Tees Valley HealthWatch Evaluation: Overarching Report, May 2014

This report covers those issues and themes which impact on all five Tees valley HealthWatches. Many are themes which will affect all 152 local HealthWatches in England. This report will outline the way they impact in the Tees Valley context.

Health System Complexity post 2013

The establishment of HealthWatches in April 2013 came as part of what many health policy experts and others regard as the largest re-organisation of the National Health Service (NHS) in its history. This change had included the disestablishment of Primary Care Trusts (commissioning organisations) and the Strategic Health Authorities which had regional system oversight. HealthWatches were trying to establish themselves at the same time as many other new organisations and services, including NHS England Area Teams, Clinical Commissioning Groups (CCGs), Public Health departments in local councils and Public Health England (PHE) was also trying to establish themselves.

CCGs and Commissioners

Primary Care Trusts (PCTs) had responsibility and resources for patient and public engagement (Patient Advice and Liaison) which (CCGs) do not have. Local HealthWatches are now the only body with a specific responsibility for public involvement on health and social care as well as the signposting and information services that PCTs would have provided in the past. The three CCGs which cover Tees Valley are very aware of this. All three have established good relationships with their HealthWatches and commissioned them to undertake work for them, including seeking patient and views on their commissioning plans, a response on the national Call to Action, seeking views on the strategic future of services and involvement with the Better Care planning. That the CCG and HealthWatch in Darlington are coterminous has been helpful in this. The other two CCGs (Hartlepool and Stockton and South Tees) relate to two HealthWatches each; both have recently developed mechanisms of meeting up with the two HealthWatch chairs.

NHS England and Area Teams

These are also new: NHS England was established in the year prior to the other changes but the development of the Area Teams came late. Area Teams have responsibility for primary care (GP services), a responsibility not given to CCGs because in their GP capacity members of CCGs are service providers. Area teams are small and cover large areas. They also have responsibility for commissioning highly specialised services and hosting some functions such as screening programmes. At present each Area Team has a number of HealthWatches to relate to: the Durham, Darlington & Tees Area Team has six, so relationships with HealthWatches individually are mainly through the Health and Wellbeing

Board (HWBB) meetings in each locality. The arrangements may change in the future: the Department of Health has announced that CCGs can apply to co-manage primary care in their localities.

NHS Health Providers have been undergoing a longer period of change, which has involved becoming larger, multi-site organisations and becoming Foundation Trusts (FTs), which gives them more independence, boards of governance and local members. All four major providers and the Ambulance Service covering Teesside have been NHS Foundation Trusts for some time. In 2011, the acute trusts assumed responsibility for community health services from the PCTs. The FTs continued to have staff dedicated to the patience experience (although these departments have various different names – no longer PALs). The executives of the large FTs tend to relate to HealthWatches mainly through their membership of the Health and Wellbeing Boards in each council, through work on complaints and the patient experience, and through formal consultation on changes. More direct liaison with local HealthWatches often has to be through group meetings with representatives of all HealthWatches in the areas they service: for example the Tees, Esk and Wear Valley NHS FT invites six local HealthWatches to its general liaison meetings.

Health and Wellbeing Boards

HealthWatches have few statutory powers, but a particularly important one is membership of the HWBBs. They are the only public and patient, independent voluntary sector body guaranteed a place around the table. This is appreciated by the statutory attendees, who look to HealthWatch to be 'the voice of conscience', to help reach the seldom heard and provide valuable insights from local people. All the Tees Valley local HealthWatches are represented round these tables, although in some areas, the establishment of a regular, senior (Board level) presence has taken longer. The HealthWatch chairs are generally the representatives, sometimes supported by a senior HealthWatch officer who also deputises. Each locality has a related set of standing and task groups reporting to the HWBB. HealthWatches also participate in these meetings and groups which provide structured opportunities for HealthWatches to present public and patient views and priorities. These meetings also contribute to the heavy load which HealthWatch staff and Board members have to attend.

Health Scrutiny and Enter and View

The other statutory power HealthWatch has is Enter and View. This power was one inherited from previous arrangements for patient and public involvement in health, including Local Information Networks (LINks). One difference is that inspection in health (and care) services is now a complex and crowded field, with the Care Quality Commission (CGC)

having a national lead responsibility for quality assurance in health and care. Local authority health scrutiny powers have been in place since 2003 and are now well developed.

Currently (May 2014) two Tees Valley HealthWatches (Darlington and Hartlepool) are undertaking Enter and View (this term is not always used), both after they had provided training to new and re-training members with previous experience within LINKs. They emphasis that programmes are more strategic and focused than was the case under LINKs; undertaken in close association with partners. The boards of the other 3 have agreed frameworks for their Enter and View and are also likely to use the powers in a similar focused and collaborative way.

HealthWatch England

HealthWatch England (HWE) was established from October 2012. It describes itself as:

> '…the national consumer champion in health and care. We have been given significant statutory powers to ensure the voice of the consumer is strengthened and heard by who commission, deliver and regulate health and care services.' [1]

The LINks arrangements for public and patient involvement did not include a national body: so HealthWatch England (HWE) was new. It reports to the CQC but has a degree of independence. It has had the task of establishing a national profile and there have been national studies of issues such as the use of Accident and Emergency departments (sometimes using material collected through local HealthWatches). Another role is to provide support to local HealthWatches. The Tees Valley HealthWatches report that there has been some support, in terms of frameworks and the logo itself. HealthWatch England provides an information hub, for all local HealthWatches to share. Currently, this is not functioning to full capacity. HealthWatch England was ambivalent about whether it would have a regional infrastructure; one was eventually established with one liaison officer, Gerald Crofton-Martin, covering 'the North' (NorthEast, North West and Yorkshire and the Humber) with 52 HealthWatches. A further post is being recruited. The national web-site has a 'find your local web-site' function and also showcases some of the work the local HealthWatches do, both of which are helpful. However, HealthWatch England has not conducted a national awareness raising campaign for local HealthWatch as originally intended.

The LGA has been heavily involved with local HealthWatch development, with regional project officers, responsible to a small national team. The North East's LGA development officer, Julie Turner, left at the end of March 2014 at the closure of the project. The LGA

[1] http://www.healthwatch.co.uk/what-we-do

Local Outcomes and Development Tool provided a helpful framework for external and internal work on local HealthWatches.

Complaints

Complaints about health and care have been under intense scrutiny particularly since the Mid Staffordshire Hospital NHS Foundation Trust Public Inquiry chaired by Robert Francis QC and the subsequent report and follow-up work. Local HealthWatch has responsibility for getting feedback on patient experience of health and care services and taking action on complaints (which may mean passing on to the appropriate provider) and looking for themes and patterns for which they need to obtain information from others. HealthWatches are involved as a core partner in local surveillance of complaints and information on services (hard and soft) working with the councils, CCGs and local providers. These were mentioned by CCG interviewees and FTs (especially clinical executives) as being clearly important and taken very seriously. HealthWatches are also involved with safeguarding structures in local authorities.

Advocacy and complaints signposting

Department of Health (DH) regulations require providers of NHS services to make complainants aware of the availability of advocacy (see longer description at Appendix 1). The role of the advocacy service is to help people navigate the system (level 1) and to support vulnerable individuals on a one to one basis (level 2). Complainants can request advocacy at any stage of the complaint, provided they meet the set criteria. Local authorities became responsible for procuring health advocacy alongside the HealthWatch changes. They can choose between procuring it directly or making it part of the HealthWatch contract. The five Tees Valley authorities, decided to contract for advocacy separately, with six other North East authorities (HealthWatch Northumberland is commissioned to provide an in-house service). The eleven procured the service as a consortium, led by Gateshead Council. Independent Complaints Advocacy (ICA) which is part of the Carers' Federation, won the two year contract. They had previously run the service under the DH. Feedback reports are given to the local authority commissioning leads. These are commissioning and number focused and do not provide much information on the service side of complaints, e.g. the numbers of ongoing cases was given in one report seen but not the details of which FT, hospital or service involved. ICA also does some direct liaison with HealthWatches (networking meetings) and is looking to do more. It has close working relations with hospital complaints officers and has built up a group of trained and experienced advocates across the region who work on the stage 2 advocacy cases. It should be noted that this system applies only to health complaints and advocacy which in a world where patient pathways increasingly involve both health and care is a limitation.

Future Trends

Join up between care and health has been a longstanding theme in relationships between the NHS and local authorities. The imperative for join up is becoming ever stronger, especially with increasing pressure on both systems with the changing age-structure of society. Tees Valley HealthWatches have all been involved in discussions on the Better Care Fund in recent months. Whilst this national initiative is currently stalled, it is likely that changes to bring the two systems closer will feature in the short, medium and long term. Whilst the name HealthWatch is somewhat misleading, the fact that HealthWatches has responsibilities for the both care and health positions them well for the future.

Both health and care are under considerable financial pressure from fixed or reducing resources to meet increasing demands for service. Increasingly statutory agencies will be looking at how to deliver services which are most efficient financially. These will involve major change. South Tees agencies, including the two HealthWatches have already been involved in the IMProVE (Integrated Management and Proactive care for the Vulnerable and Elderly) studies. HealthWatch chairs and board members are faced with difficult decisions on how they can best serve all interests: maintaining a balance between delivering patient/ resident views for CCGs and health providers and maintaining independence to represent views more formally during consultations on changes (the patient-led ethos).

Children and Young People

Obtaining and representing the views of children and young people (CYP) on health and care is a new area for HealthWatch. The demography of former LINk and HW volunteers is generally older (many volunteers are retired people, often with relevant professional experience) is not helpful in making involvement with HealthWatch attractive to CYP. Despite good intentions from HealthWatch staff and board members, Tees Valley HealthWatches have not yet succeeded in substantially changing the age-profile of their members and volunteers or establishing working partnerships and engagement with young people. There has been more success with work programmes where most work plans have some young people's issues (transition from Children and Adolescent Mental Health Services (CAMHS) to adult services in Redcar and Cleveland, sexual health services in Hartlepool and Middlesbrough and school nursing services in Stockton are examples from four different HealthWatches). There are opportunities in some authorities for making effective partnership links with other services and initiatives such as the You're Welcome programme which runs in Hartlepool. There are regional examples of effective youth engagement on mental health issues (Change UR mind) and inter-generational work on dementia, which might provide opportunities for local HealthWatches to develop links. There may also be two-way advantage in involving young people in helping to drive forward use of social media in public engagement in health and care.

Demands on HealthWatch

There are large demands on HealthWatch and many respondents, such as Directors of Public Health have commented on the expectations and demands. There are many issues and topics with which statutory players would like assistance. This presents capacity issues for HealthWatch and also requires judgments to be made on appropriateness, priorities or even charging by the HealthWatch boards.

The numbers of meetings alone are considerable. They include:

With statutory agencies

HWBBs and sub-structures

Relationship/contract monitoring with local authority as commissioner

Overview and Scrutiny (or equivalent)

Safeguarding (adult and children)

Complaints surveillance

With CCGs (boards, locality committee etc)

With NHS providers

With care commissioners

Liaison meetings with FTs (acute, mental health, ambulance)

HealthWatch (internal)

Board meetings

Task group meetings

Conferences, community events

HealthWatch development and networking meetings

With the VSC

Joint meetings and events, networks

Capacity

The two stand-alone HealthWatch organisations have similar levels of paid staff; Darlington has 2.7 WTE and Hartlepool has 2.77 WTE (excluding the 50+ network officer on 0.6 WTE).

The other three share a resource of 7.8 WTE. In all cases the chairs also make a substantial contribution of time, especially in attending meetings. (All Tees Valley Chairs are unpaid, it is possible to make payments but in the North East, only Sunderland does this). Contributions also come from other board members and the volunteers (and in some cases network partners). At these levels the HealthWatches are very stretched. The levels of paid staff mean that the organisations are not very resilient when staff leave or are sick. Sharing staff over more than one authority can be helpful, especially where they relate to some of the same statutory partners, although many meetings are particular to each locality and there is also a need for the community development work to take place in each locality in order to produce credible local knowledge.

General responses by/to all Tees Valley HealthWatches

Considerable support for having the HealthWatch function was expressed by interviewees and in the 360 degree study where respondents felt that HealthWatch was an improvement on LINKs. There is an understanding that they needed time to develop and most interview respondents felt that most local concerns could be overcome during the second year of operations. Some were however, concerned that the roles HealthWatch had been given were not do-able at the level of resource on offer.

Good Practice and 'boxing clever'

Working with other agencies locally is very helpful, including building relations with officers form partner organisations outside formal meetings. Good relationships can be maintained through less time-consuming methods such as phone calls and emails once trust has been established. Also learning from other HealthWatches: each of the HealthWatches in Tees Valley has examples of good practice as well as areas where there are development needs. Some of the good practice could be adapted for use by other HealthWatches. Some sharing of training might be possible on some of the topics which need to be covered.

Performance Management and re-commissioning

Impact 'stories' are important for monitoring: the 'so what' question. As yet, there are not many of these, though the ones that do exist are not always well teased out and promoted on the websites and in talking about achievements. Work and development programmes to be monitored, on a number of facets: the setting of the programmes, the topics covered and objectives, completion and recommendations and a follow up on impact form the recommendations. Development programmes could also be set and monitored through the year. The locality reports would help determine the content of such programmes. Financial review is not an area this evaluation has covered but clearly needs to be examined by the commissioners of the HealthWatch services, including the staffing element. Both the

awareness study and the 360 study could be repeated at a later time. Partners could also ask whether they could help more in terms of making linkages with other services, promoting HealthWatch on their web-sites, and helping with the gathering of patient/user experience and recruitment of volunteers.

The two year contracts now have less than one year to run and decisions will soon be needed on re-commissioning HealthWatches and the complaints and advocacy service. Given the work involved in re-commissioning and the lead-time needed for new series to become established, the case for extension seems strong for the HealthWatches. There is a stronger case for reviewing the complaints and advocacy services, given the issues of join up, exclusion of care services and the on-costs (lead commissioner) aspects (see Appendix 1). A starting point might be to explore the experience of Northumberland, where the HealthWatch has responsibility for complaints signposting and advocacy. A pan-Tees Valley service would be an option that would retain some of the advantages of larger area coverage.

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Appendix 1

Tees Valley HealthWatch Evaluation

Complaints system – complainants go through the provider of the service concerned e.g. hospital, community service or GP practice. If not simply resolved they go through the hospital patient experience service to register the details. There is then a system to investigate and try and resolve the complaint. The most serious complaints are reported to NHS Boards. There have been changes since the Francis report, a further report has recently been published and further changes to complaints systems are likely. Dissatisfied complainants can take their complaint to the Health Service Ombudsman.

Advocacy – there are DH regulations which require providers of NHS services to make complainants aware of the availability of advocacy. ICA sends information to providers to help. The role of the advocacy service is to help people navigate the system (level 1) and to support individuals on a 1 to 1 basis (level 2). Complainants can request advocacy at any stage of the complaint. DH procured the services directly up to 2013: thereafter local authorities became responsible for procuring it. They could choose between procuring it directly or making it part of the HealthWatch contract. 11 of the North East Authorities (excluding Northumberland) agreed to procure as a consortium, led by Gateshead Council.

Independent Complaints Advocacy (ICA) –is part of Carers' Federation. They held the previous NE regional contract and have 8 years' experience in the North East. The new contract is for 2 years from 2013. As part of the specification they are required to send numbers of the level 1 (signposting) contacts and the numbers of hours of level 2 support provided by the trained advocates. There is analysis by local authority, provider, service, ethnic monitoring. Infrastructure costs e.g. access to Carers Federation 24 hour call-line, are built into level 1. Numbers are approximately 500 level 1 annually and 500 cases at level 2. Advocacy requirements are approximately 130 hours per week.

Partnerships and Joint Working. There is a requirement for outreach in each local authority. These are largely used for pre-booked advocacy although quite often clients prefer another location, such as home. Some meetings have taken place in HealthWatch offices. The ICA web-site has information on HealthWatch and HW web-sites carry ICA information. ICA has good relationships with NHS trusts with individual complaints managers and networks. 64% of complaints are hospital ones, 16% ambulance and community services and 20% primary care. With Primary care there is liaison with CCGs and the NE Commissioning support organisation (NECS). ICA has some relationships with HW which they would like to develop: sharing the information which currently goes to the LA

commissioners. ICA is aware that local HealthWatch are getting only limited contacts for signposting and complaints so far. This may reflect low awareness (see HealthWatch England above on the lack of a national awareness raising campaign).

The system outlined does not cover social care and there are some long-standing separate arrangements within mental health.

Points to consider in commissioning

Pro large scale (current arrangements)

- Economies of scale for training and deployment of advocacy
- Resilience of the service to staff sickness and other absences
- Buildup of expertise on a highly specialised area
- Centralised phone line answering
- Experience of provider

Pro more localised arrangements

- Easier integration with other data on complaints
- Could be integrated with social care
- Easier for commissioners to specify and receive the information they want
- More transparent costs
- Possible savings of group cost overheads
- May help local profile of HealthWatch (reduces complexity)
- May help make local HealthWatch larger and therefore more resilient