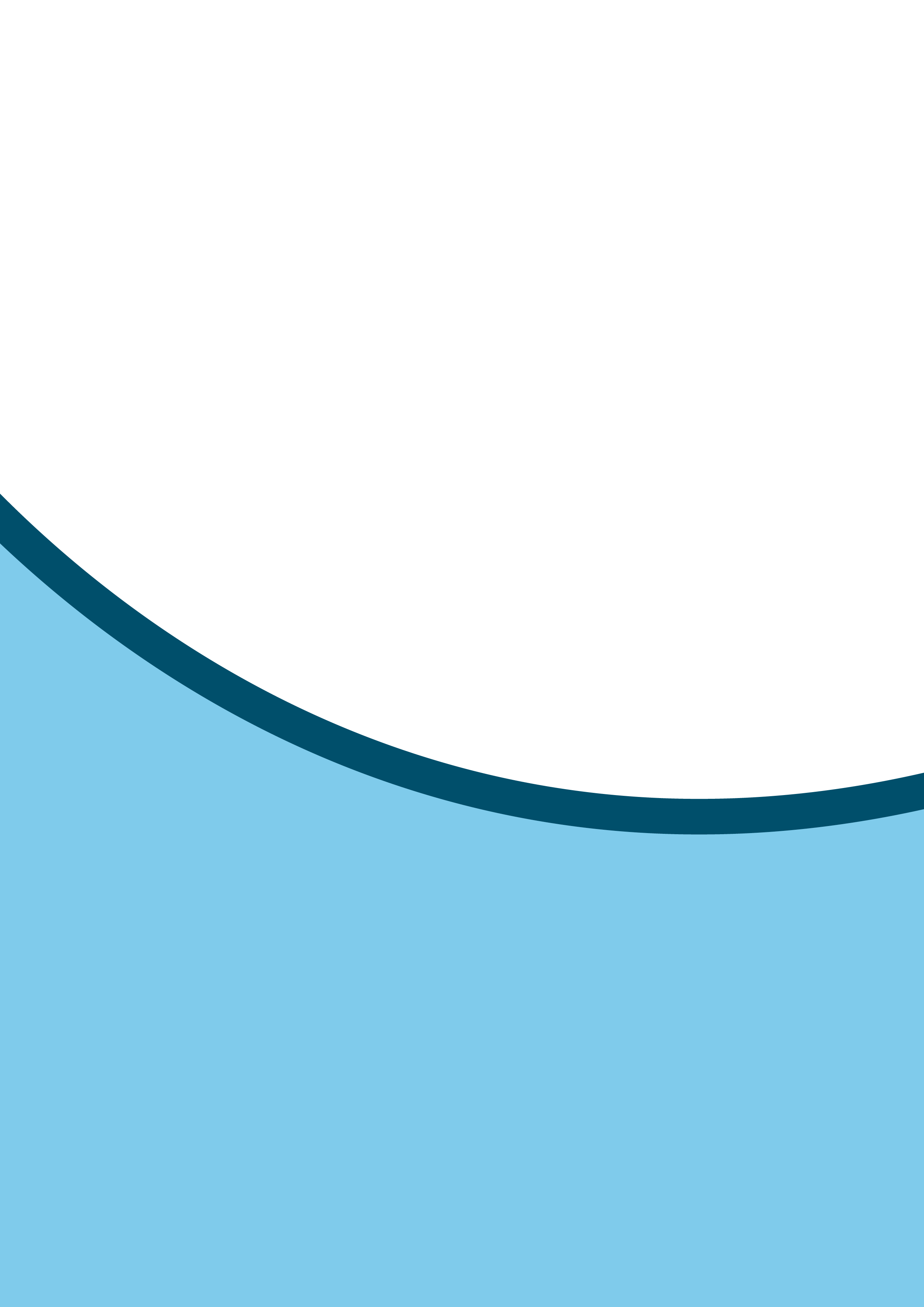
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| **Healthwatch Outcome Domains**  For development and discussion  November 2024 | |
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**Context**

We have a wide range of resources to [support Healthwatch with research projects](https://network.healthwatch.co.uk/guidance/2023-08-21/helping-you-your-research-project) backed up by a clear statement about our [approach to evidence](https://www.healthwatch.co.uk/blog/2024-04-09/our-evidence). Our existing [resources on impact](https://network.healthwatch.co.uk/impact) help focus these research projects on making a difference. What’s still to do is develop the way we describe the breadth of outcomes achieved and where and how they take effect.

**Introduction**

This document has been produced to help take forward discussions across the Healthwatch service about where and how we achieve change. This could be described as the overall Theory of Change for what local Healthwatch and Healthwatch England achieve together.

The document summarises our combined thinking so far, based on initial conversations with fifteen lead officers and reflection on the types of outcomes and impact found in annual reports and elsewhere.

Healthwatch involved so far have fed back that the discussions have helped them focus on some outcomes that they may have been overlooking, or not describing to their commissioners or the public. But this isn’t a finished product. It doesn’t claim to be comprehensive or conclusive. It’s what we hope will enable the insightful and collaborative conversations we’ve had so far to be widened out to all interested local Healthwatch colleagues.

**What are we aiming to do?**

From listening to Healthwatch, we’re keen to make sure we help the network capture and describe all the outcomes that are achieved. Sometimes the focus can be mainly on the ‘service change’ outcomes, which can be easier to describe, but this doesn’t reflect the breadth of statutory activity.

We believe that identifying a structure that sits above the individual outcomes themselves and allows us to better define and categorise them can, in turn, help us with this analysis of what we do and what we achieve. We’ve called these categories ‘domains’ for now, but maybe realms, areas, spheres, or just categories would be preferred?

Following this round of discussion across the network, we’ll also be considering where Healthwatch England outcomes fit into this picture to strengthen our shared narrative about what we achieve together.

Our thinking is that this work will be used to:

* Make sure we’re all telling the best story about each domain and enhance our overall narrative about the value of listening and of what Healthwatch offers.
* Help ensure that funders and other stakeholders recognise the breadth of Healthwatch impact.
* Ensure what Healthwatch achieve through ‘holding to account’ is better understood, considering the responsibilities covered in the [Holding to Account Toolkit](https://network.healthwatch.co.uk/guidance/2022-11-28/holding-to-account-%E2%80%93-toolkit).
* Help us all consider any relationship between the particular domains where outcomes are achieved, the approaches to influencing needed to do that, and the level of resources it takes.
* Strengthen our overall picture of Healthwatch impact to inform our support offer.

This document finishes with a range of questions to stimulate discussion. You may well bring other questions to the conversation.

**Outcome Domain Headings**

Our current list of outcome domains is split across six headings. Within each of these, there are subheadings.

Of course, there will be outcomes that overlap more than one of the domain headings or subheadings. However, the overall approach of thinking through what Healthwatch achieves using this structure seems useful.

1. Governance and oversight.

2. Strategic planning and decision-making.

3. Service design, improvement and quality.

4. Patient involvement and co-creation.

5. Patient safety and regulatory effectiveness.

6. Communication.

Outcomes achieved across all of these domains will be improving the experience of specific groups of people. This is reflected in the section below rather than being covered individually within each domain heading.

**See Appendix 1 for full details of the outcome domain headings and sub-headings.**

**Outcome Levels and People, and Mechanisms**

**Levels and People:** We’ve used the expression ‘levels and people’ here to try to describe the system level at which an outcome within one of the domains might take effect, alongside the profile of the members of the community who benefit from the positive change.

**Mechanisms:** We’ve used the word ‘mechanisms’ here as it’s a term already used in an existing framework to help think about the different types of interaction between organisations that lead to outcomes.

As conversations about our outcome domains have progressed, we’ve often reached the point where these two concepts have started to overlap and seem essential to also consider.

We’re interested in looking at how best to use them to achieve the overall aims we’ve summarised on page 2.

**See Appendices 2 and 3 for full details about Levels and People, and Mechanisms.**

**Appendix 1: The Outcome Domains**

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| **Domain 1: Governance and oversight** | **Examples of how we do this** | **Examples of impact and any recognised measures** |
| Establishing governance structures, processes and procedures. | *[This will only be on the less frequent occasions when these structures, processes and procedures are being set up. What are the best examples can we include here of how Healthwatch have influenced when this has happened?]* | Stronger oversight, scrutiny and direction of strategies and plans to improve patient experience. |
| Requirements to consult with the public and consider equity | Identify when the service commissioner or provider should involve the public about a service change and ask if that’s happened.  Support and promote the opportunity to be involved in public consultation.  Ask to see Equality Impact Assessments relating to service changes and ask questions about them. | Greater public transparency and involvement for the public in decisions made about their services. Greater opportunity for seldom heard groups to influence decisions made.  Reduced health inequalities.  System partners meet statutory requirements and don’t have to repeat exercises they’ve undertaken.  *How should we describe the sort of outcome achieved if the holding to account leads to identifying significant shortcomings in what’s been done and/or significant changes to what was going to happen?* |
| Support to Health Overview and Scrutiny Committee and Health and Wellbeing Board | Healthwatch using its seat to share insight, share local people’s concerns that only it has heard, and challenge where appropriate. | Increase Committee and Board members understanding of what service changes mean to individual residents. |
| The scrutiny role of elected representatives and supporting constituents' interests | Helping decision makers understand healthcare services from user perspectives.  Sharing Healthwatch data. | Elected representatives better understand their constituents experiences with services and impact on their wider lives so they can make better decisions and advocate in their interests. |

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| **Domain 2: Strategic planning and decision-making** | **Examples of how we do this** | **Examples of impact and any recognised measures** |
| Content of strategies and plans | Present Healthwatch insight to bodies that are setting strategies and plans and ask them to address issues identified in what they produce. | Better targeting of resources including to address health inequalities. |

| **Domain 3: Service design, improvement and quality** | **Examples of how we do this** | **Examples of impact and any recognised measures** |
| --- | --- | --- |
| Design and specification of a commissioned service | Report insight from research and engagement activity with analysis and conclusions.  Report and escalate experiences of members of the public who make contact for information and signposting support because they are experiencing problems with services.  Discuss with service commissioners how these can be resolved through the next commissioning cycle.  See also Domain 4. | Addressing unmet needs.  More effective use of short and long-term healthcare resources.  Increased patient satisfaction with delivery of services, as measured by providers and commissioners. |
| Integration of services | As above, with the Healthwatch lens benefiting from our wide remit across health and social care helping spot disconnects. | As above. |
| Accountability of a Trust to the public | Review and comment on draft Quality Accounts. | Assurance of integrity and transparency on behalf of public.  Triangulation of Trust self-assessments with public experience to influence plans and priorities.  *Does this help inform future CQC approach to inspection?* |
| Effectiveness and quality of service delivery | Presenting the public’s experience of and insight into health and social care and seeking action based on this from service providers and commissioners. | Better health outcomes.  Improved efficiency in using resources.  Supporting services to meet targets they’ve been set but also helping identify where these targets may lead to unintended consequences in other respects.  Increased patient satisfaction with delivery of services, as measured by providers and commissioners. |
| Service user experience during service delivery relating to: customer service, respect and understanding, a culture of listening to the individual, and commitment to development of staff skills in these areas | As above. | As above. |
| Assurance that strategic decisions are implemented on the ground | Being a direct and independent link between senior decision-making bodies and the public’s personal experiences.  Understanding changes made at a policy level and using this to inform engagement activity and questions asked. | Stronger oversight and scrutiny by decision-making bodies and elected representatives.  Ensuring effective use of short and long-term healthcare resources.  Better health outcomes. |
| Understanding the most appropriate feedback, concern or complaints option | Listening to people and helping them better understanding their situation in context.  Helping people better understand the scope and realities of complaints processes so they can decide on the course of action that best suits them.  Letting people know that their experience will be reported and escalated as part of Healthwatch’s remit.  Escalating some individual issues to achieve effective solutions.  Increasing providers and commissioners' focus on listening to resolve issues before formal complaints are needed. | Individuals are better informed to resolve issues effectively, with support from local Healthwatch to understand their situations and choose the most appropriate avenues, including formal complaints when necessary.  More effective and quick resolution of issues for individual members of the public.  Reduced stress for individual members of the public.  Reduced use of official complaints team resources where there would be little prospect of practical or moral satisfaction for the member of the public.  Improved effectiveness, quality and experience of services, and less official complaints where escalation of an individual’s situation helps identify and fix a wider systemic problem. |

| **Domain 4: Patient involvement and co-creation** | **Examples of how we do this** | **Examples of impact and any recognised measures** |
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| Involvement of people in co-creation: finding participants | Facilitating networking between healthcare decision-makers and diverse community groups.  Promoting opportunities for people to get involved. | More effective services.  Reduced health inequalities.  Increased patient satisfaction with delivery of services, as measured by providers and commissioners.  Community groups and individuals involved feel more closely allied to their local services.  Personal development for the individuals involved. |
| Involvement of people in co-creation: improving methodology, ensuring involvement is meaningful, developing a culture of understanding, closing the feedback loop. | Supporting providers and commissioners to plan and deliver their own activities.  Developing resources to show best practice. | As above.  Embedding a longer-term culture of decision-makers collaborating with the public because they have experienced how this leads to better results. |

| **Domain 5: Patient safety and regulatory effectiveness** | **Examples of how we do this** | **Examples of impact and any recognised measures** |
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| Increasing patient safety and protecting vulnerable adults | Asking questions that seek assurance about safety matters and safeguarding actions on behalf of the public when specific experiences shared by people suggest there could be concerns.  Highlighting some issues in the course of reporting findings which could present future risks if they worsened and weren’t addressed.  Feed public insight shared with Healthwatch into local Quality Group multi-agency discussions and remind group members about the importance of public involvement in decisions.  Membership of scrutiny groups and project teams for such things as independent reviews into culture and practices or quality improvement programmes.  Maintaining awareness of how to refer individuals to local safeguarding teams, and liaison with local Adults Safeguarding Board.  Maintaining independence so members of the public are confident they can share their experience. | Increased healthcare staff awareness around safety.  Contribute to early warning evidence around potential safety issues or more widespread organisational failures.  Conclusions of independent safety reviews and results of quality improvement programmes show a clear focus on patient experience. |
| CQC acting on concerns raised | Sharing reports and escalating insight obtained and analysis to CQC.  Use of agreed escalation processes from local Healthwatch to CQC, including prior discussion by Healthwatch board. | CQC feed back to Healthwatch that useful actions have been taken based on Healthwatch insight.  Better regulation of services, leading to improved quality. |

| **Domain 6: Communication:** | **Examples of how we do this** | **Examples of impact and any recognised measures** |
| --- | --- | --- |
| Improving public information and communications: useful and understandable content, use of appropriate channels, accessibility and reach | Providing feedback on draft or existing communications.  Identifying what information different audiences and communities need to be able to act on it.  Using Healthwatch channels to get information out. | Increased and more equitable choice and access to services.  Improved promotion of public health messages and greater ability for people to make informed decisions on how to act.  Quicker diagnosis of health problems.  Better health outcomes.  Reduced health inequalities.  Improved public satisfaction due to people having better understanding and expectations of a service. |
| Member of the public receiving a service | Information and Signposting support | As above.  Greater ability for an individual to reach closure on an issue if there isn’t a resolution possible. |

| **Domain 7: Shifting the culture and agenda towards listening** | **Examples of how we do this** | **Examples of impact and any recognised measures** |
| --- | --- | --- |
| Changing the conversation by bringing a patient-focused perspective | Introducing people's experience to health and social care meeting discussions.  Reports and briefings with qualitative insight. | Providers and commissioners better understand people’s needs and can prioritise resources appropriately. |
| Raising the understanding and priority given to an issue by helping decision makers reflect on its depth and the impact on people's lives | As above. | As above. |
| Bringing people around the table to start talking about an issue | Being the catalyst to develop a coalition of partners in the area who can in turn mobilise and reach people.  Developing momentum and being a focal point with authority on a subject to generate greater joint influence and connections.  Working with service providers to find solutions to issues. | Evaluation of or investigation into a service is triggered in relation to quality or equalities issues.  More effective services.  Reduced health inequalities.  Increased patient satisfaction with delivery of services, as measured by providers and commissioners. |

**Appendix 2: The Outcome Levels and People**

Any outcome within any of the domains will lead to change at one or more levels across the healthcare infrastructure, from national to very localised.

At the same time, the outcome that is achieved could be benefiting one person or many who experience health inequalities and contributing to reducing these inequalities.

A diagram of a diagram of a health care infrastructure

Description automatically generated

**Appendix 3: The Outcome Mechanisms**

In addition to considering the domains of outcomes achieved, the levels where change happens, and the people benefiting, it also seems useful to think about the types and stages of interaction between Healthwatch and decision-makers that can lead to an outcome.

Considering the form of these interactions could help identify Healthwatch impact that could otherwise go unnoticed.

These different types of interaction have been referred to as ‘mechanisms’ in relation to Care Quality Commission regulatory activity.

‘The King’s Fund and Alliance Manchester Business School [developed a] framework that outlines eight ways in which regulation can affect provider performance, to help regulators, providers and policy-makers understand the impact of regulation. It shows that impacts can be produced before, during and after inspection, and through interactions between regulators, providers and other key stakeholders.’[[1]](#footnote-2)

The mechanisms that the above work identified and that could also be useful to consider in relation to how Healthwatch achieves change are listed below.

Alongside each is one example of how the mechanism could relate to Healthwatch work.

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| **Mechanism** | **Summary of what causes the impact** | **Example relating to Healthwatch activity** |
| **Anticipatory** | Improvements are sought in advance of an interaction. | Knowing that a Healthwatch Enter and View visit is due, a care home improves its food menus to make them more visual. |
| **Directive** | Responding to recommendations or other feedback. | A service provider responds to a Healthwatch report with an action plan. |
| **Organisational** | Interaction leads to wider self-reflection and analysis by an organisation and results in changes in culture, motivation, team dynamics, responding to colleagues and whistleblowing. | Following Healthwatch involving members of the public in a co-creation event a service provider better appreciates the value this can have for them and sets up their own system for the future. |
| **Relational** | Informal soft influencing. | Having experienced how Healthwatch was a solutions-focused partner on a joint project, a service commissioner later seeks out Healthwatch again for views on the contents of a new specification. |
| **Informational** | Publishing of data and findings about individual services or wider analysis. | Following Healthwatch publishing a summary of findings from reviewing a number of GP services’ websites, other GPs use this to make improvements to their own. |
| **Stakeholder** | Other stakeholders are influenced or motivated to engage with the service. | Hearing that Healthwatch has recommended a provider makes premises more dementia friendly, a local dementia charity contact the provider to offer a full audit. |
| **Lateral** | Peer to peer activity is generated to develop support and learning. | At a Healthwatch led community event, two GP practice managers meet and agree to share approaches around developing their Patient Participation Groups. |
| **Systemic** | A wider summary or aggregated information and conclusions are published that influences on a wider scale. | Reporting on information from across the Healthwatch network about travel to hospital appointments led to an NHS review and new DHSC guidance. |

**Appendix 4: Questions for discussion**

We can only develop a clearer, shared understanding of the domains where our service achieves outcomes by getting as many people’s input as possible.

The questions below have been put together as a prompt for thinking about the domains, levels and people, and mechanisms. There are a lot of questions, and many elements overlap. Some people might prefer to consider each question in turn; others will prefer to reflect and give feedback in a more general way. Maybe certain question themes will be of more interest to you to focus on than others.

There will be opportunities for discussion in a series of meetings that will be held during January 2025. Additionally, please do share your thoughts by email to [impact@healthwatch.co.uk](mailto:impact@healthwatch.co.uk)

**Domains, including the levels and people**

1. Are the domains that we’ve identified correct, complete and clearly described?
2. Can you suggest examples and descriptions at the points where there are gaps or the current content is too limited?
3. In which domains do Healthwatch tend to achieve more outcomes and in which less? Does this vary between Healthwatch, and what are the factors that influence that?
4. Does it matter that an individual Healthwatch or the network overall achieves more outcomes in some domains than others?
5. Comparing time spent and time needed to achieve outcomes in some domains rather than others, can we learn anything about the most effective use of Healthwatch resources?
6. Do you feel that Healthwatch probably do achieve more outcomes in some domains but are less able to identify when this happens?
7. Do you feel that when Healthwatch achieve outcomes in some domains then the way that’s communicated is easier and achieved more successfully than in others?
8. Do we have the strongest ‘elevator pitch’ story ready to tell about what Healthwatch achieve in each domain? Locally, nationally, and the interaction between the two?
9. Does our overall narrative about the importance of listening and the breadth of Healthwatch value to funders and system stakeholders take sufficient account of all the domain areas? Locally and nationally, and considering the interaction between the two?
10. Healthcare commissioners and providers will often be interested in outcomes that increase efficiency in the use of resources and staff wellbeing and satisfaction. Do outcomes in some domain areas lend themselves to communicating that?
11. Discussions with the public have suggested that many people are more likely to be motivated to share their experience with Healthwatch if they hear about tangible changes achieved with specific services locally rather than hearing about influence on larger and, at times, difficult-to-resolve systemic issues. On this basis, which domains would involve outcomes that would be most likely to grab people’s attention?
12. Are different approaches to influencing decision-makers more suitable or useful to achieve outcomes in particular domains?
13. Is there any more support that could be provided to help Healthwatch achieve outcomes in some of the less common domains?
14. Is there any value in creating some form of self-assessment summary sheet to help a Healthwatch consider priorities for the development of activity and/or communications?  
    [eg. Does our work cover that domain area/Do we achieve outcomes in that domain? Do we recognise what we achieve in that domain? Do we need or want to do more in that domain? How do we describe our outcomes in that domain?]

**Mechanisms**

1. Is referring to this model useful in helping pinpoint how Healthwatch contributes to change in ways that may not always be evident and recognised?
2. Could considering this further help us enhance our communications about outcomes achieved and the overall narrative about the value of the Healthwatch statutory role?

1. Smithson, R., Richardson, E., Roberts, J., Walshe, K., Wenzel, L., Robertson, R., Boyd, A., Allen, T., & Proudlove, N. (2018). *Impact of the Care Quality Commission on provider performance: Room for improvement?* King's Fund. [↑](#footnote-ref-2)