

Independent Patient & Public Voice in Greater Manchester

Stakeholder feedback on the draft IPPVS model from our survey, written submissions and meetings

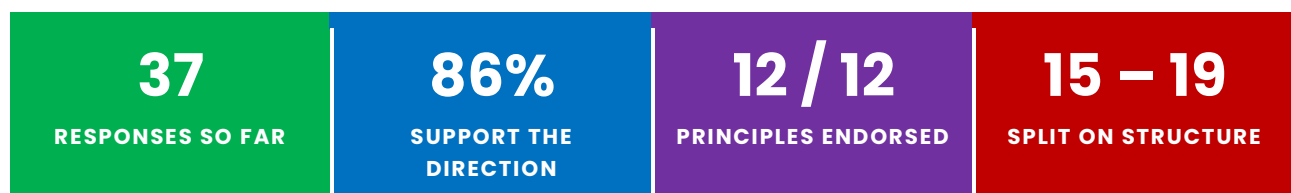
Healthwatch in Greater Manchester

Introduction

This is the analysis of stakeholder feedback on the draft model for a future Independent Patient & Public Voice Service (IPPVS) in Greater Manchester. The survey opened on 21 May 2026 and closed on 13 July 2026.

Feedback arrived through three channels, an online stakeholder survey, formal written submissions from partner organisations, and direct feedback meetings.

What the responses tell us



Five headline messages

- **Strong backing.** 32 of 37 support the direction; 2 are neutral and 3 disagree. Every principle is rated essential or very important by a clear majority.
- **No winner on structure.** Across all 37 responses, 19 back a centrally coordinated network and 15 a locally driven one, with 3 open to either, a modest lean to central coordination, not a clear mandate. Most want the strengths of both, “must be both!”
- **Get the tone right, critical friend, not stone-thrower.** independence and challenge are welcome, but only within genuine partnership, “respect works both ways.”
- **Make accountability real.** The most consistent ask across sectors: recommendations must carry weight, with system leaders expected to respond and act, “you said, we did.”
- **Build on what exists, and don’t duplicate it.** Fund and trust established Healthwatch, VCSE and community networks; avoid creating a new voice that overlaps what already works, “trust your communities.”

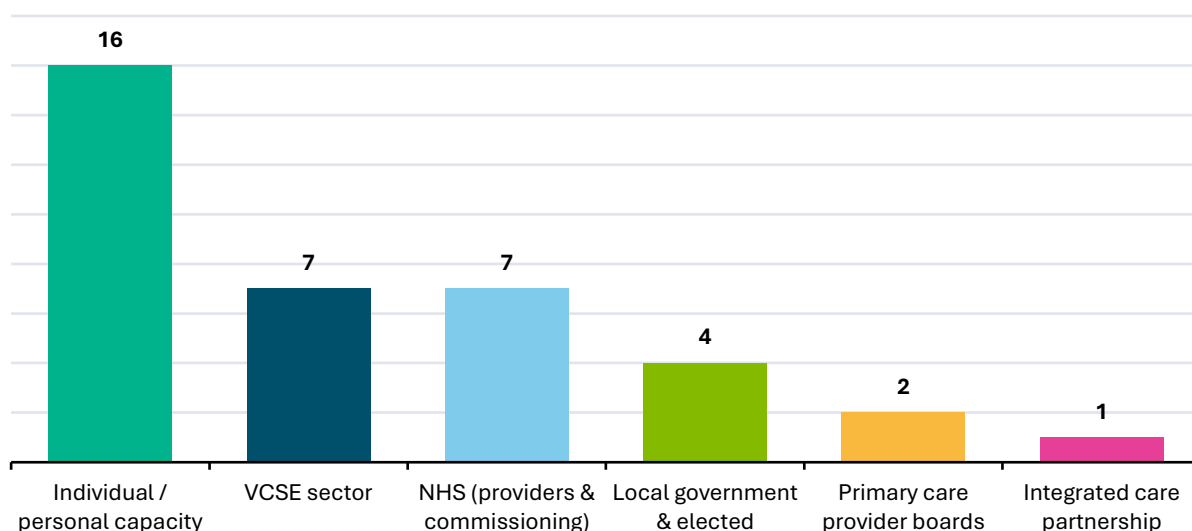
Who gave us feedback

This report draws on three strands of feedback, the online stakeholder survey, formal written submissions, and direct feedback meetings, all counted together. The charts below profile all 37 responses; two of them (a written submission and a meeting) are set out at more length under “A closer look”, which follows this section.

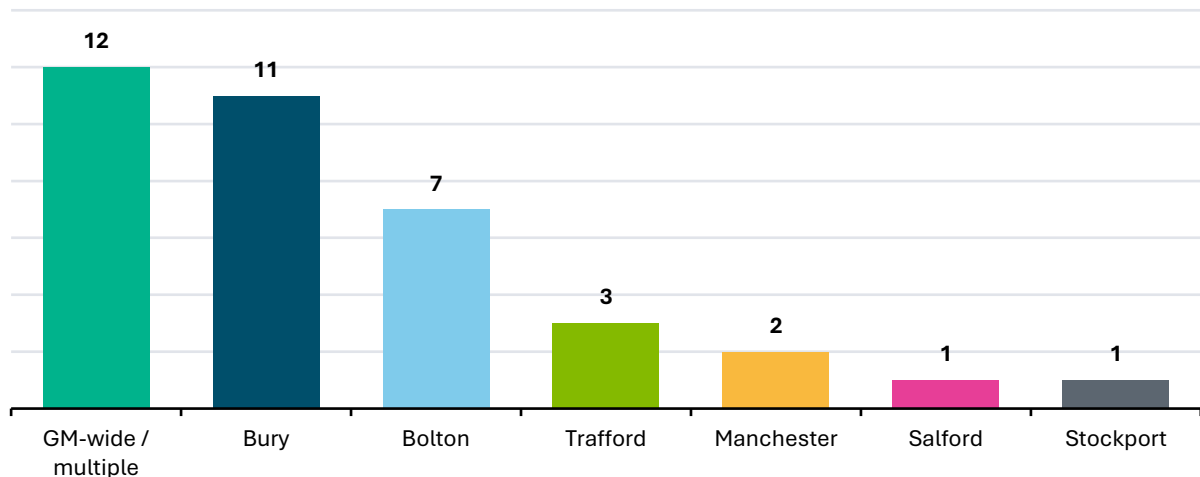
Feedback spans the voluntary, community and social enterprise (VCSE) sector, the NHS, local government, primary care provider boards and system partnership leadership. Of the 37, 21 came on behalf of an organisation and 16 in a personal capacity, a marked rise in individual voices.

Organisations heard from include Age UK Bolton (and the Age UK Greater Manchester Collective), Bolton CVS, Bolton Together, BACKUP North West, Bolton Dementia Support Group, Salford CVS, George House Trust, the Northern Care Alliance, Bolton and Greater Manchester Mental Health NHS Foundation Trusts, NHS GM (Bury), Bolton Council, Trafford Council & NHS GM, Manchester Integrated Care Partnership, the Optometry Provider Board, Community Pharmacy Greater Manchester, Bolton NHS Foundation Trust, Bury Metropolitan Borough Council, Bury Council Public Health and Pennine Care NHS Foundation Trust.

Who responded — by sector



Where responses came from — by locality



Three responses in more depth

Three of the 37 responses came not through the survey but as a written submission and two feedback meetings. Each is substantial, so we set them out at more length here, their views are already counted in the figures above.

Written submission, Greater Manchester Mental Health NHS Foundation Trust

The first formal written submission is from **GMMH**, whose Executive Leadership Team, with director-level representation from across the Trust, discussed the draft model and responded in strong support of continuing an independent voice.

“The Trust highly values the role of our local Healthwatch organisations in enabling the patient and public voice to be heard... which the independent nature of the organisations supports.”

“[We would be] happy to support either model that provides a sustainable way forward and protects the independent voice... and, given the Trust provides services in a number of localities, would value a consistent approach across GM that enables the local voices... to be heard and influence the future service provision.”

— Elizabeth Calder, Director of Strategy & Partnerships, Greater Manchester Mental Health NHS Foundation Trust

Feedback meeting, Trafford Council & NHS GM

In a feedback meeting on 26 June 2026, **Thomas Maloney, Programme Director for Health & Care at Trafford Council & NHS GM**, set out how the service could work in practice. He described local Healthwatch as “*custodians of lived experience*” and a “*repository of community intelligence and insight*” that is not yet consistently used across all areas. His main points:

- **Stay embedded in local governance.** Healthwatch should remain in formal governance structures at place level, with the leadership to hold NHS and council colleagues to account, while integrating more closely with place partnerships and co-locating with voluntary and statutory partners.
- **Align to system priorities.** Work plans should align more closely with system-wide priorities, rather than focusing solely on recurring public concerns such as GPs and A&E, to maximise impact.
- **Prove the value of GM coordination.** Supportive of GM-level collaboration, but he questioned whether localities have felt the benefit, calling for clear mechanisms to share and transfer learning, citing a Trafford urgent-care review whose methodology “could be applied elsewhere if there is a GM-level function to facilitate this transfer.”

Feedback meeting, Pennine Care NHS Foundation Trust

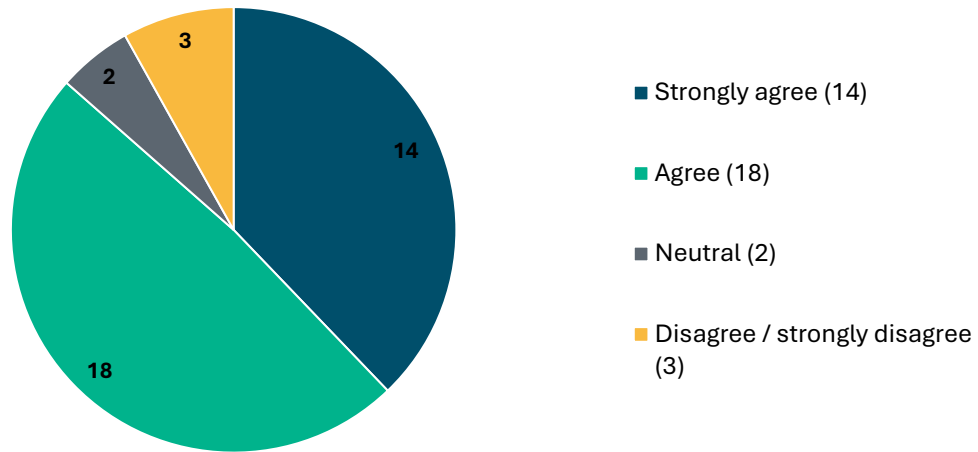
In a feedback meeting on 9 July 2026, **Ben Woffenden, Head of Patient & Carer Experience & Engagement at Pennine Care NHS Foundation Trust**, the mental health, learning disability and community provider spanning Stockport, Tameside, Heywood, Middleton & Rochdale, Oldham and Bury, gave strong support for the model’s principles, with strong agreement from the Trust’s governance group. His main points:

- **Breadth over frequency.** The service must cover the full range of issues and services, giving parity to mental health, disability and seldom-heard groups, so the work plan is not dominated by the most common concerns such as GPs and A&E.
- **Independence, answered by the community.** Maintain a genuinely independent patient and carer voice aligned with Healthwatch principles; questions of independence and impact should ultimately be answered by the community, through co-design, co-production and centring EDI.
- **Strong provider links, clear boundaries.** Build transparent, structural connections with provider organisations to enable feedback loops and accountability, with clear boundaries, so partners cannot use the service to defer their own responsibility for acting on feedback.
- **Align, don’t duplicate.** Multiple organisations engaging the same communities causes confusion and dilutes impact; consolidating engagement through a trusted, independent vehicle could simplify processes and empower communities, provided independence is preserved.
- **Central and local both matter.** A central GM function offers consistency, while locality functions address specific population needs; any model should align with providers’ own structures — Pennine Care’s care hubs and networks — to be effective at every level.

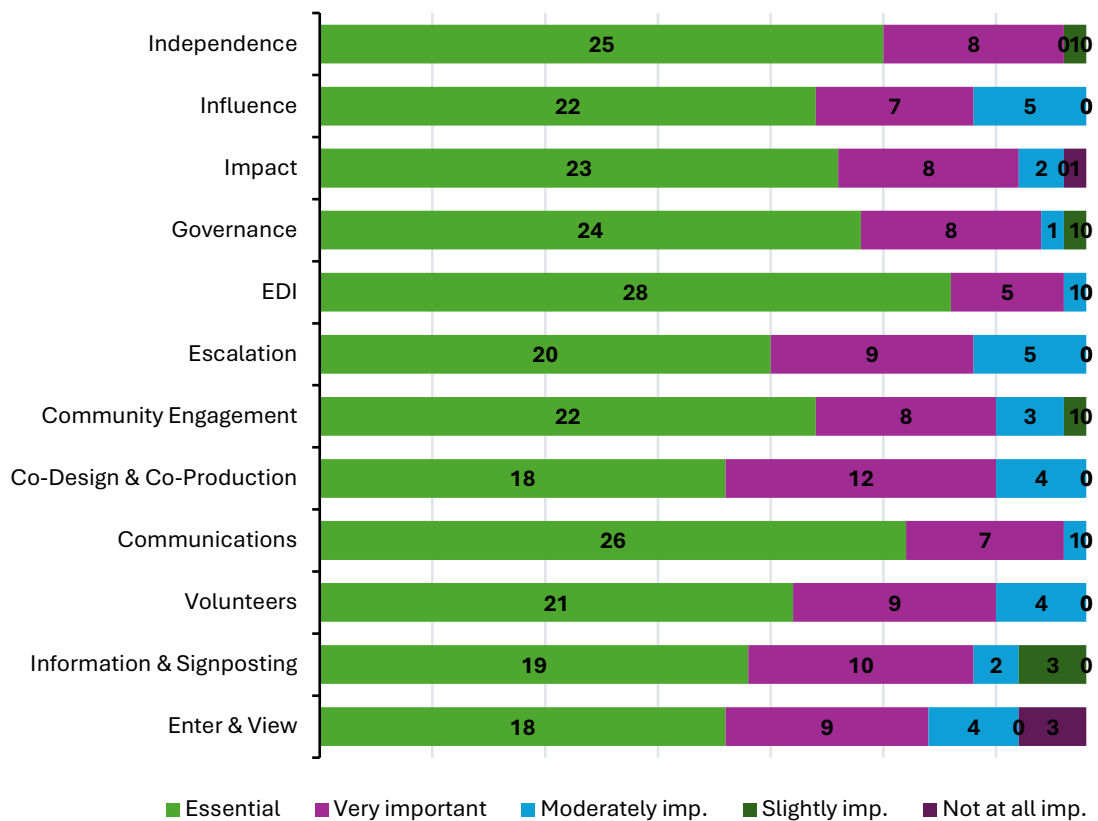
Support for the model and focusses for implementation

Support for the overall direction remains strong: 32 of 37 responses back it.

Overall support for the draft model



How important is each principle? (from those who rated them)



What stands out

- **EDI, Communications and Independence draw the strongest backing**, EDI, Communications and Independence draw the strongest backing, each rated essential or very important by all but one of the 34 who rated them.
- **Every principle keeps a clear majority**, rating it essential or very important, the draft principles can be carried forward with confidence.
- **Enter & View is the most contested**, three respondents rated it “not at all important,” questioning duplication with regulators, whereas others insisted it must be retained with real teeth.
- **Volunteers remain valued but need resourcing**, welcomed as a “core asset,” yet with clear warnings against over-reliance: “volunteering is not free!”

How should the service be organised?

Asked to choose between a locally driven collaborative network and a centrally coordinated model with a local focus, responses now lean modestly to central coordination, 19 for centrally coordinated and 15 for locally driven, with 3 explicitly open to either. No structure commands a majority, and the comments suggest a hybrid approach should be explored.

The three open to either illustrate why. Greater Manchester Mental Health NHS Foundation Trust, a provider operating across several GM localities, is content with either, provided it is sustainable and protects the independent voice, while valuing “a consistent approach across GM that enables the local voices ... to be heard.” The feedback meeting with Trafford Council & NHS GM added a condition: any GM-level function must demonstrably add value locally, with real mechanisms to transfer learning between places, not coordination for its own sake. Ben Woffenden of Pennine Care NHS Foundation Trust, a provider spanning several boroughs, likewise valued a central GM function for consistency alongside locality functions for specific population needs.



Why “locally driven”

People trust and use local services and relationships, “communities know what they need rather than central.”
Keeps the focus on place and flexibility, “dividing everything by ten won’t be effective.”
Reflects subsidiarity, “GM being an 11 (not 1 or 10).”
Guards against GM detachment, centralised GM ICB engagement has felt “not [enough] aligned with locality needs.”

Why “centrally coordinated”

- Consistency, efficiency and resilience across GM.
- A stronger, combined voice and system-wide influence.
- Matches the ICB footprint — “so much commissioning decision-making is pan-GM.”

Reduces duplication and dilution of resource across localities.

What this means for the organisational model

Feedback indicates a modest lean to central coordination (19 to 15, with 3 open to either), and still no mandate for one structure over the other. The comments point to a **hybrid**: strong local relationships and identity, held together by light-touch GM coordination for shared influence, consistency and escalation, with clear neighbourhood to place to GM pathways, and resource shared by need rather than in equal tenths. As one respondent put it, “**must be both!**”

What stakeholders are telling us

The survey’s free-text comments give important detail. Ten themes run through them, some reinforcing the draft model, others challenging it.

Make accountability real

The strongest recurring message was that insight must lead to change, and the system must be seen to respond.

“If we don’t do this, there is no point asking people for their input and involvement.”

BACKUP NORTH WEST

“Demonstrate the ‘You Said, We Did’ feedback loops.”

, OPTOMETRY PROVIDER BOARD

Tone: a critical friend, not throwing stones

Especially from NHS partners, challenge is welcome, but within partnership.

“...part of partnership arrangements... rather than standing on the side throwing stones.”

, NHS GM (BURY)

“The moment Healthwatch start to feel... they are trying to catch people out... there is a problem. Respect works both ways.”

, NHS GM (BURY) & BURY COUNCIL

Independence, in practice, not on paper

Independence is prized, but respondents want the mechanisms that guarantee it.

"...useful to understand what mechanisms will be in place to ensure this is realised in practice, not just in design."

, BOLTON CVS

"If an IPPVS is to be 'hosted' it must not be by a provider organisation of any description."

, VCSE RESPONDENT

Build on, and fund, what already exists

A clear VCSE message: don't reinvent; resource and trust existing networks.

"Please do not miss this opportunity to position the VCFSE sector as experts in their localities... Trust your communities!"

, BACKUP NORTH WEST

"GM being an 11 (not 1 or 10), a local organisation tapping into a GM network is a trusted and effective model."

, SALFORD CVS

Don't duplicate, be honest about reach

Some question whether another "voice" helps or crowds an already busy space.

"Another voice in this space could actually complicate things... I think another community influencing voice could muddy the pitch."

, GEORGE HOUSE TRUST

"It's essential not to duplicate what is already in place."

, MANCHESTER INTEGRATED CARE PARTNERSHIP

Be realistic about impact and capacity

A caution against over-promising, and against the wrong success measure.

"If the impact measure is 'improvement in services', then it's going to fail... challenging it and shaping it is [what's achievable]."

GEORGE HOUSE TRUST

"Hugely intensive at the level of 67 neighbourhoods — be careful not to over-promise with limited capability."

, NHS GM (BURY) & BURY COUNCIL

Be honest about co-production

Support for co-production, but with a plea for clarity and realism.

"There needs to be transparency as to what is consultation or engagement and what is true co-design and co-production."

, BOLTON TOGETHER

**, VCSE RESPONDENT
VCSE RESPONDENT**

Widen the lens: prevention & ageing well

Several want the service to look upstream, not only at service problems.

"Patient and public voice begins long before people enter formal services."

, AGE UK BOLTON / GM COLLECTIVE

"Recognise information and signposting as a source of preventative insight."

, AGE UK BOLTON / GM COLLECTIVE

Enter & View, keep it, but sharpen it

Strongly defended by some; questioned as duplicative by others.

"There needs to be power behind the recommendations following visits, required changes need to be enforceable in some way."

, **BOLTON TOGETHER**

"Enter and View... often provides only a snapshot... resource-intensive and potentially duplicative."

, **COMMUNITY PHARMACY GM**

Don't forget primary care

Primary care partners want to be explicitly built into the model.

"Primary care... is often patients' first point of contact... it is therefore important that primary care is explicitly included within the IPPVS's engagement, reporting, and influence structures."

, **OPTOMETRY PROVIDER BOARD**

EDI at every level

The top-rated principle draws the most pointed calls for genuine reach.

"Must ensure the individuals and communities who data shows are likely to get the most raw deals are involved at all levels of governance and operational delivery."

BURY (INDIVIDUAL)

"Support local organisations to engage with seldom-heard groups – act as the conduit between public, patients, communities and organisations."

BOLTON NHS FOUNDATION TRUST

Impact, or it's wasted money

The accountability message is, if anything, sharper in the wider response.

"Without impact it is a waste of public money."

BURY (INDIVIDUAL)

"Reports can be vague and misleading. Impact reports and data capture on efficacy, reach and impact are much needed."

BURY (INDIVIDUAL)

Value lived experience; fund the work

Community voice and volunteering must be resourced, not assumed.

"Using the people's voice and people of lived experience to guide projects – the hidden voices are essential."

BURY COUNCIL PUBLIC HEALTH

"Enter and View should be properly funded so visits can take place to all relevant establishments on a regular basis."

SALFORD CVS

Look upstream, and include primary care

Several want a broader, preventative remit and a clear route into the system.

"Position the IPPVS as a strategic asset within GM's wider ambitions around neighbourhood health, prevention and population health."

AGE UK BOLTON / GM COLLECTIVE

"A clear escalation route into the system is critical to reduce risk and enact change."

OPTOMETRY PROVIDER BOARD

How these views shape IPPVS implementation

The feedback confirms the overall direction while sharpening what implementation must get right. Taken dimension by dimension, the responses translate into the following implications for how the service should be built.

1. A firmer mandate, but win over the sceptics

The direction is endorsed, not just tolerated. Support holds at 32 of 37 (86%), with 2 neutral and 3 in disagreement. The doubters are few but specific: their concern is duplication and GM detachment, not the principle of an independent voice. Implementation should answer these directly with a published scope statement, what the IPPVS is, what it is not, and how it complements existing bodies.

“Be clear on the role of the IPPVS, what it is and what it isn’t, and how it can support members of the public.” Bolton NHS Foundation Trust

“It’s essential not to duplicate what is already in place.” Manchester Integrated Care Partnership

2. Structure: design for a hybrid, with a modest tilt to GM coordination

The larger sample shifts the structural question only slightly. The forced choice now runs 19 for a centrally coordinated model and 15 for a locally driven network, with 3 open to either, a modest lean to coordination, but no majority for either design. The practical answer is a hybrid: strong local relationships and identity, held together by light-touch GM coordination for shared influence, consistency and escalation, with clear neighbourhood → place → GM pathways and resource shared by need, not in equal tenths. Any GM-level function must demonstrably add value locally.

“A centralised GM model is always more likely to be too detached from the needs of people in the ten localities.” Manchester Integrated Care Partnership

“GM being an 11 (not 1 or 10), a local organisation tapping into a GM network is a trusted and effective model.” Salford CVS

3. Independence: specify the mechanisms, not just the principle

Independence is the most-valued foundation, and the one respondents most want pinned down. Rated essential or very important by all but one of those who rated it, independence is prized, but the recurring ask is for the guarantees that make it real: hosting outside the ICB, GMCA and local authorities; an independent chair; published conflict-of-interest arrangements; and secured multi-year funding, accountable first to the public.

“It would be useful to understand what mechanisms will be in place to ensure this is realised in practice, not just in design.” Bolton CVS

“Secured independent funding, robust conflict of interest and clear accountability framework.” Bury Metropolitan Borough Council

4. Accountability and impact: hard-wire “you said, we did”

The single most consistent message across sectors is that insight must lead to change. Impact is rated essential or very important by 91%. Respondents want a duty on system leaders to respond publicly to recommendations, recommendation trackers, and credible impact reporting, and they warn against vague reporting or the wrong success measure. Build an impact framework into the operating model from day one.

"A clear impact framework, credible information on what has changed as a result of co-design and involvement, along with transparency around the challenges the system has when trying to progress improvements." Manchester Integrated Care Partnership

"Without impact it is a waste of public money." Bury (individual)

5. Tone: a critical friend, not a stone-thrower

Challenge is welcome, but within genuine partnership. Escalation powers are backed (85% essential or very important) and Enter & View defended, yet NHS and council partners are clear that these must be used transparently and proportionately, not as a threat. Implementation should set out escalation thresholds and pathways, a standard escalation route, and a commitment to balanced, evidence-based reporting.

"It certainly needs to have this competence, but to be carefully used so as not to undermine the commitment to partnership working, it needs to be transparently used." NHS GM (Bury)

"Clear escalation agreement, utilisation of the Locality Board / Place Partnership that has the power to escalate into GM governance and upwards thereafter." Trafford (individual)

6. Equality, diversity and inclusion: the top-rated principle

EDI draws the strongest backing of all twelve principles. It is rated essential by 28 of 34 and essential or very important by all but one, the clearest signal in the dataset. Implementation should treat EDI as structural, not an add-on: broker partnerships with VCSE organisations to reach seldom-heard communities, build diversity into governance and volunteering, and use equality impact assessments across workstreams.

"Must ensure the individuals and communities who data shows are likely to get the most raw deals are involved at all levels of governance and operational delivery." Bury (individual)

"Support local organisations to engage with seldom-heard groups, act as the conduit between public, patients, communities and organisations." Bolton NHS Foundation Trust

7. Build on existing infrastructure – and don't duplicate it

The clearest VCSE message is: resource and trust what already works. Fund and partner with established VCSE, Healthwatch and community networks, and map the service against social prescribing, Live Well and the regulators so it complements rather than replicates. This directly addresses the sceptics' duplication concern.

"Please do not miss this opportunity to position the VCFSE sector as experts in their localities ... Trust your communities!" BACKUP North West

"Another community influencing voice could muddy the pitch." George House Trust

8. Volunteers and Enter & View: resource them, and sharpen the scope

Both are valued, but each comes with a condition. Volunteers are welcomed as a core asset (88% essential or very important) but respondents are emphatic that volunteering is not free and needs proper infrastructure. Enter & View is the most contested principle (79%; three rated it "not at all important"); defenders want recommendations with real teeth, while others question duplication with regulators. Implementation should fund volunteer support properly, retain Enter & View with enforceable follow-through, and define it clearly against existing statutory inspection.

"Volunteers are not instead of paid staff. Establish the core investment needed ... then the investment to ensure volunteers can be supported properly." APC

"There needs to be power behind the recommendations following visits, and required changes need to be enforceable in some way." Bolton Together

9. Scope: look upstream and embed primary care

Several respondents want the service to reach beyond service complaints. The strengthened response reinforces a broader remit, prevention, neighbourhood health and ageing well, and explicit inclusion of primary care in engagement, reporting and influence structures. Positioning the IPPVS as a strategic asset, not only a feedback-and-challenge mechanism, would align it with GM's wider ambitions.

"Consider the IPPVS as more than a feedback and challenge mechanism, positioning it as a strategic asset within GM's wider ambitions around neighbourhood health, prevention and population health." Age UK Bolton / GM Collective

"Primary care is often patients' first point of contact ... it is therefore important that primary care is explicitly included within the IPPVS's engagement, reporting and influence structures."
Optometry Provider Board

10. A provider lens: breadth, parity and clear boundaries

The Pennine Care meeting adds a mental-health and learning-disability provider perspective. Ben Woffenden strongly backed the principles but pressed points the survey touches only lightly. First, breadth and parity: the service must give equal weight to mental health, disability and seldom-heard groups rather than letting the most common concerns, GPs and A&E, dominate the work plan. Second, clear boundaries: an independent voice must not let partner organisations defer their own responsibility for acting on feedback. He also favoured aligning and consolidating engagement through a single trusted vehicle to cut duplication and empower communities, provided independence is preserved, and stressed strong, transparent structural links with providers so feedback loops actually close.

"Questions of independence and impact should ultimately be answered by the community."
Ben Woffenden, Pennine Care NHS Foundation Trust

Prepared by Steve Inett, steve@steveinettconsultancy.co.uk.