Overview

1.1. In its White Paper, the Government has set out a clear intention to follow a formal "system by default" model, where key decisions about health and care service planning and delivery will be made by the new Integrated Care Systems (ICS).

1.2. To ensure these ICSs make good, well-informed decisions that meet the needs of their communities and deliver truly integrated and personalised care it is vital that local people have a way of formally inputting into the process.

1.3. We know from independent stakeholder research, conducted for Healthwatch England by Comres, that 9 out of 10 local NHS leaders believe the public should be involved in these sorts of decisions. However, we also know that local and regional leaders often find this hard to do.

1.4. With our strong existing presence at Place level and our reach in to seldom heard communities, Healthwatch is the natural partner to help the system as the new structures evolve.

1.5. We therefore welcome this reference in the White Paper to the role of user experience and engagement at ICS level:

"We know from the vanguard ICSs that taking a joined-up, population focused approach means you cannot see the people that services are meant for as just units within the system – their voice and sense of what matters to them becomes really central. That focus won't come through structures alone of course but working with organisations ***such as Healthwatch*** *there is a real chance to strengthen and assess patient voice at place and system levels, not just as a commentary on services but as a source of genuine co-production."*

1.6. It was also positive to see NHSE's response to the consultation set out an expectation that Healthwatch will be part of the new health and care partnership level arrangements and on the place-level committees.

1.7. The key questions are how these arrangements will work in practice and how this will be sustainably resourced going forward. To support the Committee's inquiries this document sets out:

- A brief overview of the current return on investment in the Healthwatch network
- The added value that would be generated by creating an ICS and Regional level role for user experience and engagement.

1.8. The draft bill, like the Local Government and Public Involvement in Health Act 2007 and the Health and Social Care Act 2012, should take this into consideration when setting out the requirement for arrangements for patient and public involvement activities at ICS level.

2. The current role and reach of Healthwatch

2.1 Through the creation of Healthwatch, the Health and Social Care Act 2012 put in place the mechanisms for a strong voice for users and the public in health and care decision making at local or 'Place' level and national level. This function is delivered through four core activities:

- Gathering views from users and communities to produce actionable insights.
- Encouraging and supporting the system to involve and engage people directly.
- Holding the system to account where it is clear people have not been appropriately or sufficiently involved.
- Providing information and advice to the public so they can get the best out of local services.

2.2 To deliver the above, the Healthwatch network has spent the last eight years developing strong relationships in communities up and down the country, underpinned by strong national support and coordination.

2.3 **In 2019/20 Healthwatch collectively engaged with over 1 million people**:

- 350,000 people shared their views and experiences with us.
- 950,000 people came to us seeking advice and information about local health and care services.

2.4 As the Arm's Length Body that has responsibility for ensuring the views of people are heard across both health and social care, (including primary and secondary care, care homes, services for people with learning difficulties mental health services etc).our insight, collected at a local level, could be aggregated to assist ICSs to understand the needs of the vast and diverse communities they serve.

2.5 Investment would be needed to enable Healthwatch to operate at an ICS level, but the infrastructure is there to make this happen quickly.

2.6 Healthwatch reaches those others find harder to engage:

- Roughly a quarter of those we hear from consider themselves to have caring responsibilities and more than a third have a disability.
- Over the last 12 months in particular, we have seen how vital the network's links with Black, Asian and Minority Ethnic communities really are – from Arabic and Urdu speaking women in South Tees to the Turkish and Kurdish community in Haringey, our work has brought new insights to the Place level and national level pandemic response.

2.7 Healthwatch turns this wealth of qualitative evidence into actionable insight for the health and care system – **generating 5,870 suggested improvements in the last financial year**. (See this *article* as an example of how Healthwatch South Tyneside's recommendations have led to significant improvements in local sexual health services following engagement with 165 young people.)

2.8 Healthwatch has built our evidence base over time – with **our national reports library now containing 5,344 local research reports** covering a huge variety of issues:

- Healthwatch Bolton's work on *cervical screening* identified important improvements to help encourage uptake among local Black, Asian and Minority Ethnic communities.

- Healthwatch Oxfordshire's work *engaging with 87 local families living in military bases*, uncovered the admin challenges they face registering with and accessing primary care services.

2.9 We draw on this insight to help the system develop key policy decisions – including the NHS Long Term Plan where we were able to offer *85,000 people's views* on issues such as investment in mental health and the changing skill mix in primary care to inform NHSE's thinking during the Plan's development phase.

2.10 Healthwatch also proactively investigates issues of specific interest to the system – for example our work analysing the views of over 10,000 people to *inform* the Clinical Review of Standards in A&E.

2.11 During the pandemic we have further solidified our strong reputation by mobilising incredibly quickly:

- In the first three months of the pandemic alone we engaged with over 500k people.
- We have provided a vital channel to get information and advice out to local communities.
- Coordinated volunteer efforts getting food parcels and medications out to those shielding.
- Fed back real-time insights from the frontline to local and national decision makers.
- Carried out dedicated research on issues such as *hospital discharge* and *digital health services* to ensure major policy changes to support the pandemic response work for people.

2.12 Whilst we have a positive story to tell about the development of the Healthwatch network, this must also be seen in the context of reduced local investment in Healthwatch.

2.13 Healthwatch are commissioned by local authorities and that funding is for work carried out in their local authority area. Asking the network to gather the views of their communities and bring these insights consistently into discussions at ICS and regional levels will require additional resource.

3. The added value of ICS and regional level coordination

3.1 Effective regional working is already going on in some areas but this is often dependent on local decisions to resource the activity. The lack of consistency in approach across the country means that DHSC, NHSE/I and others across the sector are unable to unlock a range of potential added value.

3.2 When brought forward, the draft Bill needs to clearly set out a non-voting, independent role for Healthwatch on the ICS governance boards. Doing so would unlock the following benefits:

- We are independent and trusted by our communities, with Equality Diversity and Inclusion central to our values. Investing in Healthwatch to operate at all levels would be a relatively low-cost way of providing assistance to a sector that often struggles to show how it has engaged, even when it has done it well.
- With the right legal powers and data sharing agreements in place, Healthwatch would be able to provide additional analytical capacity to understand a whole variety of sources of user insight which the system currently collects but often doesn't have time or expertise to interrogate fully. For example, ICS or regional analysis of feedback left on NHS.UK or data from qualitative comments collected through the Friends and Family Test.
- If commissioned consistently, every ICS in the country would have ready access to our expertise to help support their engagement own activity. This is supported by our ability to reach and recruit people to support with co-production exercises.

3.3 This would also provide a ready-made support network for other key patient engagement roles across the NHS. In addition to patient engagement and experience teams, this includes notable new additions:

- Patient safety partners – of which there are now two per quality board for each provider and aspiration of one per PCN. These people need external support to feed them with insight about patient safety issues (notably where people might be slipping between institutional gaps).
- Equality champions on ICS boards – these people will need to be able to call on external insight to help them scrutinise how well systems are doing at addressing health inequalities.

3.4 ICS and regional Healthwatch activity would be able to make best use of the network's broader evidence base and bring in insights and relevant evidence collected in other parts of the country into ICS level discussions. This would support the sharing of learning and spreading of good practice throughout the NHS and social care.

3.5 As witnessed during the COVID-19 pandemic, Healthwatch can also play a vital link between the NHS and the local VCSE sector at ICS level – helping to bring the right VCSE partners to the table on discussions rather than the NHS always going through the same routes.

3.6 Providing core and sustainable funding for the Healthwatch network at local, regional and national level also means there is a strong infrastructure to call on should the NHS or DHSC need to carry out additional engagement work that goes above and beyond the network's standard workplan – the NHSE LTP engagement project is a good example of this. Without sufficient core funding, similar pieces of nationally-commissioned work will simply not be possible in the future.

3.7 The new health and care landscape may seem complex to those not directly involved. A properly supported Healthwatch network will be able to ensure that local voices are heard where they need to be heard within the health and care system, and providing a mechanism for effective communication with people and communities across the area.

February 2021