Exploring the work and organisation of local Healthwatch in England: a mixed-methods ethnographic study

Giulia Zoccatelli,[1*] Amit Desai,[1*] Glenn Robert,[1] Graham Martin[2] and Sally Brearley[1]

[1]Florence Nightingale Faculty of Nursing, Midwifery and Palliative Care, King's College London, London, UK
[2]The Healthcare Improvement Studies Institute, University of Cambridge, Cambridge, UK

*Corresponding authors giulia.zoccatelli@kcl.ac.uk and amit.desai@kcl.ac.uk

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Scientific summary

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Scientific summary

Background

Introduced as part of the 2012 Health and Social Care Act (Great Britain. *Health and Social Care Act 2012*. London: The Stationery Office; 2012) and formally launched the following year, the 150 Healthwatch organisations in England are an important part of the local landscape of health and care commissioning and provision. Healthwatch organisations are intended to be key means by which users of services are given voice to influence decisions about health and care, working with other agencies to ensure that the views of local communities are considered. Local Healthwatch organisations have statutory functions to advise local authorities and NHS commissioners about their communities' needs and concerns. Although all Healthwatch organisations are required to be social enterprises, there is no nationally mandated model for Healthwatch. Such flexibility in terms of organisational arrangements contributes to the range of organisational models on which Healthwatch can draw.

Funding for Healthwatch has substantially decreased since its launch in 2013. Originally set at £40.3M in 2013/14, it fell to an estimated £25.5M in 2019/20, which is in line with wider reductions in funding to local government. In general, there is a lack of transparency in the way in which local authorities allocate funding to their local Healthwatch, leading to significant variability of Healthwatch budgets across England.

The *NHS Long Term Plan* [NHS. *NHS Long Term Plan*. 2019. URL: www.longtermplan.nhs.uk/publication/nhs-long-term-plan (accessed 27 May 2022)] envisaged that all areas in England would be covered by integrated care systems (ICSs) from 2021. Building on this, the government published a health and care White Paper in February 2021 [Department of Health and Social Care (DHSC). *Integration and Innovation: Working Together to Improve Health and Social Care for All*. London: DHSC; 2021] and it proposed that such ICSs be made statutory organisations with commensurate powers. However, although Healthwatch was mentioned in the 2021 White Paper as a way in which public and patient voice could be represented at the ICS level, its involvement was not formally mandated in the subsequent Health and Care Act 2022. Healthwatch's involvement in integrated care to date has been variable.

Although studies have indicated the importance of local relationships and context to the activities of specific Healthwatch organisations, to date, Healthwatch work has not been systematically examined through national research. This study, undertaken from 2018 to 2021, addresses this research gap.

Objectives

The aim of our study was to explore and enhance the operation and impact of local Healthwatch in ensuring effective patient and public voice in the commissioning and provision of NHS services. We have achieved this aim by pursuing the following four objectives:

1. establish current priorities, activities and organisational arrangements of local Healthwatch in England
2. explore the processes and interactions that link local Healthwatch organisations to a range of individual and institutional actors [e.g. commissioners, general practitioners, Clinical Commissioning Groups (CCGs), trusts, patients, local authority staff, care homes, third-sector organisations and Healthwatch England] and to the wider contexts through which they operate (e.g. funding, contracts, reports) to assess their impact on local health-care commissioning and provision

3. build consensus about what might constitute 'good practice' in terms of the operation of local Healthwatch
4. distil and then disseminate generalisable principles around what facilitates and/or limits the influence of local Healthwatch as a key element of patient and public voice in the NHS.

Methods

This mixed-methods study was organised in four phases.

Phase1

Phase 1 comprised the design, development, distribution and analysis of a national survey of all 150 local Healthwatch organisations in England. We received responses to our survey from 96 local Healthwatch organisations and this was a response rate of 68% (as eight Healthwatch organisations responded on behalf of two or more Healthwatch organisations that operated as a combined organisation).

Phase 2

Phase 2 included:

- the purposive sampling and recruitment of five case study sites and the recruitment of 15 members of the Healthwatch Involvement Panel (HIP)
- 75 days of ethnographic fieldwork in the case study sites to gather documentary evidence, carry out observations and conduct 84 semistructured interviews
- a switch to virtual fieldwork in March 2020, comprising 114 virtual contacts
- data-gathering and iterative data analysis with the HIP across five meetings (analysis of ethnographic data identified key points of divergence that were consequential for the activities of Healthwatch).

Phase 3

Phase 3 included 27 online interviews and four small-group discussions with HIP members to explore Healthwatch experiences during the COVID-19 pandemic and to generate statements of good practice.

Phase 4

Phase 4 consisted of five participatory sense-making workshops modelled on joint interpretive forums (JIFs). The first workshop was held virtually (with representatives from all five Healthwatch study sites) and it was followed by virtual workshops at four of the individual local Healthwatch study sites.

Results

Phase 1: survey

The survey revealed variation in the organisation and work of Healthwatch nationally, including hosting arrangements, scale of operations, complexity of relationships with other health and care bodies, and sources of income beyond core funding. Over half (58.3%) of local Healthwatch organisations reported that they are standalone organisations that do only Healthwatch-related work. Since 2013, budget cuts have affected almost 80% (79.3%) of local Healthwatch organisations. Seventy-four per cent of local Healthwatch organisations currently receive funding external to that provided by their local authority for their Healthwatch functions. Most Healthwatch organisations do not engage with more than one of any given category of external stakeholder, and most engage with only one CCG (56.3%), one mental health trust (82.3%) and one community health trust (62.5%), although almost 60% (59.4%) engage with more than one hospital trust. Few local Healthwatch organisations reported impact that was national (10.4%), but all reported local impact.

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Phase 2: ethnographic fieldwork

Our ethnographic fieldwork found four key axes of Healthwatch variability that shape Healthwatch's everyday work and these are:

1. organisational structures ('hosted' or 'standalone')
2. funding arrangements
3. institutional landscape
4. strategies and practices of engagement.

Organisational structures ('hosted' or 'standalone')

We found variability in Healthwatch's organisational arrangements at our five study sites, and such variability complicates the straightforward dualism between 'hosted' and 'standalone' organisations. In addition, the variability shows how Healthwatch's organisational structures are the product of a broader range of factors (including organisational histories and board composition, strategic planning to better exploit financial resources and the lack of geographical overlap between the work of the host organisation and hosted Healthwatch), leading to a degree of separateness. Looking specifically at our three study sites 'hosted' by other organisations, our findings show a great variability in their organisational arrangements. Although two of these study sites were hosted by a small local charitable company that held only one Healthwatch contract, each has its own ways of organising and conceiving Healthwatch work.

Funding arrangements

Money is a major axis of variability between Healthwatch organisations. Different amounts of funding in different areas enable the creation and maintenance of radically different sorts of organisations, which, nevertheless, ostensibly share the same mission. Healthwatch contract value is partly justified based on population. Therefore, larger local authority areas tend to receive larger absolute amounts of funding than smaller areas. However, these larger absolute amounts of funding are not used to help these Healthwatch organisations replicate the services of smaller Healthwatch organisations on a larger scale; rather, the larger contract value enables such Healthwatch organisations to hire greater numbers of staff specialised in a greater range of disciplines and skills, and therefore to offer additional (and qualitatively different) services. In so doing, the larger organisations become very different from smaller Healthwatch, despite sharing a name.

The value of Healthwatch contracts influences the ability of Healthwatch organisations to engage local people and promote their involvement in the monitoring and planning of services. We also found that, as a result of a fall in the value of local Healthwatch contracts over the past 8 years, many Healthwatch organisations have chosen to solicit additional funding from the NHS and local authorities. However, some Healthwatch organisations have questioned whether this lessens or enhances the organisation's independence. It may also be the case that larger Healthwatch organisations are in a better position than smaller ones to obtain substantial external funding for research or engagement activities, thereby widening the gap between Healthwatch organisations even further and raising questions of equity for people in different areas of England. Perhaps the most striking consequence of the differential levels of funding is the impact on the capacity of Healthwatch as an organisation to grow and diversify and, in doing so, expand not only the notion of Healthwatch, but also the notion of patient and public voice itself.

Institutional landscape

Healthwatch is embedded in an ecosystem of relationships with people in the health and social care system, as well as in the material and institutional infrastructures of the areas where they operate (e.g. a successful provider trust, a long-standing partnership board, a large number of district-level health and well-being boards). We found that these various ecosystems shape individual Healthwatch strategies and practices. For instance, one Healthwatch study site's focus on local people's in-depth, lived experience of specific health and social care topics was influenced by the sheer complexity and size of the health and social care system, and challenges associated with maintaining meaningful relationships with a large number of partners. However, two of the other study sites were part of well-integrated systems even before the formal development of their integrated care partnerships. In these areas, the relationships

forged by Healthwatch were more predictable because of the smaller identifiable number of people and institutions with whom Healthwatch can have regular and consistent contact. This meant that these Healthwatch's practices and strategies were more easily embedded in local institutional conversations around health and social care.

Strategies and practices of engagement

One of the key statutory functions of Healthwatch is to obtain the views of people about their needs and experience of local health and social care services. Many Healthwatch organisations receive unsolicited feedback, conduct surveys of residents and patients (both by type of service and by type of user), carry out enter and view visits, and organise Healthwatch stalls in public places and events. However, the strategies and practices of engagement are varied and are substantially determined by individual Healthwatch organisational structure, funding and local landscape. Two of our study sites provide an instructive comparison about how engagement is shaped by different levels of funding. The funding arrangements of one study site meant that it could not initiate or substantially direct engagement activities itself. Rather, the main source of the site's engagement was work carried out by other organisations, such as local Voluntary, Community and Social Enterprises, which are granted money from the Local Reform and Community Voices grant. This means that this Healthwatch site had little control over the design, the execution and the end results of the engagement that is carried out in its name. Conversely, the second Healthwatch site – the best-funded Healthwatch site among our study sites – had a great deal of autonomy over the type of engagement projects it undertook. This autonomy extended to individual members of Healthwatch staff, who were largely free to pursue projects based on their personal or professional interests (as long as they were regarded as within Healthwatch's remit by senior managers, the board or the local authority commissioner).

Phase 3: experiences during COVID-19

As the COVID-19 pandemic unfolded, we also examined the ways in which Healthwatch's approaches to giving voice to the views of the public and to forming effective relationships with other agencies evolved. For instance, involvement in mutual aid groups' WhatsApp chats (Meta Platforms, Inc., Menlo Park, CA, USA) allowed access to the views and experiences of people (e.g. those who were self-isolating), which might otherwise be difficult to access. We found that crucial to Healthwatch's ability to act effectively in conveying patient and public voice throughout the course of the pandemic was its formally mandated position in England's health and social care system (as well as the expertise, reputation and relationships built up over time because of that status). Local Healthwatch also reported a tension between being responsive to the needs of the system during an emergency and managing its own sense of autonomy to set its own work agenda. Not only was this tension bound up for some in a cherished notion of Healthwatch independence but it also had practical effects such as the increased risk of staff burnout, which respondents feared would in the long run lead to a less effective local Healthwatch.

Phase 4: joint interpretive forums and principles of good practice

We used the analysis of the JIFs combined with the ethnographic data from phases 2 and 3 to draft a series of 'principles of good practice' relating to how Healthwatch collects, organises and communicates evidence about people's experiences of health and care to their local system. We chose to focus on this area because Healthwatch's practices and strategies for the gathering and use of patient and public voice constitute the very core of its mission and are crucial to better inform health and social care commissioning and provision. This focus was substantiated by insights from all the five case study sites during the planning of phase 4. These 'principles' were later circulated to HIP members to test their relevance and usefulness to the broader Healthwatch network beyond the specificities of the five Healthwatch study sites. The principles are:

- use a broad range of techniques to collect patient and public voice and to communicate this to local partners
- enhance Healthwatch influence by adopting a more locality-based approach to patient and public voice

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- co-ordinate evidence-gathering with other Healthwatch organisations within ICS areas
- adapt communication strategies with local democratic representatives in innovative ways
- panels of service users can be a rich and sustainable source of insight if organised as a partnership between Healthwatch and statutory and voluntary sector organisations.

Conclusions

The study produced generalisable principles of good practice regarding the collection and communication of evidence regarding local people's views and needs, and communicating it effectively. Policy implications relate to the (1) overall funding regime for Healthwatch and its potential to generate inequalities in what is available to local populations and (2) development of Healthwatch's role given the evolution of local health and care systems since 2012. Our recommendations for future research (in priority order) are as follows:

- Explore the consequences for local Healthwatch of the development of ICSs.
- Explore Healthwatch in an international comparative perspective. It may prove instructive to conduct a comprehensive comparison of such provision across the nations of the UK, and between England and other health systems around the world.
- Explore how the response to the COVID-19 pandemic has reconfigured the voluntary sector locally. It may be important to track these changes and their effects to optimise the ways in which health and care planning and provision is organised post-pandemic.
- Explore how Healthwatch respond formally and informally to a newly emerging focus on public health and health inequalities.

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