Establishing HealthWatch

27 September 2010

Attendance: Jean Moxon (Acting Chair), Barbara Smith, Michael Snee (Federation of Irish Societies), Keith Parry (The Nerve Centre), Griff Gay (Adult Services Kirklees Metropolitan Council), Carol Simmons, Dennis Killin, Elaine Hutton, Stephanie Harp, Lyz McKenna (Voluntary Action Kirklees)

This workshop looked at responding to the consultation on HealthWatch, which forms part of the wider consultation on Equity and Excellence: Liberating the NHS.

Preliminary observations

A few issues were raised before the document was addressed by the group, these were as follows:

- Getting qualified members of the public who are in full time employment to volunteer their services to HealthWatch.

  Solution – workers get paid time off to attend meetings and do work for HealthWatch.

- Discussion about LINks future and the year before HealthWatch starts.

  Answer – by law every local authority has to have a LINk so even though our contract ends on 31 March 2011 the council must have a LINk so it is probable that the same organisation and staff team will be in the Host role. As for funding, we cannot say what will happen until the national spending review is published on 20 October.

- The group was uncertain about the role of HealthWatch and whether the extra requirements would require the development of partnerships with other organisations such as the Citizen's Advice Bureaux.

Responses to consultation questions

There follows Kirklees LINk's responses to the consultation questions heading by heading.

Expanding the role of LINks as Local HealthWatch

The group believes that high levels of training are required to undertake the roles described. Although these roles could be undertaken by volunteers using the analogy of the Citizen's Advice Bureau for common concerns and complaints, the group believes that only well trained paid workers would be in a position to carry out complex case work. This type of case could also necessitate

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visiting clients in care settings or their own homes. There is a concern that demand would increase due to the ability to drop in to a local office, rather than contact ICAS at a regional centre by either phone or email.

Non instructed advocacy, for people who lack mental capacity, is a complex area of advocacy practice that requires robust supervision and large amounts of contact time to get right. This activity will be resource intensive.

There will be a tendency for complaints advocacy and signposting to become the dominant activities of the LINk because they are client driven. A person centred, one to one service, will only have credibility if it is delivered effectively with minimal waiting times.

For people who lack capacity, clear and binding referral pathways will have to be established with clinicians and others so that members of this group can gain access to HealthWatch. At present, clinician's do not have a strong track record at referring patients to advocacy and/or advice services, especially if it is perceived as the first step in a complaints process.

Patient Voice

Kirklees LINk believes that statutory agencies will only include HealthWatch at an early stage in service planning or reconfiguration if there is a statutory framework that makes this a clear duty. For HealthWatch to have true strategic engagement with change processes early engagement is an absolute requirement. The local experience of consultations is that they are designed to marginally refine or defend decisions that have already been made.

There should be a clear expectation that GP Consortia and Local Authorities will share with Local HealthWatch plans for change so that Local HealthWatch can determine which require further engagement. It should not be the case that Local HealthWatch finds out about service changes through press releases, newspaper reports, or being asked to validate the design of a patient information leaflet.

Voluntary Sector and Community Groups can, at present, elect to talk directly to service planners and providers. Sometimes these relationships are also contractual relationships. It is our experience that this can make access to decision makers a matter of happenstance and preference. This can have the effect of marginalising the LINk and rewarding those organisations with the capacity to maintain a lobbying process or contractual relationship. After some debate and reflection, the group decided that if HealthWatch aspires to be an effective patient voice it would have to become the single Clearing House for statutory engagement with individuals and CVS organisations. In this way inclusion processes would become more transparent and be part of a process of deliberation. This

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would of course require HealthWatch to have strong governance structures that guarantee robust and fair access, decision making and accountability.

To enable HealthWatch to amplify the patient voice the profile of HealthWatch will have to be raised with adequate promotion at a national and local level. Promotion will be required across Local Authorities, GP Consortia and NHS Providers and the Public. Local HealthWatch will be taken as seriously as it is taken by central government.

Vulnerable people and people without capacity are best dealt with on a case by case basis using well established models of Non Instructed Advocacy. Case visits will most likely take place in Care Homes or other service settings which will again increase the resource requirements of this service.

Governance

There should be a national, one size fits all, governance model for Local Health Watch. Vast amounts of time and good will were wasted by many LINk's in the process of crafting a local and acceptable governance arrangements.

Statutory agencies should have a statutory duty to account for their actions and decisions to HealthWatch in line with section 26a of the NHS Act, 2006. This accountability should have an emphasis on how services are delivered as opposed to organisational changes.

HealthWatch England should be independent of CQC.

The group was resistant to the idea that Local HealthWatch should be tightly performance managed by the Local Authority. This was seen as a conflict of interest as the LA is a provider of services. However people did recognise that if HealthWatch was to be a standalone agency that provided direct personal services of advocacy and advice then some kind of Local Authority oversight could be required. The group decided that HealthWatch performance could be managed by a Local Authority if the key performance indicators were nationally set and outcome based. The group also suggested that HealthWatch England could have an arbitration role if there were disputes between the Local Authority and Local HealthWatch.

Independence and Accountability

This area has been touched upon above as governance can be a guarantor of independence and accountability.

Covering the same topics it was decided that HealthWatch England should have a role in monitoring the effectiveness of Local HealthWatch.

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The amount of money to be spent on HealthWatch in each locality should be published so that decisions made by Councillors when allocating resources are informed by clear expectations from the Department of Health.

In Kirklees people have had no problem identifying issues that cut across the health and social care barrier. One of our challenges is engaging with six statutory agencies delivering services in one Metropolitan Council area that are not always coherent when delivered on the ground. Kirklees LINk uses a Participatory Appraisal[1] approach to generating our work plan. In this way, people from a range of communities can participate directly in agenda setting.

The group could not remember the NHS Constitution being raised at any of the events hosted by Kirklees LINk. It seems to be the case that people are not aware of this document or its consequences for NHS practice. This means the NHS Constitution has the status of an internal governance document.

National/Local Balance

The group felt very strongly that HealthWatch England should be an enabling national body. Many members of Kirklees LINk have experience of organising local branches of national charities. Over recent years, as the Third Sector has become more entrepreneurial and contract driven, local branches have lost autonomy. Our members feel this has damaged the local effectiveness of these organisations. They feel it would be a shame if local people volunteered their time just to follow instructions from a national body that are not always relevant to local people. Kirklees LINk has large elements of direct democracy built into its constitution and this is valued by people.

Relationships

No strong views were expressed about the relationships of HealthWatch England.

As has been indicated in earlier responses, Local HealthWatch could find itself only able to engage in change processes once all the major decisions have been made. It is our experience that consultation is commonly used to defend decisions rather than share decision making processes. This has proven to be a barrier to recruitment as individuals and CVS organisations identify that their time could be better spent carrying out activities that effect change. The group strongly suggested that the involvement of HealthWatch should be a requirement in change processes at an early stage. There is a risk that this could swamp HealthWatch, and render it a destination for consultations so some thought will have to be given to the way in which HealthWatch is allowed to control its own agenda.

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Transition

There are a number of anxieties about the potentially abrupt cessation of LINk and commencement of HealthWatch. Some members of the group went through this kind of transition between Patient's Forums and the LINk, they do not want to repeat this process. One anxiety is due to the uncertainty of funding for Kirklees LINk's Host Organisation in the year 2011/12. This anxiety is compounded by uncertainty about whether the same staff team will be in a support role after April 2012. So much involvement activity is based on personal relationships and the group placed a great stress on continuity. In Kirklees, the group responding, and the wider membership, value the existing staff team and want to retain the services of these individuals. This objective is seen as more important than the structure within which these individuals would work.

The group recognised that the expanded role of HealthWatch would require additional resources and a refocusing of competencies and roles. The group found some reassurance in the fact that Kirklees LINk's Support Team is managed by a person whose previous role was manager of advocacy services available to all the vulnerable adults in Kirklees. This means that Kirklees LINk has access to relevant skills and experience in house.

From the perspective of a long serving professional advocate, the exact model of advocacy proposed for HealthWatch is not defined enough to go into detail about what skills people would need. There are good training packages in existence for non-instructed advocacy that would not need a great deal of adaptation. There does need to be some clarity about the difference between providing advice, which many people require, and a more specialist advocacy service, especially non instructed advocacy for people who lack capacity.

A move to offering a direct personal service is a marked change. HealthWatch will then be engaged in three distinct if related activities.

- Advocacy and advice work with individuals
- Supporting individuals represent HealthWatch as a community of interest on Boards and Panels
- Engage with populations and communities to find out what people think about existing or planned services.

Each area of activity has to be adequately funded using realistic assessments of expected service levels and specified adequately using a contract specification and budget. If not, then advocacy and advice work will become the dominant activity because it is demand lead.

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Final remarks

The group have many reservations about the proposed changes but accept that they are going to happen. Their main interest is to preserve the positive aspects of Kirklees LINk, which have been hard won.

Drafted by Julian Grove-Haworth, Coordinator, LINk Support Team, Cloverleaf Advocacy, based on a workshop held on 27th September 2010.

[1] http://www.peopleandparticipation.net/display/Methods/Participatory+Appraisal

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