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The local operation and impact of Healthwatch
Emerging themes

Introduction

In this document, we outline four themes that we will be discussing at the workshop on 28th January 2021. They introduce some of the key points that are emerging from our work with you.

Please refer to them during and after the workshop.

Each section is followed by questions that we're raising in the analysis of our data. Please feel free to send us any additional thoughts on these questions after the workshop.

Themes:

1. Relationship and ethics
2. Scale and scope
3. Engagement
4. Volunteering

1. Relationships and ethics

A principle that is often mentioned in discussions about Healthwatch is that of the 'critical friend'. This principle expresses the need to be a good partner to the health and social care system while also questioning decisions and processes made by the system from the perspective of patients and the public. It is well recognised, both in the studies about Healthwatch and by Healthwatch themselves, that this is a difficult balance to strike. There is a tension at the heart of this principle which forces you to think about yourselves (whether now or in the past) or other Healthwatch as either 'too critical' or 'too friendly'. But is it that straightforward?

In our work with you we found that abstract reflections about being a 'critical friend' - which are questions about what an 'ideal Healthwatch' is - are not particularly useful. In narratives about your organisations, it was always another Healthwatch or the past of your Healthwatch, that was either 'too critical' or 'too friendly'. But when you talked about where your respective organisations stand in the present, your focus shifted to more detailed reflections on the range, modes and quality of your current relationships rather than where you sit on the critical-friend continuum. For instance, when offered the chance to work with

the CCG or other local partners, some of you wonder whether it is appropriate to accept or demand payment for that work, whether such work might be detrimental to your independence, or whether it would enhance your ability to effect change on behalf of local people.

In our presentation, we will explore how looking at relationships opens productive questions about practical, pressing aspects of your work. These include:

- Will closeness to local stakeholders help or hinder the ability of Healthwatch to fulfil its mission? How close is too close?
- What qualities of the partner in the relationship (weak, dominant, big, small, successful, unsuccessful etc) affect the desirability of closeness?
- How does a financial relationship change the nature and ethical value of partnership working? This calls into consideration issues of financial sustainability as well as ethical sustainability – i.e. the ability of Healthwatch to represent the voice of local people in the most effective way possible is at least partly dependent upon financial sustainability. How are the two related?
- In what ways do new/emerging local relationships (with or without money attached) reshape the identity of Healthwatch?
- Is the identity of Healthwatch a fixed thing that needs to be preserved/protected? Or is it something that evolves through time i.e. the outcome of the various relationships in which you are embedded?

2. Scale and scope

Recent changes to the health and social care landscape in terms of greater integration – e.g. ICSs – are shifting the scale of Healthwatch work. Healthwatch are increasingly involved in activities that span beyond the borders of their local authorities, and towards informing ICS engagement work, carrying out ICS-commissioned projects, and attending newly-merged CCG commissioning committees.

These changes were initiated while our research (and the pandemic) were happening. The sense is of still-forming structures and relationships, which raises questions about whether it is legitimate for Healthwatch to operate at that level given that they are contracted to operate locally; moreover, no additional resources are offered.

For instance, at the ICS level, the arrangements through which Healthwatch are involved are varied. Some Healthwatch sit independently alongside other Healthwatch at specially constituted ICS engagement panels; others are ICS Board members. In other areas (e.g. South East London or Berkshire-Oxfordshire-Buckinghamshire [BOB]), by way of contrast, the ICS has paid for new roles – e.g. Director of Healthwatch South East London, Healthwatch BOB Liaison Lead – which is hosted by a local Healthwatch but represents all Healthwatch for the region. Other Healthwatch have come together informally. For example, Healthwatch East Sussex, Healthwatch West Sussex and Healthwatch Brighton & Hove (which are all independent of each other) have, with permission from Healthwatch England, formed a loose confederation called 'Healthwatch in Sussex'. This 'Healthwatch in Sussex' is jointly commissioned to carry out pieces of work in the region.

These emerging arrangements are likely to strongly shape the qualities and possibilities of existing and emerging relationships, not only with key institutional stakeholders but also with local people and other Healthwatch. Some questions to discuss:

- In what ways might closer involvement with ICSs/merged CCGs enhance or hamper Healthwatch's ability to fulfil their statutory functions? This question has two main aspects: first, in operational terms, is it sustainable to divert resources, e.g. staff time, to these new involvements? Secondly, in strategic terms, does involvement remove you from the local nature of your mission? Is such expanded involvement sustainable in both ethical and financial terms?
- How do the different ways in which Healthwatch is involved beyond the borders of their local authority (i.e. in the ways we highlighted above) change or complicate whose voice Healthwatch represents? For example, if one Healthwatch represents all the other Healthwatch at the merged CCG/ ICS level, what dilemmas are raised about how adequately the local voice of other Healthwatch (and the populations they cover) are conveyed?
- How do these arrangements affect relationships with other local Healthwatch? How can these new forms of interaction among Healthwatch be made to work to represent the voice of the people at this new level? Or are new (perhaps unequal) power relationships among Healthwatch a fundamental challenge to success at such levels?

3. Engagement

Healthwatch engagement is commonly understood as Healthwatch staff or volunteers soliciting the views of patients and residents through a range of activities. A recent literature review commissioned by Healthwatch England and compiled by the University of Plymouth, defined engagement as 'the way in which the patient voice can be captured and used to influence service provision, allowing the possibility of tailoring services to adequately meet the true needs of the end-users'.

The practice of engagement raises dilemmas both about the methods of engagement and the focus of Healthwatch's engagement activities. The varied way in which Healthwatch organisations are composed – funding, staffing, relationships – shape how engagement is done by each different Healthwatch. Some of you doubted whether staffing a Healthwatch stall in a local library for a morning was a productive use of staff time or of doing effective engagement. Would the resource be better used to conduct more targeted surveys? Or to constitute a standing panel composed of a fixed number of local people with whom you consult about specific topics? Or to ask a member of staff to collect lived experiences of a specific population for three months?

These latter operational dilemmas that Healthwatch staff and organisations face in relation to the more effective way(s) of doing engagement point to deeper questions about Healthwatch. Different forms of engagement access different types of voice. For instance, the processes of gathering feedback at a library stall gives Healthwatch access to a seemingly random, individual voice. Compare this to the activities of a standing panel comprising, say, young adult users of social care, which Healthwatch convenes to gather experiences, which may be more targeted, and which Healthwatch might be more easily able to synthesise into a collective voice.

The question of engagement is also shaped by particular local conditions which include staff and volunteers' individual and activist histories, politics, demographics, and social deprivation. For instance, these elements influence whether you choose to prioritise engagement with particular marginalised communities or whether you aim for a more 'generalised' community engagement on people's experiences of care services e.g. an untargeted survey sent to a non-sampled participant group. Prioritising one over the other may have consequences not only for the kind of voice accessed by Healthwatch but also the character of the voice of Healthwatch itself. Focusing on the marginalised for instance, might emphasise to a greater extent than before Healthwatch's role in tackling health inequalities, which while valued by Healthwatch staff and external stakeholders, is not a statutory function.

Even when Healthwatch chooses to engage with marginalised communities, different models of engagement can change the way in which community voice is heard and transmitted. For instance, some Healthwatch organise and coordinate for a attended by specific communities of people, accessed through the involvement of VCSE. Other Healthwatch directly fund VCSE organisations to carry out specific engagement projects with their service-users to capture voices which would be otherwise difficult to access. Both models may have unintended consequences for Healthwatch's role in conveying the voice of local people in terms of undermining transparency, credibility, inclusivity by blurring the distinction between Healthwatch's voice and that of the VCSE.

- How does the focus and practices of engagement affect the voice that Healthwatch are able to gather?
- Is it desirable that Healthwatch shift to engage particular groups of people (e.g. marginalised or seldom-heard) rather than seek to conduct a generalised engagement with all local residents about the quality of health and social care services? What effect might such a shift have on the ability of Healthwatch to fulfil its function?
- How do the individual professional and personal backgrounds of Healthwatch staff shape the practices and focus of engagement?
- Is the involvement of the VCSE in Healthwatch engagement work unequivocally a good thing?

4. Volunteering

All of our Healthwatch study-sites had volunteer involvement. We found that local arrangements – e.g. funding and staffing, geographical size of Healthwatch's patch – shape how volunteers contribute to Healthwatch's activities. Volunteers, in turn, not only shape the organisation's work but also the character of the 'patient and public voice'. Indeed, for some Healthwatch, volunteers are a major source and expression of such a voice.

There are different types of volunteering associated with Healthwatch. First, there are those who are identified as 'Healthwatch volunteers'. These are called volunteers because of the official volunteer infrastructure that a local Healthwatch creates and which often involves a volunteer coordinator who trains them, sends them updates and offers them opportunities to get involved. Secondly, some Healthwatch also convene regular engagement panels or groups; these often have a fairly stable membership. The members of these panels are not often called 'Healthwatch volunteers' though they do give their time to be involved in Healthwatch activities. Finally, some Healthwatch have Boards of differing types, which are mainly composed of people who contribute their labour for free.

While there are different types of volunteers, we think it is interesting to examine the work such people do, which may blur distinctions among these different types and also between Healthwatch and the public. We would like to discuss the ways in which volunteering intersects with and articulates key practices such as 'independence' and 'voice'.

Some questions to think about:

- What defines a volunteer? If a volunteer is someone who gives their work and their time for no payment, who then might we include in this category? Does it go as far as those who volunteer to give you their feedback about services e.g. people who sit on engagement panels, ambassadors? Does it go as far as someone who takes the time to fill in a survey that you've distributed? What issues might an elastic definition such as this raise for Healthwatch practices of engagement? What are the implications (for the individual and the organisation) of a decision to label someone a volunteer, or not to do so?
- How do volunteers contribute through their activities to the articulation of Healthwatch's valued principle of 'independence'?
- When volunteers attend external meetings (e.g. CCG, provider Trust committees), do they embody Healthwatch? Or themselves? If the latter, do they present the direct 'voice of the people'? How is this different to other understandings of voice?