HEALTHWATCH ENGLAND

COMMITTEE MEETING PAPERS

Wednesday 31 January 2018
Stafford

Yarnfield Park Training &
Conference Centre, Stafford

Healthwatch England – Committee Meeting Agenda

Wednesday 31 January 2018

Time	Agenda		Presenter
08.30 – 09.00	Tea, Coffee, Pastries & Fruit		
1. INTRODUCTION			
09:00 – 10:00	1.1	Welcome and apologies	Jane Mordue
	1.2	Minutes, action log and agenda review	Jane Mordue
	1.3	Declarations of Interest	Jane Mordue
	1.4	Chair's Report (including Annual Report)	Jane Mordue
	1.5	National Director's Report	Imelda Redmond
	1.6 1.7	Committee Members Update Report back from Audit Finance and Risk Sub Committee	Committee Members Deborah Fowler
1. GOVERNANCE AND ASSURANCE			
10:00 – 10:45	2.1	Sustainability Challenges of the Healthwatch Network	Jacob Lant
10:45 – 11:00		BREAK	
11:00 – 12:30	2.2	Quarter 3 2017/18 - Delivery Report	Neil Tester
	2.3	Quarter 3 2017/18 – Financial update	Joanne Crossley
	2.4	Quarter 3 2017/18 – Performance Report	Imelda Redmond
	2.5	Summary of audit completed by PricewaterhouseCoopers	Deborah Fowler
	2.6	Strategy engagement update	Imelda Redmond
3. PUBLIC PARTICIPATION			
12:30 – 13:15	3.1	Including presentations from:	
		• Healthwatch Stoke	
		• Healthwatch Worcestershire	
ANY OTHER BUSINESS AND CLOSE OF SESSION			

The next Committee Meeting will be Wednesday 25 April in Blackpool.

TABLE OF CONTENTS - MEETING IN PUBLIC

A number of pages have been left deliberatively blank for formatting purposes.

MEETING REFERENCE: CM180131
AGENDA ITEM No:1.2

AGENDA ITEM: Minutes, action log and matters arising

PREVIOUS DECISION: The minutes of the Committee meeting of Monday 31 July 2017 were agreed as a true record of the meeting subject to a number of amendments

EXECUTIVE SUMMARY: This report reflects the minutes and actions of the Committee meeting of Wednesday 25 October 2017

RECOMMENDATIONS: The Committee are asked to **APPROVE** the minutes and **NOTE** the action log of the Committee meeting of Wednesday 25 October 2017

Healthwatch England Committee Meeting
Minutes of meeting No. 21

Location: Care Quality Commission, Buckingham Palace Road, London SW1W
Date: Wednesday 25 October 2017

Attendees

- Jane Mordue - Chair
- Jenny Baker – Committee Member and Chair of Healthwatch Bucks
- Andrew Barnett – Committee Member
- Pam Bradbury – Committee Member and Chair of Healthwatch Dudley
- Deborah Fowler - Committee Member and Chair of Healthwatch Enfield
- Helen Horne - Committee Member and Chair of Healthwatch Cumbria
- Liz Sayce – Committee Member

Apologies

- None

In attendance:

- Imelda Redmond –National Director
- Neil Tester – Deputy Director
- Joanne Crossley - Head of Operations
- Jacob Lant – Head of Policy & Partnerships
- Amie McWilliam-Reynolds – Intelligence & Analytics
- Hilary Davies – Committee Secretary (minutes)

1.0	Introduction	Action
1.1	Apologies There were no apologies	
1.2	Agenda review The Committee confirmed the agenda	
2.0	**Minutes of previous meeting**	
2.1	Review minutes of previous meeting The Chair presented the minutes of Monday 31 July 2017 the Committee approved them.	
2.2	Matters arising not covered elsewhere on the agenda PB reported on work with Health Education England. IR has met with them and will be taking forward some joint work in the new year.	
3.0	**Declarations of interests**	
3.1	The Committee noted that there were no real, perceived or potential conflicts of interest experienced by any member in relation to the items on the agenda.	
4.0	**Agenda Item 1.4 – Chair's Report (Jane Mordue)**	
4.1	JM presented the Chair's report, highlighting the launch of the CQC State of Care report which provides comprehensive picture of all parts of the system. State Of Care Report 2017 The Healthwatch Annual Report will be presented to Parliament 2nd November 2017. HWE Annual Report JM updated the Committee on the recruitment of new Committee members. She informed the committee that the recruitment agency Gatenby Sanderson has been engaged. Responding to a question from Helen Horne, she confirmed that members will be chosen to fit the criteria with included knowledge of local Healthwatch and a good geographical spread of Committee members from across the country.	

5.0	**Agenda item 1.5 –National Director's Report (Imelda Redmond)**	
5.1	IR presented the report highlighting the work on building relationships with external stakeholders. She also informed the committee that team development days had been held with the Leadership team and one is planned for all HWE in December. She informed the meeting that the work on the new strategy continues to proceed well and the draft strategy will be brought to the next Committee meeting in January 2018 IR has been out around the country visiting many local Healthwatch, attending events and network meetings. She reported that she found these very informative, with a good engagement and the right sort of challenge back to HWE. IR highlighted a number of reports that have been published in the last quarter including:- • Home Care Services • What it is like to live in a care home Committee members noted how useful they found the 'tone of voice' paper. It was suggested that this might make a useful theme for a future workshop Jenny Baker raised the issue of the disproportionate amount of LHW time that is spent on tendering &procurement. IR reported that a significant amount of work was underway with Commissioners that will continue next year.	Imelda Redmond to circulate full documentation to the Committee.
5.2	The Committee noted the report	
6.0	**Agenda item 1.6 – Committee Members update - verbal**	
6.1	PB informed the meeting that she worked with staff on the development of call handling and signposting toolkit and guidance for the network.	

6.2	LS reported that she attended a workshop with NHS Digital on how to opt out of the process on data collection. The comms process is led by NHS Digital who would like to work with Healthwatch on its development. Discussed the importance of a fair balance and due process.	
6.3	Jenny Baker offered to share contacts of a training provider offering apprenticeships specifically in the digital field.	Jenny Baker
7.0	**Agenda item 2.1 - Delivery Report (Neil Tester)**	
7.1	NT presented the delivery report.	
7.2	DF asked NT which achievement he was most proud of over the last quarter. NT responded that it is the increase in raw intelligence material from the network and how Healthwatch England is using it.	
7.3	Jenny Baker fed back that it is a useful report and that the graphics were very helpful. She thought it might be a useful tool to share with the network.	Neil Tester
7.4	Andrew Barnett asked if Neil is confident that the media coverage is now on message. Neil confirmed it is; we now have a dedicated member of staff who is working on media issues and we are now engaging with a much broader range of media outlets.	
7.5	Committee noted the report	
8.0	**Agenda item 2.2 – Quarter 2 2017/18 – Financial update (Joanne Crossley)**	
8.1	JC reported that we have spent 43% of budget to date so on track for the half year. She noted there were some procurements awaiting approval which, together with some staff vacancies, has led to an underspend.	
8.2	DF informed the meeting that the first meeting of the new Audit, Finance & Risk Committee was held on Tuesday 24th October.	

8.3	The Committee noted the finance papers.	
9.0	**Agenda item 2.3 – Quarter 2 2017/18 – Performance Report (Imelda Redmond)**	
9.1	IR presented the Quarter 2 performance report, stating that, after review, the Leadership Team had no concerns about ongoing delivery.	
9.2	The Committee noted the report	
10.0	**Agenda item 2.4 – Strategy Engagement update (Imelda Redmond)**	
10.1	IR introduced the paper and the draft consultation document to be used for the second phase. **Decision** With some minor amendments the Committee approved the document.	IR
11.0	**Agenda 2.5 Future work focus on Mental Health**	
11.1	JL and AMR joined the meeting and introduced the paper which gave an overview on the work Healthwatch England is considering undertaking on mental health issues. The committee were asked to consider:- • Pursuing a single policy area • Contribution of the network • Balance of activity • Ongoing Committee involvement	
11.2	AB offered a set of scoping questions that he has used elsewhere and encouraged Healthwatch to find its unique selling point (voice). He suggested looking at hunches or instincts and encouraged a phased approach, allowing opportunity for partnering.	JL/AMW

11.3	The Committee favoured a long-term approach to this work, with good engagement with the network from early on. They noted that there are gaps in the data which in itself will help us understand what change needs to happen. This highlighted the need for parity of data as part of parity of esteem. The Committee noted the importance of establishing clear criteria and focus for this piece of work as its scope could be very wide. Having established this, also to be clear about which partners and stakeholders need to be engaged.	
11.4	The Committee questioned whether it was more important to concentrate on working with a large number of people or to focus on something grave and serious i.e. the increase in detentions and impact on BAME.	
11.5	**Decision** • Agreed to pursue mental health as a major piece of work, focused on being person-centred. • Revise the timeframes to secure positive contribution from the network. • The mix of broad v deep and short v long-term to be scoped out further during the agreed phased approach. • It was agreed to set up an advisory group and Committee members were asked to volunteer. • It was agreed the importance of building on the work of local Healthwatch.	
12.0	**Agenda item 2.6 Data Return**	
12.1	This is the top line analysis from the data return. The key findings and more information around the structure of organisations to follow.	NT to bring to Committee for comment.
12.2	DF asked if we were confident that the financial data is just core funding or does it incorporate other areas of work?	AK to check and feedback
13.0	**Agenda item 2.7 – Feedback from conference**	
13.1	Report provides analysis of this year's conference, recommendations and how to move forward in the future.	

13.2	Currently looking at a change of date for next year and how to refine and develop going forward.	
13.3	Keynote speakers bring a wide range of people to the conference.	
13.4	Pairings that were set up for local teams to work together did not work for Cumbria due to being partnered with a Healthwatch in the South West – impractical.	
13.5	Commissioners change the dynamic of the conference. In the future should be one day for the network and second day opened to stakeholders/commissioners.	
13.6	Task & finish groups to be set up but will wait until the new Committee members are appointed. Engagement with the groups was limited this year – will look at this differently next year.	
14.0	**Agenda item 3.1 – Any Other Business and close of session**	
14.1	There being no further business, the meeting in public was ended. The Chair thanked everyone for their time and contribution.	
15.0	**Next meeting**	
15.1	Meeting 22 is scheduled for Wednesday 31 January in Stafford.	

19.0 – ACTION LOG						
NUM	**REFERENCE**	**LEAD**	**ITEM**	**ACTION**	**DEADLINE**	**STATUS**
1.	CM170202	Imelda Redmond	6.6 To include local Healthwatch leadership development as part of the strategy consultation	Local Healthwatch leadership support will be explored as part of the strategy consultation. In addition, this was discussed at the People and Values Sub Committee meeting (SCM170405), AP (Head of Engagement) continues to lead the work on business analysis as well as leading on the leadership of the network as part of the strategy review.	December 2017	Ongoing
2.	CM170202	Neil Tester	10.8 To consider how local Healthwatch can be included in intelligence discussions	We have reviewed messaging to local Healthwatch about the intelligence and policy issues we are working on. As the intelligence operation develops, the intention is to hold webinars on particular issues where we have an evidence gap or would benefit from information and advice from local Healthwatch.	October 2017	Ongoing
3.	CM170524	Imelda Redmond	9.1 To update the risk tolerance statement	The risk tolerance statement has been reviewed by the staff team and is subject to review by Sub Committee Members at the first meeting of the amalgamated Audit, Risk and Finance Sub Committee	October 2017	Ongoing
4.	CM170524	Imelda Redmond	13.2 To review and update the Equality and Human Rights plan	The Equality and Human Rights plan will be updated in line with other supporting documents when the strategy is finalised. An update is	April 2018	Ongoing

				shared in the National Directors report – agenda item 1.5		
5.	CM170731	Esi Addae	3.2 To update the previous minutes confirming the dissolution of the Audit and Risk Sub Committee	The minutes have been amended to confirm the dissolution of the Audit and Risk Sub Committee	October 2017	Completed
6.	CM170731	Imelda Redmond	5.10 Pam and Imelda to discuss if and how Healthwatch works with Health Education England especially in regards to system leadership and workforce planning		December 2017	Completed
7.	CM170731	Imelda Redmond	5.11 To consider governance training for local Healthwatch	As part of new offer to Network	June 2018	

MEETING REFERENCE: CM180131
AGENDA ITEM No: 1.4

AGENDA ITEM: Chair's Report

PRESENTING: Jane Mordue

PREVIOUS DECISION: N/A

RECOMMENDATIONS: Committee Members are asked to **NOTE** the content of the report.

1. People's Views – HWE's annual report 'Speak Up'

With services under a range of pressures there has been concerted effort from the NHS, government and local councils over the last 12 months to introduce changes to the way care is delivered. These changes will take time to make a tangible difference. As a result, it is no surprise that the collective feedback paints a mixed picture of good care with some variation in quality and access.

If NHS and care services are going to succeed in making changes that work for the people using them, it is crucial that local decision makers work hand in hand with their communities.

The Healthwatch network is here to help. By working together over the year ahead we can put people at the heart of the change process, helping them to speak up and ensuring their voices are heard when it comes to shaping the future of health and social care.

During this quarter we issued our Annual Report, 'Speak Up'. This outlined what we have learnt from listening to people's views last year – over 341,000 of them, of all ages and backgrounds. On top of that, we reached 650,000 people with our 'Speak up' campaign, calling on people to share their views of services. We published reports based on local Healthwatch findings looking at dementia services, children and young people with autism; leaving hospital; access to NHS dental services and complaints.
We also pushed for improvements in engagement itself, publishing 5 steps to ensure people and communities have their say:

- Set out the case for change so people understand the current situation and why things may need to be done differently.
- Involve people from the start in coming up with potential solutions
- Understand who in the community will be affected by the proposals and find out what they think

- Give people enough time to consider the plans and provide feedback
- Explain how people's feedback has been used, the difference it made to the plans and how the impact of the changes will be monitored

The good news is that there are positive signs of a growing desire amongst professionals to understand and act on the views of communities. However, many services still do not understand how to achieve this consistently in practice. Mental health services have stood out this year as a significant concern which is why, at our last board meeting, we agreed to have a major focus on mental health in the coming years.

More generally, people tell us that they want to take more control of the health and care services they need. They want clear and timely diagnoses, access to the right support at the right time and a more personalised service across the board. Frankly, they do not want to become ill in the first place! For providers this means moving the emphasis from costly later life clinical interventions towards catching and dealing with problems early. It also means thinking more broadly about the welfare of the person being treated. This view is endorsed by the Chair of the Royal College of General Practitioners. Dr Helen Stokes Lampard told me of an elderly patient who had a much happier outcome, going down, essentially, the route of social prescribing rather than medicalising her problems. We passionately believe that the best services know their customers. Our research shows that most people are willing to share their views to help improve services, but they need to know how they can speak up and professionals must be willing to listen. Our work continues!

2. Healthwatch England strategy

Our future focus is shown in the draft strategy in these papers which we shall debate today. Our three strategic aims are:

- Empowering people and communities
- A stronger Healthwatch network
- Ensuring people's views help improve care

3. Local Healthwatch

It is central to our developing strategy that there should be a sustainable Healthwatch network, able to deliver statutory activities to high standards. As we meet in Stafford, I am formally notifying the Committee that I have taken Chair's action to use the Committee's advisory power in relation to Staffordshire County Council, so that the Committee can note this. This action was in line with the Scheme of Delegation previously agreed by the Committee, with the exception that events were moving at sufficient speed that if I had waited for 20 days after an initial letter from the National Director before writing to provide formal advice, it

would have been too late to have influenced the Council's thinking before its tender for the Healthwatch Staffordshire contract went live.
I will not reiterate my message to the Council, which is on the public record, except to say two things. Firstly, people in Staffordshire know only too well, 5 years after the Francis inquiry into the tragic events at Mid-Staffordshire, what can happen when people cannot make their voices heard. Secondly, while I am glad that our advice enabled the Council to avoid actively commissioning a service that could not have discharged its statutory duties, I remain extremely concerned at the lack of a contingency plan in the event that the reduced funding now being offered fails to do so. Healthwatch England will keep Staffordshire under close scrutiny and will not hesitate to act as required.

The activity in Staffordshire formed the backdrop to our annual State of Support analysis. This year, it was clear that the situation facing the network required an unequivocal message to the Secretary of State, which I provided in my letter accompanying the analysis. I told the Department that over the past year local Healthwatch have shared with us their concerns that local authority-led decisions are putting at risk the ability of the network to deliver on its statutory obligations, that our analysis of the network's financial position confirms these fears, and that we consider that it is now necessary for the Department to step up its work with Healthwatch England and others in order to maintain an effective Healthwatch network. Officials have understood the gravity of the situation and I understand the Department is now formulating its response.

4. Work with strategic partners

In December I wrote to Steve Brine, MP, Parliamentary Under Secretary of State for Health regarding the NHS mandate about which Healthwatch England is a statutory consultee. This followed constructive conversations with both NHS England and Department of health colleagues to feed into the annual refresh process.
Six areas were explored:

- Improving public involvement in changes to local services: we emphasised the need to allow people to play a key role in shaping the future of health and care services.
- Using discharge as a success indicator for integration: we proposed that the new target on delayed transfers of care could be used to track if services are providing people with a seamless, integrated experience.
- Demonstrating how learning from feedback is improving care: still much to do, we suggested that hardwiring complaints and feedback data into the quality improvement process is a necessary next step.
- Increasing focus on evaluation of mental health services: we welcomed the support within the Mandate for the Mental Health Forward and suggested an

increased focus on evaluating how the changes are affecting people e.g. look at physical healthcare services as part of an overall improvement in people's wellbeing.

- NHS targets and the experiences of users: we suggested that the Mandate should encourage the NHS to look at a broader set of metrics that give a rounder picture of people's experiences and create a more meaningful national conversation about how the NHS is doing.
- Tackling access issues in NHS dentistry: Gaps in provision, geographical or by service sector can be overlooked in national commissioning decisions, the picture blurred by averaging out at national level. We suggested that the Mandate should raise the priority given to NHS dental services and encourage NHS England to consider a wider evidence base when commissioning services directly.

5. Committee recruitment

Following the recruitment process and interviews in November, I am delighted to welcome the following new members, whose biographies are on our website:

- Lee Adams
- Philip Huggon
- Amy Kroviak
- Andrew McCulloch
- Danielle Oum
- Helen Parker
- Ruchir Rodrigues

I am also delighted to congratulate Liz Sayce on her appointment to the Board of the Care Quality Commission.

List of meetings and events (November 2017– January 2018)

- Healthwatch Hammersmith and Fulham AGM
- Healthwatch Shropshire's 'Who's Listening'
- Committee member recruitment meetings and interviews
- Healthwatch England Committee workshop
- CQC Board meeting December
- Department of Health sponsor team
- CQC Board meeting January

1.4 Appendix 1

The Rt Hon Jeremy Hunt MP
Secretary of State
Department of Health
Richmond House
79 Whitehall
London
SW1A 2NS

04 December 2017

Dear Secretary of State,

State of Support for the Healthwatch network

Please find enclosed our annual briefing to the Department on the state of local authority funding for local Healthwatch, covering the financial year 2017/18. This is the third time we have published such a statement since the initial ministerial request. Our findings are the most concerning to date.

As you will have noted from our recent annual report to Parliament, the Healthwatch network is at the heart of making sure people's voices are heard by health and care services. Over the last year Healthwatch has heard from 341,000 people, carers and staff, all of whom have given their time to share their experiences of health and social care services. This insight helped our network of 152 local Healthwatch to produce more than 1,750 reports, creating an unparalleled source of feedback from people about how the NHS and social care services are performing in the current climate. It has helped to shape changes across the country, from improving the quality of residential care in the Isle of Wight to helping GP surgeries in West Sussex to become autism-friendly.

Over the past year local Healthwatch have shared with us their concerns that local authority-led decisions are putting at risk the ability of the network to deliver on its statutory obligations. Our analysis of the network's financial position confirms these fears. We consider that it is now necessary for the Department to step up its work with Healthwatch England and others in order to maintain an effective Healthwatch network.

Financial analysis

It may be useful to provide a brief outline of the network's financial history. As you will be aware, the Department of Health provides funding to local authorities to enable them to commission a local Healthwatch. The Department originally announced a total of £43.5m, which was allocated to local authorities in 2013/14. Following research indicating that only £33.5m got through to front line local Healthwatch services in 2013/14, the Department wrote to all councils reminding them of the statutory status of local Healthwatch and the need to ensure local Healthwatch are therefore adequately resourced to discharge their statutory functions. In a debate in the House of Lords on 15 December 2016, it was positive to see the Government's continuing commitment to an effective network, with Baroness Chisholm stating: *"It is in the interests of local authorities and other local care system partners to have a well-performing local Healthwatch that will help to drive up the quality of local services. Those local authorities* [who cut funding] *will need to*

demonstrate how their local Healthwatch organisations can still carry out their duties effectively."

However, since the debate took place, local Healthwatch have continued to see a steady decline in their financial position:

- In 2017/18 local Healthwatch have reported that the amount received to deliver their statutory activities was £27,395,178.
- This compares with the 2016/17 figure of £29,423,966 that was received to deliver their statutory activities.
- This constitutes a 6.9% reduction on last year's total, and a 37% reduction since the 2013/14 allocation.

This year, six in ten Healthwatch (59%) have seen their funding remain relatively stable, or with a maximum year-on-year budget decrease of £5,000. However, one in three (32%) have seen their funding decrease by more than £5,000. Even in areas where funding has been maintained local Healthwatch continue to operate on very tight budgets and with very small staff teams (often only two people) covering very large geographical areas and populations. They have also raised concerns around the lengths of contracts – with one or two year contracts not providing sufficient stability to enable long term planning and retain staff. We have ongoing concerns around the future financial picture and some councils' continuing confusion about the distinction between commissioning statutory Healthwatch activity and funding wider voluntary and community sector projects. As a result of this, we continue to monitor and offer support to local Healthwatch, with particular focus on those who are already facing an extremely difficult task to deliver their statutory functions within their current budgets.

Trends in commissioning – emerging areas of concern

In some areas budget reductions are now at a level where local authorities are attempting to commission local Healthwatch organisations on a basis which would leave them unable to fulfil their statutory obligations.

In particular, we are aware of:

- Tenders which have sought to remove the provision of information and advice;
- Tenders which would only provide a part-time rather than full-time Healthwatch service; and
- Instances where councils have sought to stipulate specific activity, without regard for the need for Healthwatch to function independently.

In addition, some councils have sought to include funding for advocacy services within the funding envelope for Healthwatch statutory activities. These decisions have in some cases been exacerbated by local authorities allocating budgets entirely from the Local Reform and Community Voices grant, instead of also including the funds made available through the local government finance settlement. This has served to prevent a clear and transparent audit trail concerning the level of funds local authorities have available for local Healthwatch.
We have been made aware of a number of cases in which local authorities are expecting local Healthwatch to be funded by means outside the resources made available to councils for this purpose. In particular:

- Some have argued that Clinical Commissioning Groups should contribute to the core budget for local Healthwatch;
- Others have placed an emphasis on the need for additional income generation for statutory activities.

These arguments are based on a clear misunderstanding of the legal position.

Healthwatch England is entirely supportive of, and provides active support for, local Healthwatch efforts to generate additional income from local health and social care commissioners and providers, as well as from other sources. Indeed, supplementary resources of this kind are becoming an increasingly essential means of ensuring that maximum impact and value can be extracted from the core funding provided for statutory activities. We are entirely clear, however, that this cannot excuse attempts by local authorities to avoid their responsibilities for ensuring effective delivery of those statutory functions.

Those local authorities urging their Healthwatch organisations to generate income from other sources must also take into account the need for core funding to allow for sufficient management time to undertake this additional income generation activity. The increasing pressure on management capacity has also had an unwelcome impact on the ability of local Healthwatch to participate effectively in strategic discussions including work relating to Sustainability and Transformation Partnerships and Accountable Care Systems/Organisations.

Similarly, analysis of local Healthwatch suggest that those with less resource have less time to effectively recruit and manage volunteers. Without the support of an adequate volunteer base, local Healthwatch activities and reach are disproportionately affected.

Action by Healthwatch England

We have been working hard to help councils better understand their obligations. Colleagues within Healthwatch England have been actively supporting local Healthwatch in their engagement with local authorities, and have in some cases worked directly with local government partners to advise them in the development of their plans for local Healthwatch tenders and the statutory obligations they need to fulfil. Only this week it has been necessary for us to provide statutory written advice to Staffordshire County Council regarding their proposals to halve the resource made available for statutory activity in Staffordshire.

Taking this into account, I thought it would be useful to provide an update on our plans for future work with local authorities. Over the coming months we will be working with local government colleagues to reinforce their understanding of how to maximise the value and strategic impact of the Healthwatch network. We will help councils understand how to make full use of the insight local Healthwatch offer, drawing upon examples such as the following:

- **Re-commissioning:** when Newcastle City Council needed to achieve very substantial savings through re-commissioning its home care services, Healthwatch Newcastle were able to ensure that the new specification was in line with NICE guidance and introduced new performance monitoring processes, focused on tracking improvement around the issues local people raised.

- **Service quality:** Torbay Council faced the challenge of the local care market being dominated by one principal provider. Healthwatch Torbay identified public concern regarding the quality and safety of home care services and were able to bring about action by the Care Quality Commission, leading to the provider entering special measures and an improvement plan being put in place. Healthwatch Torbay continues to monitor the situation.

We will shortly be writing to all council leaders and chief executives to share our State of Support analysis and explain how our Committee will be exercising its advisory powers to ensure local authorities are fully aware of the potential consequences of their decisions before making them. We are also building into our new strategy a substantial focus on helping local Healthwatch to operate with maximum efficiency and effectiveness, identifying and promoting their impact, and ensuring there is a sustainable offer across the network.

Proposals for joint working

In seeking to achieve our ambitions for the network we would benefit from input and support from the Department in a number of ways. Firstly, we need the Department to provide greater transparency so that local authorities are clear about the funding streams from which they are resourced to commission local Healthwatch organisations. This will enable intelligent commissioning and appropriate accountability by:

- Helping to ensure that funding is being applied by councils in line with their legal duties;
- Improving formal accountability through increasing the ability of scrutiny committees, other elected members, Health and Wellbeing Boards and the public to understand councils' Healthwatch commissioning decisions; and
- Providing the Department with a more comprehensive picture concerning the value for money achieved by councils using the resources allocated by the Department to enable them to commission local Healthwatch.

In addition to our activities with other organisations, there would also be merit in the Department facilitating and encouraging better collaboration and integration between its Arm's-Length Bodies regarding strategic opportunities to work with local Healthwatch. In the Department's most recent assessment of NHS England's performance against its Mandate, you noted your appreciation of the joint working undertaken between NHS England and Healthwatch, both nationally and locally. Without the resources necessary for local Healthwatch to carry out their statutory activities, this will be at risk. Stakeholders across health and care therefore have a practical interest in this issue. A collective approach would build upon the constructive discussions we have started to have with NHS England, NICE and the CQC in this regard and would help to identify further opportunities to develop coherent and effective engagement as well as improve the sustainability of local Healthwatch.

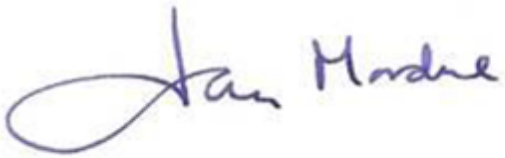
With this in mind, now seems to us to be the right time to bring those stakeholders together and identify a coordinated approach. Given the trend towards commissioning local Healthwatch and advocacy services together, and the way in which these services are interlinked from a user perspective, it would make sense to make advocacy stakeholders part of that discussion. It would also be beneficial to involve colleagues from the Department of Communities and Local Government, given their responsibilities with regards local government funding. Healthwatch England would therefore be happy to work

with your officials to organise a roundtable involving health and social care arm's-length bodies, local government, and advocacy providers to explore further some of the issues raised in this letter.

Thank you for your continued interest in the state of the Healthwatch network, and that of your officials who I know maintain effective contact with our team on these matters. I hope our briefing and the additional information in this letter are helpful in bringing into focus the increasingly pressing challenges that local Healthwatch now face in delivering their important statutory functions. I also hope this letter makes clear how Healthwatch England is responding and what the Department can do to help.

I look forward to your thoughts on our proposals concerning improvements to transparency and bringing stakeholders together, and if I can provide any further information on these or any other points please do not hesitate to get in touch.

Yours sincerely,



Jane Mordue
Chair, Healthwatch England

MEETING REFERENCE: CM180131
AGENDA ITEM: 1.5

AGENDA ITEM: National Director's report

PRESENTING: Imelda Redmond

PREVIOUS DECISION: N/A

EXECUTIVE SUMMARY: This report outlines progress on the development of our strategy and developments in our external environment since the Committee last met.

RECOMMENDATIONS: Committee Members are asked to **NOTE** this report

On 9th January I celebrated my first anniversary with Healthwatch England and so I thought I would indulge in some reflections on my first year with the organisation. In many ways it feels like I am just scratching the surface of the complexity and potential of the total body of Healthwatch England and the 152 local Healthwatch. I am excited by the potential of what we will be able to achieve and how we can mainstream putting people at the heart of health and social care in the years to come. The opportunity of creating a new strategy has afforded many opportunities to really explore how we can have best impact; it has given me the opportunity to speak to many leaders from across the sector exploring how we can add value to each other's work. I have received a very warm welcome from the sector and there is a keen interest partnership working with many influential organisations. The Healthwatch England remit and offer plus our local network make us a very attractive proposition for many of the Royal Colleges, statutory bodies and Charities for joint working and promotion. The combination of our very broad policy reach and network puts us in a unique position.

I have greatly enjoyed getting to know the people that make up this organisation, both the Healthwatch England team and the people who work at a local level. I have enjoyed the challenges that running an organisation that needs to use soft and hard power all the time to be effective. So at the end of this first year I feel optimistic about our future influence; the extensive work we have put into defining our future I believe will pay dividends and I look forward to the future.

So what have we been up top since our last Committee meeting in October? Looking back it has been busier than I remembered experiencing at the time and of course there has been considerable amount of change in the external environment which I will come back to later.

During this year we have tried to bring greater clarity to our priorities but also to improve the way we report on our performance. We put in place the beginnings of a reporting mechanism based on the previous business plan, this will stand us in good stead as we begin to plan the details of the delivery of the new strategic plan.

1. Update on activities

Since the Committee last met in Reading we have made considerable progress across a number of areas including development of the new organisational strategy, stakeholder management, relationships with the local network and profile. In October we held the final Committee workshop on the defining the future strategy; at this meeting the Committee worked on refining our vision, purpose and behaviours. Later in this meeting today you will be asked consider the final draft of the strategy with its supporting documents. The staff team are busy working on the deliverables across the next 5 year period to make the strategy a reality. Once we have an approved strategy we will produce the Business Plan which will come back to Committee at the next meeting in April.

2. Stakeholder Relationships

I have continued to spend a significant amount of time investing in building strong relationships with our many stakeholders. A list of the external stakeholders I have met during this quarter is at the end of the report for your information. I am pleased that I am continued to be asked to speak at people's events, I am also pleased other members of the team also regularly give speeches and presentations to host of conferences and events. There is more detail in the delivery report later in the papers.

During this quarter we have made good progress on developing our relationships with the media, national and trade and have also given local Healthwatch support to achieve coverage greater coverage locally. The figures on this are in the delivery report. Being better known and understood by the public and professionals is essential.

As I become more established in the sector I am pleased that I have been asked to join a number of strategic committees or working groups. These have proved useful in helping other parts of the system understand the role and contribution of Healthwatch at a local and national level. I sit on a new NHS England STP/ACO Advisory Group, the Equalities and Diversity Council; NHSE Commitment to Carers Work stream, National Adult Safeguarding Committee and the Public Health England Health Checks Board. I was also pleased to be asked by the then Minister for Social care to join the Advisory panel on the Green paper on Social Care. The work on this began in December; led by the First secretary of State at the Cabinet Office. The subsequent cabinet reshuffle has meant that the responsibility has now moved back to the Department of Health and we have now met with the Minister now responsible for this. We have established an advisory group made up of local Healthwatch

who are helping us put the reality checks into our work. We have been asked by DH to take special interest in advising them on a range of public opinions on social care and advice and information needs.

3. Internal facing work

Governance and Committee

In recent months I have assisted Jane in the recruitment of our new Committee member. We were delighted by the response to the recruitment campaign and all seven new members have been appointed, and all but one have attended an induction session on 22 January.

The new Finance, Audit and Risk Committee is now up and running with meetings planned for the coming year.

4. Staffing

We continue to build a strong team with clear accountabilities and methods of working. During the six weeks the Senior Leadership Team has had the opportunity to have two developments days to help us get to know each other so that we can play to our strengths and develop as a team. We held a staff development day in December and two strategy planning events. We have had five new members of staff join the team including Leanne Crabb who will support all the Committee work and in February we are expecting Josephine Buckle to join us as PA to Jane and me. A longstanding member of staff Andy Payne Head of Engagement left us this month; we have recruited for his replacement and should have someone in post early March. The Staff Engagement Group continues to meet and has been a very useful source of feedback and morale building. The Financial Risk and Audit Committee will meet with the Staff Engagement Group in the coming months once we have the results of the staff survey.

Price Waterhouse Cooper undertook an internal audit; this was discussed at the Finance, Audit and Risk Sub-Committee meeting. A summary of the actions needed and feedback on previous actions is dealt with later in these papers. You will be pleased to be assured that the greater integration of the organisation into CQC is going very well. We have reduced our actions from 33 to just two in this coming year; both are of low risk.

5. Annual Conference

Planning for the annual conference is underway. I would like to draw Committee attention to the dates. It will be held in Strafford Upon Avon on **3 and 4 October.** This change of date from the usual July meeting was decided on following feedback from delegates.

We are working on defining the awards and will have seven award categories including one to celebrate the work on public engagement by an exceptional team or person. This will be tied into the celebrations for NHS 70th

anniversary.

6. Network

Over the past few months I have had the opportunity to go to a number of network meetings across the country. I have attended meetings in with Healthwatch Worcestershire, Healthwatch Birmingham, a conference organised by Healthwatch North Tyneside, I met people from Healthwatch Gloucester and I attended network meetings in east Midlands, north west Midlands and had a very productive telephone meeting with teams in south west and south east networks. There is no doubt that funding continues to occupy the agenda and we'll need to progress some work soon where the points of influence are in the system so we can help people engage in the right way. The sheer number of LHW that are currently engaged in tendering activity is putting a huge amount of strain on the network and of course introduces a great deal of volatility. There are currently five organisations working on tenders and a further 21 are either waiting to hear the outcome of the bid or are expecting to have to respond to tenders in the very near future.

We have provided the network with advice on the implementation of GPDR. Healthwatch England will follow CQC in

7. Influence and Policy and Public Affairs

Government Reshuffle

The Department of Health has been renamed to the Department of Health and Social Care. Whilst this has not added any new responsibilities to the Department, and funding for council run care services will still run through the Department of Housing, Communities and Local Government, it does signal a stronger Government commitment to addressing the growing challenges in social care.

Jeremy Hunt retained his job as Secretary of State for Health and Social Care. As part of the changes he will take on responsibility for running the Government's social care green paper – due out later this year. At time of drafting it appears likely that he will be supported in this by Caroline Dinenage MP, the newly appointed Minister of State for Social Care.

Philip Dunne MP (our sponsor Minister and Minister of State for Health) left Government in the reshuffle. He has been replaced by Stephen Barclay MP, previously Economic Secretary to the Treasury.

Both new appointments to the Department Caroline Dinenage MP (Hampshire) and Steve Barclay MP (Cambridgeshire) have high performing local Healthwatch.

NHS Winter Pressures

The NHS has featured heavily in the news headlines over recent months. This follows the widespread missing of key targets – 62 day cancer care, four-hour A&E waits and 18 week referral to treatment for planned operations.

In the budget the Government announced £2.8 billion of additional resource for the NHS in England.

£335 million of provided this year to help increase capacity over winter

£1.6 billion will be provided in 2018-19

£900 million will be provided in 2019-20

To help alleviate pressures further this winter the NHS has been given permission to cancel planned operations up to the end of January. However, A&E doctors have warned that despite the winter planning patients are dying in hospital corridors as safety is compromised by "intolerable conditions".

The Secretary of State and the Prime Minister have both apologised for current performance. NHS Providers, which represents hospitals in England, has called for Government to increase funding by an extra £20 billion by 2022/23 to fix the problems.

Healthwatch England has called for a wider look at NHS targets to generate a more balanced conversation about how services are currently meeting the needs of people.

8. Hospital Discharge

In March last year the Department of Health introduced a new target to reduce the number of bed days lost to delayed transfers of care to 3.5% by September 2017. The system missed this target with the latest figures showing that the current rate is 5%. However we expect this to fall slightly when the next round of quarterly statistics are released as we know the monthly number of delayed transfers has fallen.

It is worth noting that the number of delays attributed to social care has risen significantly in the last couple of years, over the last six months local authorities have been more successful in reducing the number delays than the NHS.

Healthwatch England has welcomed the progress made to date however our two reports in October highlighted that this has yet to make a significant impact on people's experiences of moving between services.

In particular our work on emergency readmissions has helped to raise questions about the risks of focusing solely on reducing delayed discharges. Whilst getting people home quickly is important, it is also vital that they get

home safely and with the right support in place to help them stay well. This view has been expressed throughout our work on hospital discharge and we were pleased to see this echoed by the CQC in their interim local system reviews report published in December.

We have recently met with the Picker Institute to discuss developing our work on emergency readmissions further. We will continue to pursue these and other discussions with key stakeholders.

9. Social care

In November the Government announced the timeline for the upcoming green paper on the future of social care for older people. Following our work in the summer, our National Director has been asked to be one of the independent experts advising on the development of the green paper.

Also in November the Competitions and Market Authority (CMA) published their year-long study into the care homes market in the UK. They outlined that in order for people to make good decisions about their care needs the Government needs to work with the NHS, local authorities, care providers and the voluntary sector to:

Providing people with good quality, relevant and timely support when they are making life-changing decisions about care.

Helping people quickly and easily identify the relevant, local care options that are available to them.

Encouraging and helping people to prepare and plan for future care needs.

There was also a specific recommendation for Government to review the coverage of complaints advocacy services for residents of care homes. This is a long term policy ask of Healthwatch England and we were specifically referenced as a key body for the Government to engage in this review. An initial meeting has been set up for early February with the DH complaints policy team to discuss further.

10. Public Engagement in Service Change

Before Christmas the Health Select Committee announced the re-launch of its inquiry in to STPs. This was originally due to take place before the 2017 election.

The scope of the inquiry looks at how effectively STPs have engaged, the reliability of the Government's STP performance dashboard, the credibility of the plans and the governance arrangements that are being put in place.

We have drafted a response based on feedback from local Healthwatch covering 38 of the 44 STP footprints.

It is fair to say that the experiences of Healthwatch around the country to date has been mixed, but there are some broad themes emerging:

While STPs have been open and effective in engaging partners in the health sector, they have been less effective in engaging with other parts of the system such as local authorities and voluntary sector partners. Across the board, engagement with the public is seen as limited.

Financial and time constraints are viewed as limiting the plausibility of a number of plans, with others seen as strong on rhetoric but weak on clear objectives.

Workload pressures are affecting the effectiveness of STP leadership, who often lack dedicated programme teams to support their activities and hold other positions concurrently.

Amongst those aware of the STP progress dashboard, Healthwatch do not feel that it accurately measures how well STPs are doing, and focuses on the 'wrong' metrics.

Elsewhere on service change, NHS England have completed their desk based assessment of how CCGs are performing in terms of engaging and involving their communities in local decisions. They have now written to every CCG with individual report. The biggest area for improvement across the board relates to CCGs feeding back to communities how their input has helped inform and influence decision making. This is one the of Healthwatch Five Steps to Good Engagement which were adopted under the NHS Forward View refresh in March last year.

11. Mental Health

In October the CQC published the first phase of their review of mental health services for Children and Young People (CAMHS). This was requested by the Prime Minister in January 2017.

The first phase report is predominantly a literature review and largely confirms a lot of what Healthwatch and others have already heard from people about pressures on the service – in particular the difficulties people face accessing appropriate support and at the right time. It also highlights poor communication and collaboration between services as creating a fragmented experience.

The second phase of the review is due in March 2018 and will be based on targeted activity in 10 areas around the country – relevant local Healthwatch have been feeding in. This has also been supported by wider research – part of which has been outsourced to Healthwatch Hillingdon.

In December, the Government also published a green paper setting out the Government's plans to transform mental health services for children and

young people. The consultation for this closes on 2 March 2018. Healthwatch England is currently exploring our potential response.

Also in December Healthwatch England announced our intention to make mental a major policy focus – taking a birth to death look at mental wellbeing and the support people receive. This follows the paper discussed and agreed at the last committee meeting.

12. Technology

In October the NAO published the findings of their investigation into the WannaCry computer virus that attacked the NHS earlier in the year. The key findings of the investigation are:

The DH was aware of the risks of a cyberattack and had previously written to NHS trusts to advising that it was essential robust plans were put in place to move away from old software. However, before the WannaCry attack took place in May 2017, the Department had no formal mechanism for assessing whether local NHS organisations had complied with their advice and guidance.

The DH had developed a plan, which included roles and responsibilities of national and local organisations for responding to an attack, but had not tested the plan at a local level. It was therefore unclear who was supposed to take the lead in responding, and with key channels such as email either affected or taken down as a precaution communication was challenging.

The attack led to disruption in at least 81 of the 236 trusts in England although the Department and NHS England do not know the full extent of the disruption. A further 603 primary care and other NHS organisations were infected including 595 GP practices.

Thousands of appointments and operations were cancelled. In five areas patients had to travel further to accident and emergency departments.

NHS Digital told the NAO it believes no patient data were compromised/stolen.

The NHS has accepted that there are lessons to learn from WannaCry and is taking action.

Shortly before Christmas Minister confirmed that from May 2018 patients will be able to exercise a single opt-out to prevent their personal identifiable data being used to support medical research and future planning of service delivery. This means that the new arrangements will come in to force at the same time as the new GDPR rules.

Plans for the expansion of ‘GP at Hand’, the online NHS GP service run by Babylon, have been scaled back according to recent reports. The clinical review of the service reported that the use of technology was “exciting and

potentially transformational" with benefits for some patients, however it also raised concerns that the service had not been formally assessed. Concerns of unintended consequences have been raised including the fact the service is likely to attract younger, healthier patients. This could potentially destabilise the wider primary care landscape and contribute to inequalities.

13. Key Appointments

Professor Stephen Powis was announced as NHS England's new Medical Director. Powis is currently group chief medical officer at the Royal Free London NHS FT. He takes over the role from Sir Bruce Keogh and is expected to start early in 2018.

In October it was announced that Dido Harding was to become the new Chair of NHS Improvement. She is a Conservative Peer, as well as being a non-exec director of the The Court of the Bank of England. She was also CEO of TalkTalk Telecom Group plc from 2010 to May 2017.

In December NHSI also appointed Ian Dalton as its new Chief Executive. Ian has 40 years' experience in the NHS and wider Health sector, most recently working for Imperial College Healthcare NHS Trust where he was CEO. Prior to this he was COO and Deputy CEO at NHS England and Chief Executive of NHS North of England.

14. Update on Intelligence from the Local Healthwatch Network

Appendix 1 attached sets out the insight we have received from the local network both in terms of the records of feedback from individuals and the reports they have produced. The team are now producing weekly updates which are shared with Committee on a fortnightly basis.

Meetings for Imelda during last quarter:

- Journalist Dave West from HSJ
- Lord Victor Adebowale
- Equality and Diversity Council
- London Cambridge Health Network
- NHS National Innovation leadership Summit
- NHSE STP/ACO Advisory Group
- Worcestershire Healthwatch
- North Tyneside Healthwatch
- Quality Matters
- National/Local Gloucester
- Parliamentary and Health Service Ombudsman workshop and annual lecture
- NHSE Commitment to Carers Conference
- Richmond Group
- Powher

- Scope
- Diabetes UK
- Carers UK
- HSJ Summit
- Kings Fund
- East Midland Network
- North West Midlands network
- Cabinet office
- Department of Health

2.6 Appendix 1 Intelligence Summary Quarter 3 2017/18

24 January 2017 v1.0

The following briefing provides a summary of the volume and content of intelligence that Healthwatch England received from the local Healthwatch network in Q3 between 01 Oct 2017 and 31 Dec 2017.

1. Quantity of Intelligence received

Individual experiences received by Healthwatch England

In Q3 2017/18, we received **1660** individual pieces of feedback from **46** of the local Healthwatch network.

This was an increase of **85%** compared to the same period last year.

Over a third **(39%)** of the feedback received related to primary care, the majority of which was about GP services.

22% of feedback received related to hospital care, followed by social care accounting for **20%** of feedback.

Only **8%** of feedback received in Q3 related to mental health care.

Local Healthwatch Reports received by Healthwatch England

In Q3, we received **189** local Healthwatch reports from **77** of the local Healthwatch network.

This was twice as many (**103%**) compared to the same period last year.

Since July 2016, we have collated reports from **150** (**99%)** local Healthwatch network.

The majority (**27%**) of LHW reports received in Q3 related to social care, comprising mainly of those reporting on Enter and View visits to care homes.

This was followed by mental health accounting for **21%** of LHW reports received with local Healthwatch reports on GP and hospital care accounting for **20%** apiece.

2. Key Themes identified from Intelligence received

Mental Health

In Q3, 9% of the collective feedback (individual experiences and local Healthwatch reports) we received related to mental health care.

68% of this feedback concerned negative experiences of mental health care; only 6% related to positive experiences of mental health care.

Issues we continued to hear:

The issues that we continued to hear about Mental Health care in Q3 were:

- Delays in access to CAMHS and children's mental health services:
- Requests for support for those with dementia
- Accessibility to effective personalised care
- Need for clear and continuous pathway of integrated care between services
- Lack of support for those in mental health crisis
- Social isolation especially amongst older persons

New or remerging issues we heard about:

In Q3, we received feedback on the following issues that we had not heard extensively about in previous reporting periods:

- Support needed for carers of those with mental health conditions
- Signposting to mental health services

Social Care

In Q3, 20% of the collective feedback we received related to social care.

43% of this feedback concerned negative experiences of social care whilst only 7% related to positive experiences of social care.

50% of the feedback we received related to mixed experiences of social care or requests for information; we receive more requests for information about social care than any other service area

Issues we continue to hear:

The issues that we continued to hear about social care in Q3 were:

- Need to improve provision of information regarding care homes
- Quality of care varying between care homes
- Securing continuous and consistent attendance of domiciliary care workers
- Lack of support following hospital discharge

New or remerging issues we are hearing:

In Q3, we received feedback on the following issues that we had not heard extensively about in previous reporting periods:

- Issues with Continuing Health Care and changes to funding
- Lack of awareness and delays in care assessments

Hospital Care

In Q3, 21% of the collective feedback we received related to hospital care.

68% of this feedback concerned negative experiences of hospital care whilst only 18% related to positive experiences of hospitals.

Issues we continue to hear:

The issues that we continued to hear about hospital care in Q3 were:

- Patients treated by different staff leading to lack of consistency
- Poor communication between patients/families and staff
- Delays in the discharge process
- Access to clear and understandable information and support following discharge

New or remerging issues we are hearing:

In Q3, we received feedback on the following issues that we had not heard extensively about in previous reporting periods:

- Positive experiences from maternity and cancer services
- Continuity of care post pregnancy

GP services

In Q3, 29% of the collective feedback we received related to GP services.

49% of this feedback concerned negative experiences of GP services; 18% related to positive experiences of GP services.

Issues we continue to hear:

The issues that we continued to hear about GP services in Q3 were:

- Difficulty in being able to make appointments especially by phone
- Long waiting times for GP appointments
- Problems with registering at a GP surgery
- Misdiagnosis or incorrect prescriptions
- Unhelpful or indiscreet front line or reception staff

New or remerging issues we are hearing:

In Q3 2017/18, we received feedback on the following issues that we had not heard extensively about in previous reporting periods:

- GPs services closing or merging with other services
- Communication issues for deaf and hard of hearing (Accessible Information Standards)
- Positive experiences of online appointment systems

Family or Unpaid Carers

In Q3, 9% of the collective feedback we received originated from or was in relation to family or unpaid carers.

55% of this feedback concerned negative experiences of carers whilst only 5% related to positive experiences.

Issues we continue to hear:

The issue that we continued to hear about from or in relation to carers in Q3 was:

- More respite needed for carers as family members

New or remerging issues we are hearing:

In Q3, we received feedback on the following issues that we had not heard extensively about in previous reporting periods:

- Delays in care assessments and the need for ongoing assessment
- Need for specialised equipment to be installed in the home
- Training carers to undertake clinical tasks e.g. changing a colostomy bag
- Loss of confidence of carers, isolation and impact on carers mental health

Children and Younger Persons

In Q3, 6% of the collective feedback we received originated from or was in relation to health and social care for children and younger persons.

42% of this feedback concerned negative experiences of children or younger persons whilst 35% related to positive experiences.

Issues we continue to hear:

The issues that we continued to hear from and about children and younger persons in Q3 were:

- Waiting times for mental health services for children/young persons
- Young adults needing better signposting to primary care services

New or remerging issues we are hearing:

In Q3, we received feedback on the following issues that we had not heard extensively about in previous reporting periods:

- Transition from children to adult services especially mental health
- What we are not hearing about:

Older Persons

In Q3, 6% of the collective feedback we received originated from or was in relation to health and social care for older persons.

68% of this feedback concerned negative experiences of older persons whilst 18% related to positive experiences.

Issues we continue to hear:

The issues that we continued to hear from and about children and younger persons in Q3 were:

- Older people's ability to access the GP services they want
- Quality of care for older persons in care homes and receiving domiciliary care services
- Communication in hospital between older patients, families and staff
- Poor attitude of staff towards those older persons suffering dementia

New or remerging issues we are hearing:

In Q3 2017/18, we received feedback on the following issues that we had not heard extensively about in previous reporting periods:

- Delays in older persons receiving care assessments
- Older persons feeling socially isolated especially during the winter months

1.5 Appendix 2

Our tone of voice

Friendly but not informal

We want people to feel that they can approach us and talk to us, but to understand that we are a professional organisation. We should therefore use plain, simple language, but not be insincere.

✓ Use accessible, clear language and short sentences.

× Use jargon. Use vague language. Talk in long sentences. Use text speak or slang.

Compassionate but not emotional

We discuss the often difficult experiences people share with us in a delicate way, but we do not apply judgement. We don't describe people's experiences as 'awful', 'sad' or 'horrendous', we let the stories speak for themselves.

✓ Talk about real people's experiences. Use people's names (where possible).

× Apply judgements to people's stories. Describe them using words such as 'amazing' 'awful' or 'horrendous' etc.

Authoritative but not cold

Everything we say is rooted in evidence, and we do so in a human, accessible way. We should speak confidently about our evidence and state where it comes from, but we mustn't be too academic, as we're always talking about real people's experiences.

✓ Speak confidently about what you have heard. Be clear about where our evidence has come from.

× Be too academic or lose sight of the people at the heart of the story.

Informed but not superior

Everything we share is rooted in evidence, but we don't think we know everything or that we are the only ones who speak to the public. We should share what we know, but not ignore other evidence or viewpoints.

✓ Share information /evidence.

× Ignore other evidence or points of view.

Helpful but not heavy-handed

We are here to help people get the support they need. We should guide people to useful information, but we can't tell them what to do.

✓ Guide people to information. Suggest actions people could take.

× Tell people what to do.

Jargon Tips

How to avoid jargon

Instead of saying	Say
Impactful	Effective
Feeding into	Contributing to
Going forward	From now on
In the round	Generally, overall
Take this offline	Discuss this later/elsewhere
Across the piste	In general, across the board
Co-production	Working together
Co-design	Design, design/develop together
Blue sky thinking	Coming up with ideas, creativity
To action	To do, address
Joined-up thinking	Working together
Synergy	Work well together
Slide pack	Presentation
Health and social care system	Health and social care services

Instead of saying	Say
Pre-meeting/pre-reading	Meeting/reading
Cascading	Sharing
Upskill	Train, teach
Value-add	Add value, improve
Leverage	Use, make the most of
Rich conversations	Be more specific - useful discussion, lots of new ideas etc.
Touch base	Meet, discuss, give an update
Granularity	Detail
Land (e.g. How do we think this is going to land with the Minister?)	Be received by, what will he/she think?
Land (e.g. When do we think this report will land?)	Be published/launched/finished/done
Reach out	Contact, talk to
Road map	Plan, timeline
Seldom heard groups	We listen to the views of people from all areas of the community
Leading on (e.g. Who is leading on this project?)	Leading, running, in charge of

For more info go to Y:\CQC_Records\HEALTHWATCH\Communications\Brand Work\1 Healthwatch England\Tone of Voice\20170704 Healthwatch Brand Language Guide.pdf

MEETING REFERENCE: CM180131
AGENDA ITEM: 1.7

AGENDA ITEM: Report back from Audit Finance and Risk Sub Committee

PRESENTING: Deborah Fowler

EXECUTIVE SUMMARY: This is the minutes from the last Audit Finance and Risk Sub Committee (AFRSC)

RECOMMENDATIONS: Committee Members are asked to **NOTE** this report

Report to be sent separately

AGENDA ITEM No: 2.1

AGENDA ITEM: Sustainability Challenges of the Healthwork Network

PRESENTING: Jacob Lant Head of Policy and Public Affairs

EXECUTIVE SUMMARY: The presentation brings together the following:
- Findings of Healthwatch England's annual 'State of Support' briefing, which outlines the financial position of the network for 2017/18.
- Headlines from the additional analysis commissioned by the Committee to look at the challenges and opportunities regarding sustainability of the Healthwatch network.

Copies of the Chair's recent letter to the Secretary of State on local Healthwatch funding and the 'State of Support' briefing have been included as part of the committee papers.

RECOMMENDATIONS: Committee Members are asked to **NOTE** the content of the presentation and discuss.

The Healthwatch Network

341,000
people spoke to our network about their experiences of using health and social care services.

healthwatch

176,000
people contacted our network for advice and information about health and social care services.

healthwatch

4,700
volunteers gave up their time to support our work.

healthwatch

We publicised the difference local Healthwatch have helped make through their

1,745
reports and used the contents in our national work.

healthwatch

What local Healthwatch look like

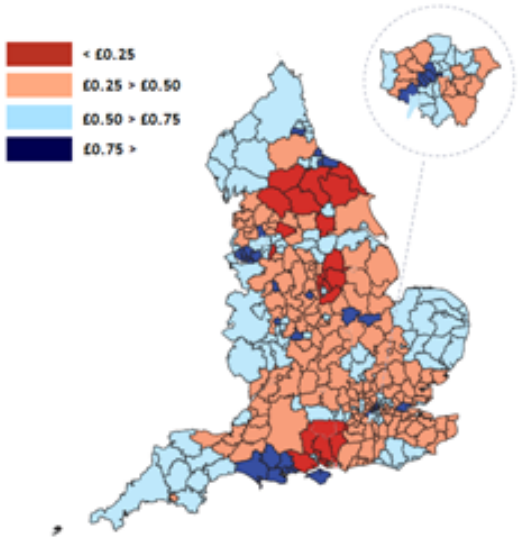
- **Stand-alone organisations running a single contract.**
  Strong understanding and focus on local patch but more likely to have resource / capacity issues.
- **Multi-contract stand-alone organisations.**
  Broader scope for strategic thinking in work with the system but face challenges managing competing commissioner priorities.
- **Hosted local Healthwatch**
  Access to wide range of skills and experience and improved resilience but challenge to the brand with Healthwatch sometimes seen as secondary function.

Funding

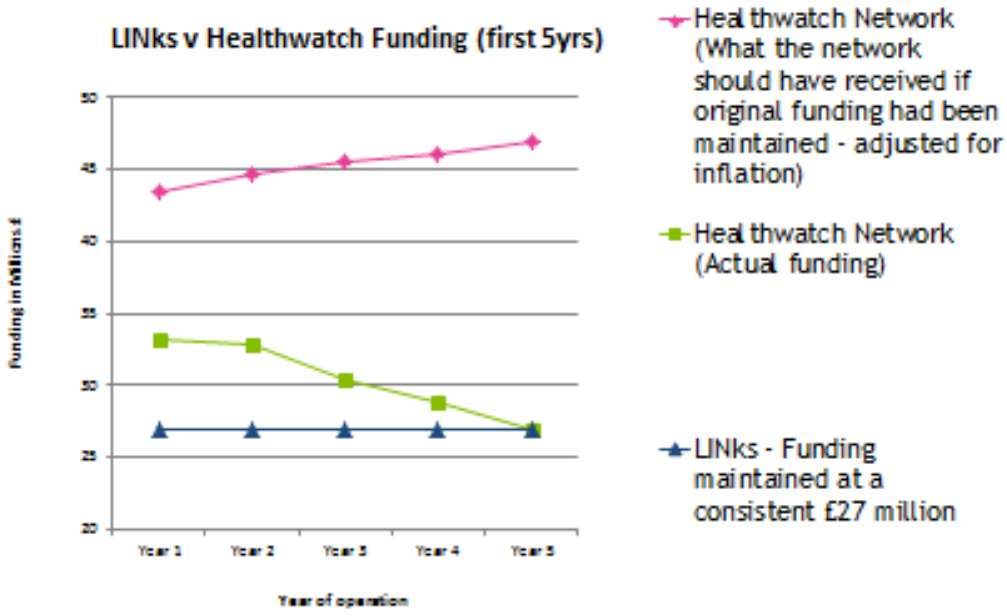
- Funding fell by 6.9% in 2017/18
- Overall reduction since 2013/14 now 37%
- Average amount a local Healthwatch receives £185k
- Two thirds expect further reductions in next 3 years
- 9 in 10 looking to take on commissioned work

Funding

- The spend per head analysis shows significant variation in funding
- Expected to get worse in areas of deprivation as councils move from grant funding to council tax and business rates.



Funding



The Market

- The spend on public engagement across health and social care is not insignificant but is often fragmented.
- Local Healthwatch on their own are often too small to win larger contracts.
- The need to engage people in the STPs has created opportunities but it is vital local Healthwatch maintain their independence.

Stakeholder view

- Local Healthwatch seen as distinct from the voluntary sector and internal engagement mechanisms within health and care - such as PALS and PPGs.
- Healthwatch also seen as strategic rather than operational.
- However, stakeholders commented that local Healthwatch require additional leadership development to maximise role.

Next steps ...

This analysis, combined with the insight gathered through the data return, highlight the need for activity in a number of areas to underpin the long-term effectiveness and sustainability of the network.

- Evidence the value of engagement
- Highlight the impact of local Healthwatch
- Broker relationships to create future opportunities
- Support local Healthwatch commissioners
- Improve network infrastructure and reach
- Make Healthwatch insight indispensable to health and care services.

Demonstrating our value

- Establish economic case for public involvement.
- Training and support to develop consistency in research outputs.
- Promote the reach and expertise of the network.
- Provide advice and guidance on how to demonstrate impact.
- Encourage Healthwatch to follow-up on work to track the difference we make over time.

Brokering relationships

- Help the network identify opportunities for commissioned work.
- Facilitate local Healthwatch to work together to attract regional and national contracts.
- Provide training in practical skills such as bid-writing.
- Create guidance on what sort of activities local Healthwatch should and should not be expected to undertake.

Work with commissioners

- Work with commissioners to shape contracts around impact rather than activity
- Develop core KPIs to enable consistent monitoring of performance
- Establish triggers for intervention by Healthwatch England in commissioning decisions.

Supporting infrastructure

- Support the maturing use of digital tools and content - both to extend reach and free up resource at a local level.
- Roll out leadership development programme - targeting areas facing particular challenges.
- Encourage the recruitment, development and retention of skilled volunteers.

2.1 Appendix

BRIEFING

State of Support

Local Healthwatch Funding 2017/18
30 November 2017

Overview

Healthwatch is the independent champion for people who use health and social care services.

Across the country there are 152 local Healthwatch gathering people's experiences of health and care services, providing people with information and advice about care and using the collective insight to inform decision making.

This briefing provides an overview of the collective funding received by the Healthwatch network for 2017/18.

Key findings:

- For 2017/18 local Healthwatch collectively report that they received **£27,395,178**[1] to deliver their statutory activities.
- This is a **6.9% reduction** on the £29,423,966 actually received in 2016/17.
- This compares with the 5.9% reduction between 2015/16 and 2016/17 we reported in last year's 'State of Support' briefing.[2]

[1] Figures checked with the network in October 2017. A small number of local Healthwatch receive NHS complaints advocacy service funding which cannot be split out from funding to deliver Healthwatch statutory activities. Footnotes indicate where this is the case.

[2] The actual percentage reduction last year rose to 7.5% when adjusted for final figures at the end of the financial year, with the budget received (£29,423,966) coming in significantly lower than the £29,940,078 reported in the October 2016 'State of Support' briefing. As there could still be in year adjustments to the funding received by local Healthwatch for this year, we have compared the figures at the same point in each financial year for consistency.

healthwatch

- Six in ten local Healthwatch have maintained the same level of funding or had a change of less than £5,000.
- However, forty-seven local Healthwatch have received more significant cuts, with an **average reduction of 17%**.
- The current level of funding means less than **50p per head** is being invested annually in Healthwatch to gather the views and experiences of people.[3]

A brief history of local Healthwatch funding

Central government provides funding to local authorities to enable them to commission a local Healthwatch.

Although this funding is not ring-fenced, central government originally announced a total of £43.5m, which was handed out to local authorities in 2013/14.

Following research indicating that only £33.5m got through to front-line local Healthwatch services in 2013/14, we were asked by the Department of Health to report how much funding was being allocated to the network. This is now the third 'State of Support' briefing. You can read the previous briefings here:

- 2015/16
- 2016/17

Whilst this year's reduction is 6.9%, when looked at over the history of the Healthwatch network funding has fallen by 37% against the government's original allocation of £43,500,000.

It is also clear that the rate of reduction is increasing year-on-year, and this year we have seen this leading to commissioning proposals by local authorities which could compromise the ability of local Healthwatch to deliver their statutory functions:

- Only commissioning the service to run part-time.
- Attempting to split out the signposting and advice function from the rest of the Healthwatch contract.

[3] Figures based on 2016 ONS population estimates

- Stipulating specific activity in the Healthwatch contract potentially compromising independence.
- Commissioning both local Healthwatch and NHS complaints advocacy under one contract with a combined budget which makes it difficult to establish spending levels.
- Expecting local Healthwatch to income generate in order to cover the cost of delivering statutory services.

How we support local Healthwatch

In keeping with our statutory role in relation to commissioning arrangements and support for local Healthwatch, we will continue to support local Healthwatch during individual negotiations on budgets when requested.

With this in mind, in May 2017 the Healthwatch England Committee introduced a new approach to how we use our statutory power to advise local authorities on the commissioning of local Healthwatch. This will enable us to formally engage with local authorities much earlier in the process and raise any concerns. Ultimately this will help us ensure adequate arrangements are put in place to provide local communities with an effective and sustainable Healthwatch service.

We will also continue to provide local Healthwatch commissioners with regular opportunities to share best practice and identify how they can work together to support a stronger, more effective network.

With local Healthwatch also being asked to play a key part in new regional health and social care reforms, we will also promote the need for this work to be resourced effectively.

What does the funding look like in my area?

Local Healthwatch	2017/18 Healthwatch funding	2016/17 Healthwatch funding
Barking and Dagenham	£131,126	£124,000
Barnet	£128,000	£120,000
Barnsley	£150,000	£150,000
Bath and North East Somerset	£80,000	£80,000

Bedford	£93,380	£92,000
Bexley	£90,000	£114,116
Birmingham	£445,382	£445,382
Blackburn with Darwen	£165,000	£165,000
Blackpool	£58,000	£63,000
Bolton	£175,000	£175,000
Bracknell Forest	£65,000	£100,122
Bradford	£180,000	£180,000
Brent	£140,000	£150,000
Brighton and Hove	£199,000	£184,000
Bristol	£198,912	£278,912
Bromley	£85,000	£113,150
Buckinghamshire	£187,500	£200,000
Bury	£122,000	£122,000
Calderdale	£51,000	£51,000
Cambridgeshire	£287,602	£287,602
Camden	£218,815	£218,815
Central Bedfordshire	£144,200	£140,000
Central West London	£450,000	£450,000
Cheshire East[4]	£168,503	£140,945
Cheshire West and Chester[5]	£167,487	£189,000
City of London	£70,000	£70,000
Cornwall	£300,000	£300,000
County Durham	£147,675	£196,900

[4] 2017/18 figure includes NHS complaints advocacy service funding, which cannot be split out from funding to deliver statutory activities.

[5] 2017/18 figure includes NHS complaints advocacy service funding, which cannot be split out from funding to deliver statutory activities.

Coventry	£195,616	£195,616
Croydon	£206,000	£206,000
Cumbria	£250,173	£238,450
Darlington	£78,000	£131,697
Derby City	£235,000	£235,000
Derbyshire	£321,114	£321,114
Devon	£410,000	£468,000
Doncaster	£225,130	£242,000
Dorset	£402,030	£402,030
Dudley	£206,000	£206,000
Ealing	£140,000	£140,000
East Riding of Yorkshire	£160,000	£171,000
East Sussex	£374,000	£380,509
Enfield	£218,666	£230,000
Essex	£680,000	£780,000
Gateshead	£150,000	£150,000
Gloucestershire	£219,907	£382,000
Greenwich	£129,000	£129,000
Hackney	£159,000	£160,000
Halton	£134,715	£134,750
Hampshire	£303,075	£417,243
Haringey	£160,000	£180,000
Harrow	£75,000	£100,000
Hartlepool	£129,056	£129,056
Havering	£117,359	£117,359
Herefordshire	£140,000	£140,000
Hertfordshire	£376,593	£466,593
Hillingdon	£166,250	£175,000

Hounslow	£85,000	£89,000
Isle of Wight[6]	£114,750	£153,000
Isles of Scilly	£45,507	£50,507
Islington	£165,000	£165,000
Kent	£511,000	£666,270
Kingston Upon Hull[7]	£177,443	£205,699
Kingston upon Thames	£122,000	£122,000
Kirklees	£185,000	£184,500
Knowsley	£171,000	£171,000
Lambeth	£225,115	£225,000
Lancashire	£438,000	£438,000
Leeds	£374,000	£375,000
Leicester[8]	£192,000	-
Leicestershire	£187,391	£187,391
Lewisham	£107,428	£107,428
Lincolnshire	£300,000	£340,000
Liverpool	£401,543	£401,543
Luton	£128,876	£128,876
Manchester	£80,000	£80,000
Medway	£128,770	£128,000
Merton	£125,000	£125,000

[6] 2017/18 figure covers funding from April 2017 – December 2017.

[7] 2017/18 figure includes NHS complaints advocacy service funding which cannot be split out from funding to deliver statutory activities. 2016/17 figure included NHS complaints advocacy service funding from December 2016 to March 2017, which cannot be split out from funding to delivery statutory activities.

[8] 2016/17 figure included NHS complaints advocacy service funding. Therefore it is not possible to make a like for like comparison.

Middlesbrough	£113,373	£140,910
Milton Keynes	£158,644	£158,000
Newcastle upon Tyne	£210,078	£215,000
Newham	£120,000	£160,000
Norfolk	£458,000	£600,760
North East Lincolnshire	£109,218	£108,504
North Lincolnshire	£121,000	£126,000
North Somerset	£125,179	£139,300
North Tyneside	£148,953	£148,953
North Yorkshire	£142,459	£144,397
Northamptonshire	£245,000	£295,000
Northumberland	£199,000	£224,000
Nottingham City	£160,000	£160,000
Nottinghamshire	£198,000	£296,000
Oldham	£138,700	£146,000
Oxfordshire	£235,948	£235,948
Peterborough	£187,500	£153,000
Plymouth	£111,899	£111,899
Portsmouth	£79,938	£79,938
Reading	£110,500	£110,000
Redbridge	£150,000	£166,000
Redcar and Cleveland	£113,373	£127,500
Richmond upon Thames	£146,000	£146,000
Rochdale	£136,000	£157,000
Rotherham	£174,150	£193,500
Rutland	£66,282	£65,000
Salford	£166,000	£166,000
Sandwell	£195,000	£195,000
Sefton	£143,281	£143,281
Sheffield	£209,960	£238,000
Shropshire	£191,487	£191,487
Slough	£90,000	£95,000

Solihull[9]	£157,573	£90,000
Somerset	£198,000	£199,047
South Gloucestershire	£100,000	£100,437
South Tyneside	£103,409	£103,409
Southampton	£126,000	£130,000
Southend	£123,000	£134,500
Southwark	£120,000	£120,000
St. Helens	£149,614	£149,615
Staffordshire	£415,109	£461,232
Stockport[10]	£88,000	£88,000
Stockton on Tees	£128,554	£128,554
Stoke-on-Trent	£195,000	£195,000
Suffolk	£484,014	£484,000
Sunderland	£150,000	£225,000
Surrey	£504,141	£519,089
Sutton	£110,000	£133,840
Swindon	£143,424	£145,000
Tameside	£115,000	£115,000
Telford and Wrekin	£100,000	£100,000
Thurrock	£124,000	£116,000
Torbay	£125,000	£135,000
Tower Hamlets	£179,716	£220,000
Trafford	£118,500	£121,072
Wakefield	£217,268	£217,268
Walsall	£175,000	£209,200
Waltham Forest	£141,000	£160,000

[9] 2016/17 figure covered funding from July 2016 - March 2017.

[10] 2017/18 and 2016/17 figures do not include funding for advice and information statutory activities.

Wandsworth	£197,512	£192,000
Warrington	£160,000	£160,000
Warwickshire	£262,000	£304,000
West Berkshire	£108,924	£110,000
West Sussex	£262,600	£430,000
Wigan	£200,000	£200,000
Wiltshire	£190,000	£205,000
Windsor, Ascot & Maidenhead	£65,000	£26,785
Wirral	£170,000	£170,000
Wokingham Borough	£107,000	£107,677
Wolverhampton	£194,289	£194,289
Worcestershire	£289,000	£289,000
York	£117,520	£115,000

AGENDA ITEM

No: 2.2

AGENDA ITEM: Quarter 3 2017/18 – Delivery Report

PRESENTING: Neil Tester

PREVIOUS DECISION: The Committee approved the 2017/18 Business Plan at its February 2017 meeting and the final plan at its May 2017 meeting.

EXECUTIVE SUMMARY: This paper provides a summary of key achievements during the third quarter of 2017/18 (October - December, 2017). The paper updates the Committee on our work on discharge and emergency readmissions. Overall performance against plan is set out in Paper 2.4.

RECOMMENDATIONS: The Committee is asked to **NOTE** the report.

1. Contents of the report

1.1. Section 6 summarises our delivery under 5 headings:

- Helping local Healthwatch and stakeholders to learn and share
- Giving the network the tools it needs
- Receiving and using more network evidence
- Sharing insight and raising awareness
- Supporting quality

1.2. Section 3 provides an update on our work on experiences of discharge and on emergency readmissions.

1.3. Section 4 represents overall media and online coverage and reach, as well as trade coverage and reach, and compares them with the same period in 2017/17.

1.4. Section 5 summarises planned Q4 activity.

2. Comments on delivery

2.1. We continued to provide regional networking opportunities for local Healthwatch alongside our regular and well-received training on communications and Enter and View activity.

2.2. The benefits, identified in previous reports, of last year's work in establishing our intelligence processes and processing backdated local Healthwatch reports continued to improve the breadth and depth of the insight we share with others. Local Healthwatch are making increased use of our research helpdesk and beginning to use our report review service. We brought 13 more Healthwatch onto the CRM, meaning that 96 are now using the system. We are now also making use

of our analysis of network information to identify where we can usefully target our own information-gathering, as with the emergency readmissions work

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2.3. In Q3 we built substantially upon Q2's progress in re-establishing media relationships and making new inroads into trade media. Sections 3 and 4 provide more detail. We also worked with the network to deliver a second phase of the #ItStartsWithYou campaign that focused on GP feedback, and to prepare for our successful January profile-raising work on the annual Healthwatch priorities list and the #SpeakUp campaign. We will evaluate this work for the Committee in the Q4 report.

2.4. The report sets out how we continued to share Healthwatch insight effectively with national partners. We delivered our Annual Report to Parliament, which this year provided our first annual intelligence assessment of people's experiences across key areas of health and social care. Section 3 describes our work on discharge and emergency readmissions, which we linked to our submission on the deliverables in the Mandate to NHS England in our role as statutory consultee.

2.5 Crucially, Q3 saw us publish our annual State of Support analysis of network funding, accompanied by a substantial letter to the Secretary of State that made clear the seriousness of the position, identified what we are planning to do as a result and proposed constructive action that others might take to help secure the sustainability of the network. We also took firm and public action to highlight the unacceptable position of Staffordshire County Council in relation to its tender for the Healthwatch Staffordshire service, and to make sure that the message was heard by other authorities.

3. Discharge and emergency readmissions

3.1. During October we published two reports on people's experiences of transferring between hospital and care in the community. This consisted of:

- An overview report on what the network has heard over the last two years - *What happens when people leave hospital and other care settings?* https://www.healthwatch.co.uk/resource/what-happens-when-people-leave-hospital-and-other-care-settings
- A more detailed analysis of emergency readmissions data - *What do the numbers say about emergency readmissions to hospital?* https://www.healthwatch.co.uk/resource/what-do-numbers-say-about-emergency-readmissions-hospital

3.2. Together, these reports provide an update on our 2015 report 'Safely Home' and continue to highlight our expertise in understanding how people experience health and social care services. Focusing on the transitions between services, they provide a unique insight in to the extent to which services are providing integrated care and support from the user's perspective. This work was also designed to illustrate how Healthwatch England analysis can provide a new way of looking at problems that can help stakeholders identify where and how to improve.

3.3 The objectives of this work were:

- To communicate what people have told Healthwatch about their experiences of leaving hospital, both good and bad, since our report in 2015;
- To use this insight to evaluate the system's progress to date on this key health and social care issue and contribute to the national debate;
- To outline specific concerns about the dangers of focusing solely on fixing 'Delayed Transfers of Care' without considering safety and quality of experience;
- To continue to push our long-term policy ask concerning the use of people's experiences of moving between services as a success measure for integration;
- To highlight where local Healthwatch interventions have already made a difference to people;
- To publicly recognise the efforts of those local Healthwatch that have continued to work on this issue and provide new avenues for future work.

3.4. While we were hoping to use the launch of the reports to continue to raise public awareness of Healthwatch, this was a lower-order target for this work. We identified our primary audience as being those who make and influence local and national policy, with the secondary audience being those who deliver and manage services.

3.5. Our intensive work with key stakeholders in the run-up to publication ensured that not only were key messages picked up but the main call to action was also acknowledged by the Department of Health, NHS England and NHS Digital. No stakeholders criticised the content or tone of the reports, with a wide range sharing and commenting on the content. Key additional commentators include: Independent Age, Royal College of Occupational Therapists, National Voices, VODG, Stroke Association, CQC, Carers UK, NHS Digital, NHS Providers, Nuffield Trust, King's Fund, PHSO, British Geriatrics Society, NAO, British Red Cross, SCIE, NHS Improvement and the Picker Institute.

3.6 During the six weeks after the two reports were published they were collectively downloaded 1,194 times. We achieved a direct social media reach of 1,743,780
including retweets from key stakeholders whose followers contain primary and secondary audiences. Comparing this with the activity for the social care reports released in Q2, the number of downloads are down. We suspect this is partly because social care was a new topic for national Healthwatch reports and therefore secured significant interest from a new audience. The

discharge reports were also published at a much busier time of year for the health and care sector in terms of reports. It is therefore positive to note that while there may have been fewer downloads the engagement on social media was slightly higher than with social care, ensuring our key messages were still widely shared.

3.7. While the overarching report received mainly local and trade media interest, the briefing on emergency readmissions, which highlighted a new angle around the data on discharge, secured 79 pieces of coverage across national, regional and trade media, including The Times Online, BBC Breakfast, BBC R4's Today programme and ITV's *Loose Women*. This coverage reached a media audience of 53 million. This level of coverage was incredibly positive given the competition from other discharge related stories in October – most notably the 'Care BnB' idea.

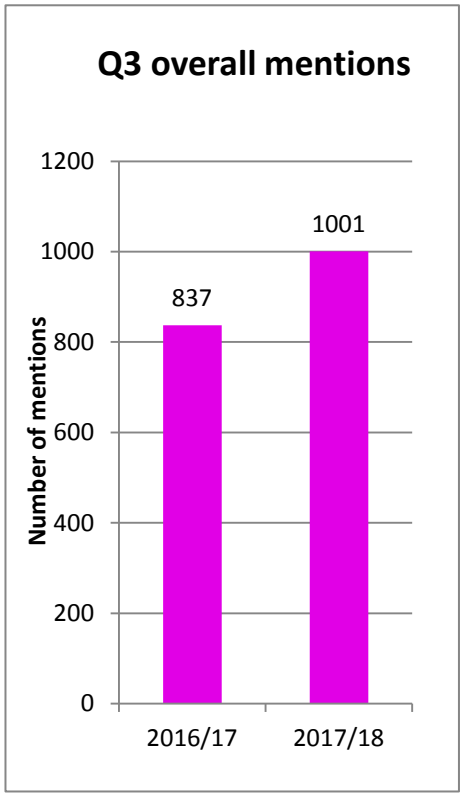
3.8. This work has helped significantly in moving the focus away simply from delays and towards a broader assessment of how people move through the health and care system. This has been supported since by the CQC's interim local system review report in December and by the King's Fund in recent blogs. We have been having positive conversations with the Department about requesting NHS Digital to start publishing emergency readmissions data again and to include this data in the new integration scorecare being developed by SCIE. We have also used our submission to this year's NHS England Mandate refresh to reiterate the need to look at people's experiences of transferring between services as a key success indicator for integration.

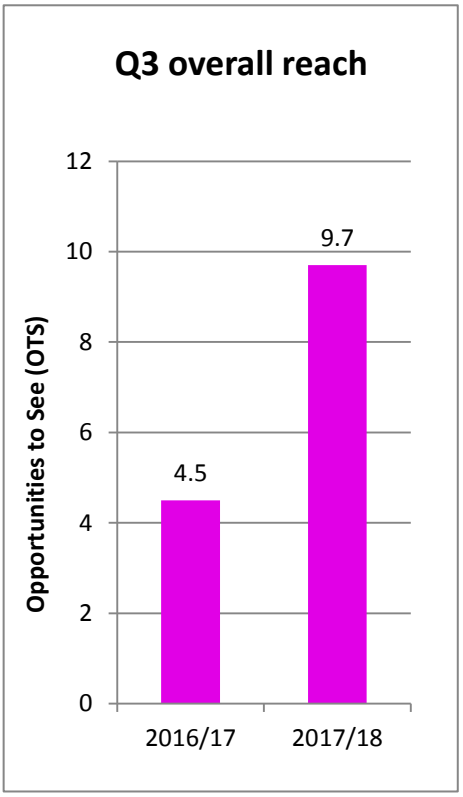
4. Comparative media coverage

4.1. Fig. 1 below represents a significant increase in volume of coverage and a doubling of opportunities to see, compared to last year's Q3.

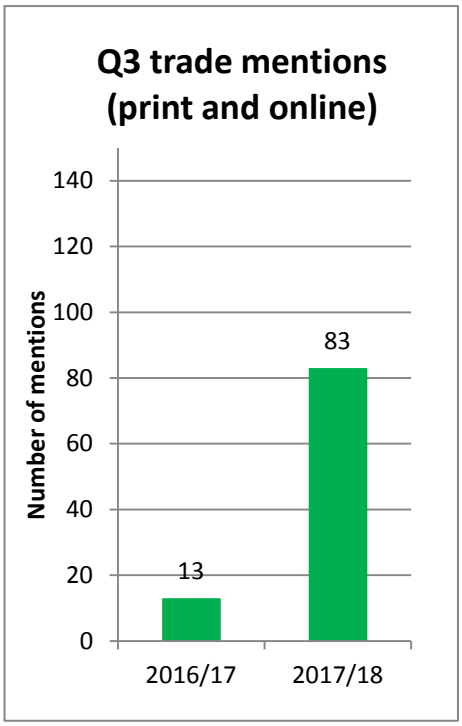
4.2. Fig. 2 represents the scale of the increase in trade coverage – a six-fold increase on Q3 last year, which can be directly attributed to the effort put into building links with the trade press and also stakeholder relationships with other organisations with substantial print and online audiences. In addition to trade news coverage of issues including mental health and access to dentistry, we have placed signed articles in GP Practice Magazine, the Journal of Community Nursing, Care Talk Magazine, and the NHS Providers Magazine.

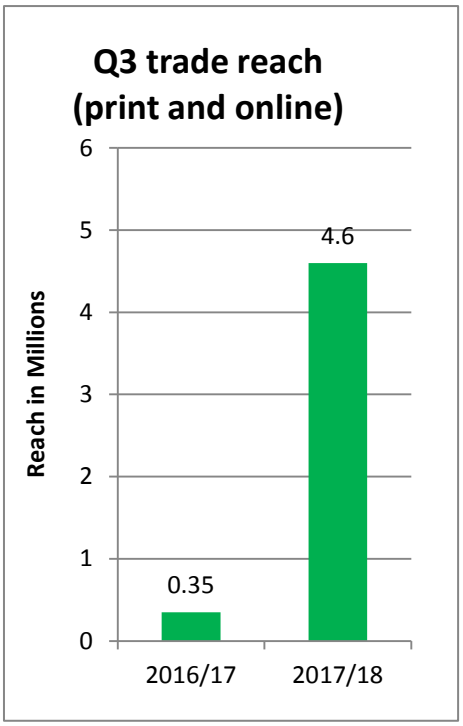
4.3. **Fig. 1: comparative overall performance (national, regional/local and trade)**





4.4. **Fig.2: comparative trade media performance**





5. Q4 activity

Subject to the Committee's approval of our new strategy, a substantial focus for the remainder of 2017/18 will be communicating our updated purpose, aims and approach to the public, to our network and to external stakeholders. Planning is underway to ensure that activity in 2018/19 will deliver the strategy effectively through a coherent business plan for consideration at the next Committee meeting.

Our discussions with local Healthwatch earlier in the year about use of the Committee's power to advise councils, together with the visibility of our approach in Staffordshire and our State of Support analysis, have encouraged other Healthwatch to feel they would like us to intervene in their own situations using the range of tools and techniques at our disposal. This is an important part of our activity in the current quarter. We are also further developing our framework to identify potential risks and challenges in the network, enabling us to tackle issues upstream.

In January our communications work has focused on highlighting the network's priority issues, publicising our future focus on mental health, raising awareness of our role in relation to the NHS England Mandate and our 6 proposals for inclusion in its updated deliverables, and encouraging people to share their experiences and

views with local Healthwatch through the #SpeakUp campaign. In the final two months of Q4, we will continue to focus on providing tangible examples of effective network activity and of how people speaking to their Healthwatch can make a real difference, alongside a further wave of strategy communication.

In Q4 we are also planning for our conference in October. Substantial planning is also underway in Q4 for the work we will be undertaking with partners in Q1-3 2018/19 as we lead the national conversation strand of the NHS70 celebrations.

There will be substantial activity this quarter with national stakeholders on a range of key policy issues, with a particular focus on the National Director's role on the expert advisory group informing development of the social care Green Paper. We are submitting evidence to the Health Select Committee's inquiry into Sustainability and Transformation Partnerships and Accountable Care, drawing upon our earlier work with the network but also using responses from our January survey of local Healthwatch. We are hopeful that this inquiry will proceed quickly enough for evidence to have been published in time for us to then make public use of this intelligence before the end of Q4.

Work to develop our mental health programme is underway and our messages about this new focus have been well received. We are in the process of procuring a supplier for the planned deliberative research as well as for a thorough literature review.

We are also seeking to procure literature reviews to support our work to identify and promote the value of public engagement and to provide us with a solid basis from which to build our approach to generating, capturing and describing our national and local impact.

The Committee will receive a report on Q4 delivery together with a 2017/18 delivery overview at its next meeting.

6. How we have made a difference in Q3, 2017-18

Helping local Healthwatch and stakeholders to learn and share

- Trained a further 70 staff and volunteers from 30 local Healthwatch on Enter and View.
- Brought together 70 local Healthwatch at 9 regional network meetings.
- 22 local Healthwatch took part in video production training to support their digital and social media activity.
- Trained 19 local Healthwatch staff on the new CRM Cases interface (recording of this webinar is available to whole network).

Supporting quality

- Provided updated local Healthwatch guidance on General Data Protection Regulations and delivered 2 awareness webinars to 73 staff from 35 local Healthwatch.
- Provided research support to 27 local Healthwatch through the research helpdesk (24 in Q2) and additional support through the Yammer research group. Reviewed 4 surveys and reports to advise local Healthwatch on quality.
- Delivered State of Support analysis of network funding to DH and wrote to Secretary of State identifying possible courses of action - covered in HSJ.
- Used statutory advisory power to ensure Staffordshire County Council tender specification covered statutory activities and put spotlight on funding proposals.

Receiving and using more network evidence

- Analysed 189 reports from 77 local Healthwatch (double the number in Q3 2016-17).
- Received and analysed 1,660 individual experiences from 46 local Healthwatch.
- 96 local Healthwatch using CRM (up from 83 in Q2).
- 50,000 unique visits to the Find Your Local Healthwatch webpage in Q1-Q3: up 28% on 2016/17.

Sharing insight and raising awareness

- In Q1-Q3 we have provided 11.8 "opportunities to see" our key messages (on how and why to interact with Healthwatch) per adult in England through our media and social media activity, in addition to our wider media and online reach.
- Published 2 briefings on hospital discharge looking at progress in improving people's experiences and analysing emergency readmissions.
- These reports helped inform development of DH integration score card and methodology behind CQC's local systems review. National Director shared findings at Inside Government conference on Ensuring Patient Safety through Effective NHS Discharge.
- We also spoke at a King's Fund event on 'Working with Patients and the Public'; NHS Clinical Commissioners (NHSCC) Lay Member Conference on the relationship between Healthwatch and CCGs; National Voices event on promoting public engagement amongst health and care professionals; and the Westminster Health Forum's Future of General Practice conference on our work on primary care feedback..
- Head of Policy shared findings of our work on prescriptions with NHS England and NHSCC at consultation event on low value medications.
- Working with the Local Government and Social Care Ombudsman we presented to the Quality Matters board updating progress developing the social care complaints tool.
- Published Annual Report to Parliament - for the first time providing an annual intelligence assessment of people's experiences across the key areas of health and social care.
- Following significant work in Q2, National Director was appointed to the expert advisory group on the Government's Green Paper on social care.
- Shared insight on NHS Continuing Health Care as part of DH review of the National Framework.
- Provided evidence on social care as part of Competition and Markets Authority review - leading to recommendation that Government should involve us in a review of complaints advocacy.
- Submitted formal advice to DH on what should be included in the refresh of this year's deliverables set out in the Mandate to NHS England - covered in HSJ.
- #ItStartsWithYou campaign phase 2 targeted GPs, supported by the BMA. Key media coverage secured in Pulse and a comment piece from National Director in Practice Business Magazine. Head of Policy reinforced messages at Westminster Health Forum conference on the Future of Primary Care.
- NHS Improvement's Dementia Assessment and Improvement Framework drew on our Dementia Briefing to guide directors of nursing and medical directors in how to achieve 'outstanding' care.
- Published Healthwatch network 2018 priorities list.
- 98 local Healthwatch took part in #SpeakUp 2018 - a 9% increase on 2017.

Giving the network the tools it needs

- Published call handling/signposting guidance for local Healthwatch.
- Published local Healthwatch communications guidance on audience insight and awareness.
- Published #SpeakUp campaign guide, tools and templates.
- Published communications planning calendar for 2018.
- 320 people and 28 local Healthwatch took part in website user research and testing to inform updated design for network websites.
- Use of online brand centre by local Healthwatch in Q1-Q3 up 55% compared to Q1-Q3 2016/17.

MEETING REFERENCE: CM180131
AGENDA ITEM No:2.3

AGENDA ITEM: Financial Update – Q3

PRESENTING: Joanne Crossley

EXECUTIVE SUMMARY:
This paper provides an update on the Q3 financial position for 2017/18

RECOMMENDATION:
Committee are asked to **NOTE** this report.

- As at Q3 we spent **£1.793m** of our Annual Budget, which equates to **62 %** of the total Annual Budget as at end December 2017.

- On Pay costs we spent **66%** of the Annual Budget as at end Q3. There were some staff movements during the quarter but we are close to where we expected to be on the budget plan for Pay at this stage.

- We spent **53%** of our Non-Pay budget against Annual Budget. The variance is mainly attributed the procurement process for certain activities which have been particularly slow.

1. Financial performance and position 2017-18 Quarter 3

The financial position at the end of Q3 is summarised below:

	2017-18 Annual Budget total	Spend as at end Q3	Variance (difference)	% of annual budget spent
PAY	£1,926,640	£1,284,985	£641,655	66%
NON PAY	£958,000	£508,124	£449,876	53%
TOTAL	**£2,884,640**	**£1,793,109**	**£1,091,531**	**62%**

Cost Centre	Description	Priority	%	Total Annual Budget (£)	Year to Date (£)			Forecast for 2017-18 (£)		
					Actual	Variance YTD	% Diff	Projected Spend 2017-18	Diff between Annual Budget and Forecast	% Diff
P35770	HWE - Staff Salary Costs	Priority 1	36%	659,564	438,544	221,020	34%	612,725	46,840	7%
		Priority 2	39%	724,134	463,100	261,034	36%	656,350	67,784	9%
		Priority 3	25%	452,942	275,563	177,379	39%	378,980	73,962	16%
P35770	HWE - Staff Non-Pay Costs			90,000	107,778	-17,778	-20%	129,778	-39,778	-44%
P35770	**Total HWE Establishment Costs Pay and Non-Pay**			1,926,640	1,284,985	641,655	33%	1,777,833	148,807	8%
P35775	To build and develop an effective learning and values based Healthwatch England			107,000	60,376	46,624	44%	106,876	124	0%
P35776	To provide leadership support and advice to local Healthwatch to have greater influence and impact			518,000	229,716	288,284	56%	266,466	251,534	49%
P35777	Bringing the public's views to the heart of national decisions about the NHS and social care			333,000	218,031	114,969	35%	358,906	-25,906	-8%
	Total Non-Pay			958,000	508,124	449,876	47%	732,249	225,751	24%
Grand Total				2,884,640	1,793,109	1,091,531	62%	2,510,082	374,558	13%

A further backlog of outstanding procurement requests had built up toward the end of Q3 awaiting approval, but these are now being cleared. However, we are at risk of not completing some work in time for financial year end and our projected forecast is that we will be significantly underspent by year end. Some of our requests were submitted later than planned which also played a part in the long procurement process.

We are currently reviewing our priorities and will aim to finish work already started for year-end completion. Activities which have not yet started pending approval may be either stopped completely or rolled over to the next financial year, if they align with our business plan for 2018-19.

We continue to have regular meetings with Commercial and Contracts to discuss our procurement pipeline, and to piggy back on existing CQC contracts (eg subscriptions) where appropriate.

MEETING REFERENCE: CM171024
AGENDA ITEM No: 2.4

AGENDA ITEM: Quarter 3 2017/18 Performance Report

PRESENTING: Imelda Redmond

EXECUTIVE SUMMARY: The report details the KPIs for Quarter 3 2017/18.

RECOMMENDATIONS: The Committee is asked to **NOTE** the Quarter 3 KPIs and Delivery Performance

1. Background:

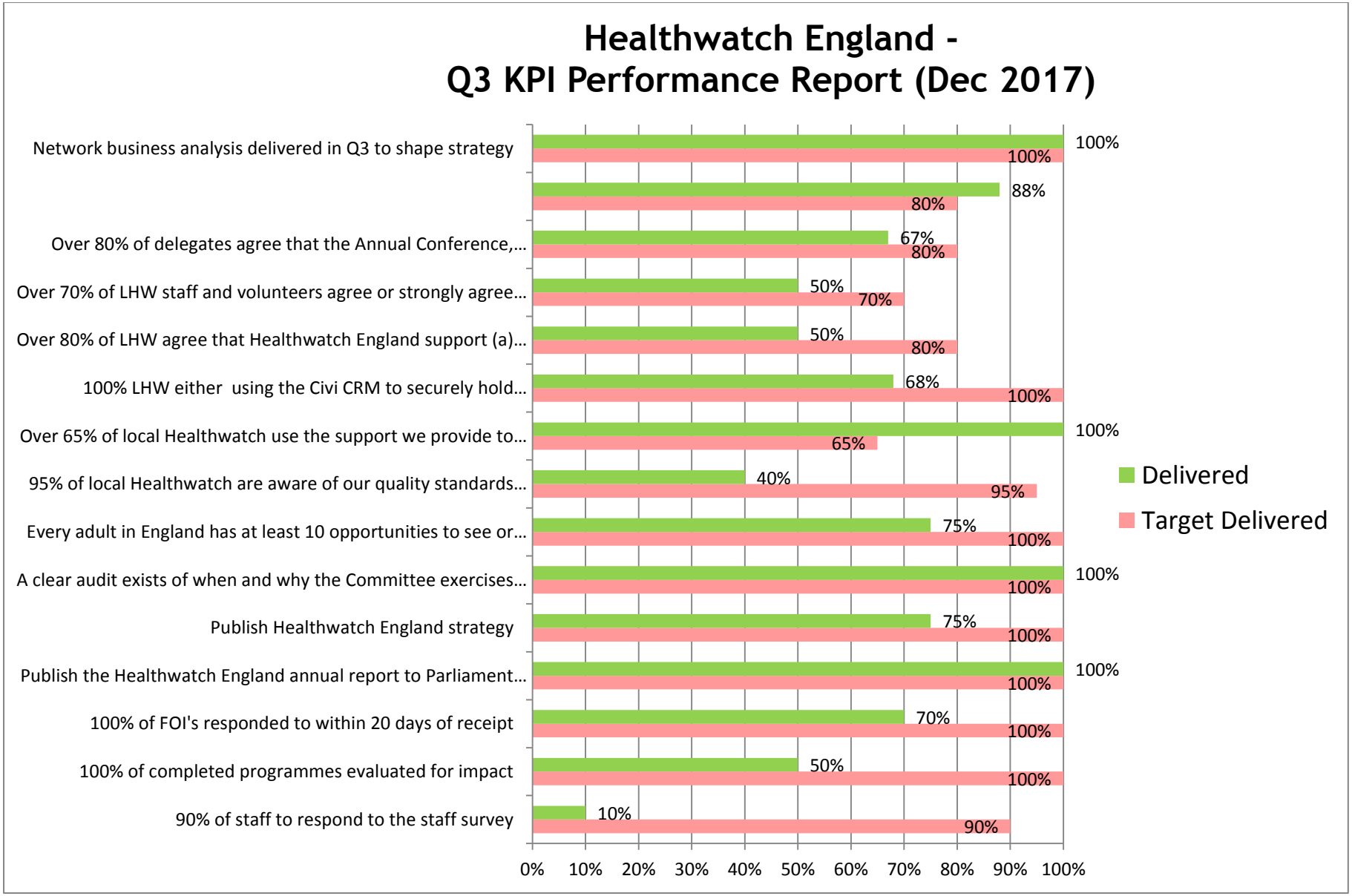
1.1 The Leadership Team looks at the full set of KPI's at our monthly meetings.

1.2 At a high level; at the end of Quarter 3 all but 1 KPI are on track. This is not a concern as we expect this KPI to be delivered in Quarter4.

HEALTHWATCH ENGLAND - QUARTER 3 KPIs PERFORMANCE REPORT

Key: Completed | On Track | Below Target No Concerns

Key Performance Indicators	Target Status	Performance Progress
Network business analysis delivered in Q3 to shape strategy.	Completed	**100%**
Over 80% of delegates agree that the Annual Conference, workshops (a) improved their Knowledge and skills and (b) will help them run their organisations better.	On Track	**88%**
Over 80% of delegates agree that the Annual Conference, workshops will help them run their organisations better.	On Track	**67%**
Over 70% of LHW staff and volunteers agree or strongly agree that the information we provide is useful and valuable.	On Track	**50%**
Over 80% of LHW agree that Healthwatch England support (a) enhanced their ability to engage effectively (b) helped them use their intelligence to influence stakeholders.	On Track	**50%**
100% LHW either using the Civi CRM to securely hold information or providing HWE with data that can be pulled into the HWE CRM.	On Track	**68%**
Over 65% of local Healthwatch use the support we provide to produce their annual reports.	Completed	**100%**
95% of local Healthwatch are aware of our quality standards for research, evaluation and information sharing.	Below Target (no concern)	**40%**
Every adult in England has at least 10 opportunities to see or hear messages about how and why to share experience with local Healthwatch, with numbers visiting "Find Your Local Healthwatch" up 40% to 80,000.	On Track	**75%**
A clear audit exists of when and why the Committee exercises its advisory functions.	Completed	**100%**
Publish Healthwatch England strategy.	On Track	**75%**
Publish the Healthwatch England annual report to Parliament on time.	Completed	**100%**
100% of FOI's responded to within 20 days of receipt.	On Track	**70%**
100% of programmes evaluated for impact.	On Track	**50%**
90% of staff responds to the staff survey.	Delivery Due Feb 2018	**10%**


Healthwatch England -
Q3 KPI Performance Report (Dec 2017)
Network business analysis delivered in Q3 to shape strategy
Over 80% of delegates agree that the Annual Conference,...
Over 70% of LHW staff and volunteers agree or strongly agree...
Over 80% of LHW agree that Healthwatch England support (a)...
100% LHW either using the Civi CRM to securely hold...
Over 65% of local Healthwatch use the support we provide to...
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Every adult in England has at least 10 opportunities to see or...
A clear audit exists of when and why the Committee exercises...
Publish Healthwatch England strategy
Publish the Healthwatch England annual report to Parliament...
100% of FOI's responded to within 20 days of receipt
100% of completed programmes evaluated for impact
90% of staff to respond to the staff survey
100%
100%
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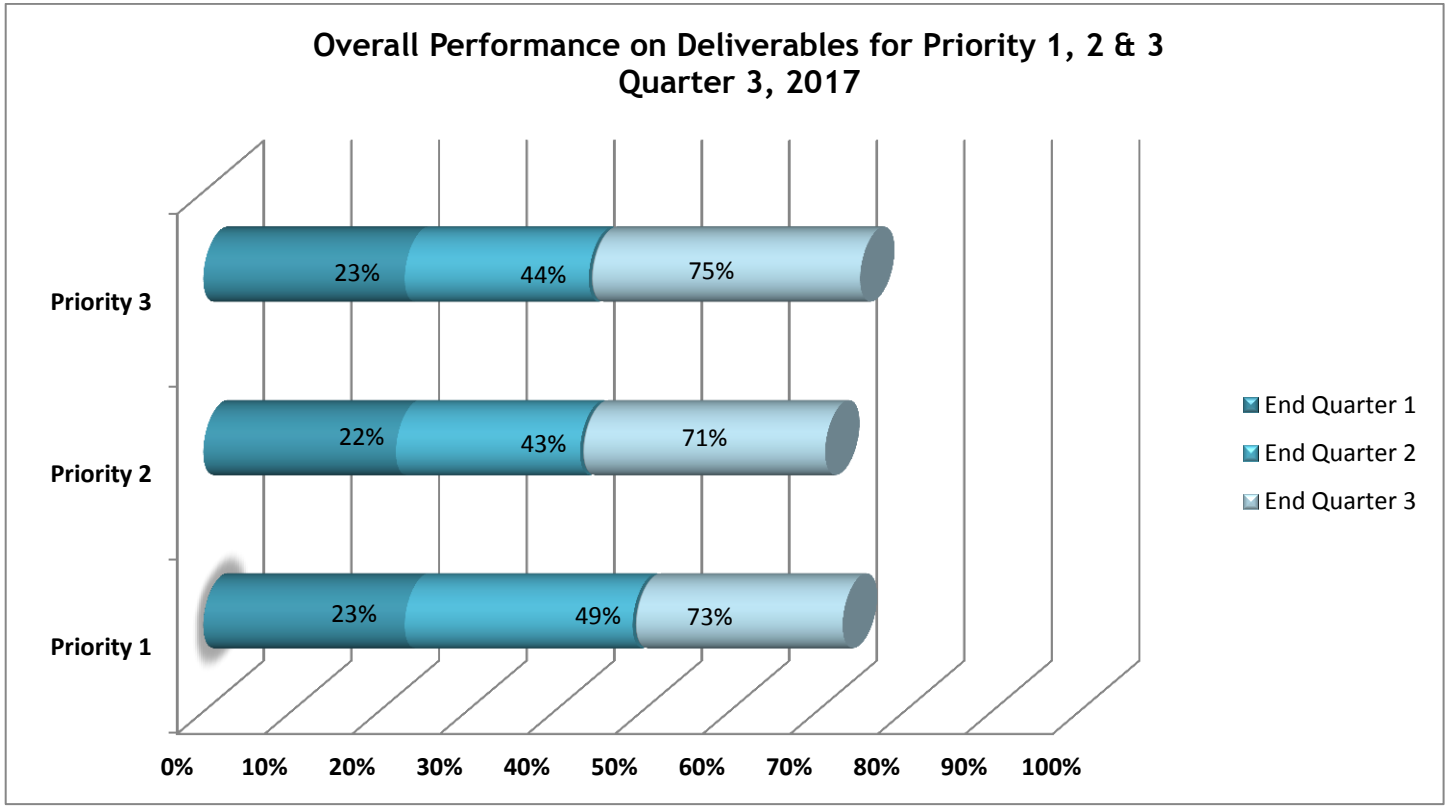
90%
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Delivered
Target Delivered

KPIs Low Target Performance		
KPI	**Current Progress %**	**Reason for Delay**
90% of staff to respond to the staff survey	10%	A Healthwatch England staff survey will now be rolled out in Feb 2018 as CQC is currently experiencing some procurement delay in purchasing the software required to conduct the survey.



MEETING REFERENCE: CM180131
AGENDA ITEM No: 2.5

AGENDA ITEM: Summary of audit completed by PricewaterhouseCoopers

PRESENTING: Deborah Fowler

This paper compares the recommendations suggested following an information Governance internal audit in Feb 2015 and a review audit in Oct 2017.

RECOMMENDATIONS: Committee are asked to **NOTE** this report

Background

In February 2015, PWC conducted an internal audit of Healthwatch England's information governance arrangements. Following this audit Healthwatch England received a **limited** rating and 14 recommendations - 4 high risks, 5 medium risk and 5 low risks.

On completion of all 14 recommendations PWC conducted a review audit. The two areas they looked at was governance and risk management. Healthwatch England received the following 2 low risk recommendations and a **moderate** rating:

1. **Governance** - The HWE Committee should review the Standing Orders to assess whether they remain appropriate and to identify whether any changes are required to be made. Thereafter they should be subject to periodic review, perhaps every 24 months or whenever any major changes to other governance arrangements take place.

2. **Risk Management** - Once the strategy for 2018/19 and beyond has been established, the HWE risk register should be reviewed and updated as necessary, with a clear linkage between strategic objectives and the risks.

Recommendations from both audits are listed in the table below. The comparison shows the improvement made to our governance and risk management process since 2015.

Internal Audit Comparison Table

For Feb 2015 & Oct 2017

RISK RATING - FEB 2015	FEBRUARY 2015 INTERNAL AUDIT RECOMMENDATIONS
1.1 High	Information Risk Accountability & Governance HWE and CQC should clarify the position of information risk accountability. If CQC are deemed to be ultimately accountable, an assurance framework will need to be established and closer engagement on information governance between the two organisations (i.e. HWE could be represented at CQC Information Governance Group; annual IG statements provided to CQC from HWE).
1.2 High	HWE should continue to formalise information governance roles as a matter of good practice. A senior executive should take on a role to champion IG and be responsible for providing assurances to HWE's sub- committee.
2 High	**Information Governance Policies** HWE should review CQC IG-related policies and procedures and identify where the principles are restrictive or are not within its own risk appetite. HWE should engage with CQC to determine how this can be managed and compliance ensured.
3 High	**Password Sharing** Password sharing should stop with immediate effect. HWE should discuss with CQC and ATOS to establish a more appropriate solution and control for access to business email (i.e. Delegated Access).
4.1 High	**Information Asset Register & Classification** An information audit should be undertaken to understand all information assets used at HWE. The results of the audit should be used to develop an information asset register. The register should record the type of information; its purpose; its risk/value; and its classification (as per CQC policy).

RISK RATING - OCT 2017	OCTOBER 2017 INTERNAL AUDIT RECOMMENDATIONS
1 Low	**Governance** The HWE Committee should review the Standing Orders to assess whether they remain appropriate and to identify whether any changes are required to be made. Thereafter they should be subject to periodic review, perhaps every 24 months or whenever any major changes to other governance arrangements take place.
2 Low	**Risk Management** Once the strategy for 2018/19 and beyond has been established, the HWE risk register should be reviewed and updated as necessary, with a clear linkage between strategic objectives and the risks.

4.2 High	The IAR could also be presented to the Audit & Risk Sub-Committee periodically to provide them visibility of the scope of information being used and for assurance. The IAR will demonstrate how information risk has been assessed and classified for the purposes of managing information risk.
4.3 High	HWE should consider using SharePoint as a secure online portal for Committee Members to access meeting packs.
5 Medium	**Information Strategy** An Information Strategy should be established to articulate how HWE aims to use information to support its mission and corporate objectives. This should cover all aspects of information – electronic; paper; information security; data quality and management information.
6.1 Medium	**Information risk register & risk assurances** An information risk register should be established. The risk register should link to the objectives of the Information Strategy and also cover wider operational risks. Where appropriate, key information risks should be escalated to HWE's strategic and operational risk register.
6.2 Medium	Periodically, the information risk register should be presented to Audit & Risk Sub-Committee for Members to have visibility and to challenge and seek assurances how information risks are being managed.
7.1 Medium	**Information Asset Owners** Information Asset Owners should be identified and recorded within the IAR (see #5). Training should be given to IAOs to help them perform their role. Information Asset Administrators (IAAs) could be considered to support the IAO in discharging its responsibilities.
7.2 Medium	Information Asset Owners (Operational Managers Team) have been identified. Training will be developed in conjunction with the development of the information asset register with CQC colleagues.
	Information Governance Training,

8.1 Medium	**Education & Awareness** Information governance training should be included as part of induction for any new member of staff (permanent or temporary). There may be an opportunity to work with CQC and integrate in to their IG induction process.
8.2 Medium	The results of the annual IG refresher training quiz should be assessed. A pass threshold (e.g. 80%) should be introduced, where re-take is required until the member of staff passes. Completion and pass rates could be reported to HWE's senior leadership.
8.3 Medium	Periodic communications should go out to staff on the latest IG risks and issues. This is potential for HWE to work with CQC to be included in their awareness campaigns.
9 Medium	**Incident Management Procedures** HWE should communicate to staff what constitutes an 'incident' and the appropriate incident management procedures to follow.
10 Low	**Records Management – Document Retention** A retention policy should be established for information being recorded and maintained by HWE or HWE information assets should form part of CQC's retention policy.
11.1 Low	**Tracking Subject Access Requests & Freedom of Information Act Requests** A system to record and track Subject Access Requests and Freedom of Information Requests should be created. This should be available to the Information Officer and the Head of Operations.
11.2 Low	Subject access requests and related response documentation should be stored in a folder with restricted access on the Y drive.
12 Low	**Information Governance Compliance** An information governance compliance regime should be established, with a summary of the results of compliance being provided to Audit & Risk Committee periodically.
13	**System Security Accreditation** It should be clarified whether all major

Low	system changes or new systems should be subject to CQC policy and require their assessment and accreditation.
14.1 Low	**<u>Supporting the Local Health Watch Network with IG</u>** HWE should identify the best mechanisms to assess level of IG awareness across the LHW network to gauge the support / IG topics to be targeted.
14.2 Low	Where information governance issues arise from the annual report review process, this should be fed-back to the individual LHW and if necessary built in to other IG support targeted at the network.

MEETING REFERENCE: CM180131
AGENDA ITEM No: 2.6

AGENDA ITEM: Strategy engagement update

PRESENTING: Imelda Redmond

FOR INFORMATION: Committee are asked to (a) **APPROVE** the Healthwatch England Strategy and (b) **SHARE** any views they may have on the supporting strategic narrative (c) **NOTE** for information the paper on how your powers and duties align with our objectives

BACKGROUND

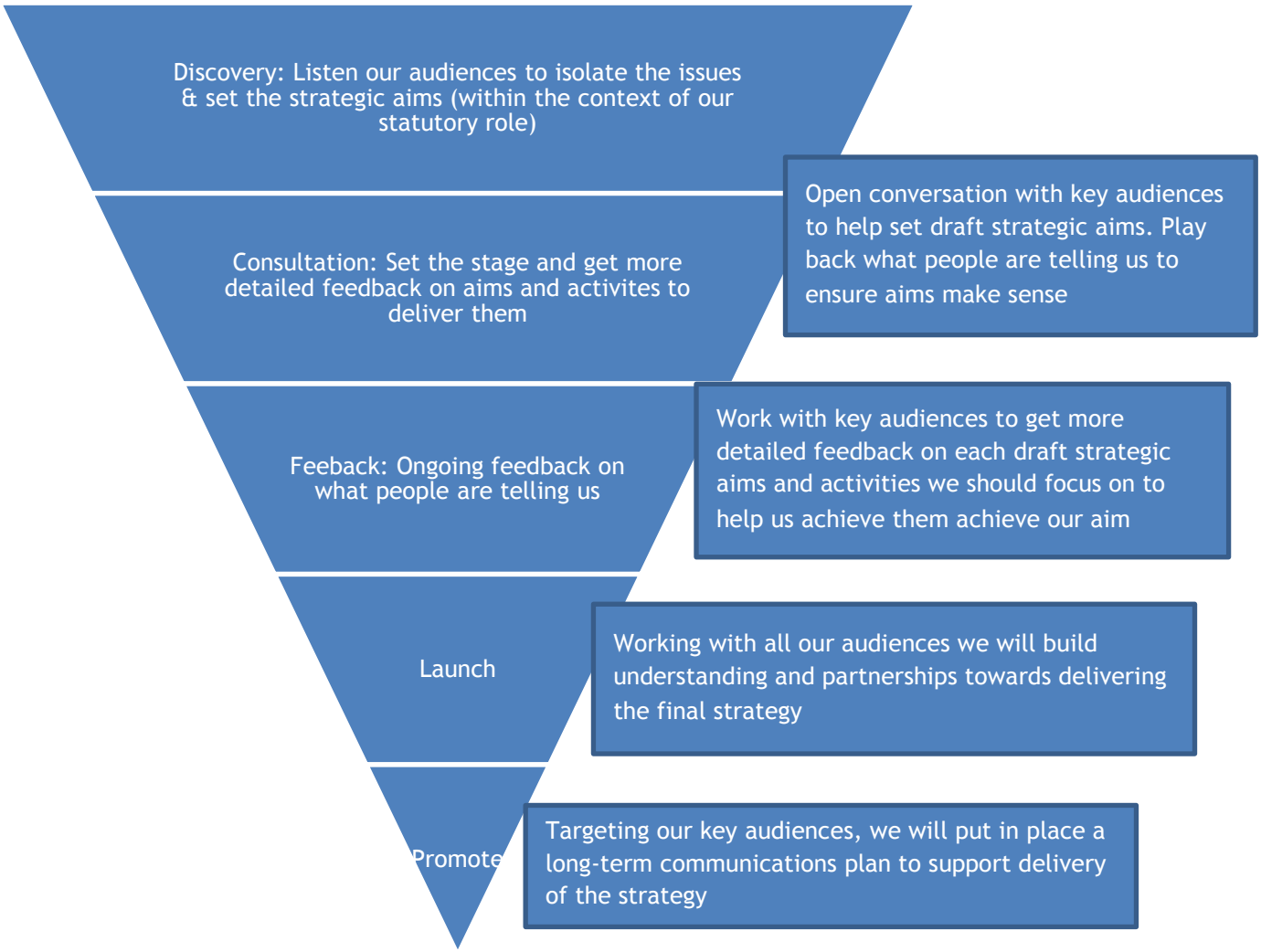
Goal: In March 2017 the Committee agreed to develop a new strategy for Healthwatch England, which we would also encourage local Healthwatch to adopt.

The goal at the outset was to develop a 'a compelling narrative – supported by the public, stakeholders and the network - that sets out how we will make the biggest difference to ensuring people's health and social care needs are heard, understood and met'.

Scope: The Committee agreed that the strategy should look at a number of strategic areas:

- Vision – What the world would look like for users of health and social care services if we were successful?
- Purpose – Given our statutory remit, what should be the primary job of Healthwatch England and local Healthwatch should be?
- Context – What are the biggest challenges we face, as well as the opportunities we could take advantage of to make the greatest impact?
- Aims - Where we should focus our efforts to have the biggest impact?

Engagement approach: The strategy was developed using a phased approach



The development of the strategy has included:

- Workshops: x3 Committee workshops, x3 Healthwatch England staff workshops
- Event sessions: x14 sessions at local Healthwatch network events x3 sessions at Healthwatch 2017 conference, x4 sessions at Healthwatch commissioner events.
- Public engagement: x2 phases of public engagement via our website, social media, email marketing and local Healthwatch activity.
- Stakeholder: x40 face to face meeting and events with charity, NHS, social care and other stakeholders.

Previous Committee Decisions: During the development of the strategy, Committee made the following decisions following feedback:

- A refreshed vision and mission
- To replace our existing values with a statement setting out what people could expect from us in terms of our approach.
- A strategy time-frame of five years focussed on the following objectives:
    - Empowering more people to their say
    - Providing a high quality Healthwatch service
    - Making sure people's views help improve health and social care

STRATEGY AND SUPPORTING PAPERS

Following this phased development approach, the following documents have been developed for your approval and information:

Annex	Name	Purpose
A	Healthwatch England Strategy	**To approve:** To set out on one page our top level ambitions and strategic direction over the next five years
B	Our strategy explained	**For comment:** To provide further information for the public about our strategy and the changes we want to achieve by 2023. This will be published alongside the final strategy.
C	Powers and duties	**For information:** To provide the Committee with an overview of how our strategic aims link to the discharge of the Committee's powers and duties, as well as Equalities and Human Rights legislation.

IMPLEMENTATION

Publication: Once the strategy has been approved by Committee, our aim will be to send the strategy to the CQC board. Following this we aim to publish the final report in March 2018. Alongside this we will also publish our equalities impact assessment.

Road map and business plan: In December 2017, Healthwatch England staff started planning the implementation of the objectives set by the Committee. The plan, which will be presented to the Committee at their 28 March 2018 Committee Workshop, will detail our business plan for 2018/19, an overview of how we will allocate resources, as well as providing a road map of the outcomes we want to achieve in year three and five of the strategy.

Transition and adoption: The focus of our work in 2018/19 will be on (a) moving away from commitments not covered by the strategy (b) working with local Healthwatch to understand and adopt the new strategic vision, mission, purpose and aims and, (c) setting up and embedding the new programmes of work required to deliver the strategy.

Review points: Like any strategy, we will need to refine our approach to respond to changing circumstances. Given this we propose reviewing the strategy after six months and then tracking progress towards our goals as part of our annual business planning process. As part of our annual report to Parliament we will also report on progress towards achieving our strategy. This approach will also enable us to take into account any issues identified while encouraging the wider network to adopt the new approach. We plan to report on the findings of this review at the September 2018 Committee Workshop.

Appendix to Strategy paper

Statutory duties and powers

The Committee wishes to assure itself and to be able to assure the CQC Board and DHSC that the strategy will discharge the relevant legal duties and make effective use of the Committee's powers.

The following table maps the duties and powers against the strategic aims.

	Health and Social Care Act duties	**Strategic Aim**
1	When performing its functions the Committee must have regard to aspects of Government policy as directed by the Secretary of State.	Cross-cutting as this direction could relate to 1 and 2, but most relevant to 3 in relation to stakeholder activity.
2	To make a report each year to CQC on the evidence we have gathered and how we have discharged our functions.	Formally relates directly to 2 and 3, though in reporting we are also likely to decide to highlight activity under theme 1.
3	To lay a report before Parliament about how we have discharged our functions, which also has to be shared with the Secretary of State and local Healthwatch.	Direct link to 3.
4	Provide general advice and assistance to local Healthwatch in relation to their statutory functions.	Formally links to 2, but in discharging this duty our activity will link to 1 and 3.
	Health and Social Care Act powers	
5	Make recommendations to local authorities about the provision of local Healthwatch functions and to give them written notice when we are of the opinion these functions are not being carried out.	Direct link to 2.
6	Provide information and advice (requiring a public response) to the Secretary of State, NHS England, Monitor (NHS Improvement), local authorities and CQC on: • The views, experiences and needs of people in terms of health and	Direct link to 3 but also relates to 1.

	social care services. • The views of local Healthwatch (and other persons) on the standard of service provision and whether or how standards could or should be improved.	
7	To publish other reports on health and care as and when we think appropriate.	Direct link to 3.
	Equality Act duties	
8	In common with other public bodies we have public sector equality duties to: • Remove or minimise disadvantages suffered by people due to their protected characteristics. • Take steps to meet the needs of people from protected groups where these are different from the needs of other people. • Encourage people from protected groups to participate in public life or in other activities where their participation is disproportionately low.	Direct link to 1 and 3, and under 2 support local Healthwatch to do this. Direct link to 1 and 3, and under 2 support local Healthwatch to do this. Direct link to 1, and under 2 support local Healthwatch to do this.
	Human Rights Act duties	
9	Ensure our work: • Is underpinned by the human rights principles of fairness, respect, equality, dignity and autonomy. • Responds to the needs of different groups and individuals and every section of the community. • Takes into account the protected characteristics of age, disability, sex, gender reassignment, pregnancy and maternity, race, sexual orientation, religion or belief, and carers.	Cross-cutting but also direct link to 1. Direct link to 1 and 3, and under 2 support local Healthwatch to do this. Direct link to 1 and 3, and under 2 support local Healthwatch to do this.

2.6 Appendix -- Health and care that works for you - Our strategy 2018-2023

This strategy sets out our ambitions and the difference we want to make by 2023 in partnership with local Healthwatch

Our vision: Health and care that works for you.

Our purpose: To find out what matters to you and help make sure your views shape the support you need.

Our approach: People's views come first - especially those who find it hardest to be heard. We champion what matters to you and work with others to find solutions that work. We are independent and committed to making the biggest difference to you.

Our starting point: People want health and social care support that works for them - helping them stay well, get the best out of services and manage any conditions they face.

The wider context: Our society faces big challenges. A growing number of people need help with long-term health conditions, while illnesses associated with our lifestyle are adding to pressures on services. People know that to get the support they need, the traditional approach to providing health and care must change. People want to help by taking control of their own health and care. They understand that information and technology can potentially help. However, to better meet their expectations services need to treat them as equal partners, find out what people need and use this information to provide targeted support.

Our aims	1. Support you to have your say *We want more people to get the information they need to make decisions about their wellbeing, care and the services that support them.*	2. Provide a high quality service to you *We want everyone who shares experiences or seeks advice from us to get a high quality service and to understand the difference their views make.*	3. Ensure your views help improve health and care *We want more services to use your views to shape the health and care support you need today and in the future.*
Our goals by 2023	Over one million people share their views or seek information from us each year.	Every person who shares a view with us understands the difference this has made.	Twice as many recommendations we make are implemented by services.
Challenges	Not enough people know how to have their say.	Lack of consistency and resources across the Healthwatch network.	Attitudes of some professionals towards involving people in their care.
Tactics	● Identify who is not being heard ● Provide the information people need to act ● Use partnerships to reach more people	● Establish common quality standards ● Focus on productivity and effectiveness ● Invest in staff and volunteer skills	● Produce strong evidence which those who work in health and care can use ● Demonstrate how people's voices make a difference
What we will do	● **Insight:** Research to understand our audiences, target engagement and track changing behaviour over time. ● **Brand:** Ensure our communications work in harmony to raise awareness, build trust and increase engagement with Healthwatch. ● **Digital:** Invest in a unified system to gather, understand and share people's experiences of care. ● **Partnership:** Work strategically with community and professional groups to hear and share what people want from care. ● **Impact:** Establish common ways to measure the effect of our work and continuously improve quality. ● **People and money:** Invest in attracting, training and retaining volunteers and staff. Share common services across Healthwatch to increase productivity.		

Our strategy explained

An introduction

The journey so far

The Health and Social Care Act 2012 set a powerful ambition to put people at the centre of health and care. To make this happen, the reforms created a local Healthwatch in every area of England, as well as Healthwatch England as the national body.

Our goal has always been to understand the needs, ideas and experiences of every section of the community and ensure they are heard by the people making national decisions about health and social care. We also support local Healthwatch to do this across the country.
Thanks to the thousands of people who have shared their views, and the readiness of services to listen, we've been able to make an impact on a range of issues over the past five years. We've come a long way since we were established. Our network is driven by volunteers and staff who speak to people every day to find out what matters most, and work with partners to help make change happen.

Looking ahead

In a rapidly changing world we need to go further. More people continue to need help with long-term health conditions, while lifestyle factors, such as a poor diet, are adding to the number of individuals who need support from services.
At a time of unprecedented pressure, it has never been more important for services to find out what people need and use this information to provide better, more targeted care.
The public recognise the challenges that services face. They want to help by taking control of their own health and care and becoming equal partners in decisions that affect them.

Making a bigger difference

We believe greater public involvement in health and social care is critical to overcoming the challenges our society faces. This is why in 2017 we asked the public, our staff and volunteers to help shape our future strategy.
We invited people to share their views about our role and what the world of health and social care would look like if we were successful. We also asked people to tell us the biggest challenges we face, the opportunities we can take advantage of and how the Healthwatch network could work differently to have an even greater impact.
We heard about the main issues people thought we should focus on to help make health and social care services work better for them. Our strategy draws on the ideas and views that people shared with us and explains what we want to achieve over the next five years.

Our vision

Health and care that works for you

People want health and social care support that works - helping them to stay well, get the best out of services and manage any conditions they face.
This means a future where:

- You are in control of your own health, care and wellbeing
- You can get the information you need to look after yourself
- You can access efficient, high-quality care when you need it, on an equal basis with others
- Services work with you to achieve the best outcomes for you
- Communities help set health and social care priorities and services are accountable to them.

Our purpose

To find out what matters to you and to help make sure your views shape the support you need.

To achieve the future that people want, we believe our role should:

- Assist you to have a greater say in your own care and the services that support you
- Help to make sure that your views are used to shape health and care policy and practice
- Encourage services to be more inclusive and focus on people's needs
- Support communities to hold services to account; and
- Provide leadership to local Healthwatch and support them to be as effective as possible.

Our approach

People's views come first - especially those who find it hardest to be heard. We champion what matters to you and work with others to find solutions that work. We are independent and committed to making the biggest difference to you.

To enable this to happen, it's important that everyone understands the approach we will take to our work and what they can expect from us.

Challenges and opportunities

The traditional approach to meeting people's health and social care needs is changing. Our society faces big challenges when it comes to making sure people have the support they need.
There are also significant opportunities for services to better meet people's expectations and for individuals to take greater control of their own health, care and wellbeing.
We want to take advantage of the opportunities available to not only make the greatest impact, but also to overcome these challenges.

Opportunities	Challenges
• Use technology to help more people share their views • Partner with charities, universities and think tanks • Maximise the use of our evidence and statutory powers • Influence health and social care reforms • Improve public awareness of health and care challenges • Encourage the public to get involved with decision-making	• Rising demand for care linked to lifestyle factors • Services face staffing and funding pressures • Public awareness of how to take control of their health • Professional attitudes to involvement and inconsistent practice • Variation in access to care and support • Impact on health, caused by wider social factors, like housing

2018 – 2023 - Our future focus

Over the next five years, we want to make the biggest difference by:

- Supporting you to have your say
- Providing a high quality service
- Ensuring your views help improve health and care

1. Supporting you to have your say

Our aim: To help more people access the information they need to take control of their health and care, make informed decisions and shape the services that support them.

Where we are now: Last year, around 176,000 people contacted Healthwatch for information and advice about health and care services and 341,000 individuals shared their ideas and experiences with us.

Our goal: We want to double the number of people we support over the next five years. By 2023, we want to help over a million people share their views or find the information they need to get the right support each year.

The main challenge we face: Not everyone knows how to have their say or has the opportunity to do so. Not everyone can access the information they need to make decisions about their care or help shape the services that support them.

Tactics to help achieve our goal:

- Identify who [in the diverse communities we serve] does not know how to have their say and finds it hardest to be heard
- Provide the information people need to act
- Work in partnership, nationally and locally, to reach more people [and target those whose views are not understood by services].

Signs of success:

2018	2021	2023
• We understand and can track public awareness, attitudes, and experience of being involved in care • We have identified the information people want to know to take control of their health and care • We have increased awareness and understanding of Healthwatch	• We provide common ways for people to get or find the information they need to have their say • We run campaigns across England to target those who find it hardest to be heard • We are working with schools, universities and others to empower more young people to have their say	• More people know their rights, and can access the information they need to make the decisions about care and the services that support them • More people are confident about how to be an equal partner in their care

2. Provide a high quality service to you

Our aim: To help ensure that everyone who shares an experience or seeks advice from us receives a high quality service and understands the difference their views have made.
Where we are now: We currently do not have a common way of measuring the quality of service across Healthwatch or the impact of our work.
Our goal: To ensure our staff and volunteers have the skills and tools they need to provide a high quality service. By 2023, we want to be able to tell anyone who shares their view how this has made a difference.
The main challenge we face: The funding local Healthwatch receives from local authorities to carry out its work can vary from area to area. We do not have a collective way of ensuring that the service we provide to people is always consistent and quality based.
Tactics to help achieve our goal:

- Establish a common way to measure the impact of our work and the quality of our service
- Focus on securing the resources we need and the ways in which we can boost our productivity and effectiveness
- Invest in developing the skills and knowledge of our staff and volunteers

Signs of success:

2018	2021	2023
• Our staff and volunteers understand our vision, purpose and approach and their role in delivering our strategy • We update the support and training we provide to our staff and volunteers • We have a common way of measuring the impact and quality of our service	• Our staff and volunteers say Healthwatch is a good place to work and that we help them build the skills they need • The majority of people who use our service report a good quality experience • Our commitment to equality, diversity and human rights is embedded in our day-to-day work with communities, colleagues and partners • We make the most of our volunteers' talent by supporting more of them to champion and	• Our people reflect the diverse communities in which we work • We can demonstrate the added value our work has on society • The number of people reporting a good quality service from Healthwatch has increased

	represent the views of their community	

Ensuring your views help improve health and care

Our aim: To ensure your views are used by professionals to shape the health and care support that works for you, today and in the future.

Where we are now: Last year, Healthwatch published 1,745 reports about people's experiences to show professionals what is working and what could be better when it comes to the support they provide. We estimate that around four in ten of the recommendations we make are currently adopted by services.

Our goal: To transform the way health and social care professionals use our evidence over the next five years. By 2023, we want twice as many of the recommendations we make to be implemented.

The main challenge we face: Not all health and social care professionals see the value of using people's views to improve support. The evidence we and others hold is not always easy to access.

Tactics to help achieve our goal:

- Focus on producing strong evidence that professionals can easily access and act on
- Demonstrate how using people's views can improve the effectiveness of services

Signs of success:

2018	2021	2023
• We understand and can track professional awareness, attitudes and experience of involving people in care • Services understand the economic and quality benefits of involving people • A network of health and social care professionals to promote and champion the value of public involvement exists	• More professionals understand our role and report a positive change in attitude towards involving people in care • Evidence about people's views of health and care can be easily accessed and reflects the diverse communities we serve • We have helped services understand and adopt better ways of mobilising their communities to solve problems	• The NHS and social care services use people's experiences of care to measure their performance • The involvement of people in shaping care is a core subject in the education of health and social care professionals • Every section of the community plays a greater role in setting health and care priorities

Steps to achieving our aims

To deliver our strategy, we will produce a yearly plan setting out our priorities and telling you how well we are doing.

Over the next five years, there are six key areas that we will focus on to achieve our aims:

1. **Insight:** Undertake research so that we fully understand the needs of our audiences. We will use this evidence to improve the way we target our work and track changing behaviour over time.
2. **Brand:** Put in place a strategy to ensure that what we say and how we communicate is consistent across the network. We will work together to raise awareness, build trust and increase engagement with Healthwatch.
3. **Digital:** Make the most of technology to enable more people to share their ideas, experiences and views with health and social care professionals.
4. **Partnerships:** Work strategically with community and professional groups, think tanks, universities and others to target our engagement and make our findings widely available to help inform decision-making.
5. **Impact:** Establish common ways to measure the effect of our work, so that we can demonstrate the value of speaking up and continue to improve the quality of our service.
6. **People and money:** Invest in attracting, training and retaining the best volunteers and staff. Identify duplication of work and invest in shared services and consistent approaches to increase our productivity and effectiveness.