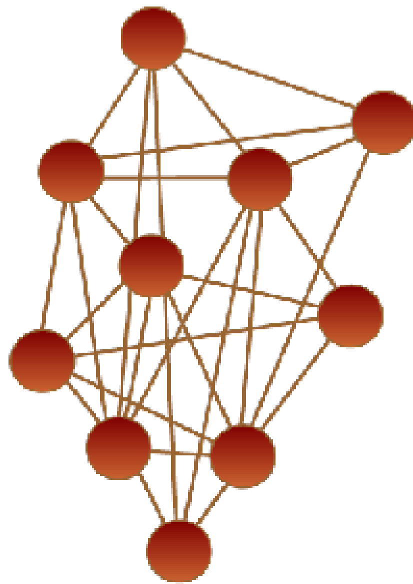
HEALTHWATCH: THE TRANSITION

Ideas and issues for discussion



Sam Ashton

Revision 4

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Preamble

A new public body is being set up called Healthwatch England to oversee involvement in care services. Local Healthwatches (referred to in this document simply as Healthwatches) will be set up in local authority areas across the country and it is with Local Healthwatch that this document is concerned.

Existing Local Involvement Networks (LINks) are transforming themselves into Healthwatches in 2012. The change process, in addition to involves the deign of new structures, strategies and practices, and decisions about what features of existing LINks' policies, systems and practices to retain, change, or discard. The philosophical basis of the new system will, in part, emerge as Healthwatches evolve into their new forms but, imminently, new policies will need be formulated and the process of translating ideas into practical systems faced.
What follows is one person's contribution to the discussion of the 'what' and the 'how' of setting up Healthwatches.

The views expressed in this document are solely those of the author.

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10 November 2011

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Introduction: the legacy of LINks

Social and health care systems are government controlled, and influencing governmental decisions about them has traditionally been difficult. But in the 1970s the then government instituted *Community Health Councils* (CHCs), a first step in making care systems *statutorily accountable* to their communities.
In 2003 these were superseded by *Public and Patient Involvement Forum*s (PPIFs) which, in 2007, were replaced by more powerful *Local Involvement Networks* (LINks). LINks still currently operate, but in 2012 they are to transform themselves into local *Healthwatches.*

LINks consist of organised volunteer groups and individuals working within their communities to influence how local care services are 'delivered'. Not intended as substitutes for these services, they (a) bring a 'stranger's eye' to their practices (b) suggest perspectives and ways of working better suited to local conditions and (c) gather information about the effectiveness of local care services. They also seek to counter 'passive recipient' attitudes in their communities and encourage members of the public to join LINks.
Although taking differing forms in different communities there are common principles to which they are expected to adhere:

- ". being open and inclusive;
- being accessible to all;
- reaching out to all communities;
- tackling health issues and the wider determinants of health;
- constructive communicating of received information to planners, commissioners and providers;
- feedback of responses and outcomes to the wider community"
  Dept. of Health[b] (2007, p7, abridged)

And "... the LINks' role is to:

- promote and support the involvement of people in the commissioning, provision
- and scrutiny of health and social care services
- obtain the views of people about their needs for, and experiences of, health and social care services and make these views known to those responsible for commissioning, providing, managing or scrutinising those services
- enable people to monitor and review the commissioning and provision of care services
- make reports and recommendations about how health and social care services could be improved, to people responsible for commissioning, providing, managing or scrutinising those services."
  Dept. of Health[a] (2007, p16)

1. HEALTHWATCH: WHAT MIGHT IT LOOK LIKE?

In 2010, the government presented a White Paper (*Equity & Excellence: liberating the NHS)* with the intention of:

> "Establishing HealthWatch as a statutory part of the Care Quality Commission to champion services users and carers across health and social care, and turning Local Involvement Networks into local HealthWatch"
> *Dept. of Health White Paper (2010 pp49-50)*

In expanded form it sets out the role of Healthwatch thus:

"At local level:

- Local HealthWatch organisations will ensure that the views and feedback from patients and carers are an integral part of local commissioning across health and social care;
- Local authorities will be able to commission local HealthWatch or HealthWatch England to provide advocacy and support, helping people access and make choices about services, and supporting individuals who want to make a complaint. In particular, they will support people who lack the means or capacity to make choices; for example, helping them choose which General Practice to register with;
- Local HealthWatch will be funded by and accountable to local authorities, and will be involved in local authorities' new partnership functions, described in chapter 4. To reinforce local accountability, local authorities will be responsible for ensuring that local HealthWatch are operating effectively, and for putting in place better arrangements if they are not; and
- Local HealthWatch will provide a source of intelligence for national HealthWatch and will be able to report concerns about the quality of providers, independently of the local authority.

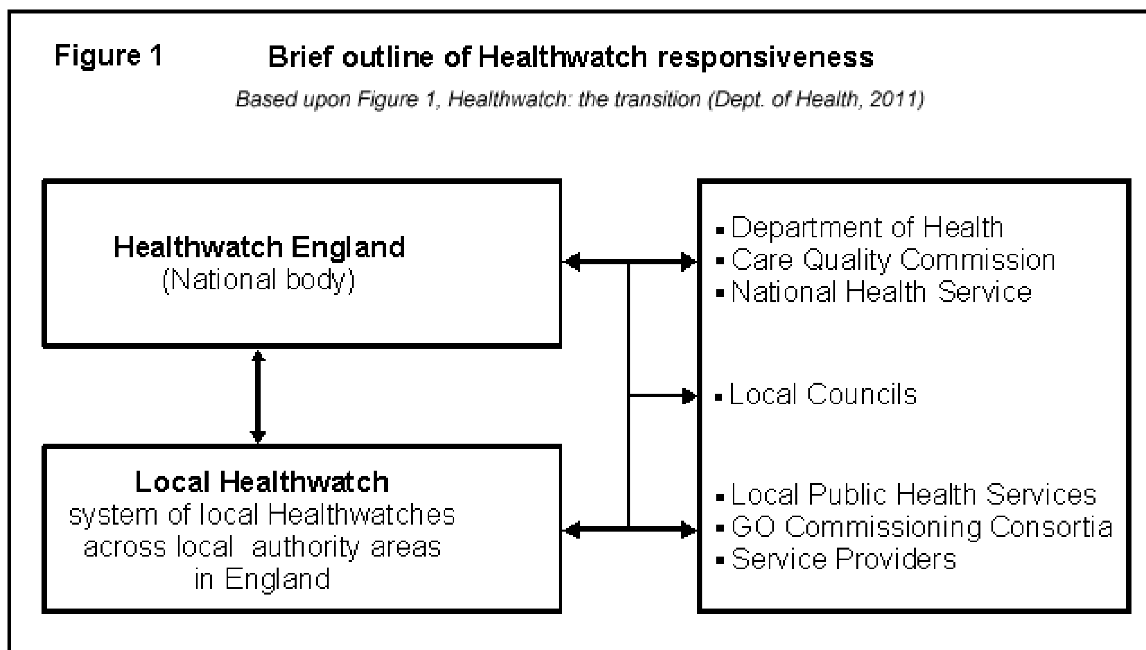
At national level:

- HealthWatch England will provide leadership, advice and support to local HealthWatch, and will be able to provide advocacy services on their behalf if the local authority wishes;
- HealthWatch England will provide advice to the Health and Social Care Information Centre on the information which would be of most use to patients to facilitate their choices about their care;
- HealthWatch England will provide advice to the NHS Commissioning Board, Monitor and the Secretary of State; and
- Based on information received from local HealthWatch and other sources, HealthWatch England will have powers to propose CQC investigations of poor services."

Dept. of Health (2010, pp8-19)
(See also later, *'Monitoring and Feedback Group?'*)

The organisation

The planned organisation is indicated in Figure 1 and carries an expectation that "... effective local HealthWatch organisations will:



"Presenting views, shaping and monitoring health and care services

- provide the strong, independent, local, consumer voice on views and experiences to help bring about better health and social care outcomes;
- monitor local health and care services and make recommendations to commissioners and providers about things that could or should be improved;
- be authoritative, credible, and influential with commissioners and providers of services, to help shape those services, and help them to improve;

Supporting Individuals

- be highly visible and accountable in the local community, known about, understood and trusted by local people as a source of information and support;
- signpost people or help them to access information thus helping them exercise choice;
- empower and facilitate people to speak out, including through NHS complaints advocacy.
- contribute information about local health care and public health services to the Joint Strategic Needs Assessment process and health and well-being strategy.

Organisational behaviour

- operate in a way that encourages and facilitates participation from all who want to be involved, including acting in a transparent way;
- actively engage and involve people that need help to be able to contribute, underpinned by principles of equality and diversity;
- have a good understanding of local voluntary and community groups, other patient and public groups, like Patient Participation Groups and foundation trust membership and how they complement each other. This will enable local Healthwatch groups to work through and with local organisations to understand

and present the views of local people, and effectively signpost people to information and advice;

- have excellent relationships with commissioners and providers,...[and]... informed about the experiences, needs and aspirations of local communities;
- have the capacity to use health, social care and public health information and to help others to do so;
- have an in-depth understanding of the issues facing the local community, and apply this as a member of the local health and well-being board;
- be a well-led and well-managed organisation, including being open to scrutiny (for example through self-assessment and peer review), seeking continuous improvement; and
- have a high level of knowledge and expertise in health and social care policy and implementation, including keeping up to date with developments for example in personalisation."

Dept. of Health[a] (2011, pp17-18)

We are told that "The Government's reforms aim to empower local organisations and professionals and make services more accountable to patients, the public and their communities" and that completion of this transition will involve:

"1. working with other healthcare professionals [and] GPs in consortia... [having responsibility for]... commissioning NHS healthcare services;
2. a new NHS Commissioning Board ... [leading] on quality improvement [to] promote patient and public involvement and choice;
3. local authorities... [establishing]... health and well-being boards in every upper-tier local authority... joint working and integrated services across health and social care. For the first time, councils will have the powers to scrutinise any NHS funded services, whoever provides them;
4. the Parliamentary and Health Service Ombudsman will have greater power to share reports more widely, strengthening the role of complaints in the system;
5. NHS foundation trusts will have strengthened internal governance making them more accountable for their results;
6. all NHS trusts will become NHS foundation trusts by 2014;
7. Monitor will become an economic regulator with responsibility for protecting the interests of patients and the public. It will do this through supporting the continuity of services, driving productivity by regulating prices, and promoting competition to ensure patients' right to choice is protected;
8. Public Health England will give public health a distinct identity to promote health protection and prevention; and
9. NICE and the NHS Information Centre for health and social care will have improved roles in the new landscape."

Dept. of Health[a] (2011, p12)

Aims...

The aims of Healthwatch difficult to identify in explicit form, but Saddler volunteers the following:

"... to ensure that... [the public's]... voice is integrated at all levels of our health and

care systems. Local HealthWatch will also have an important new focus on supporting the diverse needs of individuals, helping them to find the information they need so they can make the most of the wide range of choices available to them... Local HealthWatch will also be the place they can go to get help if they need it to make a complaint."
Dept.. of Health[a], Healthwatch Transition Plan, Introduction (2011, p8)

... and Objectives

In order to realise these aims the following objectives have been set out:

"Healthwatch [is]:

1. to become the independent consumer champion for the public - locally and nationally
2. to promote better outcomes in health for all and in social care for adults.
3. to represent diverse communities
4. to provide intelligence - including evidence from people's views and experiences - to influence the policy, planning, commissioning and delivery of health and social care. and locally...
5. to provide information and advice to help people access and make choices about services as well as access independent complaints advocacy to support people if they need help to complain about NHS services."
Dept. of Health[a] (2011, p11)

and thus:

"In the reformed NHS, people will have:

1. access to more information about healthcare and their condition;
2. ways to rate and record their experiences;
3. greater control of their medical records;
4. greater choice of provider, of consultant-led team, of general practitioner, and of how they access services; and
5. choice of treatment and support options."
Dept. of Health[a] (2011, p11, adapted)

Governance...

"... we are using the term 'governance' to describe the processes and systems by which a LINk operates and governs itself. These need to be clear to LINk participants and also to be shared with external stakeholders, including commissioners and providers of local care services."
Dept. of Health[b] (2007, p28)

The above Department of Health statement on LINks' governance is also applicable to Healthwatch. But in wider terms, the characteristics of *governance definitions* tend to revolve about:

1. "Interdependence between organizations...
2. Continuing interactions between network members, caused by the need to exchange resources and negotiate shared purposes.
3. Game-like interactions, rooted in trust and regulated by rules of the game negotiated and agreed by network participants.
4. A significant degree of autonomy... Networks are not accountable to [a central body]... they are self-organizing.. Although the [central body] does not occupy a sovereign position, it can indirectly and imperfectly steer networks."
   Rhodes (1997, p53, adapted)

'Governance' refers not to traditional-style management of monolithic structures (i.e. 'government'), but of:

> "... services provided by *any permutation* of government and the private and voluntary sectors.".
> *Rhodes (1997, p5)*

In other words, *it is a way of managing mixed networks* out of which will emerge:

> "... new forms of collective decision-making at local level which lead to development of different relationships, not simply between public agencies but between citizens and public agencies."
> *Goss (2001, p11)*

Note that, whilst governance is to do with effectiveness and efficiency, it is also to do with the manner in which activities, actions, practices and events are conducted; that is, the *ethics* which underpin them.

... and Healthwatch

Local Healthwatch will be part of a mixed network of interacting internal and external groups responsible for, or deliberating seeking to influence, the 'delivery' of local care services. Its role includes monitoring the quality of their performance and feeding back observations -- directly or indirectly -- to those organisations which regulate them. and to other interested parties (see Dept. of Health White Paper, 2010).
As this necessitates examination of governance arrangements in the services monitored, *the quality of Healthwatch's own governance arrangements must be beyond criticism* if it is to be trusted and respected by community and network.
In examining its own performance, therefore, each Healthwatch must establish (and comply with) its own governance principles, transforming them into practical guidance and negotiating their implementation. In doing this they need to take into consideration the likely impact of their activities and conduct on community and external stakeholders (e.g. Healthwatch Hosts, local government bodies, National Health Service Trusts).
It is suggested here that, to avoid potential conflicts of interest, those charged with oversight of Healthwatch governance should *only exceptionally* hold membership of other Healthwatch groups. Additionally, that they should not sit on boards or committees of external (public or private) bodies which have significant dealings with Healthwatch. It is necessary, therefore, that each local Healthwatch monitor how well

its own governance policies facilitate or hinder ethical conduct and the transparency and efficacy of:

- internal activities;
- inter-Healthwatch relations;
- networking with non-Healthwatch organisations.

Figure 2 Healthwatch Functions: new and carried forward from LINks *Based upon Figure 2, Healthwatch: the transition (Dept. of Health, 2011)*		
Influencing...	**Informing...**	**Advising...**
external and internal groups/bodies by bringing -- from local and other contexts -- different perspectives and ways of looking at the policies, planning and practices of local care services	by gathering, dissem-inating/communicating data and information on a variety and range of issues and topics of relevance to local communities, councils, care services and other organisations and agencies	supporting individuals and groups through disputes and complaints procedures/processes relating to the conduct, actions, activities of care services and related agencies.

Figure 2 illustrates government thinking. about the functions of Healthwatch, but each community must devise its own versions of such models.

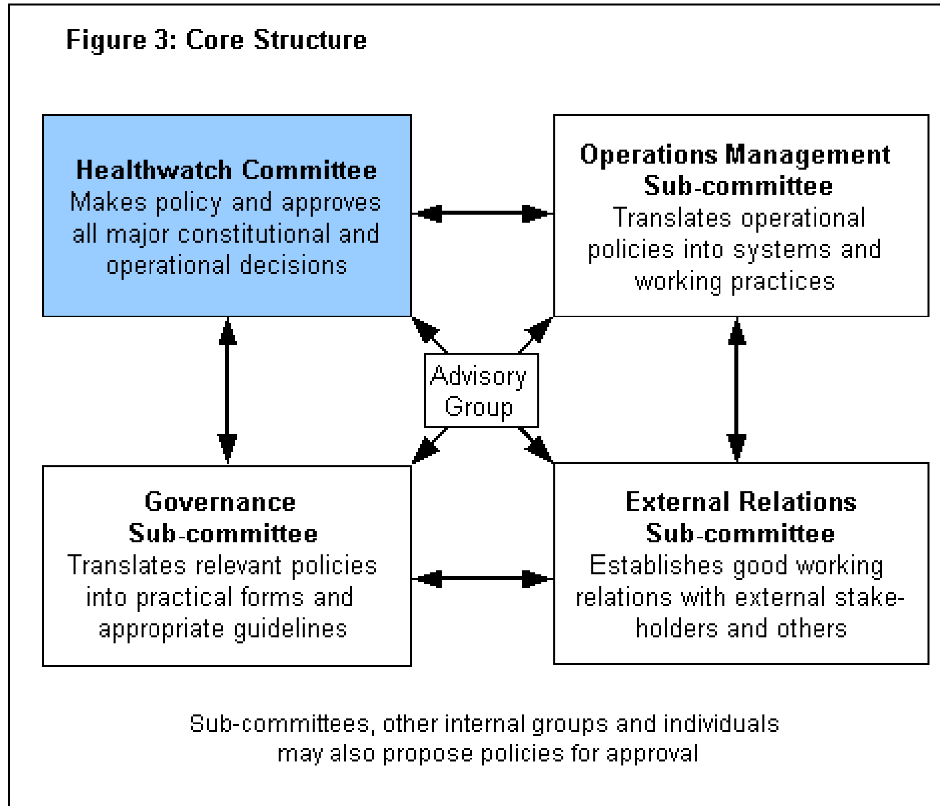
2. HEALTHWATCH: A POSSIBLE MODEL

Drawing partly upon an existing LINk's arrangements (Cheshire East) this section sets out a *possible* Healthwatch structure as a vehicle for examining issues involved in the LINk-Healthwatch transformation process.

To begin with, Healthwatch needs a small, closely integrated core around which the rest of the system can be built. The proposition is, therefore, that a central board or committee is required, which has overall responsibility and accountability for Healthwatch activity, supported by sub-committees focused upon:

1. *operations management:* ensuring that Healthwatch functions as it ought;
2. *external relations:* establishing and maintaining good working relations with external bodies;
3. *governance:* monitoring and advising on policies relating to the conduct and activities of Healthwatch groups and individual members. (Figure 3)

These are defined more clearly below and other aspects will be considered later and for present purposes the reader should refer to Figures 3 and 4.



1. Healthwatch Committee

Primary concerns: *overall responsibility and accountability for major policy-making and Healthwatch activities, and ensuring that Healthwatch realises its stated purposes.*

Functions

1. *to develop/approve policies relating to Healthwatch's community relations;*
2. *to develop/approve policies concerning Healthwatch's operational, forms, functions and development;*
3. *to establish and maintain good relations between Healthwatch and appropriate local, regional and national bodies, including other Healtwatches;*
4. *to disseminate information to about Healthwatch activities and events;*
5. *to respond appropriately to criticisms and challenges to Healthwatch policies, activities, actions, practices and conduct;*
6. *to ensure a sound basis of governance;*
7. *to protect members of Healthwatch from undue pressures and influences.*

2. Operations Management Sub-committee

Primary concerns: *transforming operational policies into comprehensible systems and working practices, overseeing them, evaluating them and updating them as appropriate.*

Functions

1. *to translate policies into effective working systems and practices;*
2. *to establish collaborative/cooperative working relations*
    a) *between internal Healthwatch groups*
    b) *between Healthwatch and external organisations and the community;*
    c) *to ensure that work is carried out properly to consistent standards;*
3. *to consider representations and challenges concerning Healthwatch's operational practices and conduct and either responding to them directly or passing them to the Healthwatch Committee for consideration;*
4. *to commission/engage in research and information-gathering relevant to Healthwatch's operational activities;*
5. *to maintain records and statistics of operations as appropriate.*

3. External Relations Sub-committee

Primary concerns: *setting up good working relations with external Healthwatch stakeholders and other organisations whose contributions to Healthwatch's work are -- or are likely to be -- positive.*

Functions

1. *to establish, maintain and develop good working relations with external stakeholders;*
2. *to find ways to utilise the knowledge, expertise, experience and know-how of private sector, volunteer, charity and public sector organisations in furthering the work of Healthwatch;*
3. *to monitor the impact, locally, of the politics of these sectors on Healthwatch and to advise the Healthwatch Committee accordingly;*
4. *to represent Healthwatch's interests within these sectors and, as appropriate, within particular organisations and groups;*
5. *to monitor external developments likely to affect Healthwatch's activities significantly and to advise the Healthwatch Committee if it considered that potentially or actually they may affect Healthwatch's activities adversely..*

[Notes: 1. This work may impact on Carewatch Task Groups and vice versa (Figure 4).
2. There is a case to be made for the Healthwatch Committee to delegate responsibility to this Subcommittee for much of the feedback of a range of information supplied to external bodies.]

(In addition see later: '*Monitoring and Feedback Group*')

4. Governance Sub-committee

Primary concerns: *the effectiveness and efficiency, legitimacy and ethics of Healthwatch's policies, activities, actions and events. In pursuing its concerns it will consult both within Healthwatch and outside.*

[See also: Appendix A: *Governance -- which model*; Appendix B: *Governance - some fundamental principles*]

Functions

1. *to help formulate and keep under governance review all Healthwatch policies and practices;*
2. *to provide advice and guidance on issues regarding the legitimacy and ethics of all Healthwatch activity;*
3. *to translate into practical forms guidelines for, and implementation of, approved policies and to suggest modifications as appropriate;*
4. *to draw to the Healthwatch Committee's attention serious infringements of Healthwatch governance policies and practices;*
5. *To intervene where such infringements occur, if approved or required by the Healthwatch Committee.*

Advisory Group

Primary concerns: *The formulation of key policies rests on sound information and data based in the realities of the organisation and its context. The Healthwatch committee should therefore create an Advisory Group consisting of individuals from within Healthwatch and from external bodies to provide relevant data, information, ideas and views to inform the deliberations of the Committee, Subcommittees and others as appropriate.*

Functions

1. *to provide balanced advice and views in relation to the desirability, practicality and 'real-worldness' of Healthwatch policies, decisions, actions and activities, and the implications of these for Healthwatch and its community;*
2. *to review the Healthwatch Committee's and Sub-committees' activities periodically and, as appropriate, suggest alternative models and methods which may more effectively meet changing needs and circumstances;*
3. *to provide, in as unbiased a form as possible, practical and theoretical knowledge, expertise and information of relevance to the processes and workings of the Healthwatch Committee, Sub-committees and other internal groups regarding any matter on which it is qualified to speak;*
4. *to engage, as appropriate, in research projects relevant to its own role, functioning and development within Healthwatch.*

Other groups

The foregoing core structure allows us to develop the Healthwatch model, and to provide brief descriptions of the responsibilities and functions of the different types of groups shown in Figure 4.
Of particular interest are two Healthwatch functions not structured into LINks. First is the monitoring of GP Commissioning Consortia:

"GP consortia will have a duty of public and patient involvement, and will need to

> engage patients and the public in their neighbourhoods in the commissioning process. Through its local infrastructure, HealthWatch will provide evidence about local communities and their needs and aspirations."
> *Dept. of Health White paper (2010, pp29-30)*

The second function is that of Advocacy:

> "Local authorities will be able to commission local HealthWatch or HealthWatch England to provide advocacy and support, helping people access and make choices about services, and supporting individuals who want to make a complaint. In particular, they will support people who lack the means or capacity to make choices; for example, helping them choose which General Practice to register with"
> *Dept. of Health White paper (2010, p9)*

However:

> "Local HealthWatch will not have a role in complaints advocacy until 2013 [and] local HealthWatch will not necessarily deliver that service."
> *Dept.. of Health[a]: Healthwatch Transition Plan (2011, p26)*

Monitoring and Feedback Group?

One theme that emerges very strongly in the government's vision of Local Healthwatch -- the range of advisory, feedback and reporting activities in which it will be engaged. The Department of Health White Paper (2010) is strewn with references to this and, more recently, published a short document from which the following passage is an extract:

> "HealthWatch will need to:

- reach out to and connect with a diverse range of local people and communities
- gather the views and experiences of patients and the public for good local intelligence that can inform local commissioning and scrutiny decisions and make people's views known through reports and recommendations to hel monitor local health and adult social care services, which will lead to more accessible, safer and higher quality services
- through their access to user feedback and data from services providers, highlight any lapses in the safety of services
- signpost to and/or provide, an advocacy service for people with complaints about NHS services
- provide information and signpost/support access to information and data in ways that local people use to exercise choice."
  Depart. of Health[b] (2011, p2)
- (See also *'The Role of Healthwatch'*, *p2,* of the present document)

If the volume of this kind work is very large -- and it appears that it may be -- then a case can be made for creating a *Monitoring Feedback Group* under the oversight of the External Relations Sub-committee, or constituted as a new Sub-committee.

Figure 4

HEALTHWATCH: A POSSIBLE MODEL

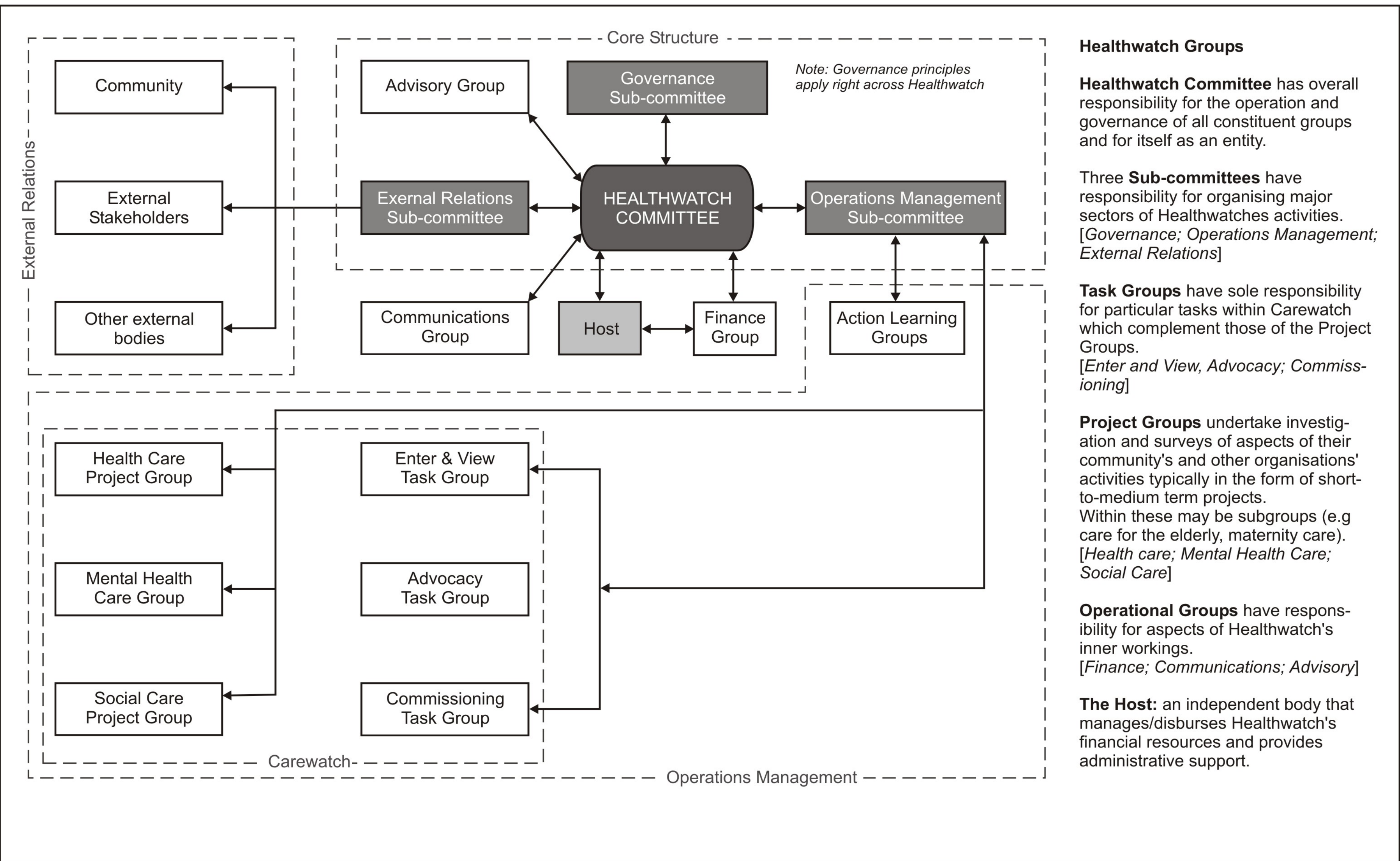
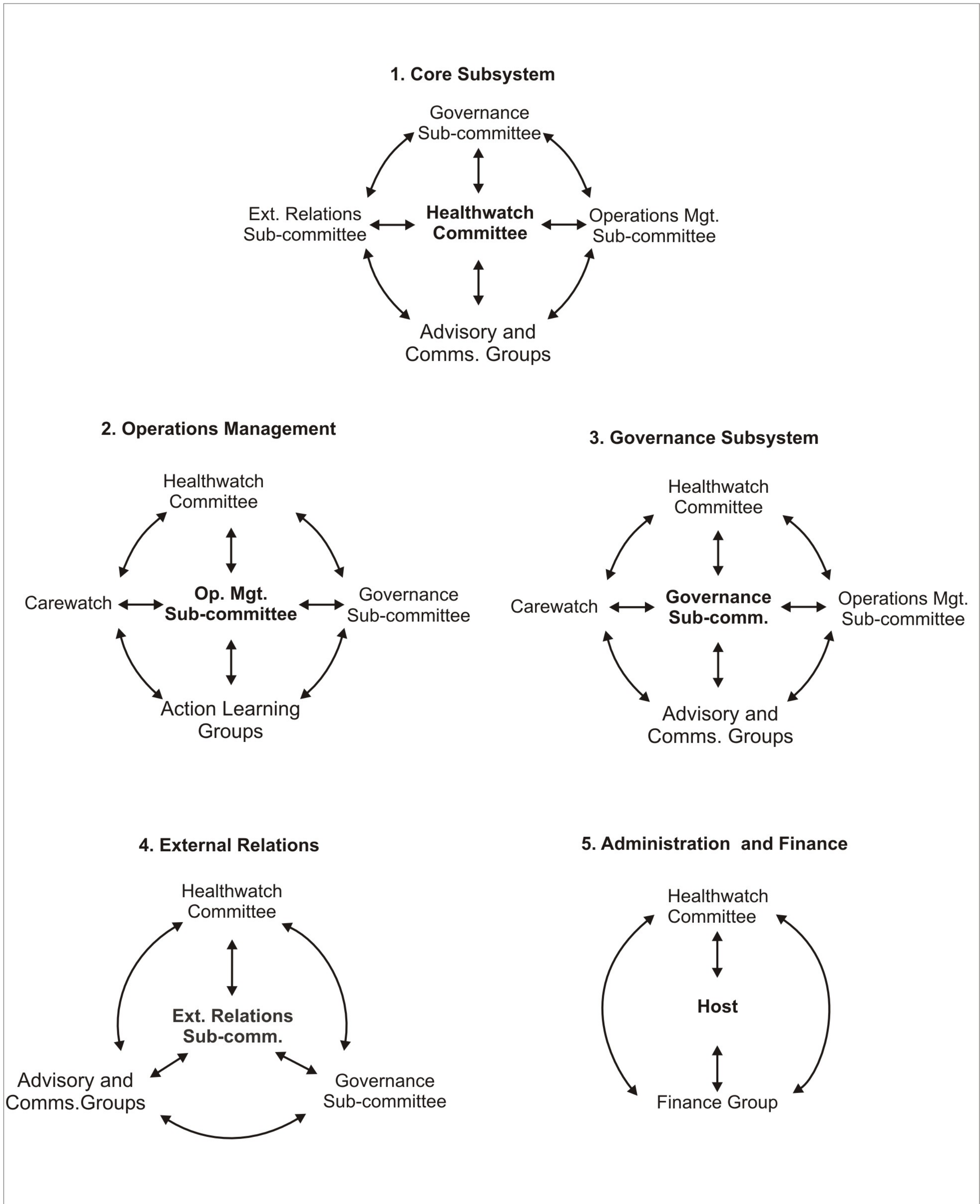


Figure 5 **Healthwatch Subsystems**

In making sense of the system set out in Figure 4, reference to the subsystems shown here will help.

Note: It should not be assumed that all elements shown (here or in Figure 4) will interact with the same or similar frequency, purpose or intensity.



The task of such a group would be to translate Healthwatch feedback information into forms appropriate for communicating, as appropriate, to regulatory authorities (e.g. Care Quality Commission), various other organisations (e.g. commissioning consortia) and the community.

Further issues

[Note: for this section's discussion, the author consulted the published responses to the White Paper *'Equity and Excellence – Liberating the NHS,* of the following LINks*:* Bristol, Essex & Southend, Halton, Hammersmith & Fulham, Harrow, Stockton-on-Tees and Swindon.]

There are issues concerning the nature of Healthwatch which appear not to have been raised generally, or to which satisfactory responses have not been published, yet which may affect the outcomes of the LINk-Healthwatch transition significantly. Below a cluster of such issues is briefly discussed.

1. *Healthwatch commissioning*

To commission is to designate a person, group or organisation as 'provider' of a service or product and Healthwatch may commission:

- internal groups/individuals to undertake Healthwatch projects;
- external organisations (stakeholders or non-stakeholders) to collaborate in such Healthwatch members' projects;
- Healthwatch groups/individuals and external providers (stakeholders or non-stakeholders) to collaborate on external Healthwatch projects;

Healthwatch projects are to do with such services or products and fall into two group*s:* those which are clearly within the compass and funding of Healthwatch and those which are not. The former can be undertaken with least difficulty. The latter -- the required skills/expertise do not exist within Healthwatch or *unless funded in other ways* (or both) -- cannot be undertaken. Out of this come the following possibilities.

2. *Paying Healthwatch staff*

Healthwatch Advocacy work appears, to date, to be the only potential area of work discussed in terms of paying staff for what they do. This *might* be interpreted as a willingness-in-principle to pay *specialist staff* but possibly opens the door to employment of staff for other purposes. Should this arise, will it affect the ways in which staff are selected/appointed to positions in Healthwatch? Will paid staff be considered senior to, or of higher status than, volunteers? How will payment of some members affect the dynamics of Healthwatch groups and recruitment? As employees, paid staff will be entitled to more detailed job descriptions and specified conditions of employment, so will the notion of accountability change? What (additional) legal compliances will be required (e.g. employment law)? How will it all be funded?

3. *Raising additional funds*

What is the legal position if Healthwatch decides that it wants to raise supplementary

funding? Will it be permitted to deploy/second volunteers to undertake *fee-based* advisory/consultancy/project work for external stakeholders and other organisations, in order to raise such funds?
What should Healthwatch's response be if it is offered unsolicited funding by other organisations (private, public or Third Sector) to undertake projects for them? What might be the implications for control of the work, conflicts of interest and the nature of working relationships between Healthwatch and such organisations?

> [If a policy of paying staff is adopted, two important questions arise (among others). Will it lead to the diversion of resources from primary tasks? Will it result in the blurring or shifting of focus on Healthwatch's primary goals?]

3. *Training and development*

Whether staff are paid or voluntary, undertaking work *competently* requires the use of initiative, appreciable levels of skill, experience and expertise, so will Healthwatch (a) simply trawl through its membership to locate such qualities; (b)'buy' them in for particular projects; (c) institute programmes of training to try to develop them 'in-house'? Underlying these questions is the matter of identifying the types of expertise, competence and experience required in order to provide appropriate staff training and development.

4. *Organisational options*

By presenting basic information about the various forms of statutory organisations, their constitutions and funding (*Dept. of Health, 2011[a]: Annex A, p35*) might the Department of Health be hinting that Local Healthwatches, *under certain conditions*, may have the choice of transforming themselves into differing organisational forms? The December (2011) issue of Cheshire East LINk's periodical 'Update' picks up on precisely this possibility, suggesting that Healthwatches might become:

> "... companies with limited or unlimited liability, companies limited by guarantee, charter companies and bodies by statute. So at some point, Local Healthwatch may need to be set up as its own charity, company or similar. As a 'body', that means Local Healthwatch:
>
> Will be an organisation in its own right...
> May appoint its own staff.
> May have to produce its own annual accounts.
> Will have standards provided by a national Healthwatch organisation, Healthwatch England, against which Local Healthwatch can be measured."

Taking all of the issues in this section together, we might do well to address them (at least in their more obvious implications) earlier rather than later.

Action learning for work groups: some notes

The Department of Health *(2011, pp25-26)* points to action learning as a supportive factor in the development initial Healthwatch systems.

> "Action learning sets are designed to share information and disseminate improvement. Participants of an action learning set would agree their terms of reference, which would include bringing issues to the table for discussion and some clear products to enable others to learn. Such products can be, for example, a set of tools for use in HealthWatch that would enable it to gather the diverse, collective views from its local community when presenting the local voice to commissioners and providers to improve health and social care services"

But action learning may also be imported into individual Healthwatches. It is an experiential learning approach involving self-organising 'sets' (i.e. groups) of 5-10 people and is based upon a small number of ideas. That:

- learning and action are *interdependen*t;
- the *primary focus* is translating what is learned into action;
- the focus is *real world* problem-solving;
- it requires *continual reflection* on solving the problems hand;
- members of sets are *mutually dependent*, learn from each other and are capable of organising and managing both themselves and the work they undertake.
  (See also Revans, 1982; McGill & Beaty, 1995; Weinstein, 2001; inter al.)

An important part of the action learning approach is the development of effective working relationships and a sense of mutual involvement. In practice, it would be possible to have a range of 'sets' continually monitoring and exploring real-world issues of relevance to Healthwatch's work and feeding their observations through the Operations Management Sub-committee to other Healthwatch groups.

There is no reason why an action learning approach should not be adopted across many operations *within* Healthwatch. Information-gathering, researching the experiences of patients, looking up material and sources for Project Groups and so forth are examples at a simple level but much more complex tasks may be tackled using action learning which, among other things, tends to increase the number of members actively participating. [See also Ashton, S. '*Healthwatch: an involving culture? 2011*]

3. INFORMATION MANAGEMENT

[This section is partly an adaptation of 'Information management'. In Ashton, S. (2008) 'Personal Reflections on the Structure & Functioning of Local Involvement Networks']

For an organisation such as Healthwatch, Milner's (*2000, p21*) suggestion is pertinent. That:

> "... the development of an overarching policy in the area of information management should be seen as critical",

and that an information management policy be based upon examination and appropriate updating of:

"1. the classification of information assets;
2. the quality of information provided;
3. the proper authorised use of information for its rightful purpose;
4. the identification of risks and appropriate protection;
5. maintenance and exploitation;
6. the development and implementation of information systems strategies"

Ashton (*2008, pp26-27, adapted*) in a discussion of LINks information management puts it thus:

> "... whether electronic or of other types, information needs to be classified properly by type, value and quantity and stored in easily retrievable form. Issues of confidentiality and sensitivity, restricted access and so forth will need to be resolved and appropriate system protection designed and installed. The quality, quantity, and form in which information is held will need to be reviewed periodically and the content properly updated. In addition, if information sits unused for long periods, consideration should be given to whether and how it may be exploited, to the benefit [Healthwatch] and its communities... Such activities should be based upon a strategic development plan for information management. Data Protection [and possibly Freedom of Information] legislation will be a major factor."

If an individual or group wishes to access information, they need to be able to locate it and, having done so, to access and use it properly. Hence some (perhaps many) members of Healthwatch may experience difficulties in:

- locating sources and resources within or outside of their community;
- researching fully enough what they seek *and* at sufficient depth;
- interpreting particular kinds of information and understanding it (e.g. 'technical' documents, statistical data);
- organising, storing and utilising the information obtained in the most effective ways.

And in addition to these general points, Healthwatch staff may need at times to access Data Protection and Freedom of Information information.

Taking all this into account (and particularly with regard to the use of computer storage and retrieval of information) Healthwatch needs to ensure that member groups have (or have access to) proper support in information handling and its management. Its systems need to be flexible enough to accommodate significant changes in the range, types and volume of information due to demographic, economic and other such changes. Further, systems cannot be properly set up unless the kinds and quantities of information likely to be handled are properly assessed, and the costs estimated (and found) in terms of finance, staffing, equipment etc.

Communication and digital technology

Healthwatch communications raise many questions. As examples, the ethical collection, editing, interpretation and dissemination of information; the protection of confidentiality; accurate and comprehensible presentation of information and so forth. Collier cites Beresford & Croft who identify the basics of effective communication in the form of several questions:

> "1. Who are we trying to reach?
> 2. Whose language are we using?
> 3. What information do people need?
> 4. When will they want it?
> 5. Where can it be provided most helpfully?
> 6. What forms will be most effective?
> 7. What support will people need to make the best use of it?"
> *Collier (1998, p71)*

... and underlying these questions are others. For example:

- who will do the information gathering?
- how will their activities be monitored, controlled, evaluated?
- what information policies will govern liaisons between Healthwatch and information gatherers from private organisations and other public agencies?
- how will communication be approached and managed with community organisations resistant to interaction with Healthwatch or its activities?

With regard to the last of these, Healthwatch's success may well be judged by how effective it is at establishing appropriate contacts with *the least accessible* groups and individuals in its community.

Turning to information technology, it would be a mistake to assume

- that everyone in the community has *access* to the Internet or World Wide Web;
- that all who have such access will *use* it readily and frequently;
- that those who access it do so *at more than a basic leve*l;
- that those who use it do so because they *like, prefer or enjoy doing so*.

Quite apart from lack of familiarity with, or anxiety about, electronic and digital means of communication, some people are simply prejudiced against them whilst others have difficulties in using them (e.g. sight impairment, physical disability). So, whilst community services and Healthwatch staff may be familiar with, or well versed in, them, many others will not be and we might do well to note the following observation : :

> "... ICT must be seen as supplementary to, not a substitute for, other forms of 'first contact' for social welfare services, whether in person, by phone or through printed material."
> *Geoghegan et al. (2004, p131)*

4. A FULLY FUNCTIONAL SYSTEM?

Of LINks it has been said that part of being successful means paying attention to individuals' and groups' performances, and aspiring to high standards concerning:

- a community's awareness of its LINk's existence;
- the LINk's visibility to its community;
- whether a LINk has demonstrably "reached out widely and deeply into the community";
- evidence of a community's perceptions of its LINk and its purposes;
- whether the LINk understands its community's needs;
- community access to (non-discriminatory) LINk services;
- a LINk's establishment of appropriate relations with health and social care organisations;
- an open relationship between a LINk and its Host;
- a LINk's accountability for its financial activities;
- whether a LINk can identify the impact of its involvement on community services. *Dept. of Health[b] (2007, pp42-43, adapted)*

Similarly Healthwatch will need to demonstrate its aspiration to high standards by showing -- quickly -- that:

- major policies are in place and being implemented;
- major systems are being 'proved out';
- major roles and functions are being assigned and beginning to operate effectively;
- major procedures have been tested and have proved to be adaptable;
- Healthwatch members are:
  - being properly registered;
  - being kept properly informed;
  - becoming increasingly active;
- Internal working and work relations are developing properly;
- external relations, with main local and national stakeholders, are being established and progressing satisfactorily.

This becomes even more important if significant opposition or resistance to Healthwatch activities emerges from sectors of national/local government, volunteer or charity organisations, private commercial organisations or the local community. Healthwatch should therefore be prepared to respond transparently to queries such as:

- *why* particular models/systems/concepts have been adopted;
- what *evidence* there is that they work well in practice;
- what *evidence* there is that they enhance Healthwatch's service *in particular ways*;
- what the *human, material and legal implications* of adopting them are .

Evaluation

We need to be able at any time to state with confidence, and if necessary demonstrate, that *this Healthwatch, in this community, at this time and under these*

circumstances is effective. It may be useful, therefore, periodically to apply a basic 'soft systems' evaluation to Healthwatch's functioning:

- Efficacy - does the operation/action/activity work?
- Efficiency - does it work well?
- Effectiveness - does it achieve its intended ends?
  (*Checkland. & Scholes 1999: adapted)*

And to these we should add:

- Ethics - does it operate ethically?

But we still have to consider who will be responsible for evaluating LINk Group work, how will they do it and what criteria will be applied?

5. ENDNOTE

This brief document raises issues concerning the setting up of Healthwatch. Being only one person's perspective on the LINk-Healthwatch transformation, accounts for the choice of topics dealt with.
The basic Healthwatch structure used as a vehicle for discussion is simply one possibility among many. However every Healthwatch structure must be adapted to its aims and objectives and its particular context, hence every one will be unique.
Perhaps the areas presenting most difficult issues are to do with variations in organisational form and matters of funding, along with the recruitment, training and development of Healthwatch staff, whether employed or volunteer.
Hopefully this discussion contributes something of value to the debate about the shape Local Healthwatch could take, how it ought to be set up and how it might be managed.

Appendix A

Governance: which model?

Adapted from Ashton, S. (2008) Personal Reflections on The Structure and Functioning of Local Involvement Networks, Revision 3: (Private Publication)

Jessop (*2000, pp16-17*) points out that:

> "... there is no one best governance mechanism... [and]... a commitment to continuing deliberation and negotiation does not exclude eventual governance failure"

whilst Rochester (2003, p. 127) observes that:

> "There is... an emerging view that governance... may be viewed as... a function or responsibility of the organisation as a whole"

Thus, there is *no single governance model* applicable to all situations or organisations. just as there is no unwritten rule that a single person or a group must be the *sole* carrier of the governance burden. It follows that governance responsibilities may be *distributed.* That is to say, aspects of (or part-responsibility for) governance may be undertaken by several groups and/or individuals distributed throughout Healthwatch but they would need to be overseen Governance Sub-committee.
Under any system of governance we might conceptualise its responsibilities as ensuring the legitimacy and appropriateness of Healthwatch's relations with its community and other organisations in terms of Healthwatch's:

- compliance with legislative requirements, contract conditions etc.
- operational stability, adequate performance levels and goal achievement;
- ethical conduct of operations and behaviour generally;
- development and adoption of best practices (including governance);
- decisive and appropriate readiness to intervene, where serious infractions of governance principles occur.
- alertness to political and practical implications of Healthwatch activities for Healthwatch, its community and its working partners;
- alertness to political and practical implications flowing from Healthwatch's and its community;s and working partners' activities;

  [Managing some of these issues would require collaboration between a Healthwatch governance body and others.]

Interestingly, Gill's (*2001, p16*) research into the governance arrangements of twenty not-for-profit Canadian organisations, revealed that...

> "The size and complexity of an organization was by far the most significant determinant of the governance model employed... 'Operational', 'Collective' and 'Management' models were affirmed as more appropriate for smaller organizations with fewer staff resources." (*See also above, p7: Healthwatch: a possible model*)

Governance groups?

Creating an appropriate governance group involves the bringing together of a number of persons who, collectively, offer a wide and relevant range of life experiences, theoretical and practical know-how plus personal principles and understanding, to focus on Healthwatch conduct, actions, activities and events.
Selection of Governance Sub-committee members, should *avoid the assumption* that prior governance experience, in any kind of organisation, automatically guarantees adequate 'qualification' for Locke, Begum & Robson (*2003*) point out, the mix must be *appropriate to the kind of organisation involved and the context within which it operates*. That is to say, candidates should be considered in the light of whether the experience, values and attitudes they bring are appropriate to working in *this* particular Healthwatch, in *this* particular community, at t*his* particular juncture. Membership of a Governance Subcommittee should be gained through a process that is common to *all* candidates whatever that process may be. (See also *Ashton 2008*)

Appendix B: Governance - some operating principles

(*Healthwatch Transition Plan: Appendix B (Department of Health, 2011)*

This extract refers to guidance for LINks, but the points made are similarly applicable to Healthwatch:

"Fundamental principles (... as a basis for discussions about governance arrangements):

- adopt shared principles and work together to change things for the better;
- demonstrate values by working with others for everyone's benefit;
- act responsibly and play a full part in the work;
- help people to help themselves;
- take responsibility and answer for your actions;
- give everyone a say in how things are done;
- act fairly and in an unbiased way;
- share interests and common purpose with others;
- be open – don't hide it when you are not perfect;
- be honest about what you do and how to do it;
- encourage people to work together to improve their community;
- support similar work that others are doing;
- make a commitment to allow anyone to take part;
- look for opportunities to work together to strengthen accountability locally and beyond; and
- recognise that some people and groups find formal structures daunting and find ways to accommodate their needs.

The governance arrangements should seek to ensure that local community based organisations can appropriately contribute to how LINks will work. In order to work effectively, LINks will need to ensure they reach out to a broader range of the community, and getting them involved will be a critical success factor. "
(Extract: *Department of Health, Healthwatch Transition Plan[a], Appendix B (2011, p38)*

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