

TELFORD & WREKIN COUNCIL

HEALTH & WELLBEING BOARD –12th September 2012

DEVELOPMENT OF LOCAL HEALTHWATCH

REPORT OF :Service Delivery Manager- Commissioning

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

- 1.1 This report provides a progress update in relation to the requirements under the Health and Social Care Act 2012 to develop a local Healthwatch.
- 1.2 The report outlines work undertaken to date and outlines the procurement approach to secure a local Healthwatch provider.

2. RECOMMENDATIONS

- 2.1 Board members/members note the progress made to date against key milestone dates to develop a local Healthwatch.

3. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to specific Priority Plan objective(s)?	
	Yes	<p>Vulnerable children, young people and adults are safeguarded from harm and neglect.</p> <p>Improved health which enables people to live active, positive and independent lives</p> <p>Even more children and young people are on the path to success in adult life through the provision of good quality education, training and jobs.</p>
	Will the proposals impact on specific groups of people?	
	Yes	The proposals impact on people of all ages who use health services and more specific groups of patients and service users who receive on-going support through or for part of their adult life
TARGET COMPLETION/DELIVERY DATE	<i>April 2013 (see key milestones in report)</i>	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes	<p>Funding of a local Healthwatch will be made up of:</p> <ul style="list-style-type: none"> • Existing LINK's contract funding- £114,000 • Department of Health funding for Healthwatch- £37,419 • Start up costs for Healthwatch- £19,228
LEGAL ISSUES	Yes	Delegated authority to enter into a contract with the preferred provider following a tender process has already been approved by the Council's Cabinet (29 th March 2012)
OTHER IMPACTS, RISKS & OPPORTUNITIES	No	
IMPACT ON SPECIFIC WARDS	No	Borough-wide impact

PART B) – ADDITIONAL INFORMATION

4. INFORMATION

Background

A report was presented to the Health and Wellbeing Board on the 22nd February. This report outlined the functions and responsibilities of Healthwatch. The report was considered by Cabinet on the 29th March and sought delegated authority to enter into contract following a procurement process.

Building on our pathfinder status gained in 2011, the approach to developing a local Healthwatch was launched at the Health and Wellbeing event held on the 3rd July 2012.

Key stakeholders were invited to contribute to the local Healthwatch development and sought to seek views on the following key questions:

- How can we ensure everyone can access local Healthwatch in ways that suit them?
- How can we ensure local Healthwatch is able to represent the views of everyone in ways that suit them?
- What does a good health and social care consumer champion look like?

These views have been collated and fed into a developing service specification (see Appendix 1)

Developing a Local Healthwatch

The development of a local Healthwatch is very much grounded in working in partnership with our local communities, and organisations in recognition that Healthwatch will be a local consumer champion for patients, service users and carers. Therefore, the approach to developing what is required for Telford and Wrekin needs to be influenced and shaped by local people and organisations to ensure we build on what is positive whilst also recognising what we need to do differently.

The first workshop held on the 8th August was positively received by those who attended and will form the basis for the service specification. To further shape the service specification we asked the following:

- What ideas do you have for how Healthwatch could be delivered locally?
- What are the challenges around delivery and what are the potential solutions?
- What organisational strengths already exist in meeting the intended functions of a local Healthwatch and how could these be utilised in a delivery model?

- How could a local Healthwatch be creative and demonstrate best value?
- What will organisations need to consider in recruiting and sustaining a vibrant volunteer infrastructure?

Again the summary information from this workshop has been collated. (See Appendix 2)

The next scheduled event on the 6th September will focus on the prospective providers becoming 'bid ready' and further develop the service specification.

To ensure we are communicating with all interested parties we have established a website:

http://www.telford.gov.uk/info/200190/health_and_wellbeing/1556/healthwatch.

We have also set up a group e-mail for interested parties following their request at the August workshop.

The next workshop in September will focus on the following:

- Developing Key Performance Indicators (KPI's)
- Clarifying roles and responsibilities, which includes:
 - Structure and governance/pathfinder models
 - Management and infrastructure (ideas)
 - Volunteer recruitment and support (your feedback)
 - Enter and View and regulations (legislation)
- The session will also provide procurement support to interested parties.

Time Lines

A small project group is leading the process to ensure the milestones are achieved. This group reports to the pathfinder group which comprises of health, social care and LINKs representatives.

The outline programme, which was communicated to key stakeholders at the Health and Wellbeing launch event on the 3rd July, to progress the procurement process is as follows:

Activity	Time Line
Community dialogue to develop and inform the service specification	Workshops scheduled 8 th August and 6 th September
Formal invitation to tender	28 th September
Closing date/return of tenders	31 st October
Evaluation of bids	November
Contract award and confirmed with providers	December

Shadow implementation	January- March
Healthwatch Telford and Wrekin operational	1 st April 2013

Next Steps

The project is on target in accordance with the milestones detailed above. The tender pack which includes the invitation to tender, contract terms and conditions, and the evaluation framework is being developed in parallel to the service specification.

Following the workshop session scheduled for September the service specification will be finalised to be include in the tender pack.

5. PREVIOUS MINUTES

- 5.1 Cabinet Report – 22.12.2011 – NHS Transformation and Implications for the Council
- 5.2 Health and Wellbeing Paper- LINK and Healthwatch transition, 22nd February 2012-

6. BACKGROUND PAPERS

Report prepared by Christine Harrison, Service Delivery Manager- Commissioning, Care and Support
Telephone: 01952 381205 Email: christine.harrison@telford.gov.uk

APPENDIX 1

DEVELOPMENT OF HEALTHWATCH FOR TELFORD AND WREKIN NOTES FROM AWAY DAY

Q1.	HOW CAN WE ENSURE EVERYONE CAN ACCESS LOCAL HEALTHWATCH IN WAYS THAT SUIT THEM?
Table 1	<ul style="list-style-type: none"> • Ensure appropriate communications (visual, translators, interpreters etc) • Promotion and publicity – need to be talked about and shared with all current groups/forums • Using existing channels allows people to be supported into the process • Need to ensure information is provided in BSL not just written English (video cameras etc, around 300 sign language users in Telford)
Table 2	<ul style="list-style-type: none"> • Social Network Site • Local GP • Library • Better communication/awareness • School packages, starter packages (advertising) – targets families • Needs quick wins i.e. on this leaflet – catchy that engages people straight away. Telling people how they are going to make a difference. • Make information relevant i.e. visit to care homes if patients are concerned or if they are able to help them – making their duty meaningful to patients/public. • More awareness i.e. box saying if not happy where to go? Better publicity – with help from LA/other org (small budget) • Advertise on appointment letters • Information hubs • Advertise where issues are likely to arise • Strap line/branding/catchy
Table 3	<ul style="list-style-type: none"> • Signposting – need to know how we are doing this • Needs to be housed in an independent neutral space • Doctors surgeries play an important part/dentists surgeries. • Ensure anonymity • Single list/computer system of info/data that everyone has access to – confidential and robust system . <ul style="list-style-type: none"> ➢ Mapping exercise of which groups currently exist. One point of access for people. ➢ Needs to be in plain English/do not have too much info on it. • Text/email doctors although recognise not everyone ICT literate • Need to cross all boundaries – age/ethnicity etc • Training.
Table 4	<ul style="list-style-type: none"> • Not like banks – closed at weekend. • Location, accessibility. • What Healthwatch can and can't deliver • Intergrated into the community – not an add on. • Promotions – various methods depending on situation and particularly on-line. • Making sure it fits the needs at the time, keeping it 'live' fresh. • Links to a wide range of other services and help to promote and support Healthwatch and understand and access.

	<ul style="list-style-type: none"> • Community champions • Community peer mentors – all links in dynamic relationships with full progression • Cascading information • Targeting.
Table 5	<ul style="list-style-type: none"> • Email and website • Social networking sites • 24 hour communication • Legislation – not include safeguarding children • Council – Your Voice – making use existing communication • Be clear about what its purpose is – don't understand concept • Public confused – LINK – Healthwatch – don't know who LINK is. • More fundamental questions – give people more information on what is Healthwatch – did not understand presentation. • Done 50 consultations and never heard of LINKs - never seen anything in paper. • Done basic SWOT. Weaknesses – not known. • Professional/representative/community well <ul style="list-style-type: none"> ➢ What are their objectives ➢ What are the outcomes Council want to see. ➢ What drives the change • Council document what it wants to secure – use workshops to define that. • Presentation – not put in context what happens now. • LINK setup to be voice – but as small group not?(unable to decipher text) - Key feature Healthwatch – need to know who are • Healthwatch is a good name!
Table 6	<ul style="list-style-type: none"> • Social media • Radio • SMS • Website • Newspaper • Forums • 2 way information eg on facebook • With local organisations • Promotion via GP surgeries • Where people meet/gather <ul style="list-style-type: none"> ➢ Churches ➢ Pubs ➢ City centres • Make it simplistic/easy to understand • Emphasise its 'independence' so people will feel happy to use it. • Be clear it is '<u>your</u>' voice • Look at working/language • Hold focus groups on key messages within the ? (unable to decipher text) • (Vicky asked for easy read versions) • Also need to focus on reaching 'individuals' not just groups/organisations. Promotions via C&YP and other groups who don't usually engage.

Table 7	<ul style="list-style-type: none"> • Promotion PR – every format • Facebook and social media • Newsletter } sign interpreted • Link with groups } 1st language • Interpreters } • Good advertising before point of need. • GP surgeries and health professional and social care • Difficulty – distinguish health and social care • Hard to reach groups • Networks – ‘network of networks’ • Local influence – going to shops/public places • Shout about it – explain purpose clearly • Use existing infrastructure • <u>People</u> have to know about it.
Table 8	<ul style="list-style-type: none"> • Healthwatch to ‘get out there’ • Internet • Use other peoples newsletters • Newsletter sent with Council Tax i.e. like fire and police do. • Healthwatch England to have a national promotion- tag onto this.
Table 9	<ul style="list-style-type: none"> • Providing access through various contacts/services (creating awareness – through GP’s, hospitals etc – as and when people need it) • Plasma screens in reception areas • Developing the relationships/partnerships – to share and promote the information • Local magazines (Council/Parish Council etc) • Community engagement • Think about timing/out of hours • What are they going to do with the information when they have got it? • Tap into other peoples resources/evidence • Costs?? (implications) – make better use of existing resources

Q2.	<p style="text-align: center;">HOW CAN WE ENSURE LOCAL HEALTH WATCH IS ABLE TO REPRESENT THE VIEWS OF EVERYONE IN WAYS THAT SUIT THEM?</p>
Table 1	<ul style="list-style-type: none"> • Have accountability measures in place. Can only work if existing group feed in two-way street need to be prepared to be involved. • You never can. Need to manage expectations and ensure a fair representation. • Understanding and knowing how people prefer to communicate • Complex process will take time • Groups of practice patients cascade down – network of networks – start local.
Table 2	<ul style="list-style-type: none"> • Those delivering front line services must be and are given information, they are in peoples homes • Cascade simple pack of information to staff/information needs to be readily available. • Anonymity/ do not want to be identified if making a complaint would encourage people to make their views • Joined-up working - how do organisations link with different groups/use common approach, best practice to target groups. (common approach to consult with harder to reach groups) part of bigger operations/pooling resources . • Must not trickle into existence needs to come in with a “big bang” – national campaign would benefit Telford and Wrekin.

	<ul style="list-style-type: none"> • Majority reached by TV • National marketing, Healthwatch needs to be proactive in finding people and use good news story. • Word of mouth best way to embed in the community • Organisation goes to harder to reach people instead of them coming to a faceless organisation • Proactive, get intelligence from other organisations i.e. complaints – care home to target their energy – burning issues. • Membership and structure – deliberately drawing from groups of individuals - identify people which will bring masses to the organisation.
Table 3	<ul style="list-style-type: none"> • Tangible • More professional • Local people looking at peoples problems • Link into patient reference group and other network groups • 2 way dialogue with Healthwatch/doctors/patients/community • Increase awareness among the community – need to spread the message. • Include as part of staff induction training in hospitals
Table 4	<ul style="list-style-type: none"> • Targeting • Broad membership • Local champions • Reflect on areas that have worked well and not so well • Proactive – challenge • Representing the issues at Health and Wellbeing - nationally. • Touchstone – in touch with local community, have to feel something is being done. • Community dialogue – working both ways. Feeding back to people the difference Healthwatch has made. • Ensure enough time to embed Healthwatch effectively Review <ul style="list-style-type: none"> ➢ Appropriate membership ➢ Re-evaluate priorities ➢ Performance measures ➢ Resolutions on complaints • Conflict of interest – as a resident of Telford and Wrekin and working for NHS/Telford and Wrekin Council – is there any exclusion?
Table 5	<ul style="list-style-type: none"> • Needs to be known • High profile • Difficult to answer until know what Healthwatch is for. • Does PALS fit in with Healthwatch? • Is this leaflet to public – terminology/jargon is difficult. • If dyslexic difficult to read. • Leaflet is awful – cut out jargon – plain English. • Own organisation – Safeguarding Children Board – Act with legislation within presentation. 2004 Children’s Act • Health governance gap – does that have a place? • Contact CVS as they can disseminate information. Age UK – see self as part of consortium. • Real visibility/obvious communication.
Table 6	<ul style="list-style-type: none"> • Hinges on being accessible • PR campaign using icon/character to bring it to life • Pick up and use intelligence gathered/encourage staff to record capturing information at the time. • Supports/facilitate GPs/organisation in understanding. • Some people need advocates to speak for them – e.g. health champions from the community • Using the community as ‘family’.
Table 7	<ul style="list-style-type: none"> • We can’t! • Guest speakers at meetings • Two way dialogue • Elected governors from parishes

	<ul style="list-style-type: none"> • Focus on needs of hard to reach communities • Representative from all groups (is this manageable?) • Events/roadshows to promote services throughout the year. Must be targets e.g. diabetes. • Coordinate meaningful events • Private businesses to assist e.g. possible sponsorship (must avoid conflict of interest)
Table 8	<ul style="list-style-type: none"> • Act as a 'voice' • Make sure not dis-proportional • Represent networks • Link to Health and Wellbeing Board • Outcomes needs to be identified
Table 9	<ul style="list-style-type: none"> • Social media • Staff newsletters • First point/family connect • Getting partners on board • Regular communication • Community engagement • Making it as local as possible/as cheap as possible • Local supermarkets • Responding • Make better use of members of trusts/local groups/ (shared resources) • Monitor who is inputting/contributing and who is not • Schools • Targeted approach where needed • <u>Potential</u> users as well as existing users • Getting local GP's on board • Not just about getting information out – it is about getting it back as well.

Q3.	WHAT DOES A GOOD HEALTH AND SOCIAL CARE 'CONSUMER CHAMPION' LOOK LIKE?
Table 1	<p>Consumer champion – group or individual who champion rights of people using the service.</p> <ul style="list-style-type: none"> • What is the role? <ul style="list-style-type: none"> ➢ Critical friend ➢ Advice and information ➢ Enter and view • Is it a lobby group? Do local individuals need to be part of it or is it professionals? • All about patient voice – find out what people's need are, what is working well, what needs improvement? • LINK led by volunteers with staff to support • Statutory powers <ul style="list-style-type: none"> ➢ Go into public funded properties and talk to users ➢ Ask questions over and above FOI ➢ Make formal commentary on annual reports of providers • Need community support. Cannot function without the public. • Representing <u>all</u> of the community ensuring appropriate communication with all (deaf, visually impaired, learning disabilities etc!) • Input from current forums/boards (e.g. carers) to help ensure representation of all. • Consumer champion group of people – uses all networks as feedback, governing body should be representative of community. • Need a mix of people to ensure agenda is not focused on one opinion. • Representatives from voluntary sector • Ability for people to feed in to particular issues of interest – working on the ground. • Service users need to be part of representation.
Table 2	<ul style="list-style-type: none"> • Links in past hidden – as patient was not visual (comm. In new structure) • Benefit from not having any past history being brought in i.e. not bringing link in, should be a 'new' organisation, should be a new entity. • Valuing/principles/characteristics <ul style="list-style-type: none"> ➢ Independent

	<ul style="list-style-type: none"> ➤ No vested interest ➤ Not part of the NHS ➤ Representation from all aspects/parts of community <ul style="list-style-type: none"> ▪ Children ▪ Disability <ul style="list-style-type: none"> • Multi-task • Realistic expectations of what organisations can/should achieve i.e. do not set up to fail. • Once people walk away can't get them back again – don't raise peoples expectations. • Relevant people to area/topic discussed at the time. • Smaller committee, working groups • Strong links with people they are 'watching' – reporting back issues(whilst still being independent. – what's going well/not well • Can't just be a complaints board • What do they look like in other organisations (model from more established organisations – i.e. thing that can be learnt taken from them) • See the changes quicker/knowledge about process/feed into annual report/look for trends • Sharing best practice.
Table 3	<ul style="list-style-type: none"> • Independence, not associated with health service/council already • Looks at good and bad practice • Unannounced visits, 'end review' • Getting things done • Having a relationship with providers • Statutory powers (rules and regulations) • Access to health and social care provision inc private homes and carers at home • Delicate and diplomatic • Looks at care for all ages • Transparency – things are recorded properly • Open to other organisations (advocacy) • Confidential – data protection • Be aware of range of local services • Good feedback loops Healthwatch – range of organisations to make changes. • Care of existing LINK organisation is good – needs to be more professional • Talk to local people in language that it can be understood – plain and simple. • Signpost people to patient ref GPs and other avenues to have your say. • Information to local people about what it provides • Train staff in social care and in health services – about Healthwatch so they can signpost. • Each individual member of Healthwatch should be seen as a champion. • Uses a range of method to communicate including social media.
Table 4	<ul style="list-style-type: none"> • Approachable • Passionate • Listens • Local • Non judgmental • Know of them • Resourceful • Able to make a difference • Accessible • Respect, integrity, communicators – relating the issue back in different ways and situations and authentic, empathy. • Facilitators – in terms of needs • Respected by the community they are dealing with • Clearly understand their role - not office, open door. • Pro active • Supporting? • What commitment they have to give to deliver priorities • Being motivated.
Table 5	<ul style="list-style-type: none"> • Visible

	<ul style="list-style-type: none"> • Network of organisations – bring in coms issues • Why/how LINK has been a success? – why are we changing? – Can't LINK expand? • Look at what works and use it. • What are the gaps – listen • Characterising like – knowledge local. How far reaching are they? • Feeling of losing what we have? • Consortium – become who not part of it – self selective • Governance of organising managing arms length. • Getting people included and engaging. • Constitutional – as a charity it is allowed to take on broader role – if charity? – save other charities • Look at governance of organisations • What do we expect them to do? – as role covered by other organisations e.g. council advisory services • Is Healthwatch about maximising what we have – then do specific targets . role is it co-ordinating, or is it duplication • Another organisations needing volunteers = pressure – or do you use cohorts already exist collectively. • Different volunteering roles – could they also be fulfilling Healthwatch role. • Does it have to be volunteers – it is £ issue? • Where does CQC fit? • Take recommendation of enquiries.
Table 6	<ul style="list-style-type: none"> • Representative/the face of the people • Flexible • Open to ideas • Non-judgemental • Credible • Respected • Independent • Not having its own agenda • Being able to listen • Open-minded • Plain speaking • Accessible <ul style="list-style-type: none"> ➢ Language ➢ Easy read documents ➢ Different formats ➢ Different channels ➢ Approachable ➢ Publicised. • Can be trusted and won't judge • Shouldn't stigmatise • Challenge in constructive way • Focus on solutions • Important that they are well known to local people.
Table 7	<ul style="list-style-type: none"> • Independent and knowledgeable • Eclectic • Strong communication • Listening • Inclusive • As many links as possible • Good networking • Professional • Credible/integrity • Engage with difficult to reach groups • No fixed agenda • Flexible

	<ul style="list-style-type: none"> • Open agenda • Keep agenda consumer led • Open minded • Operate at all levels (local) • Friendly and approachable • Committed • Representative of communities • Trustworthy and honest • Organised • Influential in getting things done • Have a purpose • Be accountable
Table 8	<ul style="list-style-type: none"> • Must have connections/links to other organisations • Easily accessible • Local champion who use services • Not appear 'official' • Impassive users • Bring together patients reference groups • Build capacity with volunteers • 'trust' 'respect' • Must ensure everyone knows about them • Social enterprise
Table 9	<ul style="list-style-type: none"> • Sharing relevant up to date information in a timely manner (at the right target audiences) • Regular communication (different methods) • People friendly/approachable • Representative of the people it is speaking for • Respected • Challenge being the most difficult thing(must be able to challenge) • Giving people a voice • Getting a response when it is needed • Needs to be very honest about what it can/can't do (of health provision in general) – managing expectations • Getting the balance right (in representing individuals/community/groups) • Have good /reliable up to date information and <u>listening</u> • Giving the opportunity to network(how do we do this?)

Further feedback from Table 5 – felt the leaflet (Healthwatch – A stronger voice for the whole community to improve Health and Social Care services) was too “jargony” and people felt that they did not understand the presentation.

APPENDIX 2

HEALTHWATCH – WORKSHOP 1 – 8 AUGUST 2012 NOTES

Q1.	WHAT IDEAS DO YOU HAVE FOR HOW HEALTHWATCH COULD BE DELIVERED LOCALLY?
Table 1	<ul style="list-style-type: none"> • LINK becomes a formal body corporate and responds to tender • Group of voluntary organisations form a “legal” collaboration and responds to tender • Public interest organisation (local or national) sets up to respond • What is local? Telford and Wrekin or Telford and Wrekin and Shropshire • Needs to be <ul style="list-style-type: none"> ➤ Visible ➤ Accessibility ➤ Easy to understand ➤ Easy to relate to • Use existing volunteer systems rather than invent new ones eg volunteer training • Power and strength should be kept at local grass roots level – this should be highly weighted as a tender criteria.
Table 2	<ul style="list-style-type: none"> • This community can’t afford to lose the expertise of LINK – a back bone for moving forward – harness it and keep it going. • We are volunteers driven by wanting to do it – not by finances • Bid from LINK – experience, values, motivation, expertise most people bring their background to improve services. • Need good back office – need to improve too • Opportunity to partner – choose? • Selection process can’t be avoided (LA) • Developing specification – in order to bid influencing it now. • Development of champions, strengthen links to communities i.e. youth link, PRG champions – giving confidence engaging and involving • Volunteers actively involved in decision making • Action not meetings and committee orientated • We can tap into action groups – but can other organisations. Tap into these so easily. Delivery model building on good things in Telford and Wrekin. • Need to see how do you think you will deliver network of networks, partner • How can the model have a more formal view of what the whole network is about • LA only small number of funding/commissioning of organisations. Want to help and support that through LA contracts. • Performance manage – Christine’s team - KPis <ul style="list-style-type: none"> ➤ Service specification ➤ What other information do we need for good service provision ➤ Connecting with CQC etc own quality • What thinking has the prospective provider done about this • Example – LINK more diverse, but still failing to engage BME groups. How do we work with to ensure involvement.

Table 3	<ul style="list-style-type: none"> • Learn from legacy of LINKS • Existing LINKS as a 'hub' for other organisations to join. Housing • Holistic vision (police/community) • Needs to be representative of wider well-being • 'mystery shopping' as a mechanism for leaving quality and risk in health and social care economy • Access/gateway needs to be very wide 'networks' – capturing new ways of 2 way communication (patient ref groups) etc. • Must link to priorities of Health and Well-being Board. Must target work. • Meeting with key stakeholders • Must be good relationships with providers/stakeholders • Use GP referral letter to access Healthwatch • TRAQs – access to website (Patient Opinion a good format for a model) • 'Enter and view' – 'needs training' and resources • Diverse community ? (children)
Table 4	<ul style="list-style-type: none"> • LINK in Telford is very active – don't lose this. • Engagement with voluntary and other organisation could be improved. • Good relationships with statutory service regardless of legal status CIC Sec, 3rd Sec, private. • Use the existing voluntary organisations • Include people who have experience of health issues – e.g. deaf and heard of hearing group • Keep it pan Shropshire • Issues raised with Shropshire County Council and Telford and Wrekin. Experience of Telford and Wrekin have been very good. • Keep it local – rural knowledge. Demographic • Some one in charge who can deliver training and keep the interest for volunteers and who has qualifications and standing to do this. • Look to promote volunteering to those out of work. • Ensure you keep up the partnership working.

Q2.	WHAT ARE THE CHALLENGES AROUND DELIVERY AND WHAT ARE THE POTENTIAL SOLUTIONS?
Table 1	<p>Challenges</p> <ul style="list-style-type: none"> • Expectations are huge for a volunteer led service • Expectations need to be managed (by Telford and Wrekin Council) • Dealing with volunteers who have their own personal agenda • Timescale to deliver performance from day 1 starting all over again to market a new brand • Healthwatch must be transparent • 'no one in Healthwatch should know something which is not in the public domain' • To have the capacity to identify trends and take action. <p>Solutions</p> <ul style="list-style-type: none"> • Don't lose good aspects of Link that is up and running • Build on knowledge already there • Use exiting local infrastructure
Table 2	<ul style="list-style-type: none"> • Challenge - Time frame is biggest challenge • Solution - not spending 2 years reinventing wheel don't lose knowledge and experience/passion • Challenge – someone else comes in – time to set up will services and people suffer – identify gaps • <u>New provider shadow form by Jan 2013 – transition</u>

	<ul style="list-style-type: none"> • Transition period??? Community suffer??? • Social enterprise less incentive for profit making organisation • Commercial morning earning – real risk of imbalance between generating income • Valuing volunteers – commercial organisations • Connect link volunteers/user led locally • Larger back room staff/governance staff will be different • Bids – positive – go for those contract that are relevant to the core work. • Contract length – needs to be long enough • Need to work • Recognised operation level • Increase of workload already overloads, under resourced as it is. • <u>Responsibility</u> of body corporate to employ staff concerns i.e.: maternity cover, long term sick smallness is an issue. Robust body corporate. • The ‘competition’ nose out of joint because of tendering process – stifles good work. • Collaborative approach to overcome.
Table 3	<ul style="list-style-type: none"> • Duplication in system (community mapping) • Identify specialists in info etc (or each function) etc that links into a ‘hub’ event that will prevent duplication. Resources should follow the ‘specialists’ • ‘network’ solution and coming together as service providers. If there is a separate infrastructure, people may fall between the gaps. • Central database - people could subscribe to (generating income) for the network data. • Need to link more closely to preventative services • Resources – ‘sharing back office’ functions • If LINKS isn’t known about, how can we get people to know about Healthwatch? • Model must be ‘representative’ • Lots of self help groups (user-led) how do we engage – link with Healthwatch • Profile needs to be raised (opening ceremony launch in park) and sustain that • ‘launch’ is opportunity to get it out and about. ‘launch’ must be <u>different</u> – get it on the map • Understand value of Healthwatch • Embrace new communications, social media etc – understanding what people need • GP surgeries is “critical”. Use professional development time. Links with CCG in developing services. • Children’s services – mail out to all Governors – a mechanism for access (every house hold) use Council tax bill for voice.
Table 4	<ul style="list-style-type: none"> • There is a massive expectation on “Healthwatch”! • We will not be able to afford what is needed • Concentrate on recruiting volunteers • Make sure there are standards • Make sure there is training • Challenge may be commitment to provide a quality service • Work with partners Doctors and hospital surgeries to ask “can you help someone else like you?” • Need to know the budget – note how Healthwatch can function in this • Health and Well-being Board – need to supply a wealth of information but need to know where to go to get it! • There is no voluntary sector rep on the Health and Well-Being Board – would like to explore this • Ever changing legislation and meetings meeting

Q3.	WHAT ORGANISATIONAL STRENGTHS ALREADY EXIST IN MEETING THE INTENDED FUNCTIONS OF A LOCAL HEALTHWATCH AND HOW COULD THESE BE UTILISED IN A DELIVERY MODEL?
Table 1	<ul style="list-style-type: none"> • There are lots of existing local organisations in Telford and Wrekin already fulfilling some of Healthwatch functions – needs mapping • Good existing volunteer body in Telford and Wrekin • Existing volunteer and organisation structures need to be the start point. • This is an opportunity to be creative and innovative and not just do the same that has gone before • Danger of national provider winning contract the local strengths might be ignored or lost

	<ul style="list-style-type: none"> Income generation important but danger of conflict on interest. Healthwatch to remain independent.
Table 2	<ul style="list-style-type: none"> Existing network of networks – strong some places and can grow (LINKS) and anyone Strong volunteers trained enter and view, youth link (time it takes) mentoring and sharing of information <u>Demonstrable</u> links to other networks – keyword how would you demonstrate that? Expand LINKS – look for gaps Awareness/relationships local commissioner/providers Strong individuals Model of training volunteers in other organisations i.e. WRVS Robust ongoing training programme for volunteers <u>Patient Ref Groups</u> in GP surgeries- a strength that can be mapped into local communities Training/supporting Linking up more within voluntary sector – interlinking Got to be able to involve Consortia – strong expertise – but strong functioning partnership – <u>How!</u> - triggers for partners LA could influence how partnerships joined up working Com members empowered and calling organisations to account. <u>Collaborative Council approach.</u> Family member of service user when things go wrong so many barriers – need to move on.
Table 3	<ul style="list-style-type: none"> Staffordshire Cares – is a good model to look at – a central database for information. Each provider is responsible for up-dating Telephone contact is important. Healthwatch could hold the database. Every contact must count. E.g. if someone goes to library, librarian must know how to “access” database 1 month email circular. Need 1 x lead for responsibility or central point responsible. If part of consortia with part of pie will have incentive for committed input Generate income/advertising An “app” for access – younger people – need to think about access all age groups. A marketing campaign – capturing people at there time of need. What does Healthwatch have to offer teenagers – until an ‘episode or event’ affects their family. Bus advertising Admin/back office functions very important Share some functions where appropriate (back office) with Shropshire Too big for organisation. Need to be a partnership approach (must be representative) organisation may not be able to fulfil/function Where are we going to get back office support, HR, employed staff? What management structure would you have? Critical Leadership is key (director role) Right staff is important
Table 4	<ul style="list-style-type: none"> How do we know all the organisations that are out there? Tap into parish councils and neighbourhoods to spread word of mouth about what’s happening. Church networks are useful. Use schools to spread word too. In Telford there is a strong LINK already with a strong leadership team.

Q4.	HOW COULD A LOCAL HEALTHWATCH BE CREATIVE IN DEMONSTRATING BEST VALUE
Table 1	<ul style="list-style-type: none"> Clear core values and aims to enable income generation Care needs to be taken to avoid conflict of interest when income generating Economies of scale and collaboration with e.g. Shropshire or volunteer organisations (Network of networks) Trading arm (income generation)being kept separate Approach research/academic establishments for research funding Charge for training

	<ul style="list-style-type: none"> • Apprenticeships and training • Best use of local knowledge
Table 2	<ul style="list-style-type: none"> • <u>Resources</u> • <u>Cost</u> • Building on things ongoing at the minute i.e. big local etc public health improvement • Addressing stronger governance – flatten staffing structure? • Encouragement to get best value • Got to indentifying ‘greatest need’ – not just priority geographical area - expand idea of communities • Targeted health inequalities? • Or universal service • What is this really • Get Healthwatch to answer everything you’re baying at the moon • Careful clear analysis what is realistic and can be done - frustration of knowing need – what are our priorities to do that value • Tap into commissioning resources • Mandatory – face of organisation. Need to have training equality • Influencing skills – feedback • Consistency of training • Information gathering/research • Working together – silos and barriers gone experience link not siloing issues a consortia might separate too much.
Table 3	<ul style="list-style-type: none"> • Charging subscription (levels, charities for free etc) • Advertising • Contracting • Application for grants for specific projects • Demonstrate best value by demonstrating ‘savings’ to community • Consultation projects for statutory organisations • Retails (community well-being) – “Hub” • Festival • Service organisations (rotary, WI) – parish councils for project – town hall guild. Churches. • NB – need to think about ‘out-reach’ service to hard to reach
Table 4.	<ul style="list-style-type: none"> • Conflict of interest? • How can be a watchdog and critic and review? • Could take away good will • Patient Reference Group funding come from PCT • Healthwatch should not aim to do it <u>ALL</u> itself when there are other organisations who can do parts of it efficiently • Facilitator rather than service provider • Ways of generating income must be a priority at every stage • Fundraising? • Police for example may commission Healthwatch to carry out research for them • Could there be a Healthwatch kite mark that business could strive to achieve • Pre inspection ‘enter and view’ visit? • Lottery like hospice • Cross boarder working – second opinions
Q5	WHAT WILL ORGANISATIONS NEED TO CONSIDER IN RECRUITING AND SUSTAINING A VIBRANT VOLUNTEER INFRASTRUCTURE?
Table 1	<ul style="list-style-type: none"> • Cost • Cost of support to meet <ul style="list-style-type: none"> ➢ volunteering needs ➢ recruiting volunteers • Change in characteristics of volunteers (away from ‘ladies that lunch’ to volunteers who do so to

	<p>add to CV)</p> <p>Questions:</p> <ul style="list-style-type: none"> • How many volunteers are need to deliver Healthwatch function? • How much training? (and recruitment to sustain) • Reliability and if 24 hour how sustainable and reliability of volunteers? • Healthwatch could sub-contract functions to other organisations (which may already do similar) • Flexible timetabling – scheduling resources properly • Receptive marketing to raise awareness and recruit volunteers
Table 2	<ul style="list-style-type: none"> • Strong values – listen to them, evaluate their strengths, interests and skills • Training and support – robust – where do you draw line – enter and view • Request rather than order • Mentoring • Community development and health link to NHS/TCAT • Enter and View – value, ensure • Skills to work within environment • Use their skills • Empower volunteers through knowledge and opportunity • Risk management • Everyone has something to offer • Support for the support/coordinator volunteers risk • Proper supervision/counselling for distressing issues • <u>Safeguarding</u> – training and process • Interesting and appropriate you involvement and children • Need money • Working together – this is about peoples health! • Could it be an ethos everyone signs up to • Sustainability • Managing this so it does not take off in the wrong direction • Times and availability of organisations • Support/or volunteers • Referral for people – access easily – local not just central
Table 3	<ul style="list-style-type: none"> • Identify dedicated people • Need a “board” (salaried?) to support staff and volunteers • Campaign/consistent for recruitment • A dedicated staff member to support volunteers • A ‘volunteer’ contract – 6 month, input • Need to identify appropriate skill-mix (?) of volunteer and clear roles • Needs to be supported – supervision, training • Need a ‘vibrant’ volunteer office • Advertise roles – ‘CV’ • Link with universities ‘for placements’ for experience • Apprenticeships • “expenses” for volunteers need to be built into business model • Volunteers should be properly reimbursed • Need to make ‘recruitment’ relevant to them. They need to see value in their contribution. • Establish links into communities i.e. BME • Target eg diabetes champions • Recruit people where issue has meaning to them.
Table 4	<ul style="list-style-type: none"> • Reality is you need both! • Ownership - get all the community to own • Look at employees in Telford and Wrekin and ask them to consider their corporate social responsibility - promote volunteering to <u>all staff</u> – resettlement schemes • Using students during their degree course – placements are a good idea as they are then supervised by their tutors in some places • Resources for training and expenses • Time is needed to manage these groups once they are trained • CRB – can this be done centrally?

	ANY OTHER BUSINESS
--	---------------------------

Table 3	<ul style="list-style-type: none"> • Needs to be better at communicating our successes. • What “made a difference”
----------------	--

	POINTS TO BE DISCUSSED AT NEXT WORKSHOP
--	--

	<ul style="list-style-type: none"> • Actual practical delivery and KPIs • Cabinet member to be invited to next session • The actual budget <ul style="list-style-type: none"> ➢ £114k per annum on link ringfenced ➢ plus £40k 13/14 ➢ £10k one off start up ➢ how long do we have this 3+1 • Attendees list • Confirm who is on the evaluation panel • Provide outcomes prior to the next event • Skill sets need for the ‘Healthwatch’ • Definition – local person re cross boundary or RSH • Working with other LA’s and do not duplicate • DONT GO BACKWARDS
--	---