What's constraining effective public and patient involvement in health and social care service improvement in Birmingham?

Findings from a large group intervention

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healthwatch
Birmingham

Contents

REPORT

1. Executive summary

Healthwatch Birmingham (HWB) has undertaken several pieces of work to develop a new strategic approach. This report focuses on one element of this work; how we promote and support public and patient involvement in commissioning and providing decisions.

We started by asking:

> "If the solution is Healthwatch Birmingham promoting and supporting the involvement of people in the commissioning and provision of health and social care services – what's the problem?"

In order to answer this question a large focus group was convened. The purpose of this group was to identify and test the constraints that limit the effectiveness of the system's capability to successfully engage patients and the public. The group realised that the main constraint is the absence of quality measures in relation to effective engagement. This gave HWB a clear steer. We intend to work with our system partners and the public to develop appropriate quality measures. We will use these, as part of the local assurance and scrutiny system, to develop a role in assuring the quality of patient and public involvement and assurance.

2. Introduction

Healthwatch Birmingham is one of a national network of 142 Local Healthwatch (LHW) conceived through the Health and Social Care Act 2012. Ultimately part of the Care Quality Commission through Healthwatch England, Local Healthwatch are part of the national scrutiny and assurance system. Healthwatch Birmingham's role is to ensure service design and redesign decisions reflect what patients, the public, service users and carers say they need and want. It is also to assure that service improvement decisions take account of and use service user experience as the focus for continuous quality improvement.

In this context Healthwatch Birmingham undertakes and uses its statutory functions and rights to:

1. Gather the views and experiences of people using health and social care services in order to identify avoidable health inequity. We use this evidence as a lever for service improvement, working cooperatively with decision makers whilst also holding them to account for designing and implementing any changes necessary to resolve the issue.
2. Try and reduce avoidable health inequities at source. We work to improve and assure the effectiveness of patient and public involvement undertaken by health and social care organisations. These organisations are obliged through legislation to ensure patients and the public are at the heart of their decision making and are mandated to reduce health inequity.

In April 2015 the Board of Healthwatch Birmingham commissioned a new strategic plan that would set a clear vision for and guide the activities of Healthwatch Birmingham as it entered its third year of operations. Healthwatch Birmingham undertook several pieces of work to develop this new strategic approach. This report focuses on one element; how we promote and support public and patient involvement in commissioning and providing decisions. It shares the process taken with key stakeholders to identify and test the obstacles, or constraints*, to the effectiveness of the system's capability to successfully engage patients and the public. It describes the insights gained from this process of identifying constraints, and explains how we will promote and support public and patient involvement in commissioning and providing decisions.

* For the purposes of this report and all work we undertake we define the term constraint as any factor that ultimately limits the performance of a system or organisation.

3. The Intervention – A Focus Group

We conducted a large focus group, which was designed to generate new knowledge and understanding of the constraints to effective patient and public involvement, as perceived by participants. The purpose of this focus group was to answer the following question:

> **"If the solution is Healthwatch Birmingham promoting and supporting the involvement of people in the commissioning and provision of health and social care services – what's the problem?"**

That is, if health and social care organisations are obliged to ensure they have sought the views of, listened to, and taken account of patients and public views and experiences of using services as they make service design, redesign and improvement decisions then why is this one of Healthwatch Birmingham's statutory functions? What is it that Healthwatch Birmingham is meant to achieve as a result of promoting and supporting patient and public involvement? And therefore what should it be doing and how should it be doing it?

The hypothesis the intervention was designed to test was as follows:

1. IF Health and Social Care organisations have a statutory responsibility to seek, listen and take account of people's views and experiences
2. AND Healthwatch Birmingham has a statutory responsibility to make sure people's views and experience is sought, listened to and taken account of
3. THEN there must be factors preventing or constraining health and social care organisations achieving their responsibilities
4. And IF Healthwatch Birmingham could work with people to identify those constraints
5. THEN it could work with the system to develop solutions to eliminate or overcome the constraints.

This is illustrated in diagram 1 below.

6. Healthwatch Birmingham and its partners in the system are more effectively achieving their statutory responsibilities. (Go to #1 and #2.).

5. Healthwatch Birmingham could work with system partners to develop solutions to eliminate or overcome the constraints

3. THEN there must be factors preventing or constraining health and social care organisations achieving their responsibilities

4. Healthwatch Birmingham could work with stakeholders in the system to identify those constraints

1. Health and Social Care organisations have a statutory responsibility to seek, listen and take account of people's views and experiences.

2. Healthwatch Birmingham has a statutory responsibility to promote and support the involvement of people in commissioning and provision of local health and social care services.
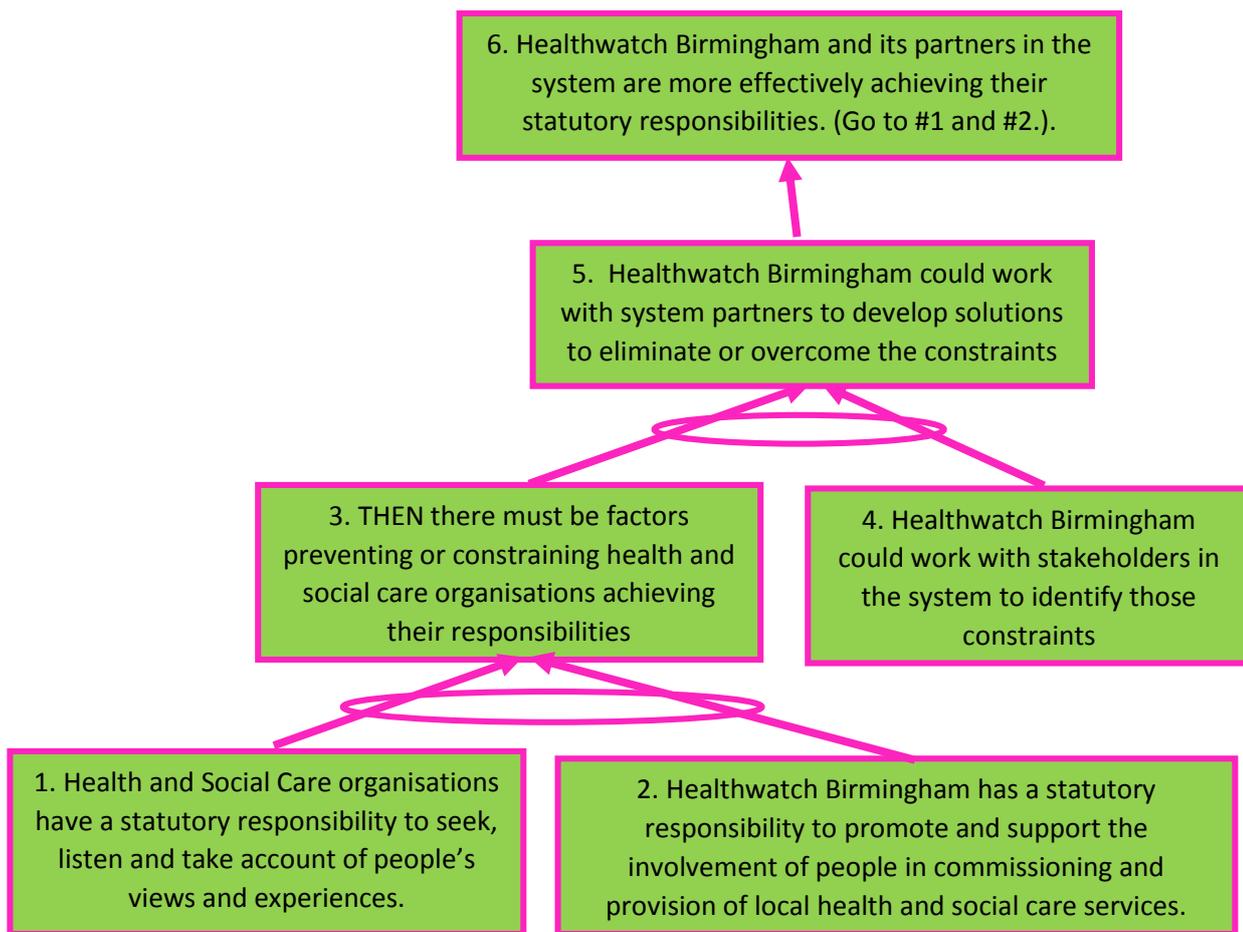
Diagram 1: The hypothesis underpinning the design of the large group intervention.

This meant the focus of effort was on how to achieve entity 5. In order to test assumptions in a way which achieves system confirmation of the existence in reality of constraints and the need to overcome them, we had to have a sense of what kind of assumptions might be being made in order to be able to design an effective intervention to test for their existence.

To do this we referred to the output of previous strategic thinking commissioned by the Healthwatch Birmingham Board. These other work streams focussed on making strategic sense of the other statutory functions which mandated activity: - 'Gather', 'Understand', 'Make known', 'Promote and support', 'Recommend', 'Provide'; but didn't link activity to a desirable outcome.

An output of this other work was a hypothetical map which suggested and linked a series of negative aspects of the current reality of the health and social care system in a public context, through a process of effect – cause – effect, in an attempt to locate and identify the purpose of each Local Healthwatch function.

This map was shared with, scrutinised by, and refined as a result of successive sessions with senior decision makers from the Care Quality Commission, Healthwatch England, Birmingham City Council

Directorate for People, both the incoming and outgoing Chairs of the Health and Wellbeing Board, and has subsequently been scrutinised and upgraded with the Accountable Officers of all three Clinical Commissioning Groups operating within Healthwatch Birmingham's geographical area of operation.

It suggests the following statements are 'true' and provided the starting point to design an intervention in which it might be possible for a group of people to independently and without prompting, produce a similar list of statements. This would enable them to explore the effect of this 'reality' in relation to the political goal to have patients and the public at the heart of health and social care services.

'True' Statements

1. Pressure to reform services in order to meet growing demand and growing complexity of demand with less operating budget is high and urgent. This is true for commissioners and providers alike.
2. A high number of services are being reviewed for design / redesign by different teams at the same time. This is without the complexity of rolling continuous improvement.
3. The people responsible for involving patients, the public, service users and carers are handling multiple projects with small timescales.
4. It is easier and quicker to capture the voices of the patients and public who are already known. The 'loudest' voices get heard.
5. Listening to the 'loud' risks not meeting the needs of the 'quiet'. And…
6. Listening to the 'loud' is tricky to defend to a public who follow what's happening in the health and social care system.
7. Services are changed to improve demand and financial efficiencies.
8. Public and patients do not always not accept proposals. And…
9. It takes a lot of resource to handle complaints and manage loss of public trust.

Two necessary conditions informed the design of and approach to the intervention. To succeed the intervention needed:

1. Participants to be willing and able to think about, identify, and examine their own assumptions in relation to what was preventing the goal being achieved, and expose them to the scrutiny of others. Creating the conditions in which this could be achieved was critical.
2. Insights and findings to be accepted by stakeholders not present. This was necessary in order that any resulting Healthwatch Birmingham strategy be similarly accepted, and for system stakeholders to actively engage and support development of solutions to overcome constraints (assuming constraints were identified).

The two necessary conditions directly informed the design of the intervention:

3.1. The need for a deliberately anti asset-based, assumptive approach that something or some things were constraining effective patient and public involvement. People needed to be thinking negatively
3.2. It was essential that if constraints were identified that they be accepted by system stakeholders. That is, if identified it was always Healthwatch Birmingham's intention to work cooperatively with system partners to develop one or more solutions to overcome the constraints. This meant

a whole systems approach was necessary and rendered the make-up of attendees important to any future credibility of the findings. Invitations were extended by the Chair and CEO of Healthwatch Birmingham to CEO's and Chairs of the three Clinical Commissioning Groups and five Foundation Trusts within the City of Birmingham. Invitations were also extended to senior stakeholders in the Council and other organisations including health and social care community interest companies and charities. Invitations stressed legislative requirement to achieve effective patient and public involvement and that the purpose of the day was to start to co-design Healthwatch Birmingham's strategy. Organisations were encouraged to bring members of the public or volunteers, and Healthwatch Birmingham similarly invited volunteers, past and present, to attend.

3.3. It also led to a decision to ensure people from each stakeholder group were mixed into groups in which they worked for the entire day as opposed to moving people around, i.e. a deliberately anti world-café approach.

3.4. Thinking in terms of identifying and acknowledging constraints can be a challenge for people better versed in taking action to achieve a target. Whilst it can be a very liberating experience to be able to finally acknowledge the reality of a current operating situation, safety is critical. To help ensure equality between participants and safety in groups, an early, deliberate decision was to discourage participants from introducing themselves by the job function and implicit hierarchy. Participants were asked to remove identifying insignia (for examples organisational name badges and lanyards containing security data) and were identified by name badges holding Christian names only. Time was not allowed for personal introductions and groups went straight in to group work to accomplish necessary ice breaking in order to establish early alignment. This was supported with minimal plenary type scene setting, which focussed on strongly emphasising the legislative imperative for ensuring public 'voice' – including from vulnerable and hard to reach groups, is central to decision making.

3.5. The methodology selected borrowed from Theory of Constraints Thinking Processes and Human Systems Dynamics (both Soft System Methodologies) in terms of logical, whole systems approaches designed to build consensus and alignment. In particular from pre-requisite planning, in which a goal is clear but assumes that one or more obstacles, or constraints, are currently standing in the way of the goal and preventing it being effectively achieved.

3.6. Pre-requisite planning entails a number of rules which create the very conditions necessary to test for the existence and identification of constraints to effective patient and public involvement. Establishment and enforcement of these rules of engagement were explained in advance, on screen throughout, and table facilitators – Members of Healthwatch Birmingham's Board and Healthwatch Birmingham's Commissioner from Birmingham City Council, were briefed in advance in order to ensure they were applied. The rules were:

- The thing preventing or constraining you from achieving [the goal] must actually exist, right now, at this moment.
- It must be described in a complete sentence written in the present tense.
- It must be worded in a way which does not imply or allocate blame.
- It must be factual and not subjective or speculative – i.e. evidence if collected would be accepted by stakeholders not present.
- Only ONE obstacle can be described at a time (no 'and' or 'which means' linkages, this implies more than one obstacle)

3.7. On-table discussion ensured each constraint statement was tested, refined and accepted by an entire table group before going through a process of robust peer challenge by one or more neighbouring table groups. These are the statements which would later be compared to the current reality map.

3.8. The intervention designer is experienced in the design and facilitation of large group interventions like these. In her experience when people are asked to think deeply about what may prevent them from achieving what they want, or are targeted to achieve, they can find it liberating that others feel similarly. But there can also be a 'heart sink' feeling; individuals realise that no matter how hard they work, if the constraint exists they will be in a lose-lose situation. It is sometimes the first time people have thought in this way. It is therefore vital that participants realise that the identified constraints are a positive lever for improvement and change. This means the intervention needed a noticeable step-change from constraint thinking to positive resolution creation. Action-thinking – "what shall we do" – is a lot of people's modus operandi. However, allowing groups to move to actions against each constraint would result in the groups considering and treating each constraint as existing separately and individually from others. This is the antithesis of systems thinking, which links constraints into a logical sequence of cause and effect enabling aligned visibility of and focus on tackling the one or two core constraints causing the others.

3.9. Pre-requisite planning is again useful here. The second part of the methodology focuses not on actions but on developing statements of actions already completed - outcomes – against each constraint, before challenging, at an individual constraint level, the sufficiency of that outcome, if it was achieved, in totally overcoming the constraint. And enabling the development of additional outcomes to be achieved if necessary. Psychologically this is moving groups to a more positive future, strengthening buy-in, alignment and consensus. Established rules for this part of the work are:

- For each constraint, agree a statement of actions completed which have overcome or evaporated the obstacle. I.e. Not a statement of actions to be completed.
- Consider the constraint and what has been designed to overcome it – is it sufficient to completely overcome it or must something else also have been implemented.
- Ideas must be worded in complete sentences.
- Each idea, written on a 'post-it' must only describe ONE idea – there must be no 'and' linkages.
- Outcome statements – objectives which have hypothetically been achieved – are paired with constraint statements.

3.10. These positive statements were envisaged as helping make sense of the context and mental models of participants during later analytical phases, which would be looking for similarities of perspectives and consensus across the groups work and comparing amalgamated statements with the original statements from the current reality map.

3.11. Facilitation and moderation therefore focussed on supporting table groups to achieve clarity of expression, consensus and effective peer review on-table and between table groups.

The thinking sessions were planned as:

A. Introductory assumption:

On the basis that numerous legislation mandates health and social care services to ensure patients, the public, carers and service users are at the heart of all changes made in the name of health or social care, let's assume the following statement is true:

"Patients, the public, carers and service users are at the heart of all changes made in the name of health or social care service improvement in the City of Birmingham"

B. Exercise 1 – Starting to understand the assumption:

Is this statement true right now, at this moment, for EVERY service-improvement-in-progress? [Rhetorical].

Has anyone at your table ever contributed their voice to any stage of a service improvement?

Why?

C. Exercise 2 – Starting to challenge the assumption and identify why it is not true from the citizen's perspective.

Everyone in the room is in some way a citizen of the City of Birmingham and, according to policy should be making our views and experiences known to health and social care service decision makers. It should therefore be a true statement for any of us to make the following statement:

"I am at the heart of all changes made in the name of service improvements in the City of Birmingham which are relevant to me or my family".

What's stopping this being true right now? Why are YOU not at the heart of all this?

D. Exercise 3 – Identifying constraints from the perspective of those with a statutory responsibility to achieve effective patient and public involvement.

Assume everyone in this room is someone with a budget and a statutory responsibility to achieve the following legislative goal:

"Patients, the public, carers and service users are at the heart of all changes made in the name of health or social care service improvement in the City of Birmingham"

What's stopping this being true right now? Why are YOU not achieving this goal?

E. Exercise 4 - Developing statements of actions completed for each constraint – developing the outcomes which if achieved would eliminate or evaporate the constraint.

4. Results

Forty-four people attended the focus group from 21 organisations from across the health and social care system. All four main commissioners were represented by senior decision makers (from the Directorate for People at Birmingham City Council, and all three Clinical Commissioning Groups: Cross City, South Central, and Sandwell and West Birmingham), and from a cross section of provider trusts: Mental Health Trust, Community Health Trust, Birmingham Children's, and Birmingham NHS

Foundation Trust. Seventeen people had responsibility for patient or public engagement in their title.

Providing a wider systems perspective were representatives from the West Midlands Clinical Senate and West Midlands Commissioning Support Unit, and from a broader social perspective representatives from Birmingham Citizen's Advice Centre, Birmingham Disability Resource Centre and St Basils as well as a number of other voluntary and community sector organisations.

Most statutory organisations brought members of the public associated with their patient or public engagement programmes. Of those attending more than half (24) personally held statutory responsibilities for ensuring patient or public voice is central to their service decisions, the remainder were there in a lay or public member capacity. Demographic data was not collected, however three young people and 3 wheelchair users attended.

On the whole the methodology worked well, a reflective piece not included here describes lessons learned and how such a session could be improved in the future. Group work was energetic and focussed, every participant contributed and feedback on the intervention was positive.

4.1. Constraints to effective public and patient involvement

Forty-five constraints were identified by all six table-groups. Every constraint was paired with one or more outcomes, which if achieved the respective group felt would evaporate or eliminate the constraint. Each table group fully shared their constraints and outcomes with a least one other table-group in a process of scrutiny, and used challenges to further upgrade the sense, logic or sufficiency of their work.

Five of the constraints related to externally driven deadlines; imposed by people to whom they reported and over which they had no control. These constraints described the felt pressure of

those responsible for engaging with patients or the public, in terms of deadlines and tight timescales within which they were expected to work and which didn't appear to be negotiable.

"External deadlines frustrate our ability to involve people"

"If I don't contribute to the deadline they will move ahead anyway"

"I have to deal with too much red tape to move quickly enough to involve everyone"

Participants wanted outcomes that enabled them to challenge and renegotiate deadlines. One group felt that to do so would be a "contribution in itself"

Nine constraints were intensely debated between table-groups, which was about not needing to involve people if the service change was "not significant enough", also "I don't have to, and because even if I have to, what I have to do is quite flexible". One particularly intense debate focussed on one individual fervently believing they were "already doing it effectively" and "didn't understand why he had to change what (I) have been doing for years".

The debate discussed the dilemma between target driven involvement and values driven involvement. This was a theme that was variously picked up during the course of the day by all groups. Summary discussion at the end of the day resulted in consensus that values based targets based on outcome would eliminate the input / output 'tick box' targets currently in place, which were open to subjective interpretation.

"What gets measured gets done - are we really measuring what really matters?"

"I don't always remember that patients and the public are at the heart of our service decisions"

Budget was an unsurprising theme discussed by three groups:

"I don't have enough money"

"I don't have sufficient resources or budget to do any more public involvement"

What was surprising is the richer picture provided by the paired desirable outcomes. Whilst participants talked about finding ways to "do it cheaper" and simply ticking the box, they also felt it was desirable to re-prioritise resources within an organisation, even working across organisations to find commonality. Public or patient engagement typically sits as a responsibility in a team. It is 'silo'd off rather than integral to a values driven way of working across organisations: "I am afraid of investing in a system which doesn't work" and the earlier quoted "if I don't contribute to the deadline they will move ahead anyway". Budget aside this feeling of being silo'd became a theme:

1. "Service priorities keep changing - I can't keep up"
2. "My accountability goals sometimes conflict with my other partners to disenable multi-agency working (internally as well as externally)"
3. "I can't influence the decision makers"
4. "I am constrained by the silo that surrounds my involvement work"
5. "We commission in isolation according to diagnosis as opposed to individuals' needs"

These were evaporated by "there has been a change in culture to support coproduction" and "I have co-produced what we are commissioning (in terms of public consultation) in the first place".

One interesting debate around one constraint "I don't know how to get the public involved in service improvement" confirmed earlier consensus regarding clarity of what 'good' looked like. Specifically, not just in terms of how to achieve 'good', but also how 'good' should be measured and by whom. That is, there is no measure for quality.

Discussions like these, for many groups, lead naturally to the notion of being able to tick a box, with seven constraints relating to this conceptually, from the earlier quoted "I don't have to and even if I have to what I have to do is very flexible" to "I don't ask the public because I have people who complain a lot and can just ask them", "can't ask everyone...so I end up compromising (from the outset)".

The final theme to emerge was around working with the public themselves. There were two aspects to this theme, one caused by the needs of the system to behave in a certain way as discussed above, and the other the needs of the public, and the lose position this entailed: "service requirements change by the time improvements are implemented, the public keeps changing its mind so I don't keep asking", "I might let the people down", "the public will want to ask for other things", and "I don't know how to (defend our decisions)".

One group summarised the whole situation and agreed the following statement, which they had scrutinised by two other table-groups who also agreed it as true:

"We avoid consultation because of the unrealistic resource requirements of the solution desired and the lead in times are too short. If not they are too long and the environment changes. Feedback from the public is challenging and we can't do everything which might come back because we are resource limited".

5. Discussion

The intervention was designed to elicit and test for factors constraining those with statutory responsibilities to seek, listen to and take account of patient and public views of health and social care services.

The strategic purpose of the intervention was to start to develop a sense of what Healthwatch Birmingham should be doing in order to meaningfully discharge its statutory responsibility to promote and support people in commissioning and provision of health and social care services. That is, to bring benefit the health and social care system rather than just undertake activity.

Forty-five constraints were identified by 44 people working together in six groups. The results show the sense of commonality of issues being raised and discussed by the groups. These constraints are left un-summarised to preserve the quality of the data. That said, the purpose of the intervention was to identify constraints which Healthwatch Birmingham could use its position to improve.

The introduction of this report indicated that some additional work has been undertaken by Healthwatch Birmingham to locate its statutory functions. A map of the current reality had revealed a number of undesirable aspects operating to confound effective patient and public involvement. Part of the intervention was to test the assumptions underpinning the effect-cause-effect linkages. The statements are repeated here with the evidence from the intervention. Note the first statement

is not included. It relates directly to Health and Social Care Reform, which is outside the realms of possibility for mitigation. How we respond to reform however is a choice made by the system.

Initial statement	Nature of constraint in relation to the goal	Evidence from focus group?
Pressure to reform services in order to meet growing demand and growing complexity of demand with less operating budget is high and urgent. This is true for commissioners and providers alike.	There are too many individual projects in our workload that require public input for all of them to be worked on them effectively.	Yes. Perception of this pressure was the felt reason for the short timescales and narrowness of specifications, which aimed to facilitate speed.
A high number of services are being reviewed for design / redesign by different teams at the same time. This is without the complexity of rolling continuous improvement.	As above.	Yes. Participants talked about duplication and competition between teams and across organisations and the number of concurrent projects at any one time all seeking to get public opinion.
People responsible for involving patients, the public, service users and carers are handling multiple projects with small timescales.	As above.	Yes. See both above points.
It is easier and quicker to capture the voices of the patients and public who are already known. The 'loudest' voices get heard. Listening to the 'loud' risks not meeting the needs of the 'quiet'. And…	There is no quality standard.	Yes. Participants clearly linked this firstly to the need for speed, and secondly because they could. I.e. no quality measure prevented this so even if there is an awareness of insufficiency, it is over ridden by the need for speed.
Listening to the 'loud' is tricky to defend to the public who do follow what's happening in the health and social care system.	There is no quality standard.	Yes. Participants discussed the difficulty of managing patient and public expectations and how this often made them feel as if they were in a lose-lose situation. Lose if you do raise your head and lose if you don't.
Services are changed to improve demand and financial efficiencies.	Quality of public contribution is not specifically and inherently part of decision making.	Yes. A very definite sense that the needs of the service would proceed inexorably with or without their work, adding to the pressure to meet deadlines.
Public and patients do not accept proposals.	There is no quality standard.	Yes. Groups described the firefighting aspect of their role

		caused by public frustration in consultation colouring their behaviour in the next consultation.
Time required to handle complaints and manage loss of public trust increases.	There is no quality standard.	Yes. See above point.

6. Next steps

As a result of this and other aspects of its work, Healthwatch Birmingham has developed a new strategic approach. The work reported here fully informs this approach. We set out to discover why Local Healthwatch were mandated to promote patient and public involvement in commissioning and providing decisions, but didn't understand the purpose of this function in Birmingham.

Our work before and during the intervention seems to confirm existence of a number of unintended consequences of not effectively engaging with the public. These avoidable health inequities are caused by a number of factors constraining effective engagement. Of these the absence of any kind of quality expectation or measure has been discussed with the three CCG Accountable Officers and senior decision makers in Birmingham City Council. Work is underway to develop a series of projects which will result in a coproduced quality standard in Birmingham which will be designed to specifically overcome each constraint. This ambition has been discussed with and has the support of Healthwatch England and NHS England.

Organisation and individuals interested in participating in this work should contact Healthwatch Birmingham in the first instance.

7. Resources

7.1. <u>Policy documents requiring one or more aspect of public or patient engagement or involvement:</u>

The NHS Constitution

The NHS Mandate: A Mandate from the Government to the NHS England (2012)

Equity and Excellence: Liberating the NHS (Dept. of Health) (2011)

NHS England Business Plan "Putting Patients First" (2013)

Everyone Counts: Planning for Patients (2013/14)

Developing Clinical Commissioning Groups: Towards Authorisation (2012)

CCG Assurance Framework – outline proposal and interim arrangements (2013/14)

The NHS Outcomes Framework (2013/14)

Healthy Lives, Healthy People White Paper (2011)

White Paper: Equity and Excellence: Liberating the NHS (Dept. of Health) (2010)

The Power of Information – putting all of us in control of the health and care information we need (Dept. of Health) (2012)

NHS Patient Experience Framework (Dept. of Health) (2012)

Principles of Consultation Guidance (Government) (2012/13)

Equality Act (2010), including the Public Sector Equality Duty.

Local Government Act (1999)

Creating Strong, Safe and Prosperous Communities; Statutory Guidance (2008)

Revised Best Value Statutory Guidance (2015)

Health and Social Care Act (2012)

7.2. <u>Statutory functions of Local Healthwatch:</u>

Gathering the views and understanding the experiences of patients and the public and

Making their views known in order to bring areas for improvement or celebration to the attention of commissioners and providers.

Promoting and supporting the involvement of people in the commissioning and provision of local health and social services and how they are scrutinised in order that services meet needs and expectations.

Recommending investigation or special review of a service via HWE or directly to the CQC in order to public-lead experience is taken seriously to inform quality improvement.

Providing advice and information about access to services and support for making informed choices in order patients, the public, services users and carers understand their constitutional rights.

Making the views and experiences of people known to Healthwatch England and the Local Healthwatch network, and providing a steer to help it carry out its role as national champion in order to work together as a network for national patient and public-lead service improvement, learn from each other and reduce duplication of effort.

Local Healthwatch have a seat on Health and Wellbeing Board and rights to Enter and View.

7.3. <u>Acknowledgements</u>

We are most grateful to the staff, lay members and volunteers of the following organisations who went to great lengths to think differently about a set of deeply embedded issues. Without their effort and contribution, and willingness to challenge and be challenged by groups of their peers and by the public, this report could not have been written:

Directorate for People Birmingham City Council

West Midlands Strategic Clinical Network and Senate

Sandwell and West Birmingham CCG

Birmingham Cross City CCG

Birmingham South Central CCG

NHS Midlands and Lancashire Commissioning Support Unit

Birmingham Community Health NHS Trust

Birmingham NHS Foundation Trust

Birmingham and Solihull Mental Health Services

Birmingham Children's Hospital

BVSC

St Basils

Witton Lodge Community Association

Birmingham Disability Resource Centre,

Birmingham Citizens Advice Bureau Service

Freshwinds

Merlin Venture

Princes Trust

Nishkam Civic Association

Princes Trust

Healthwatch Birmingham

7.4. <u>About the author</u>

Candy Perry is Interim CEO to Healthwatch Birmingham advising the Board and leading the staff team through a process of transformational change. Candy has held positions as Executive Director of National Childbirth Trust where she designed and lead transformational change programmes for the charity's trading company and separately its commissioned services operation. Before this Candy was Director of Communications and Business Development for Education for Health where she conceived, developed and led the charity's business to business operation. More recently Candy set up Concinnity Consultancy and Research Ltd to provide consultancy, coaching and training in whole systems change and performance improvement in complex service operations, working primarily with third and public sector clients. She completed an MSc in Whole Systems Improvement in Health and Social Care with Distinction from Nottingham Business School's Centre for Lean Improvement in early 2014 and in 2015 completed accredited Focus Group Training with the Market Research Society. Passionate about the lever for service improvement which effective lay involvement potentially represents, Candy is one of three Public Members of the Board of Trustees of the Institution of Occupational Safety and Health (IOSH) where she is also Chair of the Risk Management and Audit Committee; one of two Lay Members of the National Institute for Health Research (NIHR) Health Services and Delivery Research Board; and for Healthwatch Birmingham is a member of NHS England's Working Group for Patient and Public Participation in Primary Care.

7.5. <u>For more information</u>

Information relating to the work of Healthwatch Birmingham is available on the website at www.healthwatchbirmingham.co.uk or by email to info@healthwatchbirmingham.co.uk or you can call us on 0121 636 0991.

Information on the work of Healthwatch generally, including our national work with and through Healthwatch England visit www.healthwatch.co.uk.