King's College London Healthwatch study

Draft statements of Healthwatch good practice on collecting and communicating public and patient voice

1. **Healthwatch works best when it uses a broad range of techniques to collect patient and public voice and to communicate this to local partners.**
   We found that stakeholders and Healthwatch alike value a varied, flexible approach which does not privilege one way of collecting and communicating evidence over another. This allows Healthwatch to tailor evidence gathering and communication and adopt a sensible approach to the specificity of the topics being investigated as well as the needs of the people and organizations involved. Even those Healthwatch which identified their 'brand' more closely with a particular technique (e.g. a database of local patient and public feedback) felt the need to maintain and develop other methods of collecting, analysing and communicating evidence.

2. **Healthwatch can enhance their influence by adopting a more locality-based approach to patient and public voice.**
   The needs and experiences of residents in relation to health and care varies according to neighbourhood or locality within a given local authority area. This is due to varying levels of deprivation across the local authority, population density, access to local services and green spaces. We found that it is not common for Healthwatch to organise their work to capture these local or neighbourhood specificities. When such work is done, however, it has been highly regarded by local stakeholders such as Public Health, NHS trusts, CCG etc. In those areas where Healthwatch has *not* worked in this way, local partners indicated a strong interest in a more sustained focus on locality. This interest is directly linked to the move towards understanding and improving population health outlined in NHS strategies such as the Long-Term Plan and the greater importance attached to the social determinants of health and inequalities, partly prompted by the COVID-19 epidemic. Healthwatch may enhance their influence and therefore the voice of patients and the public by adopting this more granular approach. For larger Healthwatch, this might involve rethinking organisational structures to enable them to cover a range of localities in depth.

3. **Healthwatch benefit from coordinating evidence-gathering with other Healthwatch in their Integrated Care System area.**
   Providing evidence about patient and public voice to the ICS is an increasingly important area of work for many local Healthwatch. Though ICSs are still forming, and Healthwatch involvement will become better defined through the passage of the Health Bill through Parliament in 2021, it is already clear that Healthwatch gains visibility when it coordinates its evidence gathering and communicating work with other Healthwatch in the ICS through formal mechanisms such as Memoranda of Understanding or planning and conducting joint projects across the ICS footprint. Healthwatch can do this while still maintaining a clear focus on the specific needs

and experiences of patients and residents in their local area, which is valued by ICS officers.

4. **Healthwatch can engage well with local democratic representatives when they adapt their communication strategies in innovative ways**.
   Most of the evidence gathered by Healthwatch about the needs and experiences of their residents is shared with local NHS and council staff. In addition to these relevant audiences, Healthwatch find it valuable to target a broader range of local stakeholders less commonly addressed in their work. Some of these have explicitly indicated an interest to work more closely with local Healthwatch. Local councillors are one such example, who in some areas have used the evidence produced by Healthwatch to better understand the health needs and experiences of their constituents. When this has happened, Healthwatch's independence has been considered a particularly valued asset to hear constituents' views that would otherwise be difficult for them to access. To engage councillors better, some Healthwatch have modified their communication strategies. Instead of long, detailed reports, they produced regular 'quick-read', graphic-heavy briefings, which are better suited for the specific needs of this audience.

5. **Panels can be a rich and sustainable source of insight if organised as a partnership between Healthwatch and statutory and non-statutory organisations.**
   Healthwatch often explore new ways to collect patient and public voice. Panels of service-users organised by locality or health-condition have been convened by many Healthwatch in the past. We heard from Healthwatch that such panels were often beset by problems of diversity, over-reliance on individual anecdote, and increasing apathy among members as they see little change resulting from their discussions; some Healthwatch experienced logistical difficulties in organising panels on a regular basis because of these issues. However, we found that panels could be a rich and effective source of insight where local Healthwatch worked in partnership with (i) a network of VCSE organisations and (ii) a statutory body such as the local authority or NHS. This combination of partners contributing to the panel's operation means that first, panels can draw on a broader and fresh network of service-users and secondly, that panel discussions become more directly embedded in health and care decision-making processes via formal mechanisms of mutual accountability between Healthwatch and local stakeholders. The involvement of a variety of VCSE organisations means that the panel will have access to informal networks of people, many of whom would otherwise find it difficult to share their experiences. Working in partnership means that while local Healthwatch facilitates panels and lends the process their important value of independence, they are not solely responsible for them. This modified way of organising panels addresses many of their previously experienced limitations.