



# Summary Report

*Issues relating to local Healthwatch regulations*

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# Summary Report

*Issues relating to local Healthwatch regulations*

Prepared by Helen Jones

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# Executive summary

**The Health and Social Care Act 2012 (“the 2012 Act”) amends the Local Government and Public Involvement in Health Act 2007 (“the 2007 Act”) to make provisions about local Healthwatch as the consumer champion for health and social care services. The 2007 Act allows for, and in some cases requires, regulations to be made covering certain areas.**

Local Healthwatch will replace Local Involvement Networks (LINKs), carrying forward the LINKs functions while taking on new, additional functions. Certain aspects of local Healthwatch will be covered in regulations under the 2007 Act as amended. These will replace current regulations under the 2007 Act. Since mid-April the Department has been seeking out the views of stakeholders and the public relating to the proposals for the local Healthwatch regulations. We have run workshops with targeted stakeholders and experts in the field, as well as held discussions with the wider public through online web chats. We are continuing to consult on the regulations.

This report sets out the key issues that have arisen from discussions so far and provides information on the Department’s current thinking on the drafting of the regulations.

This report is a summary of the views that have been expressed so far; it should be noted that we will not include direct quotations from particular stakeholders. Instead we have aimed to capture the breadth of views that were expressed, in a clear and helpful manner.

The Department has been seeking the views of the public and many different stakeholders, including;

- the 10 regional representatives of LINKs<sup>i</sup>, the National Association of LINK Members (NALM) and a number of LINKs;
- Department of Health Strategic Partners Network<sup>ii</sup>;
- local authority officers, both through sessions run at four Local Government Association (LGA) masterclasses, and through some of the existing local authority regional networks;
- organisations that specialise in children’s issues, such as: The National Children’s Bureau, Ofsted, the Office of the Children’s Rights Commissioner, Clic Sargeant, the Who Cares Trust, the Royal College of Paediatric and Child Health, YoungMinds, Mencap and Enable East; and

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- Social Enterprise UK.

There are several areas in relation to which regulations may or must be made about local Healthwatch; while some of these are new areas (under powers created by the 2012 Act); others are areas which already exist in relation to LINKs<sup>iii</sup>.

The 2007 Act as amended allows for, and in some cases requires, regulations to be made covering the following:

1. Bodies with which local authorities are to contract to deliver the local Healthwatch statutory functions<sup>iv</sup>.
2. Contracts between local authorities and local Healthwatch.
3. Contracts between local Healthwatch and subcontractors.
4. Responding to reports, recommendations, and information requests<sup>v</sup>.
5. Referrals to scrutiny committees.
6. Duties of services-providers to allow entry to local Healthwatch<sup>vi</sup>

In addition, it is possible to make:

7. Directions in relation to the matters to be addressed in local Healthwatch annual reports.
8. Transfer schemes for the transfer of property, rights and liabilities from hosts to local Healthwatch where host contracts continue after April 2013.

# Summary of Views to Date

This section sets out each of the six areas where the Secretary of State for Health can or must make regulations, and the two additional elements of directions about annual reports and transfer schemes, and provides the legislative background for each of those areas. It sets out the main issues that have so far been raised through discussions, and the Department's current thinking on these views.

## 1. Bodies with which local authorities are to contract to deliver the local Healthwatch statutory functions

### The Legislation says:

- 1.1 The 2012 Act amends the 2007 Act to provide that the body contracted to be the local Healthwatch must be a 'body corporate' (i.e. a legal entity), which is a social enterprise.
- 1.2 The legislation also stipulates that there must be arrangements for a local Healthwatch in each local authority area. The 2012 act legislation provides that, for the purposes of local Healthwatch, a body is a social enterprise if "a person might reasonably consider that it acts for the benefit of the community in England" and "satisfies such criteria as may be prescribed by regulations".
- 1.3 'Social enterprise' does not have a single legal definition (rather, it is a collective description of social-purpose organisations<sup>vii</sup>) and there are several legal forms for it. However, a general description would be 'businesses with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community'.
- 1.4 The Secretary of State for Health is able to prescribe criteria around this concept in the regulations.

### What you have said:

- 1.5 There has been great support for the type of criteria which we have proposed to introduce. There was less support for the regulations to take an approach that is overly-prescriptive, and may narrow choice at the local level.
- 1.6 There has been less support for the regulations to list the various types of legal forms that social enterprise might take (e.g. a charitable incorporated company); it was seen as overly-prescriptive, and something that could narrow choice at the local level.
- 1.7 Putting a restriction on contracting with current providers of health and social care services generated mixed views; some felt strongly that local authorities should not be allowed to commission existing providers of health or social services to provide local Healthwatch functions (citing conflicts of interest). Others argued that it may be appropriate for some providers to be given the opportunity, due to their expertise in engaging and involving people, which they felt was key to an organisation being a local Healthwatch. This was especially felt in small local authority areas, where there may not be a large Voluntary and

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Community Sector, so it was preferred in those cases that there was no exclusion on current providers.

- 1.8 There have been several suggestions that a local Healthwatch should be a 'not for profit' organisation. However, most felt it was more important that local Healthwatch should have the opportunity to generate a profit, as long as there were provisions about reinvesting profits back into the activities of the organisation. This would therefore not stop a local Healthwatch from generating income.
- 1.9 Another point raised was whether local Healthwatch organisations should be required to have an asset lock; the reason given was that many social enterprises choose to ensure that their assets are legally protected and permanently retained for social or environmental benefit.

### What the Department says:

- 1.10 The Department supports the view of setting out appropriate and flexible criteria in the regulations that a body which is to be the local Healthwatch organisation for an area must comply with, thereby creating a working definition of social enterprise in the context of local Healthwatch.
- 1.11 The proposed criteria align with the principles promoted by organisations such as Social Enterprise UK. We are considering criteria along the lines of:
  - The constitution of the organisation must contain a statement or condition that the body's primary purpose is to carry out its activities for the benefit of the community in England. This supports the principle that the organisation should have a clear social objective, know what difference it is trying to make, who it aims to help, and how it's going to go about it.
  - Reinvestment of profits; what an organisation does with its profits is a critical way in which a social enterprise is distinct from standard businesses. We believe at least 50 per cent of a local Healthwatch organisation's profits should be reinvested to further its social objective.
  - The constitution of the organisation must where appropriate contain certain provisions relating to the distribution of assets on dissolution or winding up of the local Healthwatch organisation.
- 1.12 Although not a criterion that will be in the regulations, an important factor in the operation of a local Healthwatch (as a social enterprise) is that it is accountable to its stakeholders. Different legal structures have different accountability mechanisms; Social Enterprise UK advise that some legal forms are regulated against their social mission, others are accountable to their members. Each organisation ought to be able to demonstrate how it is accountable to the communities it serves.
- 1.13 We also intend that there will be further criteria, in relation to having a strong involvement of lay people and volunteers in the local Healthwatch
- 1.14 The implications of having a set of criteria in the regulations, is that it would allow for local Healthwatch to take one of a number of organisational forms. For example, it could



be a subsidiary with a distinct identity to help local people access it, or a new organisation i.e. under an existing statutory framework. Ultimately, it would be the decision of the local authority in their role as commissioner, guided by the criteria set out in regulations, as to which social enterprise model is most appropriate for their local area.

## 2. Contracts between local authorities and local Healthwatch

### The Legislation says:

- 2.1 The 2008 Regulations impose a requirement on local authorities to ensure that local involvement network arrangements include certain provisions about LINKs' procedures and decision-making, with the aim of ensuring open and transparent procedures.
- 2.2 These include, for example, the publication of information about the procedures behind referring a report or recommendation to a services-provider, or whether to refer a matter to an overview and scrutiny committee.
- 2.3 Local Healthwatch will hold the contracts with local authorities in the future and it is proposed that similar requirements be imposed on local authorities in relation to arrangements with local Healthwatch.

### What you have said:

- 2.4 We have been hearing that there has been some misunderstanding by some LINKs as to how the current requirements ought to be complied with. We know that LINKs have generally been transparent in their processes, but they have provided assurance in different ways; some have done this through their annual report, for example; others have also done this through their public meetings.
- 2.5 The views to date have expressed the importance of ensuring that local Healthwatch organisations act in an open and transparent way, and that the regulations help to provide the parameters for achieving this.

### What the Department says:

- 2.6 Transparency is critical for social enterprises in general, and will be crucial for local Healthwatch in particular. Therefore, it is proposed to include provisions in the regulations which will have the effect that a local authority must include in their contract certain requirements that ensure that a local Healthwatch must act in an open and transparent manner.

## 3. Contracts between local Healthwatch and subcontractors

### The Legislation says:

- 3.1 In carrying out the local Healthwatch functions, as stipulated in the 2007 Act (as amended by the 2012 Act), a local Healthwatch organisation can be authorised to make arrangements with a person (including an organisation) either to carry out some of the local Healthwatch functions, or to assist in some or all of the local Healthwatch functions.

3.2 The ambition is that local Healthwatch will be able to bring in the type of expertise and support it requires to do its job. However, it was important to explore any limitations to this, and consider whether there are any core responsibilities that a local Healthwatch must carry out itself.

### What you have said:

3.3 There have been mixed views expressed on this issue; some have been of the opinion that all of the functions should be suitable for subcontracting; the decision of whether it is appropriate or not to subcontract should be up to each local Healthwatch to decide, where authorised by the local authority as the commissioner (and managed through the contract), so no restrictions on that decision should be set by the regulations. This would provide flexibility at the local level.

3.4 There have also been views expressed about why some of the functions should not be subcontracted. For example, some expressed concerns about the possibility of local Healthwatch subcontractors making reports and recommendations without the knowledge and approval of the local Healthwatch; it was felt that making reports and recommendations to services-providers is a core function, and that only the local Healthwatch should be able to carry out this activity, as overall it is accountable for the opinion cited.

3.5 Some have raised concerns that if a local Healthwatch subcontracted all of its functions, the service to the public may become fragmented and therefore the quality of the service may suffer. However, other stakeholders pointed out that if functions are subcontracted, the overall accountability and responsibility still lies with the local Healthwatch. It would be their job to contract-manage the bodies that take on any functions on behalf of the local Healthwatch. They felt it was important to make this clear, in order to allay fears about the quality of the subcontractors.

3.6 Some have expressed the view of the need to prohibit local Healthwatch from subcontracting 'Enter and View', as it would be an inappropriate task to subcontract.

3.7 Although not within the scope of the regulations, some have raised the issue of the local Healthwatch seat on the statutory health and wellbeing board; some described the possibility of sharing health and wellbeing board representatives, as this would potentially allow for enough resource to be able to pay someone with the skills and competency necessary for this strategic role. There was a question about whether this could be viewed as "subcontracting" – this is clarified in paragraph 3.10.

3.8 Subcontracting is linked to an issue about the use of the logo (trade mark); and different concerns were expressed about this. Some have felt that:

- Subcontractors should be allowed to use the Healthwatch logo – the most important thing is that there is a seamless service for the 'person on the street'. That person would not necessarily be concerned about the person/organisation that is helping to provide local Healthwatch; they just want to receive a good service from their local Healthwatch. Therefore, any organisation providing Healthwatch services should be known as "Healthwatch [local area]".

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- Subcontractors should not be allowed to use the logo; it should be seen as a 'kite mark' owned by the local Healthwatch. For example, a subcontractor could carry out work, e.g. writing a report, but that report could not go any further until the local Healthwatch has 'approved' the content, providing them with the ability to oversee the sending of reports and recommendations to a provider or commissioner, and ensuring that only once work has been approved by the local Healthwatch, will it be endorsed with the relevant branding.

### What the Department says:

3.9 The 2012 Act says that the functions (in section 221) can be authorised to be subcontracted, but that this is subject to restrictions in the regulations; we have listened carefully to the spectrum of views expressed, and on that basis are of the view that at this stage we should not create any restrictions to prevent particular functions being subcontracted. It should be for each local Healthwatch, where authorised through the contract with the local authority, to decide the appropriateness of subcontracting its functions, in its local area.

3.10 The local Healthwatch seat on the health and wellbeing board is separate to the statutory activities of local Healthwatch (set out in section 221 of the 2007 Act, as amended by the 2012 Act), therefore it is not within the scope of these regulations. However, the seat on the health and wellbeing board is an important role for the local Healthwatch, therefore it is an important factor for those involved in the planning for local Healthwatch to consider.

3.11 Relating to views expressed about subcontractors, the issue about the use of the logo (trade mark) was raised.

3.12 Whilst not proposed to be written into the regulations, the trade mark would have to be used by local Healthwatch in an appropriate way to raise the profile and understanding of the Healthwatch brand, to enable people to recognise how to use and access their Healthwatch. CQC will be the license holder for the Healthwatch trade mark and it is anticipated that a simple process will be put in place for local Healthwatch to obtain a licence to use the trade mark, when it secures the contract to be the provider of Healthwatch. CQC will be sharing the branding toolkit with further details (visit [www.cqc.uk](http://www.cqc.uk)).

## 4. Responding to reports, recommendations, and information requests

### The Legislation says:

4.1 Amongst other things, the 2008 regulations impose certain duties on a services-provider and a relevant services-provider<sup>viii</sup> where it receives a report or recommendation from LINKs. This includes a duty on a relevant services-provider, within 20 working days, to:

- (a) acknowledge receipt of the report or recommendation in writing;

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(b) provide (in writing) an explanation of any action it intends to take in response, or if no action is to be taken, to provide an explanation of why it does not intend to take any action.

4.2 Currently exclusions apply, for example the duty does not apply to a report or recommendation relating to excluded activities, (broadly-speaking children's social care).

4.3 The Department has been seeking views on proposals to retain aspects of the 2008 Regulations but to lift the exclusion in relation to the currently excluded activities so that the duty to respond would cover reports and recommendations relating to those activities (i.e. broadly-speaking, children's social care), in addition to the duty regarding adult and children's health, and adult social care.

4.4 There is a power to impose duties as regards responding to information requests by LINKs; this power has not been exercised in the 2008 Regulations, but we have been exploring with stakeholders whether they felt such duties would be useful in relation to local Healthwatch.

4.5 The Department is continuing to consult on these regulations. Below we set out what we have heard so far.

### What you have said:

4.6 The Department has been receiving feedback from several LINKs regarding how well the provision had worked for them; there have been mixed views, with many stating that where the duty was known about by services-providers, it had worked well.

4.7 The main issue raised has been that some services-providers seemed unaware of the duty, making it harder for LINKs to get a response from them. Stakeholders have told us that in practice, a LINK has been able to go back to the provider; if that doesn't work, they have approached the commissioner of that provider. If the issue remained unresolved, they made a referral to the Overview and Scrutiny Committee. However, some stakeholders have suggested that some kind of sanction should be imposed upon services-providers who do not respond within the required period. Stakeholders did stress that when an urgent and serious matter arises, they would escalate it to the appropriate body (i.e. Overview and Scrutiny, or CQC), for them to take appropriate actions.

4.8 Many stakeholders have expressed the importance of extending the duty to respond to reports and recommendations concerning children's social care, emphasising that this would support the key role Healthwatch has in presenting the voices of children and young people, in order to influence commissioners and providers, and enable them to act on such feedback to improve health and social care.

4.9 Regarding the duty to respond to information requests, the feedback we have received so far is that where there have been good relationships between LINKs and services-providers, LINKs have found it fairly easy to gather information. However, where the relationships have not been so good, Freedom of Information Act (FOIA) requests have been used successfully. It has been suggested that in the light of the availability of FOIA requests, a duty to respond to information requests would be unnecessary.

### **What the Department says:**

4.10 On the strength of the views we have received so far, it appears that aspects of the 2008 Regulations are working well, for example 20 working days still seems to be an appropriate period of time for responses to reports and recommendations; however, we are continuing to consult on this and the outcome of the consultation will inform the making of the regulations.

4.11 At this stage the Department prefers the view that it is important that the duty to respond extends to activities concerning children's social care; such a provision would align the regulations with the policy ambition that Healthwatch will be a strong voice for children and young people, as well as adults, in both health and social care.

## **5. Referrals to scrutiny committees**

### **The Legislation says:**

5.1 Section 226 of the 2007 Act imposes certain requirements on local authority overview and scrutiny committees (OSCs) where LINKs refers social care matters to them, including to acknowledge receipt of the referral and to keep the referrer informed of the OSC's actions.

### **What you have said:**

5.2 There has been a mixed response about how well this provision has worked, with some LINKs having had a positive relationship with OSCs, while others have not experienced a good working relationship. Several people have said that OSCs in some places do not sufficiently understand the role of the LINK, thereby undermining their ability to successfully work in partnership with them.

5.3 Similarly, where the duty to respond within 20 working days has been known about, most have said it has worked well, but this view has varied across the country.

5.4 Many stakeholders have said that the key to this issue would not be in changing the current requirement, but in increasing the understanding of how local Healthwatch and scrutiny might work together, and the benefits that may bring.

### **What the Department says:**

5.5 As this provision has worked well, we are proposing to carry it forward for local Healthwatch. We have noted the need to have more clarity about the relationship between Healthwatch and scrutiny, and the LGA has undertaken to do some work around this relationship, working in partnership with the Centre for Public Scrutiny, the result of which will be made available in the autumn.

## 6. Services providers - duty to allow entry to local Healthwatch

### The Legislation says:

6.1 Section 225 of the 2007 Act requires the Secretary of State for Health to make regulations to require certain persons to allow authorised representatives to enter and view, and observe the carrying-on of activities on premises owned or controlled by the services-provider.

6.2 The 2008 Entry Regulations cover the issue of “enter and view” in two ways;

- Firstly, in terms of a duty upon services-providers to allow the LINK’s authorised representative to enter and view and observe the carrying-on of activities on premises that they own or control.
- Secondly, there are particular requirements placed upon the individuals who carry out the activity as authorised representatives.

6.3 At the moment, there are certain exclusions for example an exclusion for certain activities which mirror the excluded activities in the 2008 Regulations (i.e. broadly-speaking children’s social care) in relation to dealing with reports/recommendations by LINKs as mentioned above. Also, there is no duty on a services-provider to allow a representative of LINKs entry if this would compromise the effective provision of a service or the privacy or dignity of a person. The duty to allow entry does not apply to some types of premises such as non-communal areas of care homes and premises used as accommodation for employees of services-providers. The duty does not apply in relation to premises at any time when health and social care services are not being provided or if services-provider thinks the authorised representative, in seeking to enter and view, is not acting reasonably and proportionately.

6.4 We have heard views about proposals to carry forward these provisions in the regulations for local Healthwatch and are continuing to consult on these regulations. Below we set out what we have heard so far.

### What you have said:

6.5 In general there has been support for carrying forward these provisions. Some LINKs, local authorities and other stakeholders have said that they were not aware of the need for Healthwatch to cover health and social care for children and young people as well as adults. It has been clear that some of the misunderstanding stems from perception of the LINKs regulations; the “excluded activities” provision has caused confusion for some about the LINK’s remit in gathering the views of children and young people. Some LINKs have gathered the views of children and young people in relation to health care, but most have not seen themselves as having any role in relation to children’s social care services.

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- 6.6 However, regarding the exclusion relating to children's social care, people have strongly expressed the view that removing the exclusion would be seen to be duplication of the existing regulatory and inspection system; there has also been concern that children interacting with the social care services already have a number of professionals in their lives that would engage and obtain their views and experiences.
- 6.7 It has been apparent that there has been a mixed use of "enter and view" across the country by LINKs; some have carried out lots of "enter and view" visits, others far fewer. Some of the ones who have used it less have said that they didn't need to use it, because they had good relationships (for example with their NHS Foundation Trusts) so have found it easy to gain entry without relying on statutory enter and view provisions.
- 6.8 The CQC has made the point that they have been working with some LINKs to ensure LINKs enter and view activity and CQC inspections complement each other. It is anticipated that Healthwatch England, in liaison with CQC, will want to produce advice for local Healthwatch organisations on how the enter and view activity and CQC inspections can be coordinated and complementary. CQC have noted that it has been particularly helpful where LINKs have discussed their plans for visiting services with CQC as part of regular contact with them, as well as sharing final reports, which can inform regulatory activity and decisions.

### What the Department says:

- 6.9 It seems that there is support for generally carrying forward the current provisions and for not removing the "excluded activity" provision i.e. not imposing a duty on services-providers to allow entry to their premises for local Healthwatch to observe children's social care activities.
- 6.10 It is important for children and young people's voice to be heard by commissioners and providers of health and social care. Health issues for children and young people are not only about provision by the health services themselves, but also about how health and social care services work together for children. As the new consumer champion across health and social care, Healthwatch has a key role to play, alongside those of the Children's Rights Director and Children's Commissioner, in presenting the voice of children and young people to influence the strategic planning and the way in which health and social care services work together to meet the needs of children and young people. The information gathered could strongly inform the 'life course' approach adopted in health across all services.
- 6.11 In recognition of the specialist/specific framework under which children's social care services are provided and monitored, and the sensitive environments in which such services often operate e.g. for looked after children, Healthwatch will not be able to use its powers of entry to visit premises that provide social care to children and young people such as children's homes, foster care, etc. This, too, is in recognition of the sensitivities that such

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care services offer to the protection and vulnerability of children and young people that require specialist training and skills.

- 6.12 However, Healthwatch has an important role to play in presenting everyone's voice where health and social care issues are involved. While it does not have a power to enter and view or to make visits to social care settings, it can gather the views and experiences from children and young people in social care provision about how health and social care services work together in many ways, especially by working with the bodies that already exist to secure the views of children and young people about their welfare in social care - to ensure that these children and young people's views about health and social care are heard and acted upon.
- 6.13 It is vital that Healthwatch works collaboratively, with existing representatives, groups and organisations, in the statutory and voluntary sectors, that are data-rich because they already gather such information from children and young people; this will help to inform the collective local intelligence Healthwatch will present through their seat on the statutory health and wellbeing board. In addition, Healthwatch can present this information to Healthwatch England, which has a role as the champion on health and social care for everyone at the national level.
- 6.14 To complement this way of influencing, individuals, groups and organisations representing children and young people can, with their skills and expertise in gathering the views and experiences of this age group, enhance and support Healthwatch's role; as well as enable children and young people to access it either directly or on their behalf to ensure their voice is heard.
- 6.15 The voice of adults is equally important and Healthwatch will have a role in gathering their views and experiences of health and social care, feeding this back and presenting this local intelligence through their seat on the statutory health and wellbeing board. The adult social care sector is complex, made up of a wide range of different sizes and types of services and a mixture of small, local to large national providers. People who use adult social care services can be in the most vulnerable circumstances i.e. receiving dementia care or support for learning disabilities. This might call for a strategic approach.
- 6.16 In a similar approach to that in gathering the views of children and young people, Healthwatch can work with existing individuals, groups and organisations representing adults (including vulnerable adults) to inform their feedback of the collective concerns and views to influence commissioning and provision. Building on the work CQC has done with LINKs, Healthwatch will need to work collaboratively with CQC to share information and any plans to visit services, as they might do with health partners and others to make the best use of their visits and avoid duplication.
- 6.17 It is anticipated that Healthwatch England will provide guidance about 'enter and view' to local Healthwatch organisations, as part of their leadership role.



## 7. Content of local Healthwatch annual reports

### The Legislation says:

7.1 LINKs currently have to produce annual reports; the same duty will have to be imposed on local Healthwatch (as stipulated in section 227 of the 2007 Act, as amended by the 2012 Act).

7.2 The LINK annual reports currently have to address, in particular, such matters as the Secretary of State may direct and have to include details of certain amounts spent by hosts (i.e. persons with whom local authorities currently contract for LINKs arrangements) and what those amounts were spent on. There is flexibility to add further information for example case studies and this can be helpful.

7.3 The Department sought views on the content of those directions.

### What you have said:

7.4 Some element of the LINK annual reports were reported as working well; the quantitative data (for example finances, number of “enter and views” carried out, number of reports, membership details), and the timing of the reports.

7.5 Some element of the LINK annual reports were reported as not working well; the view was that the legislation forces an overly-bureaucratic style of reporting; some of the measures were described as not being meaningful (for example, in the LINK annual reporting, distinctions have been made about “types” of members, i.e. “informed participants”, “occasional participants”, and “active participants”<sup>ix</sup>), and that there are too many elements of quantitative data needed, with some questioning the usefulness of such details.

7.6 The following suggestions have been made for how the local Healthwatch reports might be different:

- they should be supportive of local Healthwatch organisations’ accountability to local people (i.e. demonstrate what impact the local Healthwatch has had in the area, what it has done with the views it has collected); therefore the reports need to be more user-friendly and simple;
- they should align with local reporting arrangements;
- they should be open and transparent with the local population about what local Healthwatch have done, and the outcomes.
- they should be focused on outcomes, explaining what actually changed as a result of the views and experiences gathered. The suggestion was that more emphasis on qualitative data would be more meaningful to the local community;
- they should give information on how the local Healthwatch has been representative and acted inclusively;
- they should include a forward look; not just what the local Healthwatch has done, but what their plans for the coming year are;

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7.7 Some have expressed a view that there is still a need for some quantitative data. Those in favour of having quantitative data cited reasons such as: the need to be able to do comparisons across the country, and the need to be able to compare data from a particular local Healthwatch over several years to see how it has developed.

7.8 Those against having a lot of quantitative data cited reasons such as; the data alone does not tell the story. For example, a local Healthwatch may not “enter and view” many premises because they feel other methods achieve a better result. However, if they conducted few ‘enter and view’ visits, it could be interpreted as them being less effective at gathering views. Equally, a local Healthwatch may produce a significant number of reports, but without the information about what impact those reports had, the figures alone would have little meaning. It was felt there could be a danger of drawing false conclusions from such data.

7.9 Many have suggested that information should be given on how the local Healthwatch has been representative, and how it has gone about engaging its local community, i.e. information about its methodology.

7.10 Some have suggested that the local Healthwatch representative on the health and wellbeing board should have their own section within the report to highlight their work, specifically in relation to what they contributed to the development of the.

7.11 Another suggestion was that the reports should include information on how the local Healthwatch has acted in accordance with legislation such as the Equality Act 2010 and the Freedom of Information Act 2000.

### What the Department says:

7.12 The Department is of the view that consideration needs to be given to how the reports can be improved. For example potentially, the annual reports should contain information under some broad headings:

- Financial Accounting
- How the local Healthwatch has been representative of its local area
- How the local Healthwatch has carried out engagement, and gathered the views of its local people
- Outcomes – what have they achieved
- Forward look – plans for the coming year, linked to the JSNAs and joint health and wellbeing strategy

## 8. Transfer schemes

### The Legislation says:

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8.1 The Secretary of State has the power to make transfer schemes for the transfer of property, rights and liabilities from hosts to local Healthwatch where host contracts continue after April 2013.

### **What you have said:**

8.2 It is emerging that the current host arrangements will end on the 31<sup>st</sup> of March. It has therefore been suggested that transfer schemes would not be necessary.

### **What the Department says:**

8.3 On the basis that host contracts are not expected to continue after 31<sup>st</sup> March 2013, the Department does not anticipate a need for transfer schemes; however, the Department will review the need for such schemes closer to the time.

## Next steps

We are very grateful to all those who have given views and contributed to the discussions on the issues around the local Healthwatch regulations. We are continuing to consult on aspects of the regulations and the views and issues we receive will be a vital contribution to the development of the policy that will inform the drafting of the regulations.

The Department will keep stakeholders and the public informed via the Healthwatch Programme Board, and our communications activities.

The aim is to lay the regulations (on Local Healthwatch contracts etc.) and draft regulations (on entry and viewing) in October and November respectively. The regulations relating to local Healthwatch will then come into force on 1<sup>st</sup> April 2013.

### **A summary of the Department's preferred approach to the regulations is, as follows:**

**1. Bodies with which local authorities are to contract to deliver the local Healthwatch statutory functions<sup>x</sup>.**

The Department intends to set out two sets of criteria in the regulations; the first will relate to the definition of social enterprises, the second will relate to the involvement of lay people.

**2. Contracts between local authorities and local Healthwatch.**

The details in the 2008 Regulations are intended to be carried forward in the local Healthwatch regulations, with the intention of ensuring that the local Healthwatch acts in an open and transparent manner.

**3. Contracts between local Healthwatch and subcontractors.**

The Department does not at this stage intend to set any restrictions to prevent particular functions being subcontracted. It will be for each local Healthwatch, where so authorised, to decide the appropriateness of subcontracting particular functions.

**4. Responding to reports, recommendations, and information requests<sup>xi</sup>.**

We prefer that the regulations will roll forward aspects of the 2008 Regulations, as these are generally seen to be working well. We also prefer that the duty to respond to reports and recommendations be extended in relation to children's social care, in order to align with the policy ambition that Healthwatch will be a stronger consumer voice for health and social care, for all (i.e. children and adults). The Department also prefers not to impose a duty to respond to information requests.

**5. Referrals to scrutiny committees.**

As this provision has worked well, we are proposing to carry it forward for local Healthwatch.

**6. Duties of services-providers to allow entry to local Healthwatch.<sup>xii</sup>**

## Summary Report: Issues relating to local Healthwatch regulations

The Department prefers that, for the reasons stated in section 6, the current provisions of the 2008 Entry Regulations are generally carried forward, including in relation to “excluded activities” (children’s social care).

In addition, the Department intends to make:

### **7. Directions in relation to the matters to be addressed in local Healthwatch annual reports.**

The Department is of the view that annual reports should contain information that covers; financial accounting, how the local Healthwatch has been representative of its local area, how the local Healthwatch has carried out engagement, a focus on outcomes, and a “forward look”.

It should be noted that the Department does not intend to make transfer schemes.

## References

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<sup>i</sup> **The 10 regional representatives of Local Involvement Networks** are a group which was elected by the LINks in each of the 9 former Government Office regions across England (London has 2 representatives). The representatives were originally elected to represent LINks on the Healthwatch Programme Advisory Group which ended in March 2012. They now meet monthly, and engage directly with the Department on the implementation of Healthwatch policy.

<sup>ii</sup> **The Voluntary Sector Strategic Partner Programme** – a two-way programme of activity that seeks to support the voluntary and community sector through improving the capability and support through national member organisations and networks and brings voice, representation and insight to national policy making. Eighteen strategic partners are appointed to support the sectors capacity delivering an agreed and collaborative programme of work, in partnership with both the Department and other partners, which supports the wider voluntary sector working in health and social care.

<sup>iii</sup> The current regulations are the Local Involvement Networks Regulations 2008 (“the 2008 Regulations”) and the Local Involvement Networks (Duty of Services-Providers to Allow Entry) Regulations 2008 (“the 2008 Entry Regulations”).

<sup>iv</sup> The local Healthwatch functions are described in statutory terms as “activities”. These functions/activities include: provide information and advice to the public about accessing health and social care services (local care services) and choice in relation to aspects of those services;

- make the views and experiences of people known to Healthwatch England helping it to carry out its role as national champion;
- make recommendations to Healthwatch England to advise the Care Quality Commission to carry out special reviews or investigations into areas of concern (or, if the circumstances justify it, go direct to the CQC with their recommendations, for example if urgent action were required by the CQC);
- promote and support the involvement of people in the scrutiny, commissioning and provision of local care services;
- enable people to monitor/review the commissioning and provision of local care services;
- obtain the views of people about their needs for and experiences of local care services and make those views known to those responsible for the commissioning, provision, management and scrutiny of local care services; and
- make reports and make recommendations about how those services could or ought to be improved.

<sup>v</sup> Those services-providers who can be required to respond to reports and recommendations are set out in section 224 of the 2007 Act. They are;

- A National Health Service trust;
- An NHS foundation trust;
- A Primary Care Trust;
- A local authority; or

- A person prescribed by regulations made by the Secretary of State. The 2012 Act has added to this the NHS Commissioning Board and a clinical commissioning group.

<sup>vi</sup> Those services-providers who can be required to allow entry are set out in section 225 of the 2007 Act. They are;

- A National Health Service trust;
- An NHS foundation trust;
- A Primary Care Trust;
- A local authority; or
- A person prescribed by regulations made by the Secretary of State.

<sup>vii</sup> <http://www.bis.gov.uk/assets/biscore/enterprise/docs/s/10-1076-social-enterprise-barometer-feb-2010.pdf>

<sup>viii</sup> For these purposes a services-provider, in the current regulations, is an NHS Trust, an NHS Foundation Trust, a Primary Care Trust or a local authority and a relevant services-provider is a services-provider who was responsible for commissioning any of the care services to which the report or recommendation relates.

<sup>ix</sup> This is highlighted in the Summary Analysis of the LINK annual reports, [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_130567](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_130567)

<sup>xi</sup> Those services-providers who have to respond to reports and recommendations are set out in section 224 of the 2007 Act. They are;

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<sup>xii</sup> Those services-providers who have a duty to allow entry are set out in section 225 of the 2007 Act. They are;

- A National Health Service trust;
- An NHS foundation trust;
- A Primary Care Trust;
- A local authority; or
- A person prescribed by regulations made by the Secretary of State.