'The Owl Project'

Clarifying new roles and relationships to ensure that citizens' views in health and social care are represented effectively through Healthwatch

Background

The Healthwatch programme board agreed at its December 2011 meeting, to hold a whole system simulation event that could test and clarify how Healthwatch can deliver its statutory functions most effectively. The programme board was keen to explore how the different elements of the new health and social care environment might work together most effectively, across organisational boundaries.

With this in mind, the Local Government Association has commissioned a specialist consultancy organisation, Loop2, to work in partnership with the Department of Health and other key stakeholders in order to deliver this important element of development work. Lorraine Denoris, Programme Director Healthwatch Implementation at the LGA, is leading this work on behalf of the programme board. A small design team has been established to work with Loop2 and ensure smooth delivery of the event.

This report provides an update on progress made since the programme board last met and seeks comments from the board on emerging design assumptions and planning.

The 'Owl Project' - outline process

At the centre of this work is a day-long workshop that will bring together representatives of national and local significance from stakeholders that are involved in one way or another with the interests of the public and patients in the planning and delivery of health and social care and support. They would include (at least) people who can represent:

- Local *Healthwatch*
- *Healthwatch England*
- The regulators
- The NHS Commissioning Board (national and local offices)
- Clinical Commissioning Groups (including their patient participation groups and lay members)
- Foundation Trusts (boards, governors and members)
- LINk and other third sector organisations representing different interest groups
- Local Authorities (to include Public Health, Overview and Scrutiny Committees and Health and Wellbeing Boards)

Participants will be asked to work in a hypothetical but realistic *simulated* local health and social care system. To do this Loop2 would create a high level description of organisational entities and representative structures and accountabilities. Given the complexities of relationships to be explored we suggest that the simulation focus on a single *Healthwatch* model rather than attempting to evaluate the different models of governance arrangements in the same event.

Before the simulation event Loop2 will work colleagues to identify those issues which you believe have the potential to compromise the effectiveness of either *Healthwatch* or its partner organisations in the field. Loop2 will then create a series of challenges or *contentions* that are built into the simulated context that will test the system and provide learning about how best it might evolve. These *contentions* might well include:

- The respective roles of Trusts, CCGs and *Healthwatch* in handling complaints;
- What information *Healthwatch* might collect directly and what responsibilities other parts of the system have to share their information with *Healthwatch*
- How the NHS CB might relate to *Healthwatch* e.g. in assessing CCG performance or in capturing patient views in its role as specialist commissioner?

- How *Healthwatch* might act as the consumer champion and what this means for the relationships between other groups that take on a similar role?
- How the Local Authority's Scrutiny function might be undertaken and what role *Healthwatch* might play?
- How national bodies such as the CQC might relate to *Healthwatch* e.g. in undertaking specific service or process reviews or investigating issues of concern?
- The respective roles of CCGs, health care providers and *Healthwatch* in undertaking ongoing public and patient engagement and in formal consultations.
- How local Healthwatch can most effectively and efficiently gather robust feedback, analyse and channel it to local and national commissioners, HWE, CQC, HOSC and other stakeholder groups

Loop2 will ensure that the kind of questions raised at the DH launch of the *Healthwatch* learning sets are addressed

In the first part of the meeting participants will be asked to work in different stakeholder groups to consider how they would handle each of the *contentions.* Loop2 will facilitate a highly interactive conversation between the stakeholders led by pre-prepared storyboards to surface insights about where are gaps, overlaps and uncertainties about how the new system will work. After the stakeholders have worked through the *contentions* there will be a facilitated plenary discussion about the implications of what happened and which aspects of the new public engagement and representation arrangements are in need of most clarification or refinement.

In the second part of the event participants would work in mixed stakeholder groups to try and resolve the priority issues that they have identified. This might focus on defining the specific and respective roles of different elements of the system (*Healthwatch* and others) in relation to functions such as:

- Scrutiny of commissioner/provider performance
- Engaging and consulting local people
- Providing information to individuals e.g. to inform choices about health/care
- Complaints, concerns and arbitration

Loop2 will design visual materials to record the output from this discussion so that the preferred roles and relationships for the emerging system are clear.

In the final session mixed groups will be asked to identify their development 'messages' for each parts of the engagement and representation system. These will help identify the actions that participants feel – in the light of the simulation experience – what each body should consider in order to make the right connections and relationships with *Healthwatch* and what needs to be included in the transition and development planning for the new *Healthwatch* bodies. Loop2 will use an independent, authoritative panel to moderate these messages so as to produce a rounded set of messages with national relevance.

Post event material
After the event Loop2 would produce a short power point presentation summarising the key points from the event. This would form the material for a 'whiteboard session' in which key stakeholders can agree the key conclusions and recommendations and consider how they can best be used and shared. Loop2 will also produce a formal written report.

Co-production
Loop2 expect to work *with* the design team and programme board as co-producers both in the planning and delivery of the workshop and programme outputs.

Design Assumptions

A number of design assumptions have been developed in order to ensure that a good range of "real" issues can be explored during the event. These include;

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Format

- The simulation will focus on a hypothetical place that provide a common platform for discussion
- The place will be described at a high level - details such as financial budgets, contracts etc will not be needed
- The place will need to be plausible but it cannot be representative of all the potential local authority or Healthwatch governance arrangements authority.
- The guiding criteria for the simulated location is that it should be capable of carrying the issues to be tested
- To help make the findings from the Owl project applicable to the wider range of settings we will need to a) ensure that the participants' backgrounds reflects the spread of Healthwatch circumstances b) present the findings for post event moderation to understand how the generic learning might apply in specific circumstances.
- The type of simulation we propose to use is a hypothetical. This involves the facilitators guiding a set of conversations about 'what if' issues between the different stakeholders that will be represented.
- The simulation action will focus on March 2013 when the CCGs have been authorised and Healthwatch has been commissioned by the Local Authority. This means we will need to make some assumptions about the format that Healthwatch will take – these details can be changed relatively easily up to immediately before the event.

The place

- We propose that the simulation is located in a large metropolitan council area – there are more of these than counties and we are confident it will provide some generic learning that will be applicable to other circumstances. Two tier arrangements are obviously a challenge for Healthwatch but can be picked up through reflections from participants during the event as well as the post-event moderation process.
- We suggest drawing on the patch called Crafton that we designed for the Routes simulation on social care – this simulation was jointly sponsored by the LGA, Kings Fund ADASS and SCIE so we know that it is credible with local government as well as the health sector. Watchville might have some of the following characteristics.

    - *Watchville is a large city in central England that is home to around 310,000 citizens. The council boundaries stretch beyond the urban area to include the suburban and rural fringe. Crafton's age profile is similar to that for the Region and for England as a whole.*

    - *Following many years of Labour control, the metropolitan council became politically split at the last election - the council has a Conservative leader.*

    - *There is a single clinical commissioning group for the city. It has an actively stimulated patient participation groups in each of the practices. The CCG's shadow period has been a moderate success in terms of getting things organised and keeping within budget – they have done nothing to rock the boat ---- yet. The CCG decided that it would not invite Heathwatch on to its Board*

    - *The CCG has a mix of arrangements for commissioning support – it buys in some from the former PCT and some from the private sector and has a core staff that manage these contracts, provide local analytical support and interpretation and some who undertake detailed work with the practices to improve their performance*

    - *There is one acute provider that was struggling as was too small - the takeover of community services (while hotly disputed by community staff) has put the organisation onto a more stable financial footing but it will still struggle to maintain some core services such as maternity and paediatrics. The Trust has a huge membership and local loyalty. MH is provided by a Trust that covers a larger geographical area.*

- *The council's HWB was an early pathfinder and has from the outset had a representative from LINKs and the Chair of Healthwatch is now the public representative.*

- *The council established a specification for Healthwatch following extensive consultation but it is still lacking in detail - they expect the new organisation to bring creative ideas to shaping the three functions of representing the public and patients, information and signposting and supporting complaints. The Healthwatch contract was awarded for three years with a break clause after one year to be invoked only in the event of a performance problem. The contract was won by a local organisation that had a track record in mental health advocacy: the strong bid had support from a range of local community organisations representing different health conditions who had signed up as potential partners.*

- *Healthwatch has accountability to the Health and Wellbeing Board. The Chief Executive of Healthwatch reports to the Senior Responsible Officer in the Council for citizen engagement who is the Director of Corporate Services (CHECK??)*

- *The council decided to put aside 95% of the money it received from the government for Healthwatch, retaining 5% to cover administrative costs . The contract with Healthwatch allows them to generate revenue from other sources, provided the income is used for community benefit.*

- *The new Healthwatch in the city is a social enterprise formed around a community interest company.*

The participants

- The participants in the event need to represent a diagonal slice from national bodies to local organisations. Because we are looking at strategy and policy issues we are likely to have a slight over-representation of senior decision makers but this must not preclude the inclusion of people who represent those who have direct experience as managers, volunteers and beneficiaries of Healthwatch-type activities. To understand the dynamics of how the new system will work we need to include people that have an appropriate grasp of the detail. A suggested 'cast list' is included in the Appendix.

- We will am to draw participants from across the country, mindful of access to the event which we expect will be in London.

The issues and relationships to be tested

Accountability

- How will HWE interpret its role and accountability
- How will HWE set standards for local HW – who will be involved?
- What support will HWE provide local HW – e.g. in developing appropriate methods of analysis?
- How will HW handle its complex accountability to LA and the community?
- How will LAs manage HW performance?
- What implications will the governance arrangements of HW have for their activities and performance

Representing the public and patients

- How will HW ensure that they are truly representing the views of all sections of the community? – what are the consequences of being partial?
- How would HW handle a significant quality issue (a Mid staffs repeat) where there are sections of the community that are angry about the issues being raised
- How will HW handle strong differences of opinion between different sections of the community?

- How will HW connect to FT governors and members? And to Patient Participation groups in primary care?
- How will HW go about influencing commissioners and providers?
- What are the respective roles of HW and the national/local communications and engagement service that will be part of the commissioning support arrangements?

Information giving

- How will HW interface with the various sources of information that are already out there for patients/public to tap into?
- How will those performance managing HW know if the information is robust/credible?
- What information would they want to collect directly?
- Who else is offering signposting e.g. in social care for SDS – how will HW play into this?
- If patients are increasingly having choice how wide will the information need to be that HW can provide (national?)
- How might providers react to information giving e.g. on quality and performance?

NHS Complaints Advocacy

- Will HW simply take patient views at face value or try to triangulate with other data?
- How will role in NHW Complaints Advocacy feed into HW's influencing role?
- What connections will HW need to make with other parts of the system that handle complaints?

Other

- What skills/competencies and working styles will HW need to be effective?
- Will they need to specify skills/competencies for volunteers – how will this affect the ability of HW to represent all sections of the community?
- What education and training will HW require?
- How will HW roll forward the learning and legacy from LINKs?
- What are the implications for HW if they opt for income generation –will this compromise their role? What safeguards would be effective?
- Will HW be allowed to build up a surplus or will HW's be required to work with an annual budget?
- How will commissioners handle contradictory evidence provided by HW and other sources?

Lorraine Denoris
Programme Director – Healthwatch Implementation, Local Government Association

January 17th 2012

DRAFT PROPOSED CAST LIST

Note – the places and positions are the type of positions we would suggest might be represented in the sim – the people that might invited to take on those roles may not be in them now – a bit of imagination will be needed to fit representatives to plausible positions.

National bodies

Organisation	***Places/positions***	***Names 1st invite***	***Names Back up***
DH		John Wilderspin Andrew Larter Joan Saddler	
CQC	Director Regional manager or inspector	Amanda Hutchinson Lucy Hamer	Clare Delap
	HealthWatch England	Nigel Thompson Sara Cain	
Monitor	Director	Adrian Masters	Merav Dover
LGA	2 x	Sandie Dunne Clare Holloway	Andrew Cozens
Patients Association	Director	Keiran Mullen kieran@patients-association.com	Katherine Murphy
NCVO/NACVS	2 x director level	Stuart Etherington ????	
National patient info/option orgs	2 x senior managers/directors	Paul Hodgkin, Patient Opinion Jeremy Taylor, National Voices	

Local orgs

Organisation	***Places/positions***	***Names 1st invite***	***Names Back up***
Watchville Council	CEO Council leader Director of ASC/CS Director/Head of Corporate Services Youth Parliament rep or C&YP rep DPH	Becky Shaw (CEO) Ann Naylor Oliver Mills Jessica Crowe Tim Gillings (*LGA to nominate*) Yvonne Doyle	CEO from HW programme board Ann Tidmarsh

Health and wellbeing Board	Chair	Roger Gough	
Watchville CCG	Chair – GP Vice Chair – lay rep Chief Officer and comms lead PPG rep	Mark Jones (GP) Nathan Nathan (GP) Jo Sauvage (Islington GP) Nicola	
Watchville and Elseshire Commissioning Support Service	2 people – one of whom is from comms and engagement	Helena Reeves Cathy Gritzner (Cheshire and Wirral)	
North Central Office of NHS Commissioning Board	2 people	Paul Streets Mary Simpson Steph Hood	
Watchville Hospital NHS Foundation Trust	Director of Strategy Clinical director community services Head of communications and engagement Head of PALs	Robert Stewart Dalgit Athwal (AD Nursing, Peterborough and Stamford Hospitals) **** Julie Van Ruyckevelt	
Watchville and Elseshire NHS Foundation Trust	Director of Strategy Chair of the service user forum	Katherine Blackshaw (Director of Strategy Derbyshire Partnership Trust) Jude McKenzie	
Volorg representatives	3-4	Val Harrison (CEO POhWer – advocacy organisation) (DH to nominate)	
Watchville Local citizens	4-5	Jessie Cunnet Breda Flagherty Malcolm Alexander Sally Brearley Julie Bailey (cure the NHS)	Other LINk reps?

Watchville HW		John Lewis Clare Ogley Brenda O'Neal Sara Geater	

Timescale and resources

We understand that this needs doing quickly but as you know, the rate limiting factor for these events is the lead time to secure participants rather than Loop2's or the principle client actors' availability. Normally, we would advise that clients plan for a lead time of no less than 6 weeks following agreement of the contract. It is possible to work on a shorter timescale if the right people can be secured and this is more likely to happen through personal approaches rather than via email or letter.

We would suggest an early project initiation meeting to agree the timescale for the programme including the indicative date for the workshop and completion of outputs. This meeting can also be used to agree the key tasks involved in the planning and delivery of this project and our respective roles. At this meeting we would also want to agree with you the issues and questions that you wish to cover in the workshop.

The *Owl Project* is an interesting and important assignment for us and we are keen to work with you on it. Recognising the resource limits that you have we are offering a discounted price on our normal fee rates and have scaled down the chargeable time for the workshop design. Our fees set out below are exclusive of travel expenses, the reproduction of materials and VAT. They have been discounted from our standard NHS rates by some 20%.

Please see the table of charges below.

Consultant	**LMcM**	**SH**	
Day rate	£1,500	£1,500	
Preparation and design			
Project initiation meting	0.25	0.25	
Workshop design and preparation	0.5	1	
Facilitation	1	1	
Reporting			
Analysis of workshop outputs		0.5	
Whiteboard meeting	0.25	0.25	
Optional report		0.75	

Total days	2	3.75	
Fees	£3,000	£5,625	
Total fees including report			£9,750
Fees excluding report			**£8625**

The *ChoiceNet* Process

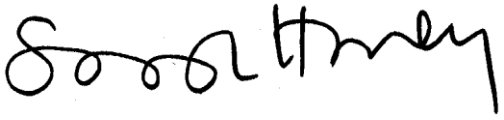
We can offer an extension of the *Owl Project* that would enable large numbers of stakeholders across the country to be actively involved. *ChoiceNet* has been developed by *Loop2* and *Policy Review TV* to support widespread public engagement in major service configuration but would be entirely appropriate in to this project.

It would involve recording the 'active' elements of the simulation process (presentations, plenary and final panel sessions) and then creating a stand-alone deliberative experience for individuals that could be accessed via the net. The material could be embedded in any number of local and national websites (NCB, CCGs, LGA, Councils, HWBs, user and representative groups, etc) and would enable people to hear the evidence and advice and then work through the simulations 'challenges' before answering a semi structured survey about the development of *HealthWatch*. We have ways of stratifying responses to be clear about which group is saying what and to prevent the process being 'gamed' by those seeking to over-represent a particular point of view. In addition we would create material that would enable any stakeholder group (perhaps including the DH learning sets) to run their own interactive and deliberative *Owl Project* sessions and record the outcomes and sentiments with little or no expert facilitation. This would provide an enormous reservoir of information to guide the development and implementation of *HealthWatch very quickly* as well as create a real sense of engagement in its development across England.

The costs of using *ChoiceNet* for the O*wl Project* are modest considering the numbers of people it can engage in meaningful deliberation. We would be happy to discuss how the reach of the *Owl Project* could be extended in this way.

We hope this gives you sufficient detail for the time being but please do contact us if you need further information. We look forward to hearing from you and hope that we have the opportunity to work with you on this interesting and hugely important project.

With best wishes



Prof. Laurie McMahon **Dr. Sarah Harvey**

Appendix 1

Appendix 2

Edited questions posed to the participants of the DH conference launching the *HealthWatch* learning sets.

- The Health Bill sees HW as the consumer champion for health and social care. How will HWBBs help to identify what this actually means on the ground? Is the responsibility understood? Who is going to lead this from the front?

- To be an effective player at the HWBB table, there needs to be clarity NOW about the skills and competencies LHW will be required to demonstrate. Are HWBBs able to co-create the skills and competency framework for both paid staff and volunteers? This is urgent since some authorities are planning to procure LHW services in the spring.

- Clearly having one LHW seat on the HWBB is not in itself going to ensure that the needs of citizens are hardwired into its work. What work will be needed to support the citizen voice being more representative (as the Bill specifies) authentic and independent. What third sector organisations and networks can be plugged into?

- The single CSF against which HW will be judged will be how well it gathers, analyses and channels good quality patient information and experience to Commissioners. Is there an individual responsible for delivering all this in 11 months time when the service is expected to go live?

- What can we learn from the PCT's experience of PPE about the blockages and how can CCG's learn from these to achieve authorisation. How can HWBBs embed good PPE into CCG's now AND bring LINk and LHW players into that dialogue from the start. How can HWBB's join up the dots here…