healthwatch Doncaster

Stakeholder Survey Executive Report 2015

1. INTRODUCTION FROM THE CHAIR

On behalf of the Board of Healthwatch Doncaster, I would like to commend this report to you. It is the result of a great deal of hard work by staff and volunteers, with particular gratitude to Philip Kerr and Mark Bright. We are committed to taking the positive and negative points raised by the survey and using them as the basis for improving the service we deliver to the citizens of Doncaster. We will build on our successes and work hard to address weaknesses.

We believe that the report is intellectually robust having been independently verified.

The next year is vitally important to Healthwatch Doncaster, as we become a social enterprise and set sail as a fully autonomous and independent organisation. We need to take our members, volunteers and stakeholders with us on the journey and I look forward to next year's report to benchmark our progress.

2. FRAME OF REFERENCE

Sections 2 to 7 here cover process and data analysis tasks, plus writing-up of analysis, findings and conclusion. These were activities undertaken and completed by Mark Bright, Ph.D. in the capacity of Independent Survey Co-ordinator. Readers wishing to gain an overview on findings may want to consult section 7 first, before reading the document in full. The next six sections describe the activity of administering and analysing the results of a stakeholder survey, on behalf of Healthwatch Doncaster (HWD), which Doncaster Metropolitan Borough Council (DMBC) wished to be undertaken by the end of 2015. The original DMBC questionnaire, on which this survey is based, required some re-design. The re-designed survey retains the spirit of the fundamental questions posed, while adapting answer formats and rating scales to several questions. It was also important to ensure neutrality in the wording of questions to minimise possible biased responses.

As this was the first administering of the re-designed questionnaire, it was decided to pilot the survey with a modest number of stakeholders (n=50). In consultation with the Lead Development Officer, there may be plans to distribute the same survey to a greater number of stakeholders sometime next year – although no commitment is in place for that as yet. The greater a response rate is from a larger pool of stakeholders, the more robust our findings can be.

Therefore, this pilot survey mostly serves to tease-out some initial baseline data, from a small number of stakeholders, which we can work from going forward. This pilot survey's general purpose then is to broadly appraise what external stakeholders currently feel about HWD and its role in the local area – as of December 2015.

3. THE PROCESS

The HWD Pilot Survey Form was produced as an Excel spreadsheet. The survey was distributed to 50 external stakeholder contacts (via email attachment) during October 2015. An external stakeholder, for the purposes of this report, is an organisation that engages in partnership work with, or has some involvement or connection with, HWD. The Pilot Survey seeks views from 'external stakeholder contacts' (meaning: a named representative of that stakeholder organisation) exploring questions/dimensions such as:

a. What do stakeholder contacts know of HWDs activities?
b. How visible is HWD as an organisation in the Doncaster locality?
c. What level of involvement does the stakeholder organisation have with HWD?
d. How effective is HWDs activities, from the stakeholder contact's viewpoint?
e. How effective does the stakeholder contact believe HWD is in sharing information and signposting?

Survey Forms were emailed out to the 50 contacts on HWDs external stakeholder list on Monday 12th October. A closing date of Friday 30th October was stated in the supporting email message. Initially this resulted in 4 completed surveys being returned. Therefore, on Tuesday 20th October a first reminder email message, with attachment, was sent-out to the 46 contacts yet to reply. This first reminder generated another 6 completions. As a result, a final reminder email message, minus attached survey form, was sent-out to 40 contacts yet to reply on Tuesday 27th October. The result was another 7 completions being returned, plus 2 respondent who did not return a completion but stated a reason for non-completion (as invited to from the final reminder email message). On the closing date of Friday 30th October, a thank you email was sent by the Independent Co-ordinator to the 19 respondents who had engaged with the survey.

From the survey distribution to 50 external stakeholders, 17 survey completions (response rate: 34%) were successfully returned and able to be analysed. In addition another 2 respondents gave a valid reason for non-completion, leaving 31 who did not respond to the survey (other than a return of a read receipt).

4. THE RETURNS (AND POST-RESULTS WORK)

The data (of each respondent's response to individual survey questions) was logged into an Excel spreadsheet file, as returns came back. Returns were analysed to gain both a quantitative and qualitative perspective on how Healthwatch Doncaster is perceived by external stakeholders. An inductive coding process was applied to respondents' textual comments to establish emerging patterns in the data.

For the purpose of this document, results in the next two sections are presented in two perspectives. Rather than attempt to integrate the qualitative and quantitative it has been chosen to present them as separate components.

Section 5, utilises a unique respondent number system – from 1 to 17 – within square brackets to show where different participants are referenced. In Section 6, where needed, respondent numbers followed by a hyphen and organisation of which the responder is a representative are placed in square brackets. This method of reporting results, strikes a balance between ensuring anonymity of respondents' individual identities, while illustrating reference to different people and representative bodies.

5. RESULTS SUMMARY – Part 1: Quantitative view

5.1 Stakeholder Representation

To the question "Which body do you represent?" all 17 completers stated a response. In total, 6 of the 17 responders represented the DMBC. CCG, NHS Provider, Safeguarding, Other category had 2 responders for each, with NHS Commissioner, Local Authority Commissioning, and Voluntary Services Organisation having 1 responder each.

5.2 Where HWD is strongest

Three questions aim to evaluate how visible and approachable HWD is to stakeholder organisations. These questions are:

Q3. Do you know how to contact Healthwatch Doncaster? [YES/NO]
Q5. Would anything put you off contacting Healthwatch Doncaster? [YES/NO]
(Q5b. Additional comment to anything putting you off) [Text]

When evaluated together, this shows very strong results for the basic visibility and approachability of HWD. The data shows that basic visibility of HWD amongst the stakeholder responders was very high. This is evidenced by 14/17 stating YES to Q3. A fifteenth person intimated YES (by deleting NO and leaving the YES option visible). As this person did not follow the instructions given it is problematic to state it as a YES response, but it is highly probable to be so. Two individuals gave NO ANSWER. No one said NO to Q3. Basic visibility is reinforced by 13/17 individuals stating NO to anything putting you-off contacting HWD. No one stated YES to Q5. No barriers to engagement with HWD were promoted by responders. All 17 people left NO COMMENT to Q5b – hence suggesting nothing puts them off contacting HWD if they needed to.

Based on a limited response rate, there is **very strong agreement** with the statement in Q11 option a: "HWD priorities are based on needs and concerns of residents, service users and patients." (n=16/17 stating mostly agree or higher; 94.1%). Across the respondent comments 13 instances of respondents explicitly referencing the factor "to represent a community voice" was found. Nine of the seventeen responders [1, 2, 7, 8, 10, 11, 12, 15, and 17] mentioned that word "voice" in their response to Q2: "What do you believe the purpose of HWD is?". Championing was used as a word preceding various orientations, whether to champion "…the patients' voice", "…rights", "…the consumer", or, "…campaign for change" in the case of four individuals [2, 3, 7 and 16]. Representing was used to orientate "the patients' voice" and "public opinion" in general,

but also for specific community groups, i.e. "vulnerable people". Collecting stories (or variant of stories by talk of experiences) and leveraging those stories to influence change featured across six returns [3, 5, 6, 8, 10, and 12]. Complaints Advocacy [10, 11 and 13] and Signposting [5, 6 and 11] were identified by at least three respondents each.

A **very strong** verdict also applies to four areas. These are Q7 option d: "How well HWD performs in its relationship with your organisation." (n=15/17 stating at least well or better; 88.2%), Q11 option b: "HWD priorities compliment Health and Wellbeing Strategy priorities." (n=14/17 stating mostly agree or higher; 82.4%), Q11 option d: "HWD priorities compliment local authority priorities." (n=12/17 stating mostly agree or higher; 70.6%), and, Q7 option b: "How well HWD performs helping improve Health and Social Care Services." (n=12/17 stating at least well or better; 70.6%).

5.3 Where HWD retains a degree of strength

Two areas can be said to be **moderately strong** from the pilot survey. These are Q7 option a: "How well HWD performs serving local residents, service users and patients" (n=11/17 stating at least well or better; 64.7%), and, Q11 option c: "HWD priorities compliment CCG priorities." (n=11/17 stating mostly agree or higher; 64.7%).

5.4 Areas to improve for HWD: Evident weaknesses

Three areas display **evident weaknesses** relative to preceding statements. These are Q7 option c: "How well HWD performs as representative on the Health and Wellbeing Board." (n=9/17 stating at least well or better; 52.9%), Q11 option e: "HWD priorities have strong evidence-based priorities." (n=9/17 stating mostly agree or higher; 52.9%), and, Q11 option f: "HWD priorities are decided in an open and fair manner." (n=9/17 stating mostly agree or higher; 52.9%).

5.5 Where results are nuanced for HWD

All 17 survey returns reflected one of two answers to Q9: "How often does HWD keep your organisation informed?" – suggesting everyone was being kept informed. In terms of frequency, 12/17 stated they were kept informed "Often". The remaining five respondents were "Occasionally" kept informed.

Again, for Q8, all respondents stated the "strength of HWDs relationship" with their organisation. In total, 11/17 responders stated their status for this relationship as being "Strong", with 5/17 saying "Variable", and one respondent saying "Not Sure".

Results varied on the subject of external stakeholders' verdict on HWDs reputation (Q6). All completed surveys had an answer for this question. No one stated "Poor", yet responses were distributed across the other 4 answer options as follows: "Excellent" (n=2); "Very Good" (n=6); "Good" (n=6); "Fair" (n=3). Another way to view this result is

that 14/17 stated the reputation of HWD as being at least "Good", with the caveat that only 2/14 are categorised as "Excellent".

When asked at the conclusion of the survey (Q16) whether the respondent wished to be kept informed of HWDs work, 5/17 either gave no answer, or no clear answer. Of the remaining twelve, eleven stated "Yes" they would like to be kept informed.

Perhaps the most divided result is reserved for question of "Changes attributable to HWD for your organisation" (Q13). All respondents offering a returned survey form completed this question. In total, 5/17 stated "Yes", 5/17 stated "No", and 4/17 stated "No Answer". Of the three remaining, 1 marked "Not sure", and two are effectively invalid completions (using an 'x' to overtype Yes or No, instead of underlining). This digression from the instruction, implied in one case "Yes", and in the other "No" – although we cannot be certain this interpretation accurately reflected their thought process.

6. RESULTS SUMMARY – Part 2: Comment-based themes

6.1 Stability and Reputation

A set of views from CCG representatives indicate in the past, too many changes have resulted in lack of stability. As a consequence reputation of HWD is seen as ultimately suffering. These views were articulated in the following ways:

> "Healthwatch has been through a period of turmoil…" [2-CCG]
>
> "…the reputation has suffered in the past because of the many changes." [1-CCG]
>
> "…there is perhaps still work to do to convince all partners of the ongoing stability of the organisation…" [2-CCG]

Despite this view, there were indicators that the future offers a more stable platform:

> "A period of stability which seems to now be happening." [1-CCG]
>
> "The impact [of HWD] will grow now that the organisation has direction and stability." [1-CCG]

6.2 Issue of presence

There are several options suggested to improve perceived reputational damage. The most frequently single cited issue is to "become more visible" [5, 7, 9, 11, and 8 twice] through measures to increase presence, as:

> "I'm not sure many people know what Healthwatch is and what it does." [5-DMBC]
>
> "I think more needs to be done to raise the HWD profile with the general public." [11-DMBC]
>
> "…greater public awareness and profile [is needed]." [7-DMBC]

Communicating and publicising "what a difference" Healthwatch has made is seen as a measure to increased presence [3, 8, 15, and 6 twice]. Involving volunteers in patient-led assessment of the care environment [12] is viewed as another means of increasing presence, typified by comments such as:

> "By getting more proactive in communicating just what a difference it has made." [3-Local Authority Commissioning]

> "…publicise where it's made a difference." [6-NHS Commissioner]

> "…celebrate and share good news or local success stories." [8-DMBC]

HWD are represented on various strategic bodies. Therefore 'visibility and presence' in this sense has a strategic level meaning, rather than an impact out in the local community. Representation can be active (as in the first quote) or more passive (second quote):

> "The Doncaster Safeguarding Adults Board is benefiting from the work of the [HWD] Keeping Safe Forum, which is very much supported by the Board with raising awareness of adult safeguarding…" [10-Safeguarding Adults Board]

> "HWD are represented at Governing Body, Engagement and Experience and the Management Group." [1-CCG]

6.3 Positive change is being witnessed

The good news is that evidence from stakeholder respondents to this survey explicitly raises the point (in one way or another) that "improving reputational position is occurring" with a further respondent stating "to improve your reputation continue as you are" (n=9/17):

> "The new leadership is really driving the organisation forward and we can see real changes." [2-CCG]

> "Definitely going in the right direction…" [3-Local Authority Commissioning]

> "I've seen lots of changes in the last year and really starting to take shape." [5-DMBC]

6.4 Increased Board-member level engagement

While some respondents felt no communication improvements were required (in terms of the question: How effectively does HWD communicate with your organisation?), there was call for greater Board member-level engagement/meetings. Five respondents in particular mentioned this factor, here are three examples:

> "We used to have formal meetings with relevant Board members which helped us to align areas of project work and share our strategic plans – this would be very useful." [2-CCG]

> "Quarterly strategic relationship meetings…look to create a wider consensus." [7-DMBC]

"Share what is happening at a higher level in timely ways." [8-DMBC]

Five respondents felt "no improvement to HWDs communication with your organisation was required.

6.5 Promotion of strategic priorities

There is a mixed picture on the subject of "HWD strategic priorities". Five respondents commented on this factor, raising nine distinct points from their comments. Six of these points articulated visibility of strategic priorities around "collecting patient stories, signposting, and complaints advocacy work". The other three points noted "HWD strategic priorities not being visible to me", exemplified by:

"I don't know how the priorities for Healthwatch are decided." [5-DMBC]

"Decision-making is not something I have exposure too, so find it hard to comment." [12-NHS Provider]

Yet, strategic priorities are revealed through at least two forums:

"…from seeing joint work…both at Healthwatch and events." [4-Voluntary Services Organisation]

"Minutes/decision-making is available for public to view." [6-NHS Commissioner]

The respondent's position in the organisation, i.e. junior, might be a factor here – if we were to (cautiously) speculate a reason for this phenomenon.

6.6 Community impact – Type and Scope

Outreach with local communities, holding services to account, engaging with patients, giving communities a voice, and helping raise concerns about services were the prime impacts HWD was perceived as making. These are tangible impacts. A minority of comment statement centred on 'intangible impacts', such as HWDs existence being a "reassuring sign", "having positive influence", "offering a promising start" or, it's organisational culture being "pleasant, friendly and approachable" for both the public to interact with, and to obtain information from. In terms of community impact then:

"HWD goes out and talks to communities." [1-CCG]

"Engagement with patients and the public" [2-CCG]

"Beginning to give communities a 'voice'" [13-Charity]

Despite HWD appearing to make a difference in the aforementioned areas, there is some evidence they have limited scope for impact. Four respondents explicitly thought the size of impact was small, depicted in the comments "small, but in keeping with its

resources" [5-DMBC], 'small, given difficult start for the organisation' [10-Safeguarding Adults Board], 'limited with public – depends on public awareness' [11-DMBC], and, 'small, given size of membership and Doncaster's population' [12-NHS Provider].

Four respondents were direct enough to comment that they could not comment on what difference HWD had made. The reasons given ranged from one who "…couldn't say for sure" [8-DMBC], two cases where respondents were "new to my role" [7-DMBC, 9-Club Doncaster Foundation], and, an intriguing point suggesting an 'increase in volunteers being witnessed, so there must be an impact' [8-DMBC].

6.7 HWD impact on stakeholder organisations

There was a second question of impact explored however. Respondents were questioned on how HWD had specifically impacted on their (the stakeholder respondents') organisation. Nine response comments in the survey provided a 'specific to our organisation' impact. Such responses were diverse and ranged from 'development of health and social care agenda on our website' [2-CCG], 'provided feedback on the Adult Social Care Local Authority' [11-DMBC], "work with engagement group of the SAB" [17-Safeguarding Board], "assisting in volunteer recruitment" [13-Charity], and two who felt "Safeguarding and Keeping Safe Forum work" [3-Local Authority Commissioning, 10-Safeguarding Adults Board] had an impact for them, to more generic aspects, like a result in an "excellent supportive network" [13-Charity], "enabling joint working" [4-Voluntary Services Organisation], and, "more people having input in their projects" [4-Voluntary Services Organisation].

6.8 Building on partnerships

On the subject of how their organisation could help HWDs work over the next 12 months, answers were again diverse – I guess given that different stakeholders have different-types of engagement relationships with HWD. "Sharing strategic priorities" and "more data sharing" where work areas are in alignment between the two organisations was broadly witnessed as important from analysing respondent comments. In terms of "more data sharing" this covers "patient experience data" [1-CCG], "joint discussion on our care and services" [15-NHS Provider], and any data/information sharing that might pertain in the area of "providing access to Best Practice Projects Care Homes" [13-Charity], or "monitoring and assessing HWDs effectiveness around engagement policies" [17-Safeguarding Board].

6.9 Reasons stakeholder organisations contact HWD

Under circumstances where your organisation would contact HWD a number of different activities were involved (which seemed dependent on the type of transactional relationship between HWD and the respective organisation). Partnership work, HWD giving advice, general support, requesting and receiving information, information gathering, and reporting experiences/stories featured in each case three times or more.

In the case of "Partnership work", this factor is explicitly referenced eighteen times by 9 respondents [2-CCG, 4-Voluntary Services Organisation, 5-DMBC, 8-DMBC, 9-Club Doncaster Foundation, 10-Safeguarding Adults Board, 12-NHS Provider, 13-Charity, and, 14-DMBC], such as:

> "…gain a better appreciation for where closer partnership working could be made." [8-DMBC]

> "Increasingly work in a mutually supportive partnership with Healthwatch Doncaster." [10-Safeguarding Adults Board]

> "Continue and improve current working/partnership working." [14-DMBC]

There were also unique modes of engagement too, i.e. 'work on quality assurance standards' [6-NHS Commissioner], 'contract management and delivery' [14-DMBC], and even 'surveillance' [12-NHS Provider].

6.10 Maintaining links with HWDs stakeholder network

The results for all 17 respondents to the final question (about whether the respondent wished to be kept informed of HWDs activities) offered both numerical and qualitative insight. It showed six stating they were already "on the contact list", another six left either their name and email address, or name, email address and telephone number. For the remaining five, no contact details were stated.

7. CONCLUSION

A small group of 50 stakeholder respondents were sampled for this pilot survey, of which 17 individuals returned completed questionnaire forms – giving a response rate of 34%. HWD is grateful for the time stakeholders have taken to consider and reply to this pilot survey. Despite too few a number of respondents to be conclusive about any patterns, indicative points of strengths, along with areas for improvement, are revealed. These insights will facilitate HWD as they progress their future. In conclusion, the main points discovered are:

Work to further increase HWDs profile with the Doncaster public is broadly viewed as one area being needed. Presence through partnership work and HWDs representative role on various boards is giving the organisation visibility with external stakeholders, beyond the public, though (see: 6.2). Nine responses in the survey promote a specific impact of HWDs work on stakeholder organisations (see: 6.7). A proportion of respondents commented on how HWD could work with them over the next 12-month period (see: 6.8). As a factor partnership work, and its general successful outcomes, came out very strongly (see: 6.9). Given the option, no respondent stated a wish to not be kept informed of HWD news updates, by being removed from HWDs contact list (see: 6.10).

There is evidence to show HWD appears to have experienced an initially tough formative period in the previous 2 years (see: 6.1). It seems to now be on the way to

finding its place in the community. New Board appointments and operational priorities and work are leading to positive changes being witnessed (see: 6.3). Some survey respondents stated how it would be helpful to have meetings with Board members in the future, to cover certain issues (see: 6.4).

Communication of strategic priorities takes place in various forums (meetings, events, the Annual Report, etc.). Despite this, a minority of respondents felt strategic priorities of Healthwatch were not visible to them (see: 6.5).

Simply having a local Healthwatch in Doncaster has important symbolic value. It is the organisation designed to champion the patient/public voice on health and social care matters. HWD is perceived as making a difference in its community outreach role, engaging with the public and holding services to account. One of HWDs strengths is the pleasant and friendly environment cultivated by front-line personnel. It performs this duty in the context of limited resources (see: 6.6). Given it is a small organisation, catering potentially for the entire population of Doncaster, scaling-up its impact could necessitate increased investment.

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Should you have any feedback to offer Healthwatch Doncaster as a result of reading this report, please contact Philip Kerr (Lead Development Officer) at philip.kerr@healthwatchdoncaster.org.uk

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