DISCOVERY REPORT

Prepared for the Steering Group undertaking a review of Healthwatch Leeds and a future ‘independent voice organisation’.

Written by Sue Hoey
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1. Background

In July 2025, the Dash review, commissioned by the central government, recommended the closing of Healthwatch England and the local Healthwatch network. It proposes separating the health and care engagement functions and bringing them within the responsibility of local Integrated Care Boards (ICBs) and Local Authority social care, respectively. Ending the statutory provision of local Healthwatch and Healthwatch England requires legislation, as yet to be published, but with a draft anticipated during Spring 2026.

In December 2025, the Leeds Health and Care Partnership Leadership Team (PLT) agreed a review process. The Partnership Leadership Team is the group of health and care chief executives from the major health and care organisations in Leeds. The review has been overseen by a Steering Group, comprising representation from all key health and care partners with direct authority from their organisations. The Steering Group's remit is to consider the strengths of Healthwatch Leeds, how the city currently listens and acts on feedback and the codesign of a new 'independent voice' model, including how any model might be resourced.

An independent consultant was commissioned by Healthwatch Leeds to undertake a listening exercise, with the purpose of:

- Understanding and articulating partners/key stakeholders and the public's current experience of Healthwatch Leeds - what they value and what could be done differently.
- Understanding and describing what characteristics and functions people would want to see as part of a future independent voice organisation in the city.
- Providing insight to help inform the codesign of a future independent voice model, by ensuring it is built around what currently works well and what stakeholders and the public need and want from a future model.

This discovery report outlines the findings of:

- ➢ 17 semi-structured interviews involving 23 senior leaders across Leeds (March - April 2026).
- ➢ Three workshops involving 26 people, one with Third Sector staff, one with young people involved with Youthwatch, and another with Involvement Leads from the Public and Third Sectors (March 2026).
- ➢ 324 responses to a public survey developed and circulated by Healthwatch Leeds (January to March 2026): 215 members of the public, 38 voluntary/community sector workers, 34 health or care provider or commissioner workers, 15 Healthwatch Leeds volunteers, 21 others.[1]

The phraseology and wording used in this report are a repetition of the phraseology and wording used by participants in the process, which was clustered but not coded to avoid losing the nuance of particular phrases (apart from with survey questions due to the volume of responses). It has been ordered and synthesised to bring structure, with additions made to bring coherence, but broadly speaking, it hasn't been interpreted. For the most part, the earlier in a paragraph wording occurs, the more it was referenced by participants. Verbatim quotes are reported in quotation marks - all remain unattributed to preserve anonymity.

It is important to highlight that, particularly in interviews, what was shared throughout this work are individuals' opinions and are not necessarily always factually accurate. They are based on their particular position within the system, their level of familiarity with both Healthwatch Leeds, their own organisational position and interests, the wider people's voice landscape in the city and also personal lived and learned experiences. This means that differing and at times contradictory perspectives have been expressed. Care has been taken to include the breadth of these opinions, not just focus on the points most commonly heard.

[1] See Appendix One for a breakdown of characteristics of survey respondents.

2. Introduction

This report has been shaped by a simple but consistent message heard across interviews, workshops and the public survey: in Leeds, we start with people. This is not an abstract principle but something which is being centred and worked towards, both within the city's health and care system and more widely. It is acknowledged that the leadership and practice of Healthwatch Leeds have significantly contributed towards this. There is an expressed desire amongst senior leaders within the city to work towards greater centring of people's lived experience and voice in the design and delivery of health and care services in the broadest sense, encompassing neighbourhood health and including the rich tapestry of sources from which insight is currently gained.

The context for this work is significant. National proposals to close Healthwatch England and the local Healthwatch network, and to separate its health and care engagement functions, have created uncertainty and prompted a need for Leeds to consider what should come next. The concern now, expressed by several participants, is that without a clear and credible independent voice organisation, the city risks losing ground at precisely the moment when people's experiences need to be brought even more to the fore.

The Steering Group overseeing this review asked for a discovery process that would listen carefully to partners, stakeholders and the public, and ensure that any future model is rooted in what people say works well, what needs to change and what the city needs now.

Across all three listening methods, there was a striking degree of commonality. Participants described a rich ecosystem of people's voice activity across Leeds - within Healthwatch Leeds, the local authority, NHS trusts and the Third Sector - but also the challenges of coherence, capacity and consistency. Many spoke of the pressures facing organisations, the difficulty of prioritising engagement and voice when resources are tight, and the risk that people's experiences become secondary to financial or operational concerns. Yet, as one interviewee noted, 'it's also the very time when you need to do it most,' because decisions made under pressure can have a significant impact on people's lives.

A recurring theme was the imperative of independence. Senior leaders were clear that an independent organisation, able to offer honest challenge without being constrained by organisational pressures, is essential to maintaining the city's commitment to person-centred health and care. At the same time, several emphasised the importance of mutual respect and a shared assumption of good intent, recognising that feedback can be uncomfortable but is necessary for improvement.

Participants also highlighted the need for greater coherence across the people's voice landscape. While there is much good practice via the existing People's Voices Partnership, listening activity is not always joined up, and the system does not consistently use the insight it already has. There is a desire for stronger accountability and a more unified approach that avoids duplication while still valuing the diversity of methods and relationships that exist across the city.

This report brings together what was heard - sometimes aligned, sometimes contradictory - and presents it in the language used by participants themselves. It does not attempt to resolve differences but to reflect them, recognising that a future independent people's voice organisation must be shaped by the breadth of perspectives across Leeds. What follows is an articulation of what people value, what they want to see done differently, and what characteristics and functions they believe are essential for a future model that is credible, trusted and able to influence change at every level of the system.

Terminology used in this report

The term 'culturally diverse communities' has been used throughout this report, in line with it being the preferred term of the **Culturally Diverse Hub**. The Hub is a partnership between Leeds City Council and local culturally diverse communities, supported by Voluntary Action Leeds. It is committed to addressing the issues of racial inequities and actively works to challenge racism, prejudice and discrimination at all levels.

3. Key findings

3.1 For people's voice work across the whole city

- People's voice should be at the centre of decision-making.
- Health and care listening should be integrated and not be separated.
- Need for more coherence and synergy across people's voice work (including a greater understanding of the role of different Third Sector organisations).
- More listening to marginalised and seldom heard voices.
- Improving feedback and accountability - 'you said, we did.'
- Design services with people's voice input at the start and throughout.
- Need across the system to synergise existing data, not duplicate data collection and for parity between quantitative and qualitative data.
- Need for listening at both a citywide and community level, coordinating with the neighbourhood health agenda.

3.2 For a future independent people's voice organisation

- Organisational independence and impartiality are imperative.
- Desire for continuity of valued existing roles of Healthwatch Leeds (as the current independent people's voice organisation), with consideration of development in response to the current review.
- Status as an equal system partner within the Provider Partnership.
- Long-term, secure funding from the Provider Partnership is central to the organisation's ability to bring robust challenge.
- Clear parameters and remit (however broad or narrow they may be).
- Maintain focus on health inequalities, with increased attention to differentials between communities (geography, interest).
- Importance of having specific feedback and recommendations for providers and the system.
- Organisational impact needs to be evidenced.

'It's amazing how listening to people's experiences makes people realise things they'd never thought of. It's the bits you can't work out through common sense, because it's not your lived experience.' Interviewee.

4. What about Healthwatch Leeds is valued by partners/key stakeholders and the public?

‘Healthwatch has a really strong reputation and has developed creative approaches like the Big Leeds Chat, which have influenced practice. Trust matters. When there’s trust, people are more willing to engage. Starting something entirely new means rebuilding trust, whereas building on what already exists offers a real opportunity.’ Interviewee.

‘I would say that, in terms of the breadth and the quality of the work, I think it's [Healthwatch Leeds] a jewel in the health and care system.’ Interviewee.

4.1 Value of current people’s voice work

The valuable contribution that Healthwatch Leeds makes, as the largest independent people’s voice organisation in the city, was emphasised in all three engagement methods. When asked to outline what they think should be done differently, survey respondents repeatedly said ‘nothing’ or highlighted the aspects of the work that they particularly value: ‘We need more, not less, of this work and to make the offer available to everyone who needs or would benefit’. Similarly, workshop participants from Third Sector organisations and Involvement Leads also reiterated a need to build on the existing good practice, not start from scratch.

‘In Leeds, we pertain to start with people, and I don't think that is just a fancy phrase with no follow through, I think it is actually embedded in many parts of the system. I have no doubt that it is through the leadership of Healthwatch that this is the case. We must attain some kind of leadership role for an independent voice organisation, otherwise I worry that with reduced capacity and resources, we could move backwards.’ Survey respondent.

4.2 Independence and impartial advocacy

Independence was the most frequently cited value in the public survey and interviews; it underpins trust and enables people to speak honestly. Healthwatch Leeds are praised for creating safe spaces where people feel empowered to speak and for translating professional language into accessible terms.

They are an independent organisation, which I think is very important when it comes to engaging with communities. I think it can help build up trust, reduce fear of speaking out, and Healthwatch can 'view' things differently as they are a separate organisation.' Survey respondent.

4.3 Focus on inequalities

Healthwatch Leeds' focus on reaching out and representing people who are marginalised or specific communities of interest is highly valued. It was emphasised by interviewees; indeed, it was the second most commented on asset (after appreciation of the skilled team). 8% of survey respondents commented on it when asked to write what they value about the organisation, for example, 'Seeking out the views and experiences of people who might otherwise fall "below the radar"' and 'Focus on communities with the least powerful voices. Through their work Healthwatch Leeds 'has brought an expectation that we start with people - that we hear, watch and talk about people's experiences in strategic meetings'. 'That's changed how the system is orientated around what it's really meant to do—serve people. That often gets lost in the machinery of organisations, reports and metrics.'

'I like how Healthwatch addresses inequalities by ensuring they hear from a variety if [stet] groups e.g. disability, people who speak a second language.' Survey respondent.

4.4 Organisational trust and leadership

Healthwatch Leeds is widely seen as a trusted partner, both within communities and by the system, that brings people's voices into strategic conversations and is aligned to the city's priorities. It plays a leadership role in the city, unafraid to challenge hierarchy and ask the right, sometimes uncomfortable, questions.

The challenges brought in the Dash review about joining messages together and making them actionable and relevant to strategic leaders, as well as practitioners, were commented on as something Healthwatch Leeds does well.

‘Engagement with groups who are less represented in services, those are the groups who are often most impacted when changes are made. On a local level, I think you're a well-regarded organisation with a strong staff team. The place that you hold strategically helps with impact as well, as you actually have power and sit around the tables where decisions are made.’ Survey respondent.

4.5 Proactive as well as reactive

Healthwatch Leeds is well regarded as a proactive organisation with a predisposition towards both listening and action and is seen by the majority as doing a great job. Their culture and way of working are more important than their statutory powers, and they bring a constant reminder to keep the ‘citizen at the heart’.

‘The Voice work, ensuring people's experiences are heard and learnt from - advocating for those who may not always have a voice.’ Survey respondent.

4.6 Translation and coordination

Healthwatch Leeds understands the gap between decision-makers and communities and helps to bridge it through their advocacy role. It takes professional language and turns it into something people understand and takes people’s experiences and translates them back into something the system can act on. That role is felt to be essential. Through the People’s Voices Partnership, they are leading a single platform that brings people’s experiences together from across the city ‘contribut[ing] significantly to how we think about what we do and the decisions we make’. There is recognition that the People's Voices Partnership could be strengthened and built upon.

‘High quality comms; great commitment and leadership from all at Healthwatch; positive and constructive challenge and co-ordination of People's Voices Partnership has been transformative for the system.’ Survey respondent.

4.7 Practical application

Examples such as the Three Cs (Communication, Coordination and Compassion), 'How does it feel for me' videos, the Big Leeds Chat (which was particularly appreciated by some as an opportunity for them as decision-makers to engage with communities) and Home First benchmarking were cited as work that has influenced service design and system change. Their reports are appreciated for turning direct experience into actionable intelligence (particularly given the size of the budget and staff team and the absence of a data unit).

'Their position in the city to be heard at very senior levels, their approach to working together for improvement as a system rather than combative, role-modelling principles of effective engagement, e.g. Big Leeds Chat.' Survey respondent.

'The three Cs have been taken in by hospitals, changed reporting, changed board processes, and changed how success or investment in clinical decision-making is understood.' Interviewee.

4.8 Accessibility of methods and specificity of ask

Healthwatch Leeds is good at using a variety of engagement methods (conversations, audio, visual capture, community hubs) to capture people's voices; this is important to extend across the people's voices landscape, as surveys and forms are not accessible to everyone.

Of 151 survey responses for what people particularly value about Healthwatch Leeds, the six most common responses are as follows:

Coded themes based on qualitative responses	Number of responses	Percentage (rounded)
Independent and impartial advocacy	31	14
Organisational trust and leadership	27	12
People's voice representation	23	10
Information sharing, advice and communication	21	9

Coded themes based on qualitative responses	Number of responses	Percentage (rounded)
System changes and strategic influence	18	8
Outreach amongst marginalised and diverse communities	17	8

Responses from people from culturally diverse backgrounds followed the same order, as did responses from people with physical and/or learning disabilities, who are neurodivergent and/or who experience mental health issues.

‘Healthwatch Leeds have the ability to hold a complicated set of working arrangements while also rolling up sleeves and getting stuck into transformation work, contributing to the detail as well as how to change systems.’ Interviewee.

‘My involvement with Healthwatch has been as a university researcher who was struggling to engage diverse communities in my health related to research. Working with Healthwatch we have been able to completely change this scenario and now we have good engagement with these communities. This is helping to focus the development of an inclusive health intervention. Their involvement really has made a huge difference.’ Survey respondent.

‘Healthwatch Leeds has helped the system. It’s part of why many of us are keen to retain independence within the system. Without them, we wouldn’t have done as well as we have. That in itself is recognition of the value they bring, and the nervousness about losing it.’ Interviewee.

5. What could be done differently to improve the people's voices landscape in the city?

5.1 Focus more on seldom-heard voices

Interviewees expressed a resounding, deep desire to hear from people and groups they don't often reach or hear from, particularly: people who don't speak English as a first language; people with low literacy levels; people with disabilities; and also, where these intersect, as there can be particular inequity. 'The advice is to not approach small organisations independently to avoid over consultation, but there is the distinct feeling that many seldom heard communities are still not being heard and concerns about the conversations that are not being had.'

Interviewees expressed how the lack of people's voices work with seldom heard communities in some parts of the health and care system can lead to inequalities in access, experience, prevention, early help and other provisions (such as the hardship fund to support access to hospital appointments). Whilst it was acknowledged it's not easy, it was also deemed to be about investment, resources and approach. As one interviewee said: 'There is currently no system and provider who hears people's voices in their own language and translates that insight; there isn't the infrastructure nationally or locally for what is needed. If it really matters and if there are ways to do it well, then this is something the system could fund.'

'I think we could be sitting on a huge amount of unmet need that we don't even know about because we cannot hear those voices consistently and authentically. I don't think we do this well across the system at all, despite what people say.' Interviewee.

Across the whole cohort of survey respondents, reaching out to people and communities whose voices are often not heard in health and care planning (e.g., culturally diverse groups, people with disabilities, young or older people, or people on low income) was considered Very important by 89% and Important by a further 9%, rising to 95% Very important and 5% Important for respondents from culturally diverse communities.[2]

Alongside this, there was a recognition that all people's voices work taking place in the city doesn't always get equal exposure.

[2] Of 95.

One interviewee suggested that, for some small organisations, particularly those working amongst culturally diverse communities, the current way of working in the system feels like it doesn't create space for their listening to be adequately recognised or recompensed.

Other seldom-heard voices named as needing prioritising within the system during interviews included:

- ➢ People who don't access services or don't know how to make sense of statutory health and care services.
- ➢ People on the fringes of the health and care system (in contrast with people receiving fairly high levels of support, who are better heard).
- ➢ Older frail people.
- ➢ People in work, who are finding it increasingly difficult to access services.
- ➢ Mental health organisations working with men.
- ➢ School children.

5.2 More coherence across people's voice work

Whilst no one advocated for a one-size-fits-all gathering of people's voices, there were loud requests to build on the work of the People's Voices Partnership and increase joining up and coordination of listening activities and a more strategic, networked approach to people's voices in the city:

- ➢ Across organisations, both to understand the distinctive offers (particularly within the Third Sector) and to avoid duplication.
- ➢ A joint framework for people's voice work within health and care organisations to enable confident engagement with people and avoid the constant reinventing, which is not experienced as iteration but rather (exhausting) starting from scratch.
- ➢ More coordination across data collection, to avoid overcollection and duplication, to use data that already exists better and to enable thematic analysis and synthesis across data sets and types.
- ➢ Avoid over consultation, as it is exhausting for people to repeat their stories and for communities to be asked the same or similar questions repeatedly (and makes them feel like they haven't been listened to).

- ➢ Establishing an overview and responsibility for responding to joint health and care feedback.
- ➢ Opportunities for cross-sector reflective practice, both to problem solve and to learn about good practice.
- ➢ More clarity for Third Sector organisations on how the people's voice data they gather (formally or informally) can be fed into a future organisation and/or into the health and care system.
- ➢ One person suggested a membership model for Third Sector organisations within a future organisation.

'Independent voice is critical, but it has to work alongside internal engagement and influence mechanisms. It doesn't replace them. We need a better coordinated approach across the city.' Interviewee.

5.3 More clarity of people's voice work within the Third Sector and including Healthwatch Leeds

There is a tapestry of Third Sector organisations working in people's voice, alongside Healthwatch Leeds, which positions itself as A-sector, sitting outside but close to both the Public Sector and the Third Sector in the city. This is experienced as both an asset and confusing, both within the Third Sector itself and within the wider system. At times, providers are aware that an organisation has a reputation for a particular specialism, such as the D/deaf forum within Leeds Involving People, but at other times, there is a distinct lack of clarity on which organisation is best placed or has a clear remit that is well-suited to a particular piece of work.

'More clarity around the role of different organisations and groups would be helpful, i.e. Healthwatch (or whoever they become), Forum Central, the PVP, the Health Inequalities Oversight Group. There's a concern that the new Provider Collaborative and Neighbourhood Health structures could make voices work less joined up and integrated. I would hope an independent voices organisation could work to mitigate this, particularly ensuring that voices of Communities of Interest and Health Inclusion Groups are not missed.' Survey respondent.

‘I’m still not clear who I should commission to provide the core infrastructure work around onboarding, recruitment, training, and leadership development for people with lived experience, because there are multiple players who could occupy that space.’ Interviewee.

5.4 Make feedback more specific and actionable

Generic feedback is harder for organisations to act on. Some stakeholders requested more specificity in the people’s voice data that is gathered within the system (who was spoken to, numbers, communities represented) and for indications of how reflective of the wider population’s experience an individual’s experience is. Similarly, generalised consultation is less meaningful for people to respond to. Interviewees also raised that supporting statutory services to work out how to do something, not just what to do, is helpful.

‘I’m more concerned about proactive work: actively seeking people’s views in specific areas and really understanding what’s happening in the system. That’s where the balance could shift, particularly towards specificity, combining quantitative and qualitative data, and focusing on what happens next and how we do it.’ Interviewee.

‘Something that does actually make NHS services accountable. Rather than a tick box/lip service exercise.’ Survey respondent.

5.5 Improve feedback loops

Some community groups reported inconsistent follow-up after engagement; they want to know who heard their feedback, what was done and why. This applies at all stages of people’s voice work. Accessible ‘you said / we did’ reporting was requested. The Issues Tracker on the Leeds Local SEND Offer website was given as one example of good practice where this type of reporting is easily accessible. It is recognised that progress on action will vary across issues and organisations, influenced by wider factors, and that any such reporting requires organisations to be honest and include feedback on why suggestions might not be workable and why as well as action that has been taken.

Third Sector organisations emphasised the need for accountability and feedback from the system when their relationships are central to mobilising people's voice, otherwise their trust is broken with communities, and that is the cornerstone of their work.

'Impact is unclear. Your engagement with my group is inconsistent, and after you have visited, we don't hear from you again. Group attendees don't know how their feedback is used, who is hearing it, what difference (if any) is made. Sometimes projects/surveys seem repetitive and always have the same feedback/outcomes - it'd be interesting if you'd do more comparative work when running similar projects (e.g. mental health in 2020 / 2024). Sorry if you do do this.' Survey respondent.

5.6 Trusted working relationships

Creating a culture of mutual respect takes time and relationship building, between providers and people's voice organisations bringing challenging feedback. Whilst many interviewees spoke about good, trusted relationships with Healthwatch Leeds, a couple felt that this was not always the case. 'There's also a fine line in how messages are communicated. Critique can sometimes feel like a personal attack on leaders, when it's really about systems and services. That can make organisations defensive. Framing feedback around how things could improve makes it much more welcome.' Language such as 'speaking truth to power', whilst commonly used across local and national people's voices networks, is not always felt to be useful, as it feels oppositional in its nature.

Several interviewees requested that any future organisation proceed on the assumption that they're working with the best intentions for Leeds' citizens and that they care about the people they work for, having sometimes felt like that hasn't been the case.

5.7 How to support independent people's voices listening across the city

Particularly in order to achieve the system-wide ambition of hearing seldom-heard voices, one interviewee highlighted the need to further include micro-organisations in gathering people's voices, not just larger organisations. This is something that Healthwatch Leeds has already started integrating into its practice.

> **'In terms of gaps in people's voice in the city, one of the elephants in the room is that we have credible organisations like Healthwatch and third-sector infrastructure bodies such as Voluntary Action Leeds, Older People's Forum, and more recently Forum Central working in partnership models, which is really welcome. However, a key gap is how effective these arrangements are for seldom-heard or disadvantaged groups. I still hear from people from diverse backgrounds that their voices aren't heard. [Where large organisations don't have expertise], they should be subcontracting or partnering with micro-organisations that are better placed locally, for example in Harehills, Chapeltown, or Beeston.' Interviewee.**

A clear outline of the distinctions and overlaps between the varying roles and responsibilities within people's voice work taking place in Third Sector organisations and Healthwatch Leeds was requested (from interviewees, workshop attendees and voluntary and community sector survey respondents), along with a request to ensure the Three Cs (coordination, communication and compassion) are applied in the relationships between organisations within the Third Sector to ensure it is a 'microsystem' which enables effective cooperation, collaboration and avoids duplication. There is also a need across all organisations to listen well consistently, and for a future organisation to listen well via relationships with Third Sector organisations.

Some interviewees expressed a desire to move (perhaps slowly) towards a model of commissioning one organisation as a preferred partner that then triages people's voice work across organisations and subcontracts to the best-placed organisation to deliver. Another suggestion was taking a consortium approach to commissioning people's voices in the city.

A third is the potential for organisations doing people's voice work in the city to learn from the statutory sector and to pull teams together across and work inter-organisationally to deliver pieces of work.

5.8 Comments on specific pieces of Healthwatch Leeds' work

There were no specific questions in any of the data collection methods about specific pieces of Healthwatch Leeds' current work. However, comments were made about some, which are captured below:

Big Leeds chat

The Big Leeds Chat was cited by some as an example of good intelligence gathering about what matters to people and what support they feel they need, an opportunity for decision-makers to engage with communities, which has really influenced practice and a model which it would be helpful if the future organisation could focus on. Conversely, other interviewees felt that it had duplicated previous listening exercises, that often people say the same things, and it doesn't feel like progress is made in terms of people's experiences. Others were unsure about the link between the effort it takes and the impact it has on people every day.

The 'value of an independent people's voice organisation would need to be demonstrated, as everything else is, because it's public money'. As such, there is a desire to really understand the impact that the future organisation is having and whether it is really shifting people's experience and making 'a proper difference to outcomes and experience…the key question is whether this is making a positive difference to people's health [and care]'. Interviewee.

Enter and view

In terms of enter and view, this was mentioned by six interviewees, with mixed responses. Four felt that enter and view is important and done in the right way: not intrusive, independent, co-produced with services, and focused on understanding what works well and what needs improvement, not blaming. However, others felt that the statutory guidance (e.g. enter and view, care homes, hospital) has restricted Healthwatch Leeds' work and that, whilst statutory powers shouldn't be thrown out, it isn't where the focus of a future organisation should be. One person also suggested that, in a time of restricted resources, the need for enter and view is being met elsewhere via CQC, albeit in a more regulatory and consequential way.

However, another reflected the opposite opinion: ‘The CQC is the regulator. It’s the big stick - it can shut services down. Providers value Healthwatch because it’s not the big stick. It helps them get to a place where the big stick doesn’t need to come down as hard. Healthwatch softens that blow by providing insight early, so services can respond before enforcement action happens.’

Of seven options given to survey respondents to grade in terms of importance for a future organisation, it came fourth, with 69% saying it was Very important, compared to 88% - 94% for the four options that scored highest.[3] [4]

Statutory powers

In terms of Healthwatch Leeds statutory powers, it was felt that this status is not understood by some. It is felt to be important to have an organisation that people recognise and understand that it’s a statutory legal entity and that there is a need for Healthwatch to promote and profile its activities more (which was also mentioned by one survey respondent). Some advocated for accountability to be maintained by Leeds setting local requirements even if statutory powers are removed. Someone else commented: ‘In terms of statutory powers, I hope we’re far enough along in our partnership approach that we wouldn’t rely on enforcement methods alone.’

People’s voice at the start of meetings - just a start

There were appreciation and recognition for the influence of people’s voices that Healthwatch Leeds has brought to strategic meetings. This expectation ‘that we start with people, that we hear, watch and talk about people's experiences, orientates the system around what it's really meant to do - serve people - that is powerful’. However, one interviewee commented that it feels very separated, and not the way to do this work. It is a start, but the need is for a body which flags what isn’t good enough and assigns it ‘to the right people with influence to take the next steps.’

‘Even now, papers are coming to partnership meetings without evidence of engagement. A recent paper on digital and the shared care record hadn’t engaged with [HW] at all, despite all the work [they’ve] done on people’s experiences of digital access.’ Interviewee.

[3] It also came forth by survey respondents from culturally diverse communities and survey respondents who are disabled, neurodivergent, experiencing mental health issues or who have a long-term illness or health conditions.

[4] See table at Appendix Two for details of all responses.

6. The importance of maintaining the independence of a future organisation

'The system needs to own the fact that it needs a bit of grist in the mill. The whole purpose of that independent organisation is to be that voice, and not hold to account, but have that check and challenge about whether or not this is making a difference and people are getting what they need and want.' Interviewee

The independence of the future organisation was considered to be key, for a variety of reasons, including:

1. Instils trust and confidence in citizens and can create more honesty.
2. Brings perspective into the system that internal mechanisms alone can't bring.
3. Provides check and challenge to internal stereotypes, assumptions or suggestions around planned improvements (not implying bad motivation, simply that people with experience of a particular service can offer valuable insight into any changes).
4. Brings additional capacity when it isn't present internally.

'Healthwatch is and has been a huge help to me and my family. Knowing that there is an organisation out there which is independent and able to voice opinions on behalf of the public to authorities which appear to be increasingly biased is extremely reassuring, especially to those who have to engage with the health system on a frequent basis.' Survey respondent.

'It's independent - because it's seen by the public as such, they are more likely to become part of it because they will not feel it's being influenced from elsewhere.' Survey respondent.

A future independent organisation feeding back information to statutory services is needed because:

1. There is a tendency to miss biases of own organisational perspectives.
2. It is a challenge for good listening to happen everywhere within large organisations due to their size and number of staff.
3. NHS reliance on standardised models and clinical good practice isn't always in people's best interests.

Of the 59 members of the public who responded to the open-ended question in the survey as to what they particularly value about Healthwatch Leeds' work, 36 cited independence or impartiality, by far the most common response. Amongst interviewees, independent people's voice was cited as particularly important for cross-cutting pieces of work, whilst desiring for it to be the 'golden thread' that runs through all practice within health and social care. One person commented that it can feel like independence can 'make our lives more complicated, but it teaches us what we need and points us to other cohorts who haven't been helped.' However, whether or not an independent voice organisation is listened to was questioned - and it was suggested that this is an imperative moving forward.

Characteristics of independence cited in order of frequency mentioned in interviews were as follows:

1. Setting own priorities.
2. Speaking truth to power - with the caveat that this language is experienced as problematic by some.
3. Public perception as truly independent and therefore trusted.
4. Part of the city's guiding leadership.
5. Independent governance.
6. Pro-active, not just reactive to issues.
7. An agenda set by the people most impacted.
8. Funded but not owned by statutory organisations.
9. Long-term contract to provide stability and confidence to challenge and publish findings without reports being tempered by organisations or fear of funding being withdrawn.

Characteristics of a future organisation cited in order of priority by survey respondents:

Characteristic	**Percentage who said very important- Whole cohort**	**Percentage who said very important- culturally diverse communities**	**Percentage who said very important - People who are disabled, neurodivergent or experiencing mental health issues**
Trusted by local people	89	95	84
Holding decision makers to account for listening to people and make improvements	88	97	88
Being independent and impartial (separate from the Council, NHS and social care services)	88	97	89
Being visible to communities	74	61	72
Sharing leadership with people and communities	45	19	41

‘Independence is particularly important for cross-cutting pieces of work. I think it’s important for individual organisations as well, because without it, everything relies on the culture of the organisation and whether it wants to hear difficult things. That often comes down to individuals, boards, and quite complex internal dynamics. Some organisations hear certain difficult messages quite well but shut themselves down to others. That’s why independent challenge is critical. It provides an alternative to the internal culture of any big organisation. We know this is a real problem. An independent voice that [can] say, “No, you need to listen,” and hold the organisation to account [would be] helpful. That’s where the specificity of what an independent organisation looks at becomes important, and how it decides where to focus. Even with strong senior leadership and good organisational values, that doesn’t guarantee good listening happens everywhere in a large institution. When you have tens of thousands of staff, it’s impossible for a small leadership team to reach every division and team. Senior leaders know their values, but they also come under enormous pressure and may compromise at the edges. Having someone who can say, “You’re not hearing this properly,” and who isn’t under the same organisational pressure, really matters.’ Interviewee.

7. The importance of not separating health and care in a future organisation

Of all the questions asked to interviewees, the one that prompted consensus was that people's voices on health and care should not be considered separately, as recommended in the Dash report. People live their lives not separating out between their health and care, and therefore, the system should not separate them either. Instead, people's real experiences should be reflected in the way they are listened to. It is exhausting for people to repeatedly tell their story. If the health and care system in Leeds wants to maintain its clear commitment to person-centred care, then there is a need for independent people's voice work within the Leeds system to cover both health and care together. The more it is joined up, the more it starts with the citizen and puts people rather than organisations, structures and silo-working at the centre. Furthermore, separating them out is completely contrary to the neighbourhood health agenda and is moving in the opposite direction to the one the system has been moving in during recent times.

'I would feel that we have failed if the local authority commissions a Healthwatch-type function, and separately our NHS partners commission something separately. It has to be one specification, one requirement to see the individuals as a whole and to work with individuals' various different care and support needs.' Interviewee.

'My question is: how important is it that people's experience of health and care are considered together rather than separately? Ideally, they should be considered together, because that's people's real experience. People experience both systems together. But our system isn't set up to receive that information in a coordinated way or respond to it in a coordinated way. That's always been the difficulty. From my position, we get lots of information about work happening across the system, like discharge into care homes, but if I got information about a joint health and care experience right now, I wouldn't know where to take it. I wouldn't know where that joint overview sits, or who owns improving it. You can look at the health impact, but there's nowhere that joins it up with the care side. I don't know how to do that.' Interviewee.

Some noted that it is a false dichotomy, or that other dichotomies also exist. Examples were given from within care, including lack of coordinated delivery in the home, and within health, such as lack of coordination between primary care and acute services, or the need for holistic treatment for people with long-term physical health conditions in terms of the impact this has on their mental health and vice versa.

One of the distinctive features of the current model of Healthwatch Leeds is that it is a people's voice organisation, listening beyond simply patients currently using the health and care system in the city. Across all engagement methods, the desire was expressed to continue and develop this focus on people's voices.

'Healthwatch's brilliant role is to say: what about the people who never walked through the door because they didn't trust the service, didn't understand the letter, or didn't know where to go next? The patient safety consequence is realised, but it won't be measured in a health organisation. It'll be measured in Leeds - in disability, unemployment, lost workdays, caring responsibilities, early death.' Interviewee.

8. Interface between a future organisation and the neighbourhood health agenda

Neighbourhood health was not a specific question or topic area across any of the engagement methods; however, it was referenced in 70% of interviews and both workshops.

It was suggested that neighbourhood health offers opportunities to be more radical and a desire to explore this in the context of people's voices. There is interest in how to join up neighbourhood health with 'voice-enabled work' elsewhere, both within health and care, for example, with GP surgeries or care homes, and more widely, such as with the new Pride of Place initiatives taking place in three communities in the city. There was also curiosity as to how to develop a voice-enabled way of working overtime in communities, genuinely being led by the community and focusing on what matters to people, rather than being professionally led as is usually currently the case. This is particularly relevant in communities where multiple initiatives centring people's voices are taking place concurrently and where it could be easy to duplicate engagement.

There is a desire for neighbourhood health to be integrated and sit within a unifying strategy for health and care, and an ambition for it to go further than the national health and care remit. There is interest in leadership from communities across health and care services, not just in the context of neighbourhood health.

'We won't get the benefits [of neighbourhood health] unless we do the wider integration work. There are challenges around risk-sharing, accountability, care planning, data sharing, and financial flows, but this is exactly why people's voices matter. What matters to people is broader than just their experience of health or social care services. It's about being treated as individuals with complex lives, not just as a set of body parts.' Interviewee

Suggestions made as to how neighbourhood health developments and people's voices could helpfully move forward include:

- ➢ Listening/learning/collaborating to benefit from Healthwatch Leeds' experience in people's voice to help inform and shape neighbourhood health.
- ➢ Linking more widely with people's voice through Third Sector and community organisations 'would be fantastic', to support neighbourhood health's emphasis on prevention and keeping people healthy and well at home.
- ➢ A future organisation helping to ensure consistency in how people are engaged, how people's voice within neighbourhood health is gathered, evaluated and then inform action.
- ➢ Developing a continual mechanism for engagement and feedback, rather than 'having an issue or a project and then doing some engagement, writing a report, or holding a workshop'.
- ➢ Working out what the value of independent voice is within the neighbourhood health context and how to ensure that neighbourhood health and a future organisation are aligned in activity to avoid duplication.

'Neighbourhood health focuses on co-designing service delivery, while Healthwatch focuses more on co-designing insight and voice. They complement each other, but they're not as aligned as they could be.' Interviewee.

In terms of engagement with people, various comments were made about how to do this effectively within the neighbourhood health context. This included:

- ➢ Moving away from one person representing an entire population, as this isn't a robust way of designing things around what people actually want - there is a distinction between participation and representation.
- ➢ There is a risk of creating 'professional patients' and yet at the same time the potential to upskill people and make voice a professional role/opportunity, rather than someone who happens to be a representative.
- ➢ There remain important questions around how to do this effectively with inclusion groups, such as people with learning disabilities, people with language barriers or people who need advocacy to be heard.

Interviewees spoke about the challenge of engaging well with seldom heard and hidden populations, whose needs are currently not being met.

There was a desire to really know and understand the needs of particular groups within particular communities. Frail older people living in suburbs was one example given, recognising that what works well to support older frail people in Harehills may be very different to what works well to support older frail people in Wetherby. Having bespoke intelligence on this, which can lead to bespoke delivery to individuals and communities, is core to the neighbourhood health agenda and something that a future organisation can usefully play a part in. For example, by supporting a process to work out how to build voice into older people staying in their homes from the start, rather than designing it in afterwards. In this way, a future organisation would help to shape and inform how things are delivered, not just what is delivered.

‘The role of an independent voice organisation should be about understanding whether the city’s health and care delivery is landing well for people. That delivery should be based on a neighbourhood approach. Individual organisations will still gather data about satisfaction in their services, but the richness Healthwatch has brought through “How Does It Feel for Me” and the Three Cs is about surfacing universal truths the city can work on.’ Interviewee.

‘Ultimately, a local citizens' assembly selected by sortition should be the superior decision-making body of Leeds healthcare.’ Survey respondent.

9. Characteristics and functions of both a future independent people's voice organisation and broader people's voice work across Leeds

A future organisation should begin with people. Across interviews, workshops and survey responses, there was a consistent expectation that people's voices should be 'at the centre, routinely valued, listened to, started with, and acted from'. This is not a rhetorical ambition but a practical requirement for a system that wants to understand real experience, reduce inequalities and design services 'from the outside in' i.e. starting with people's voice and perspectives and then developing from there.

9.1 Independence as the foundation

Independence is the single most frequently cited characteristic. It underpins trust, enables honesty, and provides the system with a perspective it cannot generate internally. As one interviewee put it, senior leaders 'come under enormous pressure and may compromise at the edges. Having someone who can say, "You're not hearing this properly,' and who isn't under the same organisational pressure, really matters".' Independence must be visible, long-term and with governance, funding and remit that allow the organisation to challenge without fear of consequences.

Independence is also what makes the organisation credible to communities. Survey respondents repeatedly emphasised that they value Healthwatch Leeds because 'they are an independent organisation… it can help build up trust, reduce fear of speaking out'. A future organisation should therefore be funded by but independent of providers, embedded but not beholden, and able to set its own priorities based on what people say matters.

9.2 Equal status within the Provider Partnership

The need for a future organisation to be an equal partner within the Provider Partnership was widely recognised. It should act as the 'third leg of the three-legged stool' alongside health and care, providing insight, challenge and a clear loop back to citizens' experience. With this status it can influence prioritisation, shape work plans, and provide regular, specific intelligence that supports decision-making.

This requires long-term, secure funding from all Provider Partnership members. Interviewees described it as a test of commitment, as one said: ‘If providers don’t commit, then it is very difficult to see that we are properly committed to people at the centre’.

9.3 A clear, focused remit

There was a clear call from the public and stakeholders that the core work of Healthwatch Leeds was valued and should continue. However, there was also a strong call for clarity, boundaries and even a ‘reset’ from some. The future organisation should ensure that the core functions delivered by Healthwatch Leeds should continue and not ‘try to do too much, but instead have a clear, focused brief’. Its remit should be shaped by what adds value, avoids duplication and maintains a strong focus on inequalities. Any widened remit should be adequately resourced.

The organisation must cover both health and care together. People do not separate their experiences, and the system should not either. Separating them, as proposed nationally, was described as the opposite of what is wanted within the Leeds system.

9.4 Deep focus on inequalities and seldom-heard voices

A future organisation must continue to prioritise the health inequalities and seldom-heard voices and support the system to go deeper and wider in gathering this insight. Interviewees expressed ‘a resounding deep desire to hear from people and groups they don’t often reach’, including people with low literacy, people who don’t speak English as a first language, disabled people, and those on the fringes of the system.

This is not optional: without it, the city risks ‘sitting on a huge amount of unmet need that we don’t even know about’. This requires investment, partnerships with micro-organisations, and approaches that recognise the richness of incidental, everyday conversations that often sit outside formal feedback routes.

9.5 Coherence, coordination and synergy

The current people's voice landscape is rich but fragmented. Stakeholders are keen for 'more joining up and coordination of listening activities' and a more strategic, networked approach across the city. The future organisation needs to help create coherence - not by centralising all listening, but by connecting it, reducing duplication, and enabling thematic analysis across datasets. This includes strengthening the People's Voices Partnership as the place where listening is brought together and supporting the system to work towards parity between qualitative and quantitative data.

9.6 Specific, actionable insight

There is a request for feedback to be more specific, targeted and actionable. Generic insight is harder for organisations to use. Stakeholders want clarity on who was spoken to, how many, and how representative the feedback is. They would like evidence that links directly to recommended actions and measurable outcomes.

'Aligning powerful case studies with quantitative data would make the message even stronger and land better with statutory bodies that are used to data-driven decision-making. It's not either/or. Stories move people emotionally and show where improvement is possible, but data gives weight and urgency.' Interviewee.

9.7 Strong feedback loops and accountability

A future organisation must help to strengthen accountability both within the system and back to communities. People want to know what happened after they shared their views. Community groups described inconsistent follow-up and a lack of clarity about impact.

Individuals have no idea what impact sharing their story has had on how things are done. 'Our feedback mechanisms aren't good. We don't explain what people told us, how it helped us make decisions, and why those decisions were made'. The organisation should support the system to develop clear, simple, accessible 'you said / we did' mechanisms, and ensure that accountability is not only upward to boards but outward to people.

9.8 Supporting co-design and co-production

Co-design and co-production were popular future developments across all listening methods. They offer a way to embed people's voices from the start, not as an afterthought. But they require time, skills, training and whole-team approaches. They are not simply buzzwords but 'means a very specific thing: a genuine partnership. If it isn't a genuine partnership, we shouldn't call it co-production'. A future organisation may not need to deliver all co-design itself, but could help build capability, set expectations and model good practice.

9.9 Connection to neighbourhood health

The connection between a future organisation and the neighbourhood health agenda needs further exploration. Some ideas that emerged included a future organisation helping to support consistency in how people are engaged, the gathering of community-specific intelligence, in order to shape delivery models that reflect what matters to people in different places. It should help avoid duplication and ensure that neighbourhood health and people's voices work are aligned.

9.10 Supporting people to navigate the system

98% of survey respondents indicated that they think 'helping people understand and use healthcare systems and know their rights' is Very important. Comments included: 'their info and advice line has been really useful', 'Information regarding positive ways to deal with health issues', 'The time and care taken to ensure that disadvantaged / marginalised people have the opportunity (access / information / guidance / support / training etc) to live well' and 'Advice being shared'. This is clearly a priority for the public and was also emphasised in the Third Sector leader's workshop.

'We're not very good at bringing people on the journey with us. People don't even know where the door is, let alone whether it's open.' Interviewee.

10. Opportunities for widening/evolving the remit of a future organisation with additional resource

Several ideas emerged in recent months for ways in which the remit of a future organisation might be expanded, detailed as five options[5]:

1. Co-design, coproduction and community power.
2. Increased coordination of listening activities (including expanding beyond just health and care and creating a hub for feedback and insight.
3. Increased accountability of feedback to action.
4. Embedding citizen voice into the provider partnership.
5. Staff voice.

Feeding back on these was the focus of the Involvement Leads workshop. Not all interviewees commented specifically on the ideas; in general, where they did, interviewees were offering a perspective on the need for the developments within the city, rather than them necessarily being the expanded remit of a future organisation.

Survey respondents were asked to allocate a priority rating to eight possible future offers from an independent voice organisation. The results have been given a comparative ranking, to ascertain top priority (1) down to lowest priority (8). Responses are given in the table below for the whole cohort, respondents from culturally diverse communities and respondents who are disabled, neurodivergent, experience mental health issues or have a long-term health condition.

Potential future offer	**Whole cohort**	**Culturally diverse communities**	**Disability, mental health, neurodivergence, long-term health condition**
Providing support and expertise to health and care organisations to design services together with people and communities (co-design)	2	1	1

[5] Full details can be read in Appendix Three - Scoping Document for the review

Potential future offer	Whole cohort	Culturally diverse communities	Disability, mental health, neurodivergence, long-term health condition
Listening to people's experiences of other issues that affect their health (e.g. housing, cost of living, employment etc)	1	2	2
Supporting and facilitating a citizen voice function into the new key health and care function within the city (the provider partnership)	3	3	3
Making sure lived experience and co-production (planning and designing services with people) is central to the city's main projects (priority workstreams)	4	4	4
Reporting annually on how the system is working for people with key priorities for improvement monitored	5	5	6
Providing opportunities for health and care staff to safely share their views	6	6	5
Creating a hub that brings together what people are feeding back to different places in the city about health and care (e.g. complaints/compliments, feedback direct to services etc)	7	7	7

Potential future offer	Whole cohort	Culturally diverse communities	Disability, mental health, neurodivergence, long-term health condition
Coordinating volunteering opportunities across the health and care system, not just Healthwatch Leeds (e.g. hospital and community settings)	8	8	8

A full list of graphs can be found in Appendix Four.

10.1 Co-design, co-production and community power

Co-design was the top priority for survey respondents from culturally diverse communities and respondents with a disability, who are neurodivergent, experiencing mental health issues or who have a long-term health condition. It was the second priority across all survey respondents. It was the second most favoured idea for development in the Involvement Leads workshop. Interestingly, ensuring lived experience and co-production is central to the city's priority workstreams scored less highly, perhaps indicating the preference amongst survey respondents for people's voice to be heard at the start of a process.

Co-design, co-production and community power offer an opportunity to all health and care providers - and indeed other organisations in the city - to learn how to truly create and shape services with people. It builds people's voice into services from the start. It would help to create services that meet people's needs and change ways of working across the system, so things are being done differently (not just talking about doing things differently). It centres on Equality, Diversity and Inclusion and engagement and makes health inequalities the focus that is needed. People's voice engagement becomes everyone's business.

‘I think there's lots of good examples of great practice where things have been designed with people at the centre. But it doesn't happen enough. It's not done at scale; it's not the norm. You have to work really hard for that to be the case, and it takes longer, and it's messier, and it might tell you things you don't want to hear about how you should design your service.’ Interviewee.

Interviewees noted the demand in the city to work in a co-design and co-production way - both within providers and in the context of neighbourhood health - moving from ‘pockets of good engagement to deeper co-production and co-design’. Third sector colleagues expressed a strong desire for meaningful participation in decision-making and suggested examples such as co-writing service specifications and policies as a way of moving things forward and ‘sharing power’.

‘I attended the West Yorkshire ICB session and really valued the focus on patient voice and system design. I’m particularly interested in how frontline clinical insight can better inform service design and access.’ Received via email to Healthwatch Leeds from an NHS Business Development Manager.

It was suggested that the city would benefit from a consistent approach and coherent offer. However, it is really important that the terms co-design and co-production are not used in circumstances where they are not actually happening. They need to be built on relationships and trust so that people want to invest their time, and this may require tools, information and training so that people with lived experience can transition from engagement opportunities into deeper co-design and co-production roles.

‘Co-production can be a buzzword. It comes in and out of vogue. But it means a very specific thing: a genuine partnership. If it isn’t a genuine partnership, we shouldn’t call it co-production. Work like the Poverty Truth Commission is a good example, where work was done in partnership with people with lived experience from the start, before bringing things to strategic boards.’ Interviewee.

Barriers to implementing effective co-design and co-production were cited, including:

- ➢ Current pressure to move quickly on transformational work.
- ➢ The amount of time that it requires - even if we’re keen on it, will we actually implement it?
- ➢ Do we really want to authentically co-produce and train the system to do so?

- ➢ Needs to be properly funded; resource pressures can lead to things being done for people rather than with them (across all organisations in any sector); within statutory organisations, it is a challenge to 'visualise a place where we could ring-fence the resource to do it really well'.
- ➢ Requires a whole team approach - just training individuals to bring it back to a team often leads to it not being implemented.

'When we trained colleagues from different levels across children, families, and the council, it felt positive at first. We gave training on different approaches and built an understanding of how people could apply this in practice. But when they returned to their services, it often didn't have much impact. They became a lone voice trying to introduce change, without the time, resources, or support needed to make it meaningful. We shifted towards working differently by offering support to whole teams and services. We went into team spaces, away days, and meetings and asked what they wanted to change and how they currently worked. That approach led to more genuine change in practice. For co-design and co-production, whole teams need to be on board.' Interviewee.

It is acknowledged that co-design can be challenging in all parts of the system, including within people's voice organisations, and a desire was expressed to identify where great co-design is already happening in the city, from which these skills could be brought in.

'It would be amazing to set up Citizens Assemblies in the longer term! And have a really mature structure that allows for coproduction and codesign across partners in health and care.' Survey respondent.

What is required?

Whilst co-design and co-production are methods and processes, they are also an expertise/skills set which shouldn't be trivialised or taken for granted. Staff across providers and at all levels need to grow in understanding, confidence and skills to work in this way, which requires training and capacity building. Alongside this, bringing in external capacity to deliver robust co-design and co-production processes is also needed. This is something that could be offered by various organisations and does not necessarily need to be the remit of a future organisation.

To do well, co-production and co-design require:

- ➢ People to have agency to be involved as much or as little as suits them - not all citizens want to be involved in a lengthy process.
- ➢ Organisations to have agency - co-design and co-production might not be used in all circumstances.
- ➢ The way of working, not just what is done, is equally important; people care how they are treated, not what they are called.

It was acknowledged that there is a danger that the same people are relied on to participate - this can become challenging and demanding for them, and also inadvertently exclude other voices from different communities (not just culturally diverse communities), thereby perpetuating improvements that don't meet the needs across communities. It is also important that people are well supported and connected to others in their communities, to enable them to represent collective views.

Across all the potential ideas for development, it was suggested that working iteratively would be an optimal way to move forward: trialling developments, assessing impact and growing steadily. 'Within an organisation or within the Provider Partnership, it will make sense to identify specific issues where, having done engagement and consultation has been done, co-design and co-production are required.'

It is also an obvious place to link feedback to action, providing a very clear opportunity to track and show impact, one example of the interrelationship between the potential developments.

'For me, this is about social justice, equality, and ensuring people are at the forefront of design work. To do that, we need the right enablers in place and a consistent approach.' Interviewee.

10.2 Increased co-ordination of listening activities (including expanding beyond just health and care and creating a hub for feedback and insight)

10.2.1 Expanding listening beyond health and care

Listening to wider determinants of health was identified as a wide-ranging and complex area. On the one hand, it makes sense and feels necessary to seek to listen to the wider determinants - people do not live compartmentalised lives, and it would be ideal to connect all the varied people's voice work that takes place across the city, much wider than health and care. There is a huge amount of listening that takes place in communities where issues are raised that are linked to people's health and care, including formal routes such as community committees, tenants' organisations, feedback to local elected representatives and so on. Indeed, oftentimes people take time to reflect and then share their reflections with someone in a completely different context outside of the statutory sector and formal feedback channels - perhaps to a community organisation, or the housing office or hairdresser, and yet it is important intelligence on what is (not) working in their experience. As one workshop participant observed: 'there is probably more rich information being shared outside the system than within it.'

There are many things that don't specifically fall into the provision of health and care services which impact on people's health and wellbeing, all of which should be listened to in the context of health. This was the top priority for future development for survey respondents (second priority for survey respondents from culturally diverse communities and respondents with a disability, who are neurodivergent, experiencing mental health issues or who have a long-term health condition). Hearing people's voices will be much more meaningful if all those systems can be aligned better (e.g. housing, public health, and education). So that potentially, rather than doing more listening, there are effective mechanisms so that existing listening is more connected and filters through to the People's Voices Partnership. There were passionate advocates for this across all engagement methods, particularly people speaking from their own lived experience of the complexities of caring for someone and the whole life perspective. How can this information be fed back and integrated into learning for the effective delivery of health and care services? Otherwise, good intentions to expand listening activities may serve to inadvertently duplicate existing sources of effective listening.

‘A lot of listening already takes place. The priority is joining up what we already hear and creating connectivity across existing listening activity before deciding where more listening is needed. Before expanding listening further, the first challenge is understanding what we already know, what’s working, and what’s not working.’ Interviewee.

Integrating wider listening also fits within the neighbourhood health agenda - being led by people and being one team working in an area to develop a responsive local way of working that works best for the people who live there. Within Leeds City Council, there were different perspectives, with one interviewee feeling that there is currently a good system within the council to manage feedback on broader issues that come back, whilst another said they would ‘welcome it, even just to start joining things up within the council’.

On the other hand, in the context of a future organisation, several interviewees advocated for a clear remit around health and care feedback; otherwise, its focus could be diluted. Others cited the challenge of implementing a workable system of tracking feedback and having a clear understanding of whose responsibility it is to act on the information and then provide feedback on it unless clear lines of responsibility and accountability are established - ‘when you don't have dedicated resource, it becomes everybody's business, but nobody's business. That's the danger, the classic cliche.’

A positive way forward suggested would be to invest in the development of the People’s Voices Partnership as the place in the city where people’s voice work is all joined up. The existence of the People's Voices Partnership needs promoting, the leadership (likely via a future organisation) needs resourcing and for participation to be encouraged across all people’s voice listening work across all sectors (including community listening on wider determinants, such as via tenants’ organisations and community committees).

‘There is metrics data—for example, Friends and Family Test data in the NHS—but that’s about an episode of care. The challenges we’re facing are chronic and ongoing across people’s lives. You might go to a leisure centre and have a brush-off conversation, and that could have a massive impact on your diabetes. The diabetes service might have great Friends and Family Test results, but that’s not the whole picture. What we actually want is for the sports centre, leisure centre, healthy eating options, exercise groups, allotment societies to be easy to use. So, it’s not just about having metrics, but about having the right measures. They need to be understandable to people who are least likely to be engaged. We love our forms, but in areas with high health need they can be treated with suspicion. It’s about the conversation that sits around them. Those measures also need to work across organisations. It’s not just “have I done my service well?” but “have we done our services well?” Has the whole offer worked?’ Interviewee.

‘The richness of [incidental] conversations is incredible because they’re off the cuff, not planned, and not agenda-driven. We need someone who can capture those little nuggets of gold and put them into a space where anyone in the city can go and see patterns emerging.’ Interviewee

10.2.2 Creating a hub for feedback and insight

The creation of a hub for data gathering and collection was of interest to many interviewees, to join up and connect existing listening and to avoid duplication and over consultation. It was prioritised in the middle during the Involvement Leads workshops and was second to the bottom of the priority list of developments for survey respondents.

‘We’re awash with data and information, but we probably don’t use it well enough. There’s a lot of effort going into collecting information, and I don’t think we’ve translated that into tangible, meaningful action or advice for people leading programmes of work.’ Interviewee

Sometimes the barrier to this taking place can be knowing what others have already consulted on. Another barrier is that staff need support to distil and understand information - being presented with lots of lengthy reports often isn't helpful, and they can be confusing to find details within. Having a person (or people) to help with clarity around what the question is a person is seeking an answer for, what information is available and whether that question has already been addressed by people's voice insight would be an asset. Somewhere with the oversight for what's being gathered, where, and to support the collation of data would be another asset.

'There is already a lot of quantitative data being collected, but it's not fully joined up around people's experience, and it's not independently analysed. Experience data tends to be less integrated than activity and performance data.' Interviewee

It is good business intelligence to elevate qualitative data to the same status as quantitative data, as good decisions can't be made on statistics alone - they don't tell you about patient experience. The richer the information coming through the system, the better it is for everyone. There needs to be parity between data analytics functions and people's voice functions within the system.

How can the intelligence from different services be brought together?

There is a threefold gap: firstly, all experience data is currently not connected together and is not connected to other datasets; secondly, qualitative data is not treated as equal to quantitative data; thirdly, there is little or no connecting and analytical capacity across datasets, to find the patterns and themes. Leeds currently has an insight library for reports and materials, which could be built on to develop a central repository that absorbs information, matches it to need, and identifies where further investigation is needed, which can feed into the creation of a work plan for further data collection.

This may be an independent hub focused on people's experience, or it could be integrated into an existing data repository within the city to facilitate cross-referencing and ensure that the work of those already working on data and intelligence within the city isn't duplicated. It was felt that coordinated and more widespread listening may be a way of being able to triangulate information, highlight issues and have an 'early warning system'. Accountability also fits in here: 'What do we do as a system with all the good listening that takes place?'

'If data shows consistent underperformance, and stories show how services could be better, that combination carries real influence. Statutory organisations often dismiss single stories if they believe overall performance is acceptable, but they respond differently when patterns are clear.' Interviewee.

As well as formal routes for people's voice work, there is a desire to explore how intelligence can be gathered from small community hubs and incidental, agenda-free conversations - these loop back to the wider determinants exploration.
One method suggested was easy digital capture, via image, text or voice note, which could be contributed in diverse languages, transcribed and translated by AI, tagged - with theme, locality - and then mobilised by a variety of audiences. This uses technology and acknowledges that the bit of the process that technology can't replace, which is having the conversations in the first place.

There remain challenges with the coordination and implementation of a people's experience data hub/insight library/dashboard/app:

- ➢ It can be challenging to do this within organisations, let alone between them.
- ➢ Strong safeguards are needed to ensure that inequalities don't get lost in coordination.
- ➢ How to build momentum and enable easy accessibility for everyone.
- ➢ People need to be receptive and open to engage.
- ➢ Will it be used/will it make a difference?

10.3 Increased accountability of feedback to action

‘A lot of groups say, “You’ve done a lot of engagement, but no one’s ever come back with feedback or followed it through.” That’s a discipline and a habit we need as statutory organisations. It’s actually quite upsetting for community groups to put in time and effort and then not receive any feedback or outcome.’ Interviewee.

Increased accountability of feedback to action is a critical gap in the way things currently work, and in the opinion of Involvement lead workshop attendees is the essential foundation on which any other developments must build. Clearer mechanisms need to be developed to both feed into the system and for clear accountability back to the people of Leeds. This is both at a large scale and in response to specific engagement. For example, when an individual shares their story at the start of a cross-provider board meeting, how does that individual know the impact that sharing their story has made and any change that has been implemented as a result?

Within the system and annual reporting

Interviewees acknowledge the importance of accountability within the system and the current lack of it. Indeed, some referenced the mutual accountability gap between organisations as a longstanding issue in Leeds. ‘Who holds the power - providers or commissioners?’ ‘Senior leaders talk about the main transformation programmes - establishing them or seeking progress - often with very little reference to individual people and without being connected to communities, with a similar lack of commitment from board chairs to this too.’ ‘Leaders often make decisions without being connected to communities or feeding back to them.’

The inadequacy of current mechanisms was highlighted. Whilst accountability and governance are in place across some specialisms via working groups and boards, the focus remains here, feeding back to professionals, rather than feeding back to people. Annual reporting was commented on as a good idea by some interviewees and was the fifth most popular priority for survey respondents (62% for the whole cohort, dropping to 55% and 54% respectively for survey respondents from culturally diverse communities and respondents with a disability, who are neurodivergent, experiencing mental health issues or who have a long-term health condition).
However, other interviewees suggested that more frequency and accessibility of reporting are needed, so that reporting is responsive to emerging issues as well as

long-term themes. Whilst several acknowledged that there will be a need for something new within the Provider Partnership arrangement, others felt that annual monitoring and reporting are the responsibility of organisations and boards. Clarity on what is being reported on, with what frequency, by whom and to whom is necessary to work out within the Provider Partnership.

Feedback to people

'We're poor at telling people what we've done after listening to them. Our feedback mechanisms aren't good. We don't explain what people told us, how it helped us make decisions, and why those decisions were made.' Interviewee.

Trust is recognised as core to hearing people's voices and the development of relationships. This involves having good 'feedback loops' to ensure that people know how their perspectives have contributed to the development of services and activities. Third Sector organisations emphasised the need for accountability and feedback from the system when their relationships are central to mobilising people's voices, otherwise their trust is broken with communities, and that is foundational to their work. Trust in a future organisation was rated as the most important characteristic (of five) by survey respondents (see Appendix Six for the full list).

'There's a real move towards this in the council now, with newer leadership focusing on listening and responding: "This is what you said, this is what we heard, and this is what we're doing in response."' Interviewee.

Robust mechanisms are required in order for feedback to people to be successfully implemented and monitored to ensure it is happening (which could be a function of the future organisation).

Suggestions for ways forward included:

- ➢ Forums for people and decision-makers to come together to influence service development.
- ➢ Embedding ongoing iterative feedback into service delivery, with people who helped shape provision initially, then offering feedback on what has been implemented.

- ➢ Clear, simple mechanisms and communication that doesn't overwhelm people - different communication methods for different audiences, e.g. the public and policy makers.

10.4 Embedding citizen voice into the Provider Partnership

10.4.1 What should a future organisation's relationship be with the Provider Partnership?

74% of survey respondents indicated that 'facilitating and supporting a citizen voice function into the new key health and care structure in the city (the Provider Partnership)' is Very important (ranked third of the eight options available).[6]

'We have always said, it's documented, that we start with people first. It's one of our values. It is within the Leeds ambitions and the health part of the Leeds ambitions. And so, if providers don't commit to that, then it'd be very difficult to see that we are properly committed to people at the centre of anything that we do.' Interviewee.

'The Provider Partnership should be like a jigsaw, with different pieces coming together to create the full picture.' Interviewees were in agreement that a future independent people's voice organisation is needed as part of the newly established Provider Partnership within Leeds. It 'should be at the heart, prioritising its work, how its money is spent, to provide check and challenge, not just an equal partner but foundational to everything that happens prior to the decision-making space.'

A future organisation was described as sitting within but independent of or 'not beholden' to the Provider Partnership. The suggestion of 'embedded independence' was made, so that it could offer insight and challenge to the system and facilitate accountability checking that recommendations are followed and functioning as an 'antidote to organisational defensiveness'. Several commented that it is difficult for providers to hold each other to account. 'We're very good at setting up mechanisms and writing reports, but who checks whether recommendations are followed? That independent voice needs to hold us to account. Without it, we're wasting our time.'

[6] See Appendix Four.

A future organisation will be an ‘important way to mitigate the risk of organisational push for efficiency’ and ensure that ‘we do the right thing for people, rather than the right thing for organisations. That has to be the vision.’

The balance within the Provider Partnership for partners, between establishing their joint work streams and accountability, therefore, alongside work which falls within the remit of their organisation, is applicable to the future organisation. The future organisation can support prioritisation work within the Provider Partnership as an equal partner and be responsive to issues as they arise, whilst also maintaining organisational independence and therefore being influenced but not directed by the Provider Partnership. It is likely that another balance within the future organisation needs to be maintained, that of both system influencing and doing provider (and wider) specific work (important, often hidden).

‘With all the reforms happening, the question becomes what council and health partners need from an independent voice over the next year. The pressure might be around changes to child protection, family hubs, and related reforms, and asking for feedback from families in specific localities. It becomes an exchange of understanding about what shapes the work, with a commitment to listen, respond, and feedback in a timely way.’ Interviewee.

‘Having an organisation that is advocating, championing, supporting, enabling, convening, facilitating - all of those things - [the] voice of influence across that partnership is really important.’ Interviewee.

‘The Provider Partnership…is about partners coming together more deliberately to work more efficiently and effectively, rather than duplicating effort. If we don’t do that, organisations will keep doing their own thing alongside a bit of system work, and we won’t make the shift we need. Dual running won’t get us to the new world - organisations will have to change.’ Interviewee.

‘If we’re definitely going to talk about an integrated health and care system, focusing around neighbourhood health and keeping people well in their own homes for as long as possible, then we need to jointly, as a Provider Partnership, contribute to purchasing the support we need from whatever a Healthwatch organisation morphs into. So, it has to be joint and together.’ Interviewee.

Some emphasised the importance of the Provider Partnership trusting the future organisation, needing to listen and not disregard it, that the organisation should be respected by partners and not a tokenistic part of the Provider Partnership. ‘We’ve all got pressures, we’ve all got differing opinions, we’ve all got different ways of working. Nobody is better than anybody else. We are all dependent on each other. And that independent voice should drive everything we do.’

‘Independence matters because organisations have competing priorities, agendas, and pressures. If people’s voice isn’t slightly separate, there’s a risk it reflects what matters to organisations rather than what matters to people. Otherwise, you end up following organisational priorities even when what people are saying is something different.’ Interviewee.

‘I could just imagine the Provider Partnership trying to do something and checking it out with an independent voice organisation, or they say something else, and then the provider partnership going, well, yeah, fine, thanks for that, and we're just going to do it anyway. So, there’ll need to be a way of having teeth in some sort of way.’ Interviewee

‘When providers work together, there’s always an inherent tension about winners and losers. Everyone will say they put the person first, but we need to hear the person independently. Otherwise, we all claim to put people first and miss the biases of our own organisational perspectives.’ Interviewees.

Integrating a future organisation (and perspectives from other people’s voice work in the city) as the ‘third leg of the three legged stool’ (health, care and people’s voice) enables strong focus and equal contribution from people’s voice within the Provider Partnership, ensuring a ‘clear loop to test and see how things sit with citizens’ and enabling independent people’s voice to be embedded ‘into our planning, strategic and tactical work’ to ensure that ‘structures and individuals are held accountable for people’s experiences and outcomes’. ‘We need shared understanding, shared learning, and shared thinking.’ Within this, Third Sector and community organisations advocated for a clearer way of feeding in their listening, particularly to places where it will be listened to by statutory services. (See Appendix Five for a list of examples of good practice in voice work across the city.)

There was recognition of the need for clear mechanisms and clarity on how this happens, and how people are experiencing health and care at a system level, with one suggestion being to use the Three Cs as a lens to monitor how integration is working. Another suggestion offered was for a future organisation to have the jurisdiction to operate in a similar way to an audit mechanism, acknowledging that this would require long-term funding stability so that challenges can be brought without worrying about funding. It was also acknowledged that it could have some limitations if it only focused only on those accessing services rather than the voice of all Leeds citizens.

'How do you have improvement work that's well-led and central to organisational and partnership functioning, while also having the "canary in the coal mine"? Whenever you focus on improvement from within, you risk leaving out the people who never come through the door. You need both. It's a both-and situation.' There needs to be an external "canary" role continually challenging the system: have we really thought about this from someone's journey across organisations? What's it like to live in Leeds? And alongside that, strong internal statutory functions for check, challenge and improvement. Are things going well, or not? There's very little conversation about that on boards. I've rarely seen open discussion saying, we're struggling here, or this has gone really well.' Interviewee.

10.4.2 Priorities for people's voice within the Provider Partnership[7]

'It's about what an independent people's voice needs to do in a new context, alongside provider partnerships and internal organisational arrangements. At a moment when there's an opportunity to pull things together and think creatively, Healthwatch needs to be part of a much bigger conversation. It's not just about Healthwatch as an organisation, but about how independent people's voice sits within what's coming next. The real question is: what is the future need, and then what structures or organisations meet that need?' Interviewee.

[7] People's voice work rather than future organisation is deliberately used here to reflect that there may be a variety of organisations contributing to this.

There is a need for the Provider Partnership to have both a community-level and system-level position where there is an up-to-date picture of current issues across many communities.

To support this, interviewees expressed a need for the following priorities for people's voice within the partnership, both to work with the partnership as a whole and individual providers within it:

- ➢ To both gather expert intelligence, particularly in areas that providers don't know how to get it in, and help to statutory organisations to gather voices.
- ➢ To provide specialist advice to engage with different communities - esp. when statutory partners are proposing or thinking about change.
- ➢ To support statutory services to work out how to do something, not just what to do.
- ➢ To track the links between people's voice activity and the impact it is having.
- ➢ To learn what's working well in one community and whether that might translate into another community.
- ➢ To identify gaps: often Third Sector colleagues 'have a better sense of what we're not hearing and who we're not hearing from'.
- ➢ To gather perspectives that people don't directly tell a provider.

'We need a more robust process now, because if we don't design these things in, we're going to see more distance being created between services and people than we've ever seen before. We really need to ensure that there's a robust people's voice organisation to ensure that pace doesn't mean we lose the people we've spent quite a lot of time in recent years really working to ensure that we hear and seek to work with.' Interviewee.

‘One key area is what happens before decisions and business cases land at the Provider Partnership. My expectation is that my teams ensure that when they are writing specifications, business cases, reviewing or evaluating services, there is clear evidence of engagement and co-production. At the moment, that’s inconsistent. There are pockets of good practice, but often by the time things reach the Provider Partnership it’s too late and people’s voice becomes an afterthought. It’s not just about people’s voice being present at the table as an equal voice within the Provider Partnership, but about people’s voice being foundational to everything that happens before anything even reaches that decision-making space.’ Interviewee.

10.4.3 How a future organisation could support the Provider Partnership

Various interviewees involved in the Provider Partnership suggested particular ways in which a future organisation could support the work of the Provider Partnership:

- ➢ Providing quarterly insights rather than an annual report, as the Provider Partnership needs to be responsive to both emerging issues and long-term themes.
- ➢ Being strongly embedded within Leeds' strategies and organisational performance tables.
- ➢ Providing information and feedback, which is:
  - ○ More specific and highly targeted, rather than generic, to support tangible action.
  - ○ Thematically analysed across feedback to complement individual stories.
  - ○ Regular and objective on particular themes.

‘We need to be careful not to move into serving organisations rather than citizens.’ Interviewee.

10.4.4 Further questions and suggestions about the Provider Partnership

Within the interviews, some questions and suggestions arose around the Provider Partnership more widely than the role of a future organisation within it. This included:

1. Who will the Provider Partnership have accountability to? Suggestions made were the Health and Wellbeing Board (statutory, cross-system, well-established, well-regarded), or the Scrutiny Board, including reporting of both insights and feedback, and how organisations have learned and responded. Another suggestion was the Scrutiny Board, particularly for the Provider Partnership to be accountable as to how it is listening to people.
2. That it works out system priority areas v organisational priorities and does system priority areas once.
3. Is it just about budgets and structures or genuinely joined-up working? Organisational boundaries make it challenging. Even with the best intent to work on a collective, collegiate basis, as that gets down to the actual tasking, that is easier said than done.
4. Are senior leadership willing to be bold and radical? Will they think around the edges or really shift things? For example, with neighbourhood health, it is important to interface at this strategic level.

'There's also loads we don't know yet. We don't link this enough to research and development agendas. What are the reasonable limits of co-production in day-to-day practice? What helps people focus on it? What do people understand by compassion? How does compassion vary across health and care circumstances? What does good coordination actually look like? There's a lot there that would benefit from more research.' Interviewee.

10.4.5 What does funding for a future organisation embedded within the Provider Partnership look like?

Amongst most interviewees, there was an acknowledgement that, despite the very challenging financial climate and the impact that has on providers, the resourcing will need to be spread across the providers within the Provider Partnership for system-wide listening, with individual providers able to commission additional work which they resource independently.

‘Enabling people to have their voices heard ensures their needs are understood and met. In a time of scarcity, that narrative becomes even more important. To spend public money well, we need to understand needs, review whether what we’re doing is working, and avoid waste.’ Interviewee.

The clear question is how, with some suggestions made:

1. All service providers contribute equal sums.
2. Proportion based on income/size of organisation.
3. Small % (e.g. 0.25%) added on to contracts.
4. Contributing funding from vacancies.
5. Local authority amount should stand, but any withdrawal of national government funding should be met from other providers.

It needs to feel fair, proportionate, have a clear methodology and a tangible commitment, ideally from all partners - or at the very least this latter part should be worked towards. ‘If providers don’t commit, then it is very difficult to see that we are properly committed to people at the centre,’ but ultimately it will be chief officers who need to be convinced and therefore willing to allocate funding to a future organisation. It was noted that there are precedents for cross-funding health and care system-wide initiatives, with the Leeds Health and Care Academy as an example.

‘We’re a multi-billion-pound system, and if we can’t each contribute relatively small amounts to put people’s voice on a stronger footing, that’s a concern.’ Interviewee.

10.5 Staff voice

This was the least favoured development in the Involvement Leads workshop and was the second lowest priority across survey respondents. Whilst participants in the workshop acknowledged the importance of insights from the workforce, reasons to not prioritise it were given as: it might overshadow and take away resources from wider people’s voice work; it might involve a different skill set; the future organisation may not be best placed to occupy this space.

However, participants also acknowledged that joining up staff voice across organisations could be useful, for example, to aid with transition points between services/provision and to support the cross-working of the Provider Partnership.

Interviewees were divided on it. Some said they would welcome it, providing an independent space to feed into for staff, who are seeing things day in and day out; to comment both on service delivery and their own experiences whilst delivering services (for example, racism). This might be especially important for staff who don't feel they are being listened to internally. However, others countered this with it being a duplication of existing internal and external mechanisms in place for staff voice to be heard (such as staff networks, Freedom to Speak Up guardian and whistle-blowing practices) internally and via CQC or Trade Unions externally. Various points of caution were raised, including:

- ➢ Such a huge area could risk diluting what a future organisation could achieve.
- ➢ Puts the focus on serving organisations rather than citizens.
- ➢ A future organisation needs a clean, clear focus on the customer, patient and people's voice.

11. Conclusion

The reflections and perspectives shared throughout this report point towards a direction of travel for the future shape of people's voice work in Leeds. Throughout interviews and workshops, phrases such as 'golden thread', 'at the heart', 'at the core' and 'front and centre' were used to emphasise that people's voice must remain central as the system evolves and as the Provider Partnership develops. There was recognition that the rich ecosystem of people's voice work across Leeds provides significant insight through its existing mechanisms - and yet some voices remain less heard. The filter of people's voice is seen as important for all strategic work, from how services are designed to how outcomes are improved, and there is therefore agreement amongst many that a future organisation should be an equal partner within a responsive health and care system.

Across all the questions posed, the one that drew the clearest consensus was that people's voices on health and care should not be separated, despite the Dash report's recommendation. People do not divide their lives into health and care, and the system should not divide their experiences either. If Leeds is to maintain its commitment to person-centred care, then independent people's voice work must span both health and care together. The more joined-up the approach, the more it begins with the citizen and places people, rather than organisations, structures or silo-working, at the centre. Separating the two would run counter to the neighbourhood health agenda and reverse the direction of travel the system has been pursuing.

There was widespread regard for the skilled and positive Healthwatch Leeds staff team, whose work is well respected across the city, and that people did not want to lose this. A distinctive strength of their model is that it is a people's voice rather than patients' voice organisation, listening beyond those already in contact with services to issues that come directly from people and communities.

'High quality comms; great commitment and leadership from all at Healthwatch; positive and constructive challenge & co-ordination of PVP has been transformative for the system.' Survey respondent.

There is a strong desire to retain and extend the excellent people's voice work in the city, which is seen as essential to strategic work, from service design to improving outcomes. However, several highlighted opportunities to address the inconsistency in people's voices work.

Issues raised were inconsistency in people's voice engagement across the system - in both quality and quantity, a lack of clarity around the remit of engagement (particularly between Healthwatch and Third Sector organisations) a desire for more specificity in feedback leading to action and shared agreement on how a future organisation can work well within the Provider Partnership.

Internally, the system lacks a standardised approach to engagement, leading to continual experimentation rather than a confident, collective method. There was interest in a shared framework, checklist or set of principles that colleagues could trust and use. Within this, interviewees emphasised the value of using existing tools well – such as Quality and Equality Impact Assessments – and learning from effective models already in use, including the 'Five Os' in Children's Services or the former Leeds Clinical Commissioning Group approach, where any transformation programmes were required to present an engagement and co-production plan to a people's voice group for scrutiny before progressing.

Finally, there was a clear desire to build on the work that has started to understand the full landscape of where people's voice is already heard across the city – community committees, race-equality groups, communities of interest and more – so that future work builds on what exists, avoids duplication, and reflects the breadth of people's lives across health, care, housing, employment, community and beyond. This does not carry with it the assumption that it is the responsibility or role of a future organisation to do this, but that this is what the city needs and would like to work towards.

So, what does best look like for Leeds?[8]

'What best looks like for Leeds, I would love us to have an organisation that is independent and really understands, and can articulate in a strong and forceful way, the experience and expectations of people in Leeds for their health and care, including the variation in those expectations and in how services are delivered.' Interviewee.

[8] These are all direct quotes from people in response to the question: 'What does best look like for Leeds?'

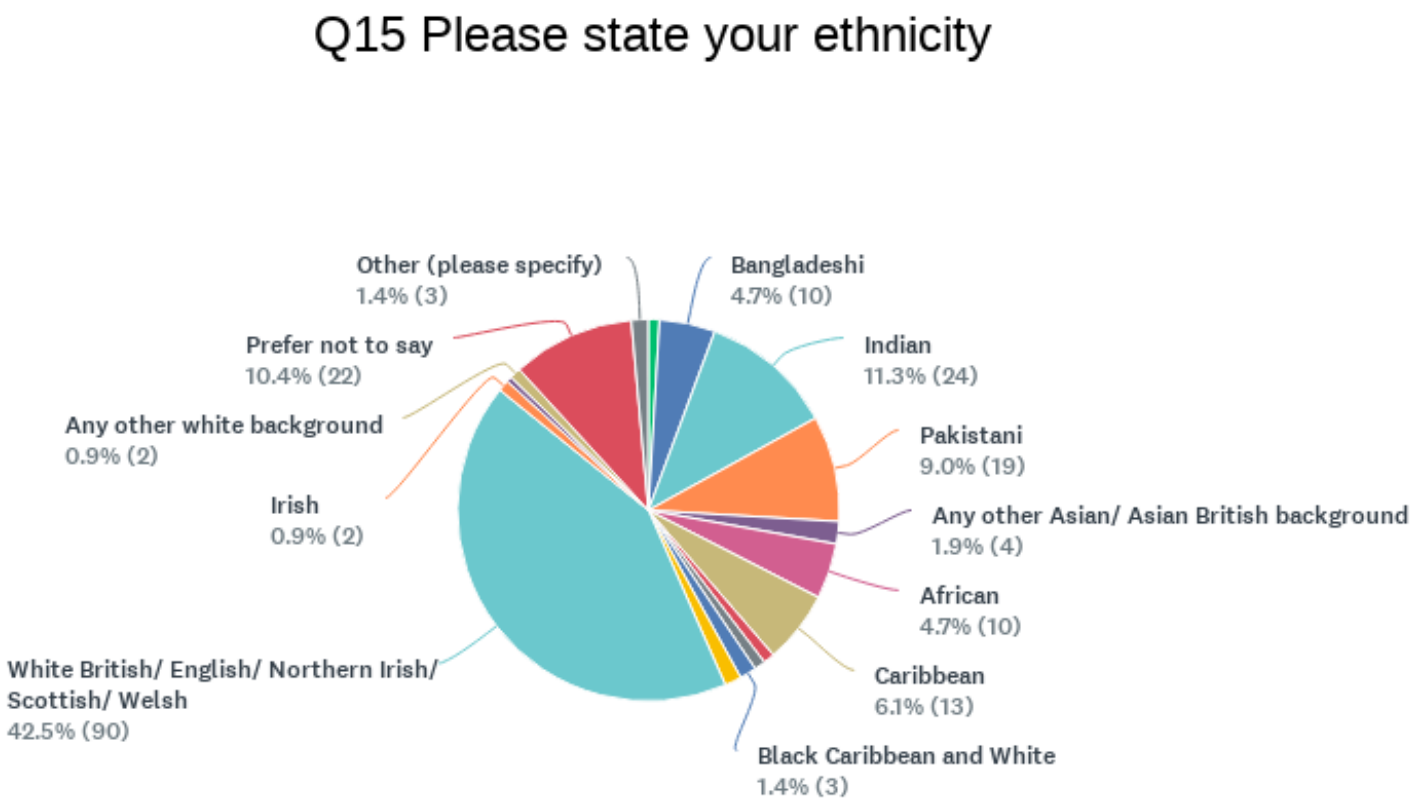
Best for Leeds is a city that hears and values voices - this is the starting place, not halfway through – everything we decide should be based on citizens' views and needs. People's voice should be at the centre, routinely valued, listened to, started with, and acted from. For some, it feels that this doesn’t happen nearly enough at the moment and that it shouldn’t have to keep being proved why that matters.

Best for Leeds is ‘a place where the hardest to hear voices are heard’, where people’s voices within small community hubs are heard and where services are designed from the outside in instead of the inside out. From an evidence-based, outcome-focused point of view, involving people in their own health and care is the way to work. ‘There are so few chances for people to influence decisions that affect their lives, so best for Leeds means grasping opportunities like this and making people’s voices real, not tokenistic.’

Best for Leeds means ‘mov[ing] away from pockets of good practice to equity across the city – currently, the quality of patient experience depends on which community you come from, where you live, etc. It means ‘organisations know how to get insight themselves and how to do something with it’; where good existing community engagement work (Asset Based Community Development, for example) is built upon to support people to improve things themselves; and where what’s strong is protected to shape what comes next.

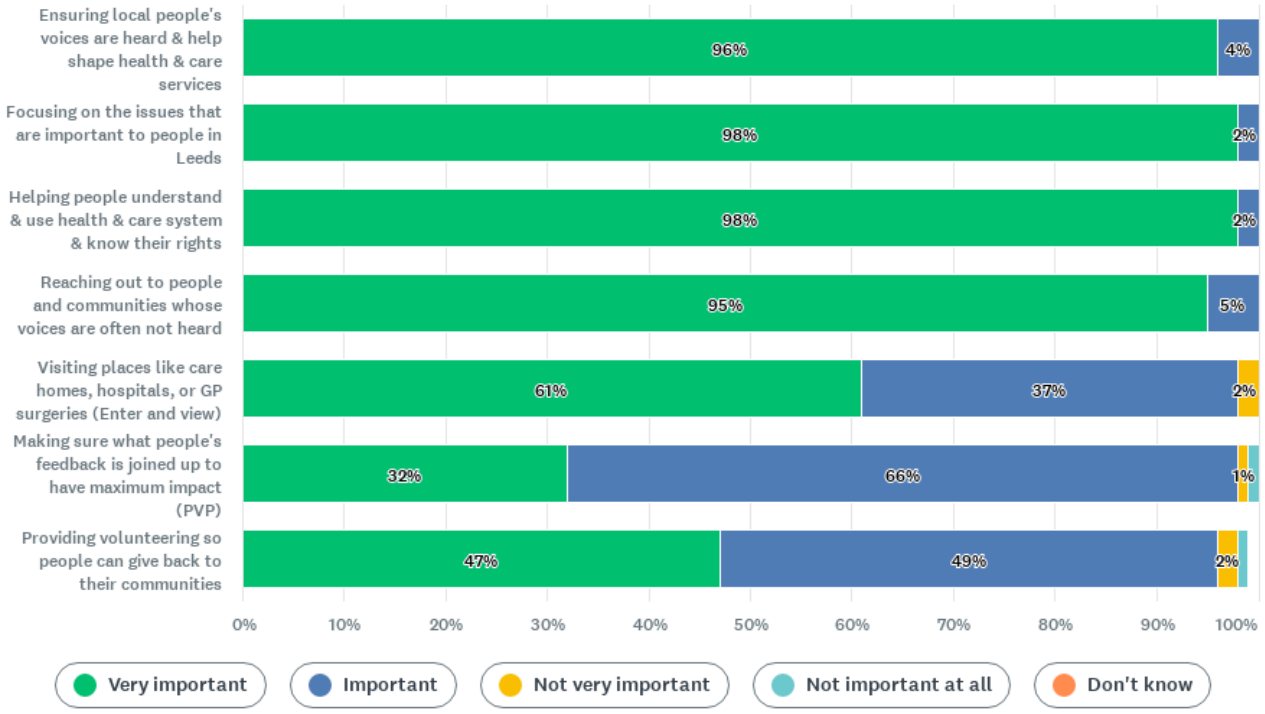
All this sounds in line with what we might expect, and yet there was frequent reference made to how it can be easy to say and harder to do; as one interviewee said: ‘Given a choice, who is going to do the harder thing? And the harder thing – the more complex thing – will 99% of the time be the thing that’s better for people and communities.’

Appendix One



Appendix Two

Q1 How important do you think each of the following is for the future of an independent local voice organisation?



Appendix Three

Scope: Review of Healthwatch Leeds and future ‘independent voice organisation’

1. Aim of the review

1.1 Building on the strengths of Healthwatch Leeds, codesign a model with key stakeholders that takes a coordinated approach to further embed the influence of people’s voices into health and care and other statutory services that have a key role to play in people’s health and wellbeing.

1.2 This is with a view to health and care partners commissioning an ‘independent people’s voice’ organisation that will make Leeds the most open and responsive system in the country and help to reduce health inequalities.

2. Current role of Healthwatch Leeds

2.1 An independent and trusted organisation that proactively engages with the people of Leeds about their experiences of health and care and wider determinants of health and inequalities.

2.2 Enabling everyone to have a say about health and care, particularly those who are less likely to be heard, experience barriers to feeding back or who are at risk of experiencing health inequalities.

2.3 Led by communities – our priorities are driven by what we hear from the communities of Leeds.

2.4 Coordination of the listening activities across health and care via the People’s Voices Partnership that brings together health and care organisations to listen, learn and act on what people tell us about their experiences of health and care.

2.5 Recognised partner in strategic health and care partnerships connecting people’s experiences with decision makers at every level of the system.

2.6 Robust relationship and direct influence with each individual health and care partner, including NHS Trusts, ICB and Leeds City Council.

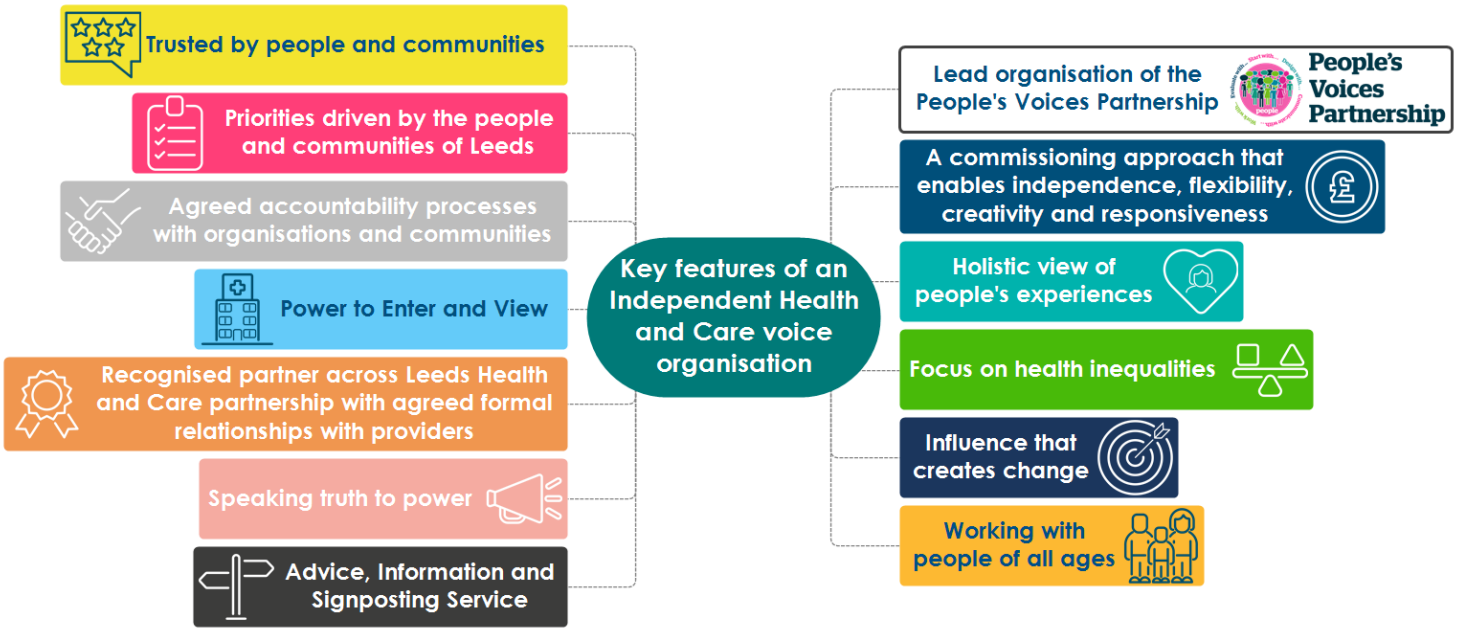
2.7 Statutory power to undertake “enter and view” of health and care services to listen directly to the experiences of people and their carers. These visits provide valuable insight into the quality of care from the perspective of people using services that complements the work of regulators and commissioners to support improvements.

2.8 Production of reports, materials and recommendations based on insight shared by people. We have agreed follow-up processes with partners including our statutory power to request a response within 20 days. This can aid rapid responses to identified issues and help maximise impact that can be fed back to people who shared their experiences.

2.9 Provider of an accessible health and care information and advice service available to the people of Leeds to help people navigate and access the health and care system, know their rights and what their options are if things go wrong. This service also provides us with valuable real-time ‘on the ground’ insight.

2.10 Our work is enhanced by a diverse group of volunteers from local communities, including our nationally recognised award-winning young volunteer group Youthwatch, who lead on our children and young people’s work. We also link our volunteers up with other opportunities with local health and care organisations.

2.11 Local, regional and national influence via our regional links with West Yorkshire ICB and other local Healthwatch organisations, and national bodies such as Healthwatch England, Kings Fund and National Voices.



3. Opportunities for widening/evolving our remit with additional resources

3.1 Co-design, coproduction and community power

Exploring new models of shared leadership with people and communities.
Provide support and expertise to health and care organisations to co-design services with people and communities.
Development of lived experience/volunteer brokerage for health and organisations in Leeds.

3.2 Increased co-ordination of listening activities

Further coordination of the listening activities across Leeds to deliver the Leeds ambitions beyond just health and care.
Creation of a hub for feedback and insight about health and care (including complaints/PALs, neighbourhood health mechanisms).

3.3 Increased accountability of feedback to action

Develop a direct relationship with the activities and accountability mechanisms of the Leeds Provider Partnership.
Report annually on the way the system is working for people with key priorities for improvement that would be monitored.

3.4 Embedding citizen voice into the provider partnership

Facilitate and support the embedding of a citizen voice function into the structures of the provider partnership.
Support embedding of coproduction and lived experience into priority workstreams.

3.5 Staff voice

Providing opportunities for health and care staff to safely share their views with an independent, impartial organisation.

4. Process

4.1 Convene a steering group for the review comprising representation from all key health and care partners with direct authority from their organisations. The group will be led by Healthwatch Leeds and Caroline Baria will be the sponsor Partnership Leadership Team member.

4.2 Undertake a stakeholder survey which identifies the strengths of the current Healthwatch model, areas of improvement and blue sky thinking/opportunities of how we can even further strengthen the voice and influence of people in health and care planning in Leeds.

4.3 Undertake a survey with the public of Leeds using various methods of engagement including outreach to understand what they value from the Healthwatch model, how they would like to be involved and what would benefit them even more.

4.4 Individual interviews with key partners/structures including the Provider Partnership and other key people's voice partners.

4.5 Understand the national context and any guidance as well as next steps being developed in other local areas across England.

5. Timescale

5.1 Steering group to meet three times, January, February and March 2026. Recommendations for PLT to be agreed at final meeting in March.

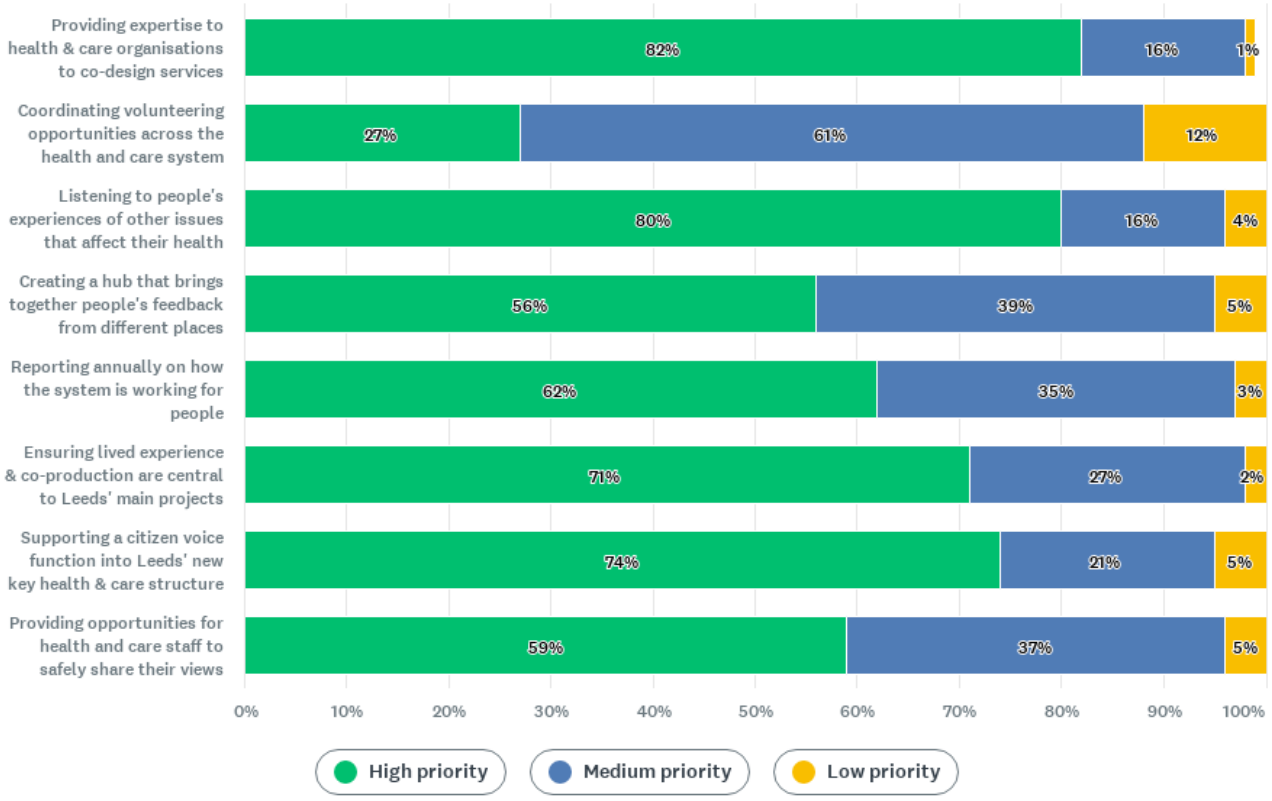
5.2 Public surveys to run November-December 2025

5.3 Stakeholder survey and individual interviews to take place January-March 2026

Appendix Four

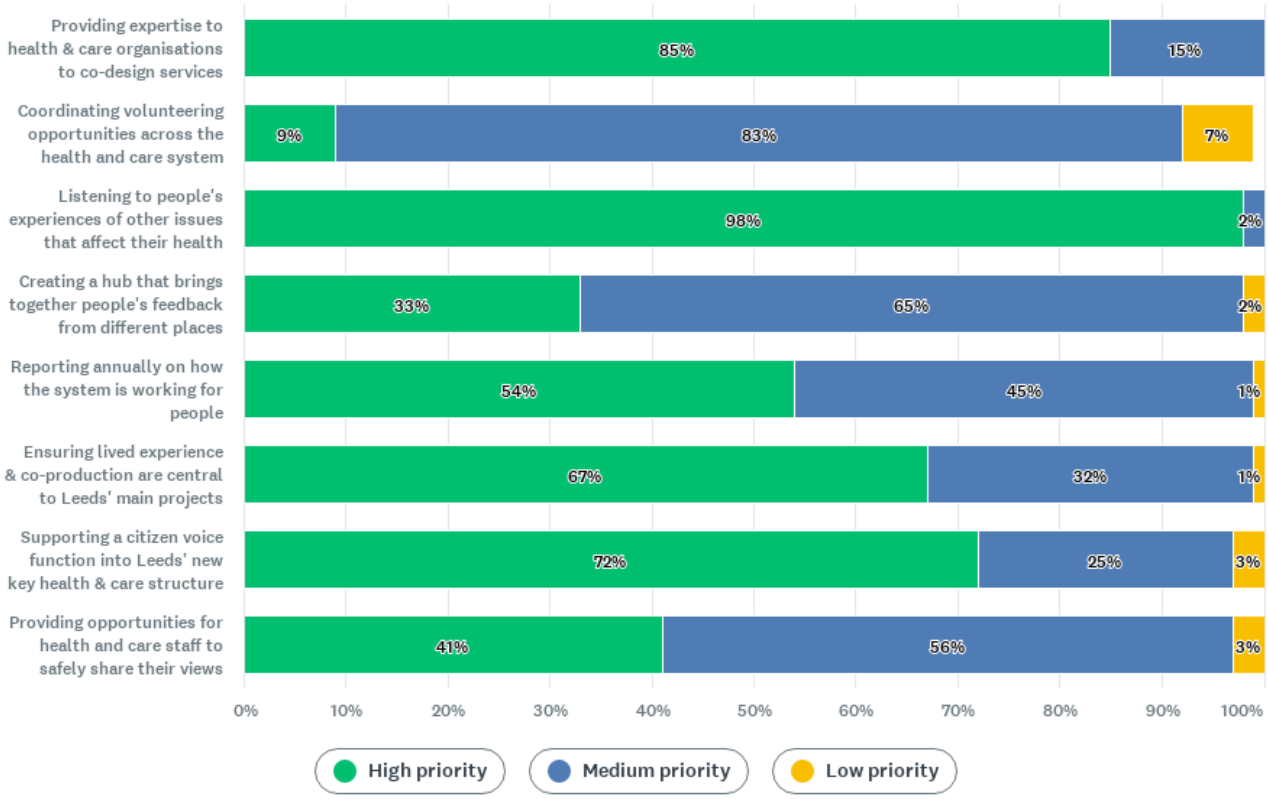
All respondents (324)

Q3 Below is a list of possible additional future offers from an independent voice organisation. Please tell us how high a priority you think each of these are.



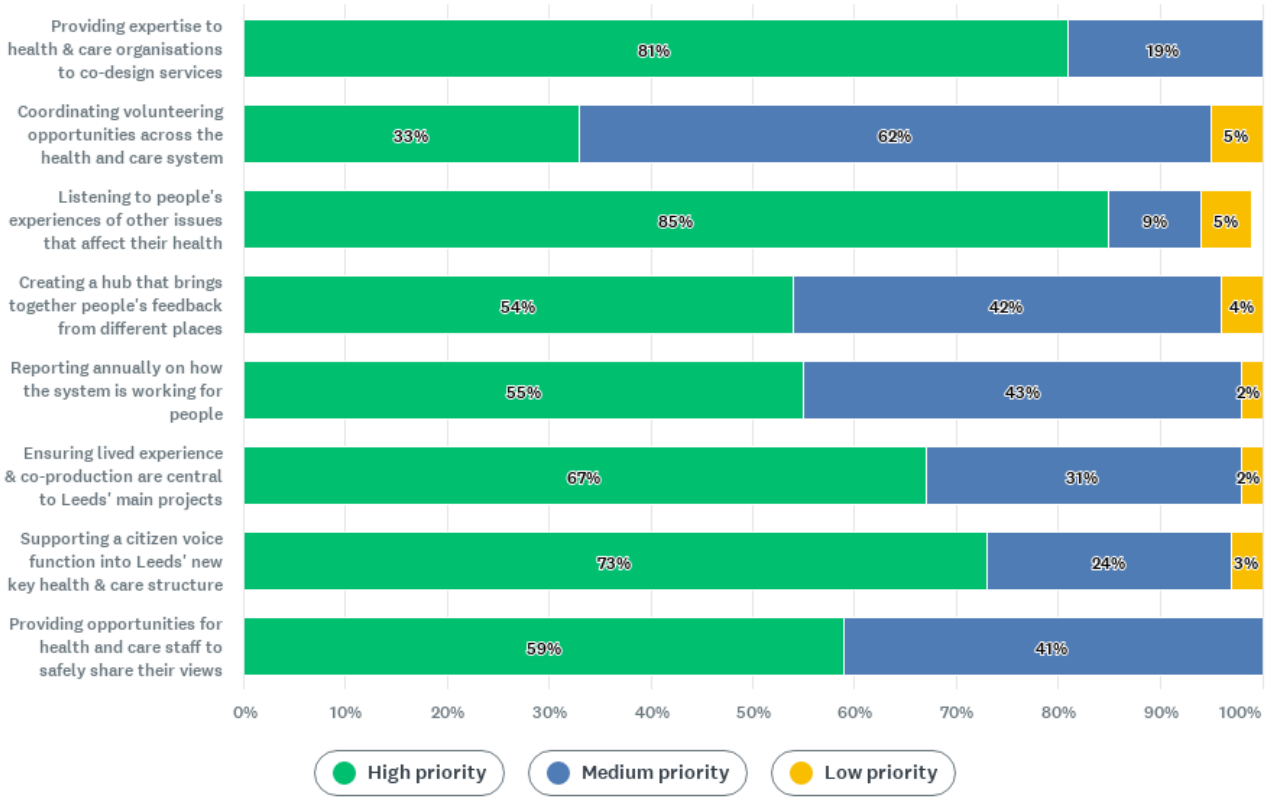
Respondents from culturally diverse communities (95 of 215 members of the public asked to complete demographic information)

Q3 Below is a list of possible additional future offers from an independent voice organisation. Please tell us how high a priority you think each of these are.



Respondents who are disabled, neurodivergent, experience mental health issues or have a long-term health condition (95 of 215 members of the public asked to complete demographic information)

Q3 Below is a list of possible additional future offers from an independent voice organisation. Please tell us how high a priority you think each of these are.



Appendix Five

During interviews and in the Third Sector workshop participants shared some of their experiences of organisations and initiatives delivering good practice around people's voice work in the city. Those named were:

- ➢ Age UK
- ➢ Allyship programme on the Health and Wellbeing board
- ➢ Anti-stigma work
- ➢ Beeston Action for Families
- ➢ Children and Young People's work within Leeds City Council
- ➢ Forum Central (with particular reference made to the work with Roma communities in partnership with Public Health)
- ➢ Healthy Communities Together inclusion health work
- ➢ Inclusion North - Good Life Leaders Project
- ➢ Leeds Domestic Violence Services Partnership Voices Project
- ➢ Leeds Gypsy and Traveller Exchange
- ➢ Leeds Older People's Forum's Age-Friendly Steering Group
- ➢ Leeds Poverty Truth Commission
- ➢ Leeds Involving People's D/deaf forum
- ➢ Patient and Carer Community (PCC) within the Universities
- ➢ Skippo
- ➢ Touchstone
- ➢ We Are Seacroft
- ➢ Visible
- ➢ Yorkshire MESMAC

And many peer led charities which are establishing due to need not being met.

From this list alone it can be seen that the Third Sector is a rich and powerful resource in the city, and that the sector and the city would benefit from it promoting a common message to those in power, influencing culture, embracing challenge, presenting key issues together - with the ultimate objective of asking for more accountability for the people of Leeds.

Appendix Six

Q2 How important to you think each of the following characteristics are for a future independent local voice organisation?