commissioning of local primary care and specialised services. This is notable given that a number of local Healthwatch organisations reported a focus on GP access. Several of our case study sites told us that changes in staffing and responsibilities within the local NHS England office made it difficult to know who to contact, and local NHS England primary care commissioners stressed that, because of the geographical areas they cover, they can deal with several Healthwatch organisations – eight in the case of one of our case study interviewees. One of our case study sites demonstrated a reasonably extensive relationship between the local Healthwatch and NHS England (with local Healthwatch running an engagement event on their behalf, for example) and the local NHS England commissioner reporting '*being on the phone with Healthwatch almost every day'*, but this level of engagement was rare and local Healthwatch organisations more often reported issues related to primary care to CCGs.

Effectiveness in this area

Respondents felt that this activity was the second most effective route for influencing change, after influencing providers, with three-quarters saying this

work was either progressing really well or that good progress was being made with more still to do.

Our CCG interviewees were generally positive about local Healthwatch's impact on commissioning, with most commenting that their influence was increasing as they become more established as organisations. One CCG chair told us that they felt their local Healthwatch organisation had helped to '*change the way that we engage with patients and communities, so it's much more meaningful and less tokenistic that we had in the PCT days*'. Another stressed how much they valued the intelligence that Healthwatch could offer. One commented that some work from their local Healthwatch into the lived experiences of people using mental health services '*gave us a quality of insight that… we would have probably never been able to grasp ourselves as an organisation'*.

Many local Healthwatch organisations highlighted the importance of building good relationships and maintaining regular communication with commissioning organisations to ensure early involvement in processes and manageable timelines for ongoing input. This approach also meant that they were able to demonstrate how their involvement had influenced the process and outcome. A few local Healthwatch organisations emphasised the importance of taking every opportunity to get involved at the commissioning level.

There were differences of view about the extent to which local stakeholders expected or wanted local Healthwatch to share their own priorities. Some expressed frustration at a lack of interest from local Healthwatch in the issues they felt were most pressing in their area (with one citing problems with hospital discharge as an example), and others expressed a more general lack of understanding about how local Healthwatch selects its priority issues. In contrast, another said they felt their local Healthwatch was not particularly influential precisely because it only raised issues which were already identified as local priorities. Others welcomed the way in which local Healthwatch's independent choice of priorities helped to ensure that issues that the commissioners were not currently prioritising were kept on the agenda, with one CCG recognising '*it helped us to remain focused on the prevention agenda'*.

At a national level, the role that local Healthwatch organisations played in raising specific issues was described as extremely useful to '*add weight'* to the argument for national attention on a particular service, citing the example of local Healthwatch organisations' work on the gender-identity pathway. In addition, local Healthwatch's involvement in the local pathfinder work (as part of the care.data programme) was noted to have been a useful approach.

(iii) Operating as a member of a health and wellbeing board

What local Healthwatch organisations are doing

One of the unique features of local Healthwatch organisations is their statutory seat on the local health and wellbeing board (HWB). Most local Healthwatch survey respondents reported attending HWB meetings and, in addition, a number reported attending sub-committees as well as the board itself. The perceived roles of local Healthwatch organisations on the board included:

- representing patient and public views
- ensuring that the patient and public voice is heard
- acting as a critical friend and offering challenge.

Some local Healthwatch organisations had a regular or standing agenda item at their HWB to present their work and share their information and intelligence. They shared a range of information including specific issues they have identified, reports and findings from completed work, examples of the impact and influence they had, and an overview of current work. In doing this they sought to:

- highlight and promote the role and work of local Healthwatch
- cascade their work through the HWB
- inform the HWB and raise concerns.

Local Healthwatch organisations also feed in to specific themes of the HWB meetings, on-going work streams, or particular elements of the HWB remit, such as the joint strategic needs assessment (JSNA). In some cases local Healthwatch organisations report that their contributions to the HWB are based on intelligence collected by the organisation; however, in others their contribution is as a representative of the public that is informed by the perspective of being a member of the public, but not necessarily by their individual views.

Respondents felt that one of the most prominent roles played by local Healthwatch organisations is ensuring appropriate engagement with the public and patients by others on the board. In practice they are supporting and facilitating this by:

- pushing for engagement to be on the agenda of the HWB and, in one instance, running development sessions for HWB members on engagement
- facilitating the involvement of members of the public both in HWB work streams and more widely by aiding HWBs to plan and run community and public engagement events
- carrying out engagement activity on behalf of the HWB
- providing feedback on engagement to date – some local Healthwatch organisations sit on the communications and engagement committee/task group, in some instances as chair or co-chair.

Some local Healthwatch organisations challenged the HWB by:

- influencing the choice and wording of priorities in the JSNA
- challenging the operation of the board, for example, by pressing for a fuller discussion of particular issues
- challenging other stakeholders present, and raising specific concerns with specific organisations
- questioning the role and leadership of the HWB
- threatening to vote against a particular decision as a means of re-negotiating concerns.

Effectiveness in this area

Only around two-thirds of local Healthwatch survey respondents felt this activity was progressing well, making this one of the areas that overall local Healthwatch feel is progressing least well. In general, the HWB interviewees in our case study sites felt that the role of Healthwatch was still developing, with several commenting that in recent months in particular '*things are beginning to work*'. One HWB interviewee acknowledged that the boards themselves are still forming and developing their role and influence.

Often both local authority commissioners and HWB members we spoke to praised local Healthwatch organisations' leaders for their '*balance*', and ability to be '*positive but challenging'*. Some contrasted this with a more adversarial and difficult relationship with previous Local Involvement Networks (LINks). They highlighted the importance of having a Healthwatch representative with the requisite experience, knowledge and confidence to build relationships and influence at a strategic level, and the ability to make contributions based on

evidence in a timely manner, which supported the credibility of local Healthwatch.

One local authority commissioner commented on how challenging it was for one voice in a large meeting of organisations wielding large commissioning budgets to represent the voice of the people. Several local Healthwatch leaders themselves told us how they feel that many decisions are taken outside of the HWB meeting itself, and so influencing those decisions is challenging '*since you're not in the room'*.

(iv) Sharing information with, and escalating concerns, to the Care Quality Commission

What local Healthwatch organisations are doing

Local Healthwatch are interacting in a range of ways with the Care Quality Commission (CQC). They are:

- sharing their reports, enter and view reports and other intelligence and feedback
- escalating specific concerns
- contributing to CQC inspections through providing intelligence via the website, communicating directly with the lead inspector and inspection teams, helping inspectors reach specific groups and contributing to listening events.

Effectiveness in this area

Around two-thirds of our local Healthwatch survey respondents felt this activity was progressing well, making this another of the areas that overall local Healthwatch organisations felt was progressing least well. Many local Healthwatch organisations spoke of named contacts as key to building a strong, constructive and mutually beneficial relationship between CQC and local Healthwatch. These individuals are a point of contact for submitting reports, facilitating local Healthwatch involvement in inspections – particularly by ensuring that local Healthwatch are given good advance notice of local inspections – and raising issues/sharing intelligence outside the inspection regime. While staff turnover and restructuring within CQC seems to have made this initially difficult, several Healthwatch organisations are reporting that good contacts have now been established.

Local Healthwatch organisations noted the value of meetings as a means of building relationships and sharing information with CQC. This included regular meetings with local CQC reps and local inspectors and joint attendance at meetings such as quality surveillance groups. These meetings serve as a means to share information and enable local Healthwatch to successfully plan and deliver engagement activity with and around inspections.

One of the major issues that local Healthwatch organisations identified was obtaining feedback from CQC. Local Healthwatch organisations were in general more likely to receive a response from CQC when raising specific issues or concerns, than when sharing data. However, their contributions more generally were not always acknowledged, and in relation to inspections many local Healthwatch were keen to understand if and how information submitted had contributed. There was a sense that the relationship with CQC was often perceived as somewhat one way, with local Healthwatch being asked to supply information but receiving little in return.

Building strong links between local Healthwatch organisations and CQC requires an understanding of what each organisation does and how. Local Healthwatch organisations reported that they were not always clear about how CQC worked, its priorities and what information it required. They also felt that often CQC lacked an understanding of the role of local Healthwatch and the potential of its relationships with the public and providers.

(v) Sharing information and intelligence with Healthwatch England

What local Healthwatch organisations are doing

Local Healthwatch organisations are interacting in a range of ways with Healthwatch England. They are:

- sharing their reports, other intelligence and feedback
- escalating specific concerns
- feeding into national Healthwatch England projects.

Effectiveness in this area

Around two-thirds of local Healthwatch survey respondents felt that this activity was progressing well, again making this activity one of those that overall local Healthwatch feel is progressing least well. As with CQC, clear lines of contact at a regional level are important to enable local Healthwatch to work effectively with Healthwatch England. Regional and wider network meetings were also felt to be valuable for sharing information and intelligence.

Respondents said that routine data-sharing with Healthwatch England was problematic, mainly owing to difficulties experienced with the Healthwatch England platform. Many local Healthwatch organisations said there were significant challenges, including problems uploading information, limited usability of subsequent data and incompatibility with the systems used by local Healthwatch organisations to collate information. One organisation described the Healthwatch England platform as '*not fit for purpose'* and as a result several local Healthwatch organisations report not sharing routine data with Healthwatch England.

Local Healthwatch organisations reported considerable uncertainty about which routine data Healthwatch England wanted and how it was used, and some of our case study sites raised questions about how Healthwatch England aggregated, analysed and used the intelligence it was sent.

Information-sharing related to specific concerns and in particular to formal escalation of concerns appeared to be more successful. Several local Healthwatch organisations reported that the new escalation process was working well. A number of local Healthwatch organisations reported positive experiences

with issues that had been escalated; however, responses were often slow and it was not always clear what action was taken as a result.

By far the greatest number of reports from local Healthwatch of data-sharing and involvement with Healthwatch England related to its national projects. Input from local Healthwatch organisations ranged from forwarding existing relevant information and evidence and questionnaire results, collecting new evidence through hosting workshops and focus groups, and engaging specific groups, such as homeless people. However, contributing to national programmes presented particular challenges. The most notable was the capacity of local Healthwatch organisations to incorporate national programmes into their own work plans. The lead time for national projects was often too short to plan activity and allocate resources appropriately, and the topics did not always align with local priorities.

One of the main ways in which contributing to the work of Healthwatch England added value to local Healthwatch organisations was the ability to influence change on a national scale. This had helped organisations to raise their profile locally and contributed to their sense of purpose: '*We value the way we are part of a national network all working to the same end.*'

D. Factors influencing the effectiveness of local Healthwatch

The work that local Healthwatch organisations report doing in relation to their statutory activities is diverse. This reflects both the variation in approach that each organisation takes and how they interpret their role in relation to each statutory activity. It is tempting to highlight individual activities and practices that have appeared to be effective or may have been important in creating impact. However, no one activity stands alone as effective in its own right, rather achieving impact is very much defined as a process of sequential activities and decision-making. As independent organisations commissioned by a local authority, the activities and approaches of local Healthwatch are embedded within and influenced by local context.

Our case study research, however, has identified a number of factors that are important in influencing the effectiveness of local Healthwatch in its role. This includes the processes involved in setting up and establishing local Healthwatch organisations, organisational factors that define how they function and their approach, operational factors key to practice, and finally their relationship to stakeholders within the local health and social care system.

- Establishing local Healthwatch

- Organisational factors:

    - governance
    - independence
    - public involvement
    - defining the unique contribution of local Healthwatch
    - balancing 'critic' and 'friend'.

- Implementation:

    - skills and experience
    - capacity and resources
    - volunteers
    - prioritising work.

- System influences:

    - oversight and accountability
    - local structures for strategic decision-making.

Establishing local Healthwatch

For the majority of local Healthwatch organisations, the first year has required a focus on setting up the organisation. This includes recruiting a board, staff, volunteers, setting a work plan and building the infrastructure required to undertake the day-to-day work. This evolution has often involved a number of re-starts, with activities starting and then stopping in order to put in place more robust processes to ensure quality and effectiveness. The board has not been immune from this process either. In a number of cases local Healthwatch organisations have changed membership of the board and the role of board members to match their emerging needs. The evolution of local Healthwatch organisations as independent social enterprises has also resulted in organisations experiencing criticism and conflict from both within and outside of the organisation. Managing these issues and the adverse effects has affected the ability of organisations to build legitimacy and undertake activities. How quickly local Healthwatch organisations have negotiated these challenges and found a more permanent form has partly determined their effectiveness.

While local Healthwatch organisations have a set of statutory activities conferred on them through legislation, this inevitably does not confer immediate legitimacy for activities and for leaders.

Local Healthwatch organisations highlighted the importance of having a public profile in order to carry out their activities, while many avenues for influence were built on establishing relationships with stakeholders. Local Healthwatch organisations have had to work hard to build legitimacy and credibility, and this takes time. As one local Healthwatch organisation noted '*we have demonstrated our worth – now we are there on merit.*'

Organisational factors

Governance

We found wide variation in how local Healthwatch organisations are structuring their governance, and also in how roles and responsibilities are carried out in practice. Although only one of the case study sites is still hosted with no independent Healthwatch board, in other areas the initial host organisations and individuals involved in setting up local Healthwatch often remained involved

either formally on the board or in an advisory capacity through steering groups. These transitional arrangements were seen to result in a lack of clarity and disagreement about roles in relation to formal governance, work planning and operations. For example, in some sites the chair and the chief executive appeared to be working in partnership, in others the local Healthwatch board very clearly led the work and delegated delivery to the chief executive and their team, and in others the board appeared to be receiving updates essentially for information only with little effective challenge or demonstration of responsibility for decision-making. We were unable to determine precisely how these different approaches impacted the organisations' work; however, the lack of demonstrable critique and accountability at board level within some local Healthwatch organisations raised some concerns within the research team. Wider general evidence demonstrates that organisations are most effective when lines of accountability and responsibilities at the top of the organisation are clear, and working relationships are respectful and constructive.

Independence

Many local Healthwatch survey respondents and our case study sites referred to independence as a core value of local Healthwatch. While some of the local Healthwatch in our case studies were seen to actively consider risks to independence, in other cases awareness varied and examples of both potential risk and actual risk were observed.

Emphasis has been placed on ensuring that local Healthwatch organisations are representative of the public and not dominated by individual voices. However, governance arrangements in several case study sites highlighted a number of potential risks to independence, including: indistinct delineation between the board of local Healthwatch and its specific responsibilities, and that of the other organisations involved such as the former host organisation; lack of clarity around the process of work planning to prevent undue influence; and sub-contracting of services from organisations who also have governance roles in relation to local Healthwatch.

The second area of risk arose around the delivery of activities. In order to raise their profile and conduct their activities, local Healthwatch organisations relied heavily on building partnerships and relationships with local stakeholders. Providers, commissioners and voluntary and community sector organisations were each involved to different degrees in supporting local Healthwatch to

disseminate materials, undertake engagement work, and facilitate scrutiny. In a number of cases local Healthwatch organisations had also been commissioned by stakeholders to conduct local engagement work on their behalf. Embedding Healthwatch activities within the provision of others can make it difficult for the public to discern the activities as those of Healthwatch. Furthermore, some local Healthwatch organisations expressed concern about undue influence over the focus and findings of work that Healthwatch are contracted to do by others, and concern about the risks to the credibility of local Healthwatch this brings. One of our case study sites had mediated this by obtaining assurances from those involved around the nature of its work and its role.

Public involvement

Several local Healthwatch organisations and national stakeholders told us that they intended the new Healthwatch model to be '*more representative*' of local communities than the previous Local Involvement Networks (LINks). In practice, this is reflected in the approach that local Healthwatch have taken to involving the public, both at the operational level and through their activities.

With one exception, our case study sites had no active participation of the public at the board level, and not all published the minutes of board meetings. In some cases, meetings focused on work planning were held in public but in others there was no discernible mechanism by which the operation and activities of local Healthwatch organisations could be independently examined and influenced by the public. It is unclear how decisions around the appropriate level of involvement were arrived at, but our observations demonstrated that in some cases they were influenced by the degree to which an organisation sees itself as part of the community or as contracted independently to carry out a function on behalf of the public and by the experience of public involvement of those at a senior level in the local Healthwatch.

Some local Healthwatch organisations pursue greater representation not at board meetings, but through the approach they adopt to work planning and activities. This includes adopting outreach approaches to gain access to the wider public, focusing on some 'seldom heard' groups, and designing their work programmes with an explicit 'research' approach in mind – focused on methods that gather views from the widest possible range of sources within the community.

While the different approaches taken by our case study sites to involving the public in their work had often been effective in creating distance from the criticisms of the LINks in some cases it had left organisations open to criticism that they were failing to respond to local concerns or that they were not involving the public. Achieving the right balance is challenging; there is an expectation of social enterprises that they have appropriate representation from key stakeholders, for example, the public, and providing a mechanism for those with specific interests and views to contribute to, but not dominate, the activities of local Healthwatch can provide access to vital expertise and capacity.

Defining the unique contribution of local Healthwatch

Some elements of local Healthwatch's role are clearly distinct from those of other organisations, for example, their formal representation of the public voice on health and wellbeing boards. Local Healthwatch organisations also have a distinctive power to 'enter and view' providers.

However, in gathering views from the public and in seeking to use those views to influence providers and commissioners, Healthwatch clearly operates alongside other existing mechanisms. Our case study sites demonstrated a range of ways in which local Healthwatch defined its unique role. Some focused on their independence and the credibility this lent to the intelligence that they developed, others on their legitimate role in monitoring provision while also using their expertise to scrutinise and influence the involvement activities of other organisations. Finally, some organisations focused on adopting a particular approach to their activities which influenced the nature of their intelligence, including the use of research methods to build robust evidence, a focus on ensuring representative views, and a focus on issues and perspectives derived solely from lived experience.

Some of our interviewees challenged whether these roles have value or are unique given the existing mechanisms and duties for involvement elsewhere in the system, and other systems for consultation, monitoring, peer review and inspection. Differences in how local Healthwatch organisations and other stakeholders perceived their respective roles affected the effectiveness of local Healthwatch organisations in carrying out their statutory activities. Some local Healthwatch organisations have developed processes such as memoranda of understanding with other local organisations, and others have more informally

developed good ways of working to establish clear roles, combine efforts where useful and avoid unnecessary duplication.

The least clear and most contentious role we found for local Healthwatch organisations was in holding local providers and commissioners to account for their actions. Some local Healthwatch organisations had received criticism from stakeholders, which did not see themselves as in any way accountable to Healthwatch, while others felt that Healthwatch organisations were going beyond their legitimate remit by seeking to hold others to account.

Balancing 'critic' and 'friend'

Local Healthwatch organisations adopted different models of operation, favouring to differing extents either:

- an independent public voice, rooted in the community (the 'critic') – some Healthwatch organisations seem to principally define themselves as the source of independent evidence of local people's views, and essentially see their core role as communicating this evidence to local bodies and in some cases holding them to account for action

- a strategic local partner working within the system (the 'friend') – some Healthwatch organisations seem to focus more on working in partnership with providers and commissioners, sharing views and evidence to support improvement in services and getting involved in how their local evidence is used and acted upon.

These different ways of operating determine both the specific activities that local Healthwatch organisations undertake (for example, the relative focus they give to community engagement versus taking part in decision-making committees and meetings), and the overall tone or approach they are perceived to be taking (for example, being seen as more or less supportive of providers '*doing the best they can*' versus seeking to operate by '*rattling cages*' and '*not being compliant*').

The design of local Healthwatch organisations and their activities requires them to combine and move between these different approaches, so as to be both independent of the system holding it to account on behalf of the public, and '*at*

the table', able to take part in strategic decisions as a part of the system. Evidence from our case study sites highlights that even when local Healthwatch organisations do not take the role of 'critic', acting solely as the public voice can bring more limited opportunities for influence, particularly in decision-making. At the same time, a more active focus on influencing the system can limit access to the unique perspectives of service users and emerging issues and give rise to conflicts of interest where local Healthwatch organisations are in effect working primarily on behalf of stakeholders and in some cases facilitating their voice. This is a difficult balance for local Healthwatch to achieve, and it brings high risks of tensions and challenges.

It is not often explicitly acknowledged when some local Healthwatch organisations move between these different models of operating, and this can sometimes lead to internal tensions and disagreement with local partners who may be interpreting Healthwatch's role differently. We sometimes found our interviewees implicitly seeing one of these approaches as more correct than another, and seeing any work using a different style of operating as inherently ineffective.

Implementation

Skills and experience

The ability of local Healthwatch organisations to be effective is heavily influenced by the skills and expertise of the board and executive team. Looking at the individual leaders within local Healthwatch, it is clear that the unique backgrounds and expertise at the board and chief executive level at least partly determine the approach the organisation takes and its effectiveness. Governance is a formal role and board members require the appropriate skills and expertise relative to the duties of the board to ensure due diligence. The role of both chair and chief executive require leadership skills. Strong and effective leadership from the chair is valuable in setting the direction of the organisation and can provide support and guidance to the chief executive.

Individuals who have considerable local knowledge, connections and influence are invaluable in getting Healthwatch on the agenda, supporting the legitimacy of local Healthwatch and being invited to take part in decision-making and strategy-setting groups. Board members with particular expertise are also beneficial in guiding and supporting the team.

Many teams appear to have benefited from ensuring that the expertise and skills of staff are aligned with the work plan and allocating clear roles and responsibilities for activities to individuals that capitalise on their particular skills. Given the limited capacity of the teams, sharing learning across local Healthwatch is particularly important. One local Healthwatch representative told us they felt like they were '*constantly reinventing the wheel*' and wished they could get more access to shared good practice, and across our case study sites we heard stories of similar learning processes they had each gone through.

Capacity and resources

Local Healthwatch organisations are very small in comparison to the potential scope of their statutory activities, and the populations and services they cover. Staffing is one of the greatest limiting factors on activity and is heavily determined by funding. Teams in our case study sites had between four and nine members of staff, with many employed on part-time and fixed-term contracts. Standard HR issues, such as maternity leave and sickness leave, can have a huge impact on the ability of the organisations to carry out their work plans.

A number of case study sites had partnered with local voluntary and community sector (VCS) organisations to maximise their capacity. This included building networks and establishing agreements to gather and share intelligence, using the physical locations of large VCS organisations to extend the reach of local Healthwatch and 'piggy backing' on the activities of other organisations. A number of local Healthwatch in the case study sites had contracted activities and pieces of work to outside agencies to increase capacity and all case study sites considered being commissioned by others to provide services as a means of fulfilling their statutory activities and establishing additional funding streams.

Five out of six local Healthwatch in our case study sites had, at some point, an underspend on their annual income, however, this often reflected challenges in having capacity to respond to demand-led activities such as providing information and support, undertaking more substantial pieces of work, and being able to invest in staffing to achieve this given the uncertainty of funding allocation. In practice, each Healthwatch organisation has to prioritise activity.

Volunteers

The contribution of volunteers to local Healthwatch organisations cannot be understated. All members of the boards in our case studies contributed mainly on a voluntary basis and in a large number of cases this represented significant time, energy and expertise. Board members, and the chair in particular, provided important legitimacy and capacity in representing Healthwatch both at other board meetings and where a level of seniority conferred authority on Healthwatch's contributions. In some cases local Healthwatch board members in our case study sites had also taken roles in developing and guiding specific activities of the team. Members of steering groups also donated time and expertise to inform the work of Healthwatch.

Healthwatch volunteers also support the capacity of the team to undertake their other activities. Volunteers in our case study sites were involved in promoting local Healthwatch organisations, supporting outreach activities and collecting intelligence, providing administrative support and attending meetings. 'Enter and view' activities were largely carried out by volunteers. In many cases volunteers bring unique expertise in specific areas. Recruiting volunteers and providing them with the right training and support required considerable and ongoing investment from the staff teams. Local Healthwatch organisations reported that not everyone was suitable be a local Healthwatch volunteer. This was particularly relevant to volunteer roles that required individuals to be a representative of local Healthwatch or where a degree of impartiality was required, as in the case of 'enter and view'. However, local Healthwatch organisations that had developed more extensive volunteer roles reported the ability to find a niche for every volunteer.

It is important to note that the value and extent of volunteer contributions were dependent on the specific individuals. The degree to which board members were able or willing to contribute varied, and some case study sites reported that members of the public were often interested in contributing to work in which they had a particular interest, but were less willing to support general engagement as a whole. Willingness of volunteers to be involved was influenced by the degree to which individuals perceived their involvement as valued and contributing to the activities of the organisation.

Prioritising work

A range of factors determine which issues or services local Healthwatch choose to focus on. These include:

- analysing public feedback or more generally reflecting on views heard through public engagement activities to identify common issues of concern
- specific consultation with members of the public about their priorities
- internal organisational decisions to focus on particular groups
- assessing key local strategic documents to identify gaps and opportunities where Healthwatch could add most value
- choosing to influence existing workstreams and priorities of local system partners (such as the CCG or health and wellbeing board)
- existing local initiatives or consultations
- being directly commissioned to conduct a piece of work
- national concerns including those raised by Healthwatch England.

Different local Healthwatch organisations use a mixture of these approaches, and each brings benefits and risks. Too great a focus on national priorities appears to limit local effectiveness, since these national priorities do not always align well with local priorities. With such a wide range of potential work, there is never a unanimous 'right answer' about what to work on, and so explicit conversations about priority-setting are important to acknowledge and, as far as possible, resolve any internal disagreement.

An associated and core element of choosing priorities is defining the unique contribution that local Healthwatch can make. In some cases this may be focusing on areas of provision or groups not covered by other organisations, in others it may be by contributing a unique perspective to inform on-going work at a strategic level. Although local Healthwatch in some case study sites took these considerations into account in defining the information they collected and potential for influence, this process did not appear to be routine. One case study interviewee questioned whether some of the work their local Healthwatch had carried out had simply stated the obvious. Other examples of work highlighted in the research provided overviews of issues that added little further insight to that available in the literature and lacked local context.

However prioritisation decisions are taken, local Healthwatch organisations appear to be perceived as more effective by local partners if those local partners

feel they understand why Healthwatch has chosen the priorities it has and the value of its contribution.

System influences

Oversight and accountability

The relationship between local Healthwatch organisations and their local authority commissioner appears to have an important influence on effectiveness. Several case study sites reported significant input from local commissioners in establishing local Healthwatch organisations, including support with developing appropriate governance and in some cases outlining work plans. Those local authority commissioners who were involved from the start were often described as having invested in Healthwatch and wanting it to succeed. Commissioners were also valued in being able to support local Healthwatch in developing relationships and getting access to different meetings, particularly within the council. However, it is clear that these relationships have required negotiation as organisations develop, with local Healthwatch organisations requiring greater freedom to apply learning to guide and develop their activities. Two local authority commissioners told us how they intended to '*step back'* from their close involvement with their local Healthwatch now it is becoming more established.

Although performance management could be conceived as overbearing, in practice use of process measures particularly focused on activities appears to have benefited local Healthwatch in some case study sites by providing focus. It also provided a measure of success that was visible and achievable. It was notable from the interviews with local authority commissioners that while some had a clear picture of the strengths and weaknesses of their local Healthwatch organisations, others reported that they had limited knowledge beyond what had been reported to them.

A few local Healthwatch organisations reported conflicts of interest arising from being commissioned by the same local authority directorate they were scrutinising. One local Healthwatch described being moved between social care, public health and ultimately to the supply-side directorate within their local authority in order to reduce conflicts of interests.

Local structures for strategic decision-making

One of the main intentions behind the design of Healthwatch was that it would have a unique ability to share in local strategic decision-making through its membership of the local health and wellbeing board. However, survey respondents and a number of local Healthwatch case study sites highlighted considerable challenges related to the dynamics that exist within local government, appropriate representation on the board and agenda items that seek to maximise contributions of those present. In practice, local Healthwatch organisations noted that the health and wellbeing board largely considered proposals in the late stage of development and functioned primarily as a forum for approval as opposed to active challenge and discussion, precluding the opportunity to influence.

With much of the strategic decision-making occurring in numerous sub-committees and working groups, the onus was on local Healthwatch organisations to build and maintain relationships with all the major stakeholders to ensure that they were 'at the table'. In some cases this enabled local Healthwatch organisations to influence both the process and the outcome positively. However, it was noted that local Healthwatch organisations were often invited to the table too late to influence the design of proposals while the inherent timetables and processes around decision-making processes, such as development of the Better Care Fund proposals, precluded the opportunity for meaningful contributions from both the public and local Healthwatch organisations.

In practice, many local Healthwatch organisations are experiencing continuing challenges with influencing local decision-making because much of their evidence and work feeds into pre-existing organisations or power structures that retain the ultimate power to act or not on the evidence from Healthwatch. Overall it appears that the practice of local public and community involvement in strategic decision-making continues to lag behind the policy aspirations.

4. What makes an effective local Healthwatch?

Many of the factors that influence the effectiveness of local Healthwatch organisations are not unique. Indeed, they are well documented in the wider literature related to small businesses, social enterprises, community organisations, and other mechanisms for public, patient and community involvement. Drawing on elements of this evidence to add to our research, we set out here some of the main points of learning for local Healthwatch organisations and their local system partners.

Organisational effectiveness

Governance

Effective governing boards can strengthen leadership and ensure success.

Local Healthwatch organisations would benefit from having board members:

- with adequate time and ability to invest in the organisation
- whose values and goals are aligned with those of the organisation and have a balance of personalities
- with diverse and relevant areas of expertise and experience (including legal and financial management) that can provide a range of insights and perspectives and are complementary to the activities of local Healthwatch and the wider skills of the operational team
- who have connections with the key stakeholder groups that local Healthwatch organisations seek to engage and influence.

The roles, responsibilities and lines of accountability of the board chair, members and the chief executive/officer should be clearly defined with a clear process in place for decision-making and reporting. There should be a clear line of definition between the tasks and responsibilities of the board and those of the management team.

The board of local Healthwatch organisations should be expected to develop and adapt in line with the organisation. Reviewing the role of the board, and the skills and engagement of members, should be considered on a regular basis.

Independence

Independence is a key characteristic of local Healthwatch organisations. Maintaining this should be a primary concern.

All local Healthwatch organisations should have an independent board that oversees the financial and strategic management of local Healthwatch. Defining a clear role that outlines how each local Healthwatch organisation determines its activities and achieves impact provides a good basis for assessing where independence may be compromised. Consideration should be given to the role of board members in decision-making and in relation to the prioritisation of work and the commissioning of services.

All conflicts of interest should be acknowledged and shared for discussion. Local Healthwatch organisations should develop policies and procedures to address and deal with emerging issues related to conflicts of interest. Where conflicts of interest emerge repeatedly, efforts should be taken to tackle the underlying cause.

Public involvement

Patients and the public are key stakeholders in local Healthwatch organisations, and as local Healthwatch organisations are social enterprises in receipt of public funding there should be transparency to the public. Board minutes should be publically available, and the public should have an opportunity to scrutinise the process of decision-making around work planning. Under the legislation, local Healthwatch organisations should involve the public and volunteers in the actual carrying out of their statutory activities.

Local Healthwatch organisations may benefit from ensuring they have appropriate skills and expertise around public involvement at both the board and team level. The involvement of lay members on the board is advantageous and public members may be invited to attend board meetings. Alternatively, the development of an advisory board involving the public and other key stakeholders can provide a valuable opportunity for ensuring appropriate representation, sharing of local intelligence and to inform work planning.

Making a unique contribution

In many of the areas in which local Healthwatch organisations operate there is overlap of activities with other organisations, including the voluntary and community sector and statutory providers. Considering how the role and activities of a local Healthwatch organisation fit within these and what it can uniquely contribute can support greater legitimacy and recognition locally. This may include providing a particular perspective or engaging specific groups, taking a distinct role or adopting a particular approach to delivery. Working with other stakeholders such as the local authority can ensure that this role has local value.

Balancing 'critic' and 'friend'

Local Healthwatch organisations need to strike a balance between being both a critic and a friend. This is a difficult balance to achieve but can be supported by developing and strengthening relationships with stakeholders in order to build trust through a shared understanding of values, roles and responsibilities. This requires local Healthwatch organisations to have a clear understanding of the value of their role and approach and to be able to articulate this. At the same time local Healthwatch organisations need to work with key stakeholders to develop an understanding of their values and how they operate.

Operational effectiveness

Skills and experience

It is important that both the board chair and chief executive/officer have appropriate skills to manage and lead their respective board and staff teams. Ensuring that the skills of the team are aligned with the work plan and staff are allocated clear roles and responsibilities for activities that capitalise on their particular skills is important. Where staff are required to undertake core activities that they do not have the requisite skills and experience to complete, training should be provided. Board members with requisite skills may also be valuable in providing guidance to the Healthwatch team.

Capacity and resources

Local Healthwatch organisations can maximise their capacity in a number of ways. Board members can provide support in attending strategic meetings on behalf of local Healthwatch. Establishing mutually beneficial relationships with other voluntary and community sector organisations can also support the collection of views and experiences and provide access to wider forums for engagement. Local Healthwatch organisations may benefit from working in partnership or commissioning work externally where their own skills and/or capacity are limited.

Volunteers

Volunteers are a vital resource for local Healthwatch organisations in terms of providing expertise and increasing capacity. Therefore, employing staff with experience in developing and managing volunteers is important. Local Healthwatch organisations need to consider the different roles that volunteers may play and develop appropriate training and support for them to fulfil those roles. The more flexible an organisation is in which roles volunteers can take on, the more likely it is to maximise involvement. Taking into account volunteers' motivations for volunteering and ensuring their contributions are valued may support sustained involvement.

Prioritising work

In order to maximise effectiveness, local Healthwatch organisations need to consider how they prioritise work. There should be a strategic approach to work planning and prioritisation. Consideration should be given as to how information that emerges from the activities of local Healthwatch influences this process. Work plans will need to balance between fulfilling the statutory activities, resourcing demand-led activities and responding to emerging local issues and requests from local and national stakeholders. The degree to which activities will present new insights and opportunities for impact should also be considered in work planning and defining individual pieces of work. Ensuring that this process is transparent and is of value to key stakeholders is important in creating legitimacy.

Support from local system partners

Oversight and accountability

Active engagement of local authority commissioners is important to support local Healthwatch organisations to identify where they can play a unique role and ascertain and challenge how their activities create value. Given the early stages of development, local authority commissioners should expect to have an understanding of the scale and scope of the activities being undertaken by their local Healthwatch organisation and seek to ensure that governance is adequate. Developing a framework for regular reporting across the statutory activities and an overview of work planning may support local Healthwatch organisations to achieve greater focus and ensure improved accountability.

Local structures for strategic decision-making

To maximise opportunities for local Healthwatch organisations to be fully involved in strategic decision-making, stakeholders such as other members of the local health and wellbeing board should seek to involve their local Healthwatch organisation early in any given project or process and identify, in collaboration with local Healthwatch, how their activities can contribute and add value. Clear timescales should be set but need to be realistic and in line with the role agreed. As with all public engagement processes, it is likely that the intelligence gathered by local Healthwatch organisations may at times challenge existing views and processes. Appropriate mechanisms should be sought through which challenge can be raised and discussed by all stakeholders involved. Peer challenge can be a useful process for local structures to gain insights from others to identify potential improvements to their processes and approach.

5. Conclusions

Local Healthwatch organisations vary widely both in how they are interpreting and carrying out their statutory activities, and in the impact of their work. While there are common activities being undertaken, there is variation in the purpose of activities and the perceived process by which activities create influence. Overall, our local Healthwatch survey respondents and case study participants clearly felt some progress was being made in all their statutory activities, but there was much more they wanted to do.

It was disappointing how few health and wellbeing board representatives, local authority commissioners, CCG leads, and other local system partners responded to the national survey, so we are unable to establish a national picture of whether there are any consistent differences in perceived effectiveness and impact between local Healthwatch and these groups.

Setting up the necessary structures, appointing the right people, developing a knowledge base and building relationships with providers, commissioners and other bodies all take considerable time. It is clear that local Healthwatch organisations are in the process of shifting from setting up the organisation and developing local relationships, to developing effective processes for carrying out their activities, and then ultimately to achieving impact in terms of changes to services. So while it is instructive to look at their effectiveness at this point, it is crucially important to recognise that their impact is very likely to increase as the organisations continue to build their programmes of work.

Broadly, local Healthwatch and its local partners have highlighted the impact of local Healthwatch activities resulting in:

- greater attention in key decision-making groups given to the views of the local community
- more extensive engagement taking place with local communities
- obtaining extensions to consultation deadlines for service design and commissioning programmes to ensure appropriate engagement with the public
- obtaining commitments from providers and commissioners to review, adopt and endorse recommendations
- greater consideration or explicit inclusion of commitments to meet the needs of particular groups in local strategies, commissioning plans and provider policies
- escalating serious concerns to scrutiny committees and regulators

- specific changes to services such as improved patient information.

This evidence of impact often arises in relation to individual activities and pieces of work, and is neither uniform across the range of statutory activities within any given Healthwatch nor uniform across the local Healthwatch network.

Intelligence from our case study sites pointed to a number of key areas that influence the effectiveness of local Healthwatch. These include issues related to governance, the skills and experience of those involved, and the capacity of the organisation in relation to its statutory activities and remit across the local health and social care system. The case study sites also highlighted challenges and issues that local Healthwatch organisations face in relation to establishing a legitimate role and programme of work that enable them to undertake their statutory activities but also to contribute to the local health and social care economy in a way that is meaningful to other key stakeholders. And finally they demonstrated issues that arise, such as conflicts of interest, which can undermine the credibility of local Healthwatch. No organisation we engaged with had been immune from all these challenges, and several were subject to many. As local Healthwatch organisations begin to mature it is important that these issues are addressed as they not only threaten to weaken the legitimacy of individual organisations but the network as a whole.

Finally, it is important to acknowledge that local Healthwatch organisations are reliant on the receptiveness of local stakeholders and in particular providers and commissioners in creating impact. Local Healthwatch organisations continue to face the same broad challenges experienced by any group or body responsible for or engaged in representing public and community voice and seeking to influence others on their behalf. Despite repeated policy commitments, various forms of duties to consult and involve, and a long history of different public involvement mechanisms and bodies, in practice the legitimacy and credibility of those providing that public voice often remains contested.

6. Recommendations

Our research demonstrated that there has been significant progress in setting up the local Healthwatch network of organisations. However, it is clear that disparities remain around how local Healthwatch organisations interpret their role, how this is understood within the local health and social care system, and their effectiveness in carrying out their statutory activities. Using examples drawn from the data, along with insights from interviews with local and national stakeholders and our own knowledge and evaluation of local Healthwatch and the context in which it operates, our recommendations consider the steps that now need to be taken and the support that would be valuable in developing the effectiveness of local Healthwatch organisations.

With the exception of those recommendations that pertain specifically to individual bodies and organisations, recommendations require local authorities as commissioners of local Healthwatch, and Healthwatch England through its remit of supporting local Healthwatch, to play a key role. The role of the Local Government Association is also considered with regard to its indirect support of local Healthwatch through local authority commissioners. Finally, it is noted that although the Department of Health does not have a direct influence on the network, as overall steward of the health and social care system it plays a role in guiding those involved to maximise the effectiveness of local Healthwatch.

Recognise and, where possible, resolve continued debate about local Healthwatch's role and purpose

A range of guidance and advice has been produced by national bodies to explain the role, purpose and statutory activities of local Healthwatch organisations and to support them to become established. Despite this there remains a lack of clarity both among local and national stakeholders, and wide variation in how the role of Healthwatch is interpreted, which impacts on effectiveness. Particular challenges include:

- achieving a balance between being both an independent voice and a strategic partner and local leader in the system
- the fact that whereas some functions of local Healthwatch are unique to them, others (such as gathering local views and scrutiny) are shared with many others locally, and so effectiveness depends on co-ordinating work with

many others and clearly defining the unique contribution of Healthwatch locally.

There is not a single national answer to these issues. Ultimately the role of local Healthwatch is defined by local implementation of legislation. As such, we recommend that local Healthwatch and its partners take time to reflect on their shared understanding of Healthwatch's role and purpose, and address any disagreements or areas of uncertainty that emerge. Most notable is the role of local authority commissioners and local Healthwatch organisations in establishing a role which is both contextually relevant while fulfilling the statutory activities of local Healthwatch. Further clarification from Department of Health as to the core role of local Healthwatch as envisaged by the legislation may be beneficial. In addition Healthwatch England may provide valuable support in collating and outlining a range of different approaches.

Seek consensus on local Healthwatch priorities and on how priorities are determined

Effective prioritisation of work is central to the ability of local Healthwatch organisations to have an impact. Local Healthwatch organisations should develop clear processes for how they make decisions on priorities, and where possible achieve consensus with local partners on both the process and the priorities themselves.

The size and capacity of Healthwatch organisations mean that it is not practical to expect them to carry out all of their activities for all of the population. Ultimately, local Healthwatch organisations have to prioritise. Although this is in part influenced by the role that local Healthwatch organisations play, establishing a balance also requires decisions about how this is achieved. Healthwatch England could provide useful support in producing guidance on prioritisation and work planning for local Healthwatch.

Review local Healthwatch's role in providing access to information and advice about local services

This role for local Healthwatch organisations is one of its most resource-intensive and specialist responsibilities and does not cohere as neatly as the other

responsibilities do into a consistent, simple role and purpose. We are unconvinced that local Healthwatch organisations are automatically the appropriate local bodies to have this role. Moreover, the incoming Care Act also places new requirements on the system that need to be considered in relation to local Healthwatch's role. It is not within the remit of this study to propose changes to Healthwatch's statutory activities, but we recommend that local areas carefully review how the public access and use information and signposting services, so that the right role for local Healthwatch can be defined.

Build the profile of local Healthwatch

The effectiveness of local Healthwatch organisations and their ability to influence is dependent on their relationships with the public and local stakeholders. Local and national effort is required to build public awareness and understanding of the role, purpose and activities of local Healthwatch.

Local authority commissioners should continue to support local Healthwatch

Our work shows that where local authority commissioners have invested time and energy in establishing and supporting local Healthwatch organisations, this has been beneficial to effectiveness. While most local Healthwatch organisations have the basics in place and are gaining experience in all their activities, we recommend that there is a good case for local authority commissioners to continue to provide specific and significant support to local Healthwatch, at least in the short term, as they continue to become more firmly embedded in the local system.

We recognise that there may well be a handful of essentially 'failing' local Healthwatch organisations where a re-commissioning process should seek to identify a new provider. In general we recommend that any re-commissioning of local Healthwatch seeks for now to further refine the process and outcome performance expectations of existing providers, and support them to improve, rather than look to appoint alternative providers.

Ensure sufficient capacity and sustainability for local Healthwatch

Wide variation also exists in funding, staffing and capacity within local Healthwatch organisations, and in their use of volunteers and wider networks to leverage greater support. As budgets across public services continue to be squeezed, it is essential that local Healthwatch organisations have sufficient capacity and sustainability to carry out their statutory activities.

Specific recommendations for national bodies

Healthwatch England

- Healthwatch England and local Healthwatch often describe themselves as forming a 'network', working closely together to champion the consumer perspective. As we have described, local Healthwatch organisations vary in where they see themselves as operating on the spectrum of 'critic' to 'friend'. We did not look specifically at Healthwatch England's work as part of the study. However, our overall reflection is that Healthwatch England's public-facing work is often positioned as campaigning, and that there is therefore at times a difference in approach between Healthwatch England and those local Healthwatch organisations operating closer to the 'friend' end of the spectrum. Healthwatch England may want to acknowledge and reflect on this in any narrative around how it works with local Healthwatch and the respective roles of Healthwatch England and local Healthwatch.

- While it is recognised that the support needs of local Healthwatch organisations may vary, our evidence highlights that all would benefit from support and guidance in relation to:

  - good governance
  - using information to develop evidence and recommendations
  - prioritisation
  - understanding the complexity and interrelationships within the health and care system
  - opportunities to share experiences and learn from each other.

  This may include highlighting and collating resources available more widely, developing tools and training, and considering mechanisms for peer support. It is important that wherever possible support seeks to facilitate development

by focusing not just on what to achieve but also on the processes and behaviours that will help to achieve it.

- Ensure that requests from local Healthwatch organisations for involvement in national work are clear about the information needed and how it will be used, and give due notice for submission deadlines so that local Healthwatch organisations can contribute meaningfully.

- Develop a national leadership development programme or scheme to support and develop leaders within local Healthwatch organisations.

- Consider adapting the Local Government Association peer challenge model to enable local Healthwatch organisations to benefit from peer review, support and development.

- Consider developing a database of local Healthwatch's priorities, so that national stakeholders initiating work in particular areas can identify which local Healthwatch organisations might want to input.

NHS England

- Ensure local Healthwatch organisations have a named contact within the relevant local area primary care commissioning team.

- Particularly as new co-commissioning arrangements come into operation, produce guidance for local Healthwatch organisations on commissioning responsibilities to help them identify who to involve in their work.

- Continue to consider the role of local Healthwatch within the wider remit of NHS England around patient voice and involvement, and NHS Citizen.

Local Government Association

- Consider the role of local Healthwatch organisations in health and wellbeing peer challenges, including the mechanisms required to support increased involvement, and provide guidance to local councils/reviewers as to recommendations and advice.

- Continue to provide support for local authority commissioners of local Healthwatch in how to support and performance manage local Healthwatch effectively.

- Working with Healthwatch England and the Department of Health, develop minimum standards for the governance and activities of local Healthwatch, to help strengthen their accountability and ensure basic standards of performance are being met against their statutory activities.

Care Quality Commission

- Some remaining issues with the basic functioning of the relationship between local Healthwatch and CQC should be addressed, including:

    - CQC should ensure that all local Healthwatch organisations are made aware of their named local contact
    - as a minimum, CQC should acknowledge receipt of all data submissions from local Healthwatch
    - a clear process should be developed for two-way sharing of data around the CQC inspection regime – this would cover issues including: when local Healthwatch will be engaged; types of data that are needed; when and with whom to share plans to avoid duplication; what feedback local Healthwatch organisations can expect to receive; and the role of 'enter and view' in relation to inspections.

- Develop good practice for joint work where boundaries for regional inspection teams and local Healthwatch are not co-terminous – regarding hospital inspection teams (which work across regional areas – especially pertinent for ambulance services that often cover large areas) and primary and integrated care inspection teams (which work across CCG boundaries).