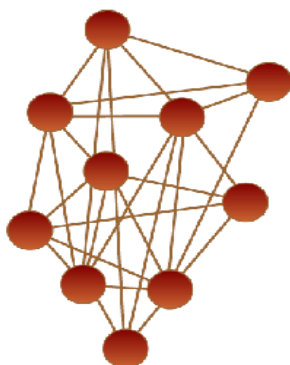


Healthwatch: an involving culture?



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Preamble

In 2012 Local Involvement Networks (LINKs) are to transform into a new community-based organisation named Local Healthwatch. Such a transformation involves examination of existing LINKs' cultures, systems and practices in order to determine what needs to be changed, added or carried forward into Healthwatch.

However, in the welter of documents published about the process, there is virtually nothing that clarifies or even discusses the issue of Healthwatch cultures despite the fact that those which emerge will profoundly affect how groups approach and manage their tasks.

Reflection on these ideas provided the purposes for writing this brief article.

1. The involving culture

"... for the first time in forty years, there will be a real local democratic accountability and legitimacy in the NHS. Elected councillors and councils will have a new role in ensuring the NHS is responsible and answerable to local communities. By commissioning Healthwatch... councils will be responsible for ensuring local voices are heard and patients are able to exercise genuine choice...In this new role, councils will be assessing local needs, promoting more joined up services, and supporting joint commissioning.
Dept. of Health & Communities and Local Government (2010)"

The above passage refers to *democratic legitimacy*: i.e. the relationship between any 'authority's' actions and the level of support given to them by those who are subject to the effects of those actions (e.g. a community's support for council actions). The passage also presents the strengthened role and power of local authorities as a means of increasing the democratic legitimacy of *statutory care services* by holding them to account on behalf of communities.

Local Healthwatch's role in this, apart from reporting factual information, is to identify and explain to councils the realities of care service 'delivery' through the eyes of local communities and the experiences of care service 'users'. [From this point, the term 'Healthwatch' refers any local Healthwatch]

Representation and involvement

Looking at LINKs, we will find a number -- probably most -- that are not fully representative of ethnic or other significant community groups. This tends to produce *self-selecting memberships* (Ryfe, 2005) which may not be properly representative of their communities. So if, in Healthwatch, we aim merely to rely on membership 'head-counts' we will not know how representative of communities our Healthwatches are. If we add to this:

"[A belief that]... public decisions ought to be influenced in some way by the citizenry that will be affected by them... [it]... of course, makes it vital that such citizens participate actively in the process of decision making."
Ryfe (2005, p50)

then Healthwatch has a responsibility not only to recruit more individuals, but a *more representative range* of individuals.

Accountability

The prospect of much more accountability to the public and particularly to service 'users', may seem daunting to many within care systems. But they could, if they wished, encourage participation directly, either (a) in partnership with or (b) through Healthwatch by setting up community panels, forums etc.

An example of how that might be done (although not solely concerned with healthcare issues) is described by Horner et al. (2006, p19):

"...the London Borough of Lewisham has for the last ten years run a citizens' panel of 1,000 residents and held a series of citizens' juries that consider pressing local problems, take evidence from expert witnesses and advise the authority on issues such as local transport and car use. These are examples of 'inclusive management', in which public managers do not merely exercise professional judgement, but also seek to maximise public participation. Here, accountability is not simply to elected officials, but also to the public, to the community and to service recipients"

A genuine approach to generating public involvement requires an attitude of trust in the ability of ordinary members of the public (a) to deal with serious issues *seriously* and (b) to reach conclusions *deliberatively*. If this attitude is absent or low level, on the part of the the care services and/or Healthwatch, then involving people in community initiatives will meet with limited success. [See also '*Autonomous action learning sets*' below.]

2. Healthwatch cultures

Reflecting on such matters prompts thoughts about the culture *within* Healthwatches. 'Culture' in this context refers to the manner in which people conduct themselves, both towards each other and in their manner of working.

We know that the LINKs-Healthwatch transformation will probably transfer the basic elements of these existing cultures to Healthwatch so it is highly probable that, at least on the surface, Healthwatch cultures generally will start out as more rather than less democratic in character. Unfortunately, there appears to be no significant body of research into existing LINKs' cultures so we must draw upon experience and other sources in discussing Healthwatch cultures and consider the question of how they will develop.

Democratic work groups?

Bearing in mind Healthwatch's new 'top end' structure, a redefined relationship with local councils, a wider range of stakeholder relationships and increased functions (hence an increased workload) *will Healthwatch groups be supported in their volunteer traditions of working or pressured towards more traditional 'business' patterns of organisation and working?*

Gastil (1993, p16: *adapted*) suggests that in small groups key democratic factors are:

- genuine group autonomy;
- equal distribution of ultimate authority;
- inclusiveness;
- collective deliberations (and, particularly, speaking and listening rights and responsibilities);
- commitment to democratic process;

However, underpinning these are other factors such as (a) responsibility for what we do, say, think and feel; (b) how we behave; (c) mutual respect; (d) adequate coincidence of beliefs and values, and so forth.

Assuming that Healthwatch groups will operate more-or-less on democratic principles, we should expect to see them reflected in Healthwatch affairs at *all* levels, But simply setting out such principles will not ensure the emergence of any kind of culture. *It requires conscious effort* to create a culture within which people feel more, rather than less, inclination to work in this way.

This way?

One concrete way of encouraging it is to adopt action learning or some similar approach as the *preferred* way of working.

[Note: Indicative precedents are the application of a learning approach in the formation Health and Wellbeing Boards (*Healthwatch; Transition Plan, 2010, Section 5*) and a statement of intent by the the Care Quality Commission (November 2011, p2):

"The Department of Health has launched 75 HealthWatch pathfinders, to help develop the local HealthWatch model. It also intends to run action learning sets with LINKs across the country to support LINK development to underpin strong local HealthWatch."]

Thus, the application of action learning is fact in the higher reaches of the Healthwatch system, so why should we not utilise it within local Healthwatches?

3. Action learning: what is it?

R.W. Revans, the founder of action learning developed his approach initially whilst working with private and public sector managers (including those in care services) and then people at other staffing levels. He was interested in the relationship between learning and actions taken as a result of it particularly and how groups/individuals drew upon their pooled experience in the process. In his own words:

'The learning achieved is not so much an acquaintance with new factual knowledge... [as]... reinterpretation of the subject's existing knowledge, including... recollections of past lived experiences.. a social process, carried on among two or more learners who... frequently cause each other to examine afresh many ideas that they would otherwise have continued to take for granted, however false or misconceived.'

Revans (1982, p627)

Here the concern is with our understanding/experience of real-world issues (i.e. learning about) relevant to Healthwatch's work, and acting to deal with the issues and problems that emerge. These processes are focused within self-organising 'sets' (i.e. groups) of 5-10 people and based upon a small number of ideas, namely:

- learning and action are interdependent;
- the primary process is translating learning into action;
- focus is upon real-world projects;

- thoughtful reflection is necessary to solving complex problems;
- self-managed sets where each member learns from, and helps, every other member with collective or individual projects.

Sets tend to meet weekly or monthly to 'report back' to fellow members regarding their projects and issues arising from them.

Of course, existing LINK committees, sub-committees and working groups may be self-managing, and may work well together. However, it requires conscious effort to develop/refine an action learning attitude and approach so, if such groups do not operate according to the above principles, it is unlikely that they are action learning sets.

Autonomous action learning sets?

Discussing the widely held belief that facilitators, teachers etc. are necessary to 'lead' action learning sets, Ashton (2008, p6:) argued that in general they are not. He pointed out that:

"In the main, set members seem to manage their private lives adequately and to be competent in managing situations in their workplaces. Most cope with complicated social lives, considerable debt, illnesses, bereavements, intimate relationships and so on and manage to raise children.

But although they may well take advice on such matters, they do not require set advisers, because they are ... competent adults [competent] to navigate systems and organisations, to find and utilise necessary information effectively, to make autonomous decisions, manage adult relationships, take considered, and informed actions, and deal with ensuing consequences appropriately."

Turning to Healthwatch then, action learning should not require the continual (or even frequent) *unrequested* presence of facilitators. But this doesn't imply that sets should not choose one or two of their own number to keep order, co-ordinate activities etc.

4. Action learning in Healthwatch

Action learning sets are used in Healthwatch, may be involved in:

- a single project where everyone works on all aspects of it *OR*
- a collective project divided into sub-projects (according to topics/tasks/specialist interests and so forth), each undertaken by a sub-group or individual *as agreed by the set as a whole OR*
- each member brings their own project to the set for suggestions on how to proceed, for assistance with particular aspects of it and so forth.

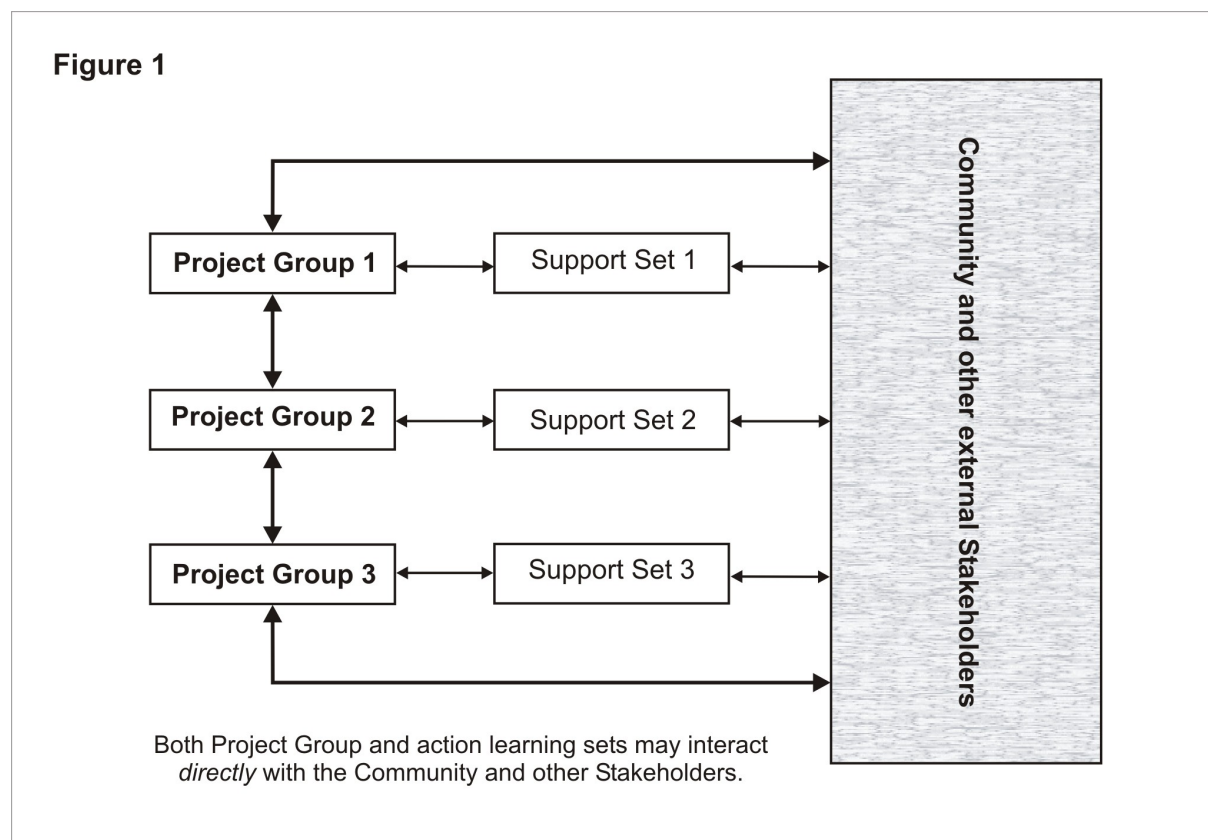
In fact any real-world project can be approached through action learning. For example, data and information gathering etc.; community support using interviewing/ community meetings/mounting events and so on; researching into trends/changes/

issues/disputes in care services and communities; entry-and-view team practices and development.

Below are two examples of how action learning might be used in *project support*. The first is suitable for those wanting fairly limited active involvement in Healthwatch. The second is suitable for those wanting a significant level of involvement.

Example 1 (Figure 1)

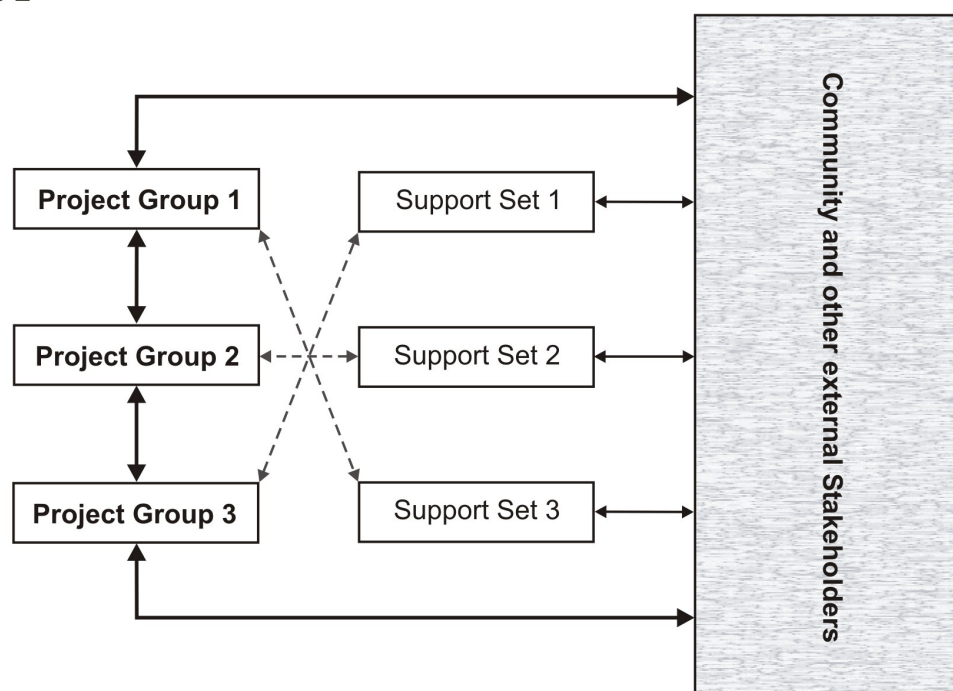
- a) *Aim of project*: to develop an understanding of community-wide change and development in order to formulate coordinated Healthwatch responses to issues arising.
- b) *Objectives*:
- to understand significant attitudes towards care services in each area and
 - to monitor public views and experiences of those services;
 - to provide local opportunities for community members to access information about Healthwatch projects in their areas.
 - to provide local access to Healthwatch help and support.
- c) *Action learning project Support Set activity*: Information/data-gathering. Each geographical area has one or more action learning Support Sets which provide information and data from that area for a 'parent' Project Group. Project Groups from each area pool the information/data and analyse it, acting directly on the basis of what they discover and/or passing the results to the Healthwatch Committee and appropriate sub-committees for action.



Example 2 (Figure 2)

- a) *Aim of project*: improving project work efficiency and effectiveness in general.
- b) *Objectives*:
- to gather/research information and data in support of on-going projects;
 - to process that information and data into readily usable form;
 - to identify particular implications, trends, possibilities etc. emerging from analysis and examination of the information and data.
- c) *Optional Modes of operation*:
- single set: working together on all material collected for each project;
 - two or more sets (i): splitting the workload with each set working on the whole range of material, and all aspects of it or (ii) dividing the material between them and working on selected or specialist aspects of it.
- d) *Action learning project Support Set activity*: providing information, data-gathering and analysis. (Here the Supports Sets are not geographically based but operate anywhere within the Healthwatch catchment area). All Project Groups may call upon any Support Set for assistance but must provide a brief outlining the type and extent of assistance sought. This is then *negotiated* with the particular Support Sets. As each Support Set is autonomous they may (a) accept or reject a brief; (b) request that the brief be modified. Whatever their response, they must have good grounds for it.

Figure 2



1. Each Project Group may negotiate with any/all Support Group(s) for the provision of support
2. Both Project Group and action learning sets may interact *directly* with the Community and other Stakeholders.

[These examples are illustrative. They should not be treated as case studies.]

Commentary

The first example is a conventional support arrangement with Sets providing information and data to designated Project Groups.

The second is based upon negotiations for support between *independent* Project Groups and Support Sets. Apart from the support provided by the Sets there are two other potential benefits of this system:

(a) prior to negotiating, Project Groups *must be clear about their aims and objectives* or they cannot identify accurately the areas which require support and (b) Support Sets *must be clear about their resources and operational limitations* or they cannot respond appropriately.

The processes involved in the second example will tend to develop/reinforce feelings of group cohesion and involvement more strongly both *within and between* Project Groups and Support Sets.

Experimenting

It is not difficult to run experimental action learning sets. First establish the sets by an appropriate means then:

- if a rapid startup is required, identify someone who has worked in/with action learning sets, who will monitor the sets in the initial meetings and offer them feedback about how they functions etc.
- alternatively, provide set members with sound and relevant information about action learning -- by an experienced person or in other available form -- then allow them to find their own way (help being available if they need it).

In either case there will need to be an evaluative process. Accordingly, sets should develop the habit of reserving a part of each meeting in which to review (a) the benefits and drawbacks of their ways of working; (b) the progress of their projects; (c) the concrete actions/solutions resulting from their project work.

4. Summary

The stance taken in this article rests upon three assumptions:

1. That LINKs' cultures tend to be more rather than less democratic.
2. That LINKs' cultures will be, at least at a basic level, carried into Healthwatch.
3. That democratic ways of working are in general more desirable and appropriate for Healthwatch than other approaches.

On the basis of these assumptions, four major points have been made:

1. That within a local Healthwatch, support for more, rather than less, democratic ways of working (both from within and without) will critical to its emergent cultures.

2. That a democratic culture will not appear simply because people profess appropriate principles: it require people to act to make them reality.
3. That democratic ways of working in Healthwatch should operate at all levels.
4. That action learning is an appropriate vehicle for supporting/reinforcing democratic ways of working.

Concluding remarks

The cultures that emerge in Healthwatch will profoundly affect how groups behave generally and how they work. Reflection on that provided the purposes of writing this article, namely:

- a) to raise general awareness of the issue Healthwatch culture and
- b) the need to address them it a useful level.

Now it is up to those managing LINks-Healthwatch transitions to choose to take such matters under consideration.

References

- Ashton, S. (2008) *Action Learning: Facilitation and Autonomy* (Unpublished paper: sam@crowsnest.myzen.co.uk)
- Ashton, S. (2011) *Healthwatch: the transition -- some issues for discussion*, Rev. 3 (Private publication: sam@crowsnest.myzen.co.uk)
- Care Quality Commission (2011) *Care Quality Commission and LINKs/local HealthWatch: a national project 2011-2012* (London: Care Quality Commission)
- Department of Health (2010) *Equity and excellence: Liberating the NHS*, White Paper Ref. Cm 7881 (London: Department of Health)
- Department of Health[a] (2011) *HealthWatch Transition Plan*, Gateway Reference 15822 (London: Department of Health)
- Departments of Health & Communities and Local Government (2010) Foreword. In *Local Democratic Legitimacy in Health*, Gateway Ref: 14531 (London: Department of Health)
- Gastil J (1993) *Democracy in Small Groups* (Philadelphia, PA: New Society Publishers)
- Horner, L., Lekhi, R. Blaug, R. (2006) *Deliberative democracy and the role of public managers: final report of The Work Foundation's public value consortium* (London: The Work Foundation)
- Revans, R. W. (1982) *The Origins and Growth of Action Learning* (Bromley: Chartwell Bratt, publishers)
- Ryfe, D. M. (2005) Does deliberative democracy work? *Annual Reviews in Political Science*, Volume 8, pp49-71