The local operation and impact of Healthwatch

Seven ways of producing evidence

1. The community insights repository of patient and public experiences

One Healthwatch developed a comprehensive database of patient and public feedback on health and social care services.

- The database contains **coded qualitative feedback** (e.g. free-text comments from surveys, patient stories etc) which is then used to **produce reports** on patient or public views and experience on particular themes or services over a defined period of time.

- Includes **feedback** received and collected by Healthwatch **as well as by health and social care providers and commissioners.** For instance, this Healthwatch regularly asks for and receives patient experience data collected by the main hospital Trust in the area, which is then added to the database.

- The coding is **organised by different elements of a patient's pathway** and also includes additional codes which relate to the social determinants of health (e.g. poverty, clean air, housing etc).

- Healthwatch's research analyst runs **regular database training sessions for local authority, public health, CCG and Trust staff**. The people who attend the training are attracted by the qualitative sources of such data, which they hope will complement their own largely quantitative datasets.

- **The ICS has funded the expansion of the database** across all the 7 Healthwatch in its footprint. All Healthwatch (and other health and social care stakeholders) will use it.

This Healthwatch's Chair said:

[The insights database] does reduce a lot of the stories that we capture to percentages and when we're talking to the science-based people on the Health & Wellbeing Board, they respond to '79%' much more than 'the lived experience of the people they tell us is this'.

2. Investigating social determinants of health in economically diverse neighbourhoods

One Healthwatch focuses much on its work on what are commonly called the **social determinants of health** e.g., income and job security, unemployment, indebtedness, quality of housing (overcrowding etc), access to green space and shops selling fresh vegetables, presence of unhealthy takeaway shops, air pollution etc.

- This wider focus is aimed to capture the range of experiences of their **socially and economically diverse residents**, e.g., the health and life experiences of people living in poor housing or subject to crime or air pollution.

- This work, which is sensitive to locality-based social and economic differences, is **encouraged by the local NHS, public health and local authority,** and also with the well-developed local Integrated Care Partnership, all of which articulate this 'social' approach to questions of health and wellbeing.

- For example, in 2019-2020 this Healthwatch was involved in planning and carrying out engagement work on the area's **new Health and Wellbeing Strategy**. Working in collaboration with the public health department, other local authority officials and the CCG.

- This Healthwatch organised **several day-long events at libraries in four different neighbourhoods in their area**. The engagement activities consisted of Healthwatch **staff talking at length to local residents (30-60 minutes) one-on-one** about their lives, family, and experiences of health, wellbeing, poverty, precarity, diet and environment. Staff noted each respondent's experiences in a specially

designed booklet, which they used to **code and analyse each individual's responses based on themes.**

- They **used a map of the local area to guide their questioning** so that Healthwatch staff could identify **hyperlocal issues** e.g. a badly-lit street which, in winter discourages older people in the area from leaving their homes, thus causing isolation and lack of exercise.

- The results of this work were **presented** to local stakeholders **at the Health and Wellbeing Board,** and they were **used in the development of the council's strategy.**

3. Gathering evidence about the experiences of specific ethnic minority groups

When, in the first phases of the COVID-19 crisis in England, it became clear that BAME communities were being disproportionately affected by the pandemic, one local Healthwatch launched a pilot project to explore how **a local ethnic community** was managing the challenges brought about by Covid-19.

- This Healthwatch used the specific case of the Pakistani-origin community as a **starting point to explore broader issues affecting other BAME communities** in the area. These included:
    - language barriers that could hamper the access to correct information;
    - the role of comorbidities such as diabetes and lung conditions particularly prevalent among BAME communities;
    - cultural differences in the use of healthcare services (e.g. greater reliance on A&E departments rather than GPs).

- Healthwatch **conducted a survey with community organisations** in their local authority area and a neighbouring council. All the community organizations involved had developed initiatives supporting local Pakistani-origin residents directly. Healthwatch **also conducted online and phone interviews** with the staff and volunteers within these organizations and with local councillors and NHS staff from Pakistani backgrounds.

- The project had two aims: 1. **gathering evidence about the experiences** of Pakistani-origin residents; 2. **mapping the different activities done by community organisations** to support Pakistani-origin residents in the pandemic, e.g., operating as emergency help centres and food banks, offering befriending services, and health information and advice.

- Based on this evidence, Healthwatch produced a report, which was circulated and **presented to the council, CCG and the main VCSE organization** working with other BAME groups in the area. This Healthwatch also sent the report to **Healthwatch England** and was invited to present this work at their **Healthwatch Regional Network** as an example of good engagement practice.

- The report led the council to fund a **£150,000 project to conduct similar engagement work** on other local BAME and seldom-heard communities.

4. Acting on unsolicited feedback from patients and the public

One Healthwatch mainly does engagement **projects prompted by unsolicited feedback** from members of the public or patient groups. Here is one example:

- Healthwatch began receiving feedback from local residents informing them that a **hearing aid repair 'drop-in' service** that they relied on was being withdrawn. Hearing aids need regular maintenance and repair.

- This service was **provided by a local hearing loss charity** and it **ran sessions in accessible settings** such as libraries and GP surgeries around the county. The **charity could no longer run the service** due to a loss of funding; users would now have to travel to NHS audiology clinics at a limited number of hospital locations. These were inaccessible to people who relied on public transport or lived in remote parts of this large, rural county; these people would be compelled to live with defective equipment.

- Healthwatch held a number of **feedback sessions at community settings** (GP surgeries, libraries) which had formerly hosted the hearing aid repair services, **and at the hospital-based clinics.** They distributed a **survey** at these sessions and listened to user experience as told to them. They also invited people with hearing loss to attend a **focus group**.

- The evidence collected by Healthwatch were used in a **report that was shared with the local Trust and the CCG.** Their responses were included in the published version.

5. Qualitative reports

One Healthwatch's approach to evidence is for the most part qualitative, based on the collection of the 'lived experiences' of local people, which are gathered through long-term, in-depth engagement.

- This Healthwatch collects lived experiences through **staff-initiated projects** which usually involve interviews and observations of people and services. Each member of Healthwatch's engagement and research team conducts at least one long-term engagement project based on their personal interests.

- Once they identify a project they want to carry out, staff members **draft a research proposal** (need for project, methods, impact, possible funding). This information alongside the project's budget is then presented to the Healthwatch Board. If the Board agrees, the project is signed off and can start.

- Evidence come from interviews, focus groups and observations **carried out over a period of several months.**

- This Healthwatch routinely uses **local radio, newspaper, podcasts and tv channels** to disseminate their evidence to the general public.

- They regularly involve relevant departments at **local Universities** (e.g. nursing students) in reflection on and dissemination of their findings

6. Evidence collected by VCSE organisations

This Healthwatch uses the Local Reform Community Voices (LRCV) funding - which it receives separately from its core contract - to fund grants to local VCSE organisations; these latter then conduct engagement with the public and patients.

- Healthwatch runs a **competitive process** for these grants every year. Awards are decided by the Board in accordance with their priorities.
- Projects which receive funding commit to completing the work within a certain time, to producing a **final report which features Healthwatch's logo**
- Completed projects are presented to Healthwatch staff and volunteers, and **staff discuss with grantees** the potential impact of such evidence.
- Award recipients grant Healthwatch the **right to use any evidence** gathered as a result of the engagement project.
- This scheme provides Healthwatch with **access to voices it might not otherwise hear** e.g. on young people's mental health.

7. Evidence from residents' panels

One Healthwatch makes extensive use of a **standing panel** of residents to gather evidence about local services.

- The panel is composed of members who live with different disabilities or are carers of someone living with disability.

- Members are also chosen because they **represent a network of people** affected by the same condition and whom they can involve in the work of the panel.

- The majority of panel members are **representatives of communities and local charities** addressing the needs of people living with specific disabilities (e.g. visually impaired, armed forces veterans).

- Panel meetings are **attended by council officers** and occasionally by other health and care stakeholders.

- The meetings raise and discuss issues and themes that are then **explored in more detail at specially organised focus groups**; these are attended by a greater number of people affected by that specific form of disability.

- **Healthwatch staff draft action points and propose solutions.** These are also usually discussed and planned outside panel meetings, in collaboration with the communities and organizations with which panel members are associated.

- Action points and solutions are **continuously worked on by council officers in a shared document folder**.

The integration between the work of the panel and the more granular engagement done through specific focus groups makes

it possible for this Healthwatch to translate individual lived experiences of panel members into forms of evidence about the collective experience of a broader network of local people affected by a specific condition.

Healthwatch staff and the members of the panel regarded the structure of general panel and focus group to be important because, in many cases, an individual's lived experience was not considered a good enough form of evidence by itself.