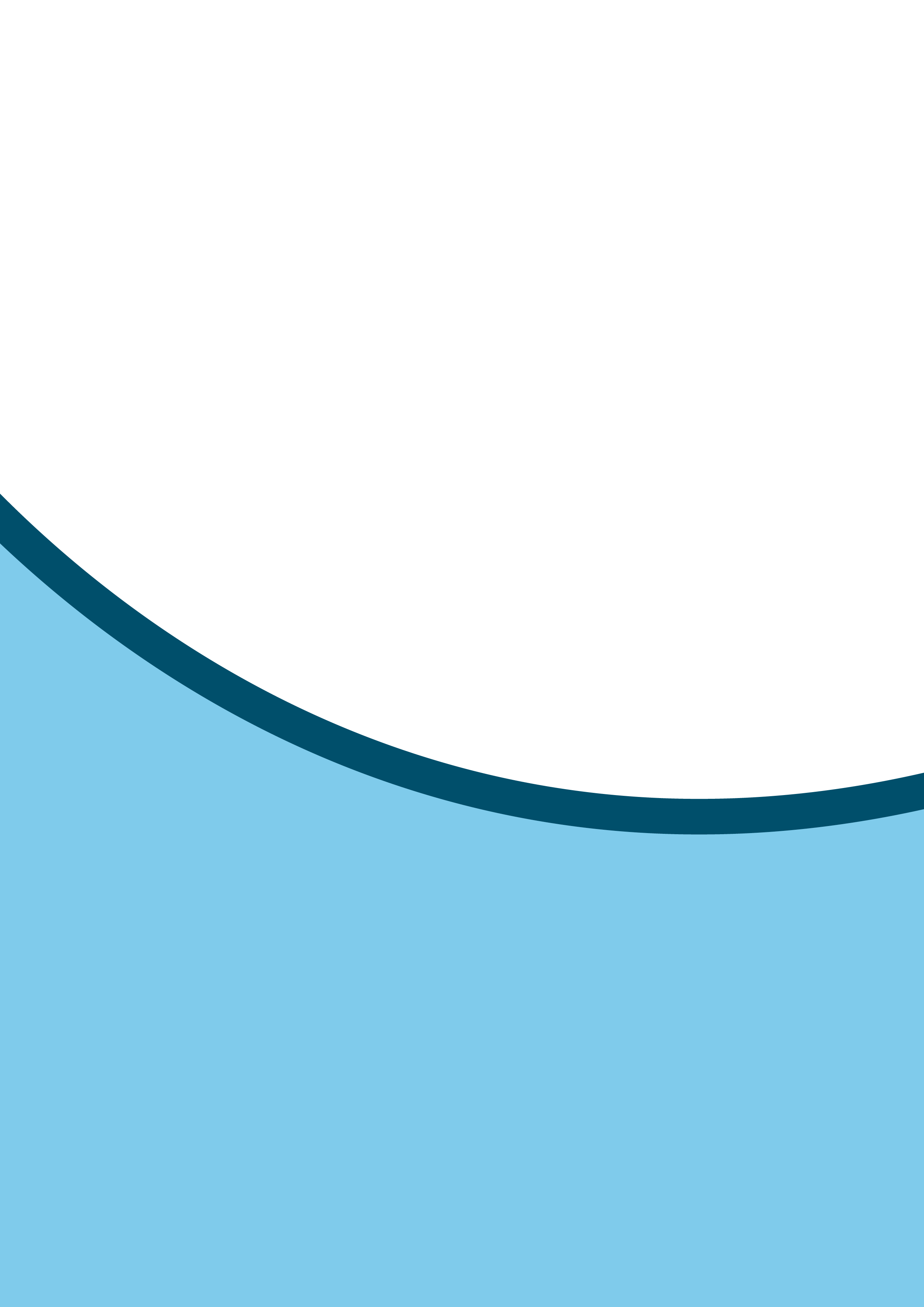
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| **Healthwatch Outcome Categories**  Version 2  Spring 2025 | |
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**Context**

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. This could be described as the overall Theory of Change for what local Healthwatch and Healthwatch England achieve together.

**Introduction**

The initial version of this document for discussion (November 2024) was developed following conversations with fifteen Healthwatch lead officers. This latest version has been updated following further input from a range of Healthwatch lead officers and other experienced staff.

In this latest version we have changed what were begin referred to as ‘Outcome domains’ to ‘Outcome categories’ as a response to feedback that this is a more accessible term.

**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 ‘outcome categories’.

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 outcome category 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 categories 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.

**Next, we need to turn the model presented here into a resource that can be more easily used in practice by local Healthwatch teams.**

**Outcome Category Headings**

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

Of course, there will be outcomes that overlap more than one of the category 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. Involvement and co-creation.

5. Safety and regulatory effectiveness.

6. Good communication in health and social care.

7: Shifting the culture and agenda towards listening

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

**See Appendix 1 for full details of the outcome category 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 categories 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 categories have progressed, we’ve often reached the point where these two concepts have started to overlap and seem essential to also consider.

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

**Appendix 1: The Outcome Categories**

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| **Outcome Category 1: Governance and oversight** | **Examples of how we do this** | **Examples of impact** |
| Establishing governance structures, processes and procedures. | Commenting on draft Terms of Reference for new or revised bodies or working groups. | Stronger oversight, scrutiny and direction of strategies and plans to improve the experience of people receiving health and social care services.  More reference to public’s experience and insight is added to a Terms of Reference. |
| 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.  System partners revise their approach, if necessary, to ensure accountability to the public and avoid future challenges for legal non-compliance. |
| 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 it is uniquely placed to hear, and challenge where appropriate.  Additional conversations with Committee/Board members are arranged outside of meetings to further explore local people’s insight. | 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 health and social care 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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| **Outcome Category 2: Strategic planning and decision-making** | **Examples of how we do this** | **Examples of impact** |
| 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. |
| **Outcome Category 3: Service design, improvement and quality** | **Examples of how we do this** | **Examples of impact** |
| Design and specification of a commissioned service. | Report insight from research and engagement activity with analysis and conclusions.  Identify needs of people who are currently using a service, those unable to access it, and those of other members of the public who could need it in future.  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 problems can be resolved through the next commissioning cycle.  See also Outcome Category 4. | Unmet needs are addressed.  More effective use of short and long-term health and social care resources.  Increased patient satisfaction with delivery of services, as measured by providers and commissioners. |
| Coordination of services. | As above, with Healthwatch’s wide remit across health and social care helping spot where provision is disconnected and the implications of this for both people and services themselves. | As above. |
| Accountability of a Trust, ICS or other commissioner to the public. | Review and comment on draft Quality Accounts.  Provide scrutiny of decisions and actions on behalf of the public. | Assurance of integrity and transparency on behalf of the public.  Triangulation of provider self-assessments with public experience to influence plans and priorities. |
| 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 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 health and social care resources.  Better health outcomes. |
| Individual members of the public understand the most appropriate option for their feedback or complaints. | Listening to individual people and helping them better understanding their situation in context.  Helping individual people better understand the scope and realities of complaints processes so they can decide on the course of action that best suits them.  Letting individuals 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 people to resolve their 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.  Signposting or referral to complaints advocacy service.  More effective and quick resolution of issues for individual members of the public.  Reduced frustration for individual members of the public who have not heard back from another service.  Reduced stress for individual members of the public who are clearer about their options and chances of resolving the issue.  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. |
| **Outcome Category 4:**  **Involvement and co-creation** | **Examples of how we do this** | **Examples of impact** |
| 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.  Keeping in touch with different local communities and their needs. | More effective services.  Reduced health inequalities.  Increased satisfaction with delivery of services, as measured by providers and commissioners.  Community groups and individuals involved feel more closely allied to their local services.  People involved in the co-creation activity have developed their skills and confidence to share their experience more in future and are more likely to do so as they believe they can achieve influence. |
| Involvement of people in co-creation: improving methodology, ensuring involvement is meaningful, developing understanding of its usefulness, closing the feedback loop, upskilling individuals. | Running involvement activities to demonstrate an approach.  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. |
| Involvement of people in events. | Bringing the public and professionals together to hear each other’s perspectives.  Helping members of residents’ groups and community organisations better understand how to influence services. | Greater mutual understanding between individual members of the public and health and social care staff leading to more productive interactions and service delivery in future.  More members of the public get involved in influencing services. Knowledge is more embedded in ongoing community group activity to represent its members. |
| **Outcome Category 5: Safety and regulatory effectiveness** | **Examples of how we do this** | **Examples of impact** |
| Increasing safety in health and social care and protecting vulnerable adults and children. | 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.  Whilst reporting a range of findings,  highlighting some issues which could present future risks if they worsened and weren’t addressed.  Identifying potential safeguarding issues during Enter and View visits and highlighting that they need addressing.  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 Safeguarding Boards.  Sitting in as observers of local Safeguarding Boards. Maintaining independence so members of the public are confident they can share their experience. | Increased health and social care staff awareness around safety.  Contribute to early warning evidence around potential safety issues or more widespread organisational failures.  A provider takes action to address a potential safeguarding issue identified during a Healthwatch visit.  Conclusions of independent safety reviews and results of quality improvement programmes show a clear focus on service user experience. |
| CQC can consider 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. |
| **Outcome Category 6: Good communication in health and social care** | **Examples of how we do this** | **Examples of impact** |
| Improving public information and communications from health and social care: useful and understandable content, reliable and accurate information, use of appropriate channels, accessibility for different audiences, reach to different audiences. | 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 some degree of closure on an issue when there isn’t a resolution possible. |
| **Outcome Category 7: Shifting the culture and agenda towards listening** | **Examples of how we do this** | **Examples of impact** |
| Changing the conversation by bringing a person-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 prioritise resources appropriately.  Providers and commissioners are more committed to engaging and involving people in future as they are reminded of the value this can bring to decision making. |
| 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 satisfaction with delivery of services, as measured by providers and commissioners. |

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

Any outcome within any of the categories will lead to change at one or more levels across the health and/or social care 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 medical care system

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**Appendix 3: The Outcome Mechanisms**

In addition to considering the categories 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.  Healthwatch brings different organisations together to collaborate on a topic having identified shared interests. |

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)