HEALTHWATCH ENGLAND – PUBLIC COMMITTEE MEETING

Wednesday 25th September, 1.30pm – 4.30pm

Holiday Inn, Plymouth, Armada Way, PL1 2HJ

AGENDA

13.30 – 13.35
Welcome, Actions and Declarations

1.	**Welcome and apologies**	The Chair will open the meeting.
2.	**Minutes of last meeting, actions log and matters arising**	Members are invited to CONFIRM the minutes of the last meeting and DISCUSS any matters arising.
3.	**Declarations of interests**	Members are invited to DECLARE any interests they have in items appearing on the agenda.

13.35 -14.20
Business Updates

4.	**The Chair's Report**	The Chair will provide an update on forthcoming strategic plans and any other topical items. Members are invited to DISCUSS the report.
5.	**The Chief Executive's Report**	The Chief Executive will provide an update on operational work progress, including a report on the first quarter. Members are invited to DISCUSS the report.
6.	**Members' Updates**	Members are invited to update the Committee on any other topical items. Members are invited to DISCUSS the updates.

14.20 -14.40
Governance

7.	**Strategic Partnerships**	The Chief Executive will provide an update on the development of our strategic partnerships with NHS England. Members are invited to DISCUSS. Members are invited to APPROVE the Memorandum of Understanding with Department of Health.
8.	**Transitional Members**	Members will be invited to APPROVE the process for selection of transitional members.

14.40 – 16.00
Issues, Organisational Development and Future Planning

9.	**Local Healthwatch Engagement to date and next steps**	Members will be provided with an update on local Healthwatch. Members will be invited to DISCUSS next steps.
10.	**Public Policy Update**	Members will be invited to DISCUSS and APPROVE the approach to using our advisory powers and APPROVE themes for special reports. Members will be provided with an update on our response to the recommendations of Francis, Keogh and Berwick and invited to DISCUSS and APPROVE next steps.
11.	**Intelligence Update**	Members will be provided with an update on information governance and invited to DISCUSS and APPROVE next steps.
12.	**Organisational Development**	Members will be provided with an update on organisational development and invited to DISCUSS.

16.00-16.30
Public Participation

13.	**Public Participation Session**	This is an opportunity for members of the public and other interested parties to bring to the committees attention issues or information of public interest.

AGENDA ITEM 2 – PREVIOUS MINUTES

HEALTHWATCH ENGLAND – COMMITTEE MINUTES

12th June, The Sage, Gateshead

Present (Committee Members): Anna Bradley (Chair), John Carvel, Michael Hughes, Jane Mordue, David Rogers, Dag Saunders, Dave Shields, Patrick Vernon, Christine Vigars, Alun Davies, Christine Lenehan, Jane Macfarlane.

In attendance: Dr. Katherine Rake (Chief Executive), Gerard Crofton-Martin (Policy Manager), Liz Prudhoe (Strategic Lead, Healthwatch, Northumberland), Kara Danks, (Carers Federation), Grahame Tinsley (Senior Performance and Planning Manager), Susan Robertson, (Local Healthwatch Development Manager)

A full recording of this session is available at www.healthwatch.co.uk

AGENDA ITEM 1

WELCOME

The Chair opened the meeting and welcomed everyone. Special welcome was extended to our two incoming Directors - Director of Communications & Engagement, Claire Pimm and Director of Policy & Intelligence, Dr. Marc Bush. Anna Bradley took the opportunity to thank Karen Riches, outgoing Interim Director of Communications & Engagement for her work in setting up the team, the brand, the site and the structures of Healthwatch.

Ahead of the meeting, Anna read a statement about the decision by the Secretary of State to suspend decision on the closure of three Children's Heart Surgery Units.

AGENDA ITEM 2

PREVIOUS MINUTES

No comments on previous minutes or actions. No further matters arising.

AGENDA ITEM 3

DECLARATIONS OF INTERESTS

No declarations of interest on the agenda items.

AGENDA ITEM 4

CHAIR'S REPORT

Anna Bradley picked out two particular points from her report to talk about with the Committee.

NHS Constitution

- Anna took part in a meeting about the NHS Constitution. She clarified that the conversation about the NHS constitution is ongoing and no final agreement had been

made about Healthwatch England being an approved interpreter of the constitution.

CQC – Fundamental Standards

- Healthwatch England has had an initial meeting with the CQC on fundamental standards. Several Committee members were present and inputted their thoughts as to who to make these consumer-focused.
- Anna Bradley was keen to note that this conversation was at the early stage of CQC thinking, and that this is exactly the mode that Healthwatch England should be meeting CQC and other system players in.

Members' discussed the Chair's report and added the following comments:

- There is ongoing work in the voluntary sector around the creation of a version of the NHS constitution that speaks to the needs of children and families.
- The engagement with strategic partners was welcomed – there was a suggestion to widen this to trade unions and organisations representing those working in social care.

AGENDA ITEM 5

CHIEF EXECUTIVE'S REPORT

Dr. Katherine Rake, Chief Executive pulled out several key points.

Appointments

- Katherine Rake announced the appointment of two new Directors – Claire Pimm, who will be the Director of Communications and Engagement and Dr. Marc Bush who will be the Director of Policy and Intelligence.
- Katherine acknowledged the key role that Interim Director of Communications and Engagement, Karen Riches has played in the successful set up of Healthwatch England.

National conference 20th June

- The team are busily preparing for next week's National Conference in Birmingham. This is the first time that the local Healthwatch and Healthwatch England will be together. It is a great opportunity for us to discuss how we frame the consumer rights debate and showcase our support for local Healthwatch.

Annual Report

- This will be the first annual report. In future we will have a full year of Healthwatch England and local Healthwatch to report on, however this year we will be using it to set out a mandate particularly around consumer rights and have the evidence to show what this means.

Members' discussed the CEO's report and added the following comments:

- What take up has there been around "Website in a box"?
- How many local Healthwatch network meetings have been held?

1. **ACTION – Katherine Rake to circulate this information to the Committee. At subsequent meetings, this data will form part of the metrics that will be presented as a matter of course. Digital Manager and the Development Team to collate these answers for Katherine Rake in advance of September.**

Katherine Rake stated that the question brought up a wider point around key performance measurements and indicators which would be referenced later.

AGENDA ITEM 6

MEMBERS' UPDATES

- Members reported their visits to local Healthwatch, events attended and fed back intelligence to the Committee.
- Feedback from Staffordshire Healthwatch who felt they were out of the loop on the findings around the Stafford enquiry. This brings us a key point on how major systems players engage with local Healthwatch as issues develop.

AGENDA ITEM 7

AUDIT AND RISK

Terms of Reference

AGREED: - Terms of reference for the Audit and Risk committee were presented and approved by the committee.

Risk Register

The risk register has been reordered and more detail has been added to make it abundantly clear what the risk is, what the mitigation is and what stage we are at.

Comments from the committee:-

- Feedback from local Healthwatch is that they have concerns about using the HUB particularly around data sharing and confidentiality.

Katherine Rake responded that we would cover issues around this in our upcoming discussion on Information Governance.

- Specific point on Risk 4 around receiving more requests from local Healthwatch than can be delivered.

2. **ACTION - Audit and Risk Sub Committee to have another look at the specific mitigation of each risk**.

AGENDA ITEM 8

NATIONAL INFORMATION AND GOVERNANCE COMMITTEE

This is an advisory committee of the CQC. It was agreed that John Carvel be part of this for Healthwatch England.

AGENDA ITEM 9

BUSINESS PLAN & BUDGET

Additional Priority

We have extended the four priorities of the public facing business plan to five. This adds a priority around Intelligence. As there are concerns around building a robust evidence base around the HUB, we wanted to strip this out from a management point of view to ensure that it was clear.

Budget

Originally the grant from Healthwatch was £3m. Additional conversations have been had and an additional £825k for local Healthwatch development has been granted. We have a letter confirming £3m. The letter of cover for the additional 825k is imminent. The approval of the budget and business plan is conditional on the extra money being formally confirmed.

Comments from committee:-

- On budget, there is no specific item line for 'Enter and View'.

This is because the figures given are top line. Our intention is to put up a more detailed budget on a quarter by quarter basis as costs and expenditure becomes clear.

- Is there a "key phrase" to pull out regarding this new priority five?

3. **ACTION – Grahame Tinsley to circulate priority five to the Committee members and ensure that they are clear as to how to talk about this if asked.**

The business plan is approved pending sight of the fifth priority. The budget is approved subject to receipt of the additional cover for £825k by DH.

Performance Management Measures

Going forward within the CE report there will be set of Performance Management Measures that allow us to easily take the temperature of our internal performance and the external engagement with partners.

AGENDA ITEM 10

STRATEGIC PARTNERSHIPS

CQC

This is an ongoing relationship. The CQC, like us, have a joint responsibility for Health and Social Care therefore the relationship is even more critical.

Comments from committee:-

- Questions were raised about CQC not having a remit across social care for children.
- Concerns were raised about social care consumers making private arrangements for their care.

AGREED: - Approach to CQC has been approved pending amends and comments.

LGA

Formal approval sought on the MOU with the LGA.

Comments from committee:-

- We need to continue to be clear at the local level the distinction between what the LGA will be doing and what Healthwatch England are doing.
- Make sure within the drafting that references to Adult Social Care are changed to Social Care, thus including Children.

4. **Action: To be rectified within the drafting to make this complete.**

AGREED: - Pending stated amends

AGENDA ITEM 11

INFORMATION GOVERNANCE

This is a two pronged approach. One is to develop our own information governance approach and the other is to support local Healthwatch to do the same.

Healthwatch England

The approach is to integrate all seven Caldicott Principles into our policies and take expert advice as we go forward. We need to develop a balance between information and security. We feel it has become clear we will need separate guidance around the use and collation of information where it will form a case study.

ACTION:-Policy to come back to the Committee in September

Local Healthwatch

We have been developing an information sharing agreement. It is in draft form currently and we are aware we need to develop a suite of training and support for local Healthwatch to ensure that the guidance is adhered to.

Comments from committee:-

- If we adopt all seven principles we will be the first organization to do so.
- We need to be clear about ownership of data in the hub. One issue that arose for the LINks was what to do with data when LINks closed down.

AGREED: - Comments were noted and this approach was approved.

AGENDA ITEM 12

ESCALATION POLICY

The proposal is for all issues escalated from local Healthwatch to be put before the Committee. These should be presented against criteria which help us to decide when and where to pursue issues and publish special reports.

Comments from Committee:-

- Should we be sharing information around escalation with local partners such as the Quality Surveillance Group?

This is a matter for local Healthwatch, but agreed that guidance needs to be given to them.

- What is the process and consequence of making a special report?

We can issue a special report ourselves with recommendations about an issue that has been brought to our attention and system players need to respond.

- Concerns were raised about the criteria we use to agree whether or not to escalate. It might be that we are putting too many barriers in the way.

5. **Action – Policy Manager to look at criteria again, in particular to reference criteria used in business planning.**

AGREED: - Approval sought and given for this policy.

WHISTLEBLOWING POLICY

AGREED: - Approval sought and given for this policy

COMPLAINTS POLICY

AGREED: - Approval sought and given for this policy

AGENDA ITEM 13

COMPLAINTS

Healthwatch England will be launching a mini report on the 20th June as well as a package of items around this. A video was shown indicating some of the issues and a discussion was facilitated between local representatives and committee members.

Conclusion

The Chair thanked everyone for their time and contribution.

HEALTHWATCH ENGLAND COMMITTEE MEETINGS - SUMMARY OF DECISIONS AND ACTIONS 2013 - UPDATED 05/08/2013

Date	Lead	Item	Action	Deadline	Progress	STATUS
12/06/2013	Katherine Rake/ Susan Robinson	5.Chief Executive's Report	Answers to the following questions from committee need to be compiled and distributed - What take up has there been of "Website in a box?" and "how many local Healthwatch meetings have been held?"	Sept-13		Complete
12/06/2013	Committee Secretary/ Audit and Risk Sub Committee	7. Audit and Risk	Committee asked the Audit and Risk Sub-committee to have another look at the Risk Register - specifically around the wording of the specific mitigation of each risk.	Sept-13	The Risk Register was taken back to the Audit and Risk Subcommittee and gradings added to each risk.	Complete
12/06/2013	Committee Secretary/Head of Operations	9. Business Plan & Budget	In order to clarify the budget - Healthwatch England has added an additional priority to the four we already have. Although this is only for internal purposes. Committee asked what the "key phase" to this would be.	Sept 13		In Progress
12/06/2013	Hilary Manning/ Committee	10. Strategic Partnerships	In the MOU with LGA an amend to be made from Adult Social Care to just Social Care, thus including Children	Sept 13	Amendment made	Complete
12/06/2013	Committee Secretary	11.Information Governance	Healthwatch England - Guidance on how we develop our information governance approach to come back to Committee in Sept	Sept 13	This is on the September agenda	Complete
12/06/2013	Policy Manager	12. Escalation Policy	Policy Manager to look at criteria again, in particular reference criteria used in business planning. Escalation policy and special reports back on the agenda for Sept.	Sept 13	This is on the September agenda	Complete

AGENDA ITEM 4 – CHAIR'S REPORT

CHAIR'S REPORT

My report will provide an update on forthcoming strategic plans for Healthwatch England, as well as provide further information on:

- Strategy of Healthwatch England
- Healthwatch England Committee
- Strategic Partners.

Strategy of Healthwatch England

Healthwatch England is developing its strategic priorities for the next three years. This started with an analysis of the external environment in which Healthwatch exists in order to define further where Healthwatch England and the network can add most value.

Immediately before this public committee, the Committee will have spent two half days in workshop developing this strategy and determining key strategic priorities for the next three years. With our strategy and annual report in hand, we will now focus on engagement and consultation with our key stakeholders, and directly with consumers which will commence in October and conclude in advance of World Consumer Rights Day in March 2014.

We will complete strategy development for approval by the Healthwatch England Committee at the public committee meeting in February 2014.

Healthwatch England Committee

I am aware of the many local Healthwatch launches the Healthwatch England Committee have attended, or are scheduled to attend, and I would like to thank all of those who have undertaken this local engagement. The feedback I have heard through the Healthwatch England Development Team has been extremely positive.

I have also recently established a Healthwatch Chairs' Network. This network should provide an opportunity for Chairs of local Healthwatch to come together, share information and best practice, seek advice from others in the same position and have direct contact with the Chair of Healthwatch England on a regular basis. The first meeting occurred on 16th September, with another to occur on 30th September 2013, the primary purpose of which is to establish what Chairs of local Healthwatch would find useful so we can develop a plan for further Chair networking.

Finally, the Healthwatch England Committee currently has four transitional members recruited to fulfil the regulatory requirements for local Healthwatch to be present on the Healthwatch England Committee. With all local Healthwatch now commissioned across the country, and nearly all set-up, we will shortly be looking to recruit four Healthwatch England Committee members who can bring local Healthwatch experience to our discussions (see Agenda Item 8).

Strategic Partners

Statutory Partners

DH

The Chief Executive of Healthwatch England and the Director of People, Communities and Local Government (Director of the Healthwatch England sponsorship team within DH), have signed the Memorandum of Understanding between DH and Healthwatch England which is to now be approved by the Committee.

CQC

The Chief Executives of CQC and Healthwatch England are in the process of agreeing on the Memorandum of Understanding between CQC and Healthwatch England, which was informed by the strategic alliances, benefits and accountability arrangements noted at the previous Healthwatch England Committee meeting.

This Memorandum of Understanding is a high-level agreement under which will sit the Standing Financial Instructions and other important governance documents for Healthwatch England.

In addition, CQC and Healthwatch England are now beginning a joint work programme to realise these benefits, including:

- Working with CQC local Involvement leads to ensure local Healthwatch engage with local CQC inspectorates. This also includes working with the new Chief Inspector CQC in how to engage local Healthwatch in the inspection of the first four hospitals identified by CQC;
- working with CQC on the development of its Fundamental Standards; and
- Working with CQC Risk Profiling and Information Governance leads to track information both Healthwatch England and CQC receive from local Healthwatch.

LGA

Healthwatch England continues to have a positive working relationship with LGA. Together we are developing an 'Outcome and Impact Tool' to support local Healthwatch deliver quality standards in governance, finance, operations and relationships. Feedback so far has been very positive and the Development Team will be holding further sessions with local Healthwatch throughout September to assess how the tool can help support performance management.

NHS England

Healthwatch England continues to forge operational links with NHS England, with a number of local Healthwatch attending their Annual General Meeting on 12th September 2013, and on-going quarterly meetings with Directors of Policy and Commissioning to establish strategic alliance between the two organisations.

The Chief Executive of NHS England, Sir David Nicholson, accepted our invitation to present at our Healthwatch England Committee workshop on 10th July 2013. He presented on the role of NHS England and our work with them. The Committee challenged Sir David to ensure that everyone within NHS England understands Healthwatch England and local Healthwatch and engages with us at all appropriate stages of their work.

Professional Bodies and Voluntary Sector

I continue to engage with a varied number of professional bodies and voluntary sector organisations to promote the public face of Healthwatch England and undertake important

system influencing on behalf of Healthwatch England. Recent notable meetings have included:

- Professional Standards Authority
- Royal College of GPs
- Royal College of Physicians
- British Medical Association
- Baroness Jolly, Specialised Healthcare
- National Association Primary Care
- Which?

I have also met with representatives from NICE and Health Education England, with whom we are exploring potential joint work programmes.

Broader Influencing

Healthwatch England continues to engage with broader issues in the community, for example in our response to Morecombe Bay and the Berwick report:

Morecambe Bay

Events in the Care Quality Commission in July 2013 in relation to University Hospitals Morecambe Bay highlighted once again the devastation caused to children and their families by a system that failed to listen.

We are determined to ensure that in the future the consumer's voice is and that is why we have written to NHS England, the Department of Health, the Care Quality Commission, Monitor and the LGA requesting discussion to ensure we get the complaints system right for consumers.

Berwick Review

The focus of putting patient safety and experience at the heart of healthcare planning, delivery and evaluation in the Don Berwick review was welcomed by Healthwatch England. I noted publicly that the recommendation that patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of Trusts is one we fully endorse.

External Board Engagement

National Quality Board

The National Quality Board met on 16th July 2013 to discuss:

- Its role and future work programme, in which it concluded that its benefit lies in providing the system with an important mechanism for supporting and nurturing cooperation and collaboration at the highest and most strategic level.

The National Quality Board has now established a number of sub-groups, including the following: alignment of the overall quality architecture; Patient Safety; and Patient Experience and Clinical Effectiveness. Discussion is on-going about the way in which Healthwatch England will be involved in this work.

NHS Constitution

The NHS Constitution Expert Advisory Group met on 9th July 2013 and the discussions about Healthwatch England's role in disseminating the constitution, following our work on the consumer rights, are on-going.

We are also currently undertaking a workshop around empowering patients to realise their rights when they have a concern or complaint, which will be held in the next few weeks.

Ministerial Board on the Integration Transformation Fund

Healthwatch England has been invited to be part of the Ministerial Board for the Integration Transformation Fund. The Board is jointly chaired by Norman Lamb MP, Minister of State for Care and Support and Brandon Lewis MP, Parliamentary Under Secretary of State at the Department for Communities and Local Government, with joint secretariat support coming from both the Department of Health and the Department for Communities and Local Government. The £3.8 billion fund will fully flow from April 2015 to local commissioners and support commissioning of integrated health and social care services.

This fund represents a significant new initiative in the way that health and social care services are delivered at a local level and our place on the Board provides an excellent opportunity to influence this emerging programme of activity to ensure that it remains focussed on delivering to consumer needs and improving the quality and experience of care.

Its work will be informed by the Health and Social Care Integration Pioneers, a programme of local partnerships that will be testing new ways of delivering integrated services. Healthwatch England has also been working with the Department of Health to ensure that public and local Healthwatch engagement is included in these pioneer programmes.

AGENDA ITEM 5 - CHIEF EXECUTIVE'S REPORT

CHIEF EXECUTIVE'S REPORT

This report provides an update on the operational work progress of Healthwatch England in the period since the last Committee meeting.

Operational

Delivery on key activities and metrics

I am pleased to report that, even without a full complement of staff and continuing resources spent in set up, key activities planned have been completed or are well underway. There are only 7 activities out of 28 planned for Q1 that were partially delivered and these have been carried forward for completion in the current quarter. The activities for Q2 were presented to the last Committee meeting and are similarly in hand and progress is regularly monitored by the Senior Management Team using a new management tool that tracks progress so that appropriate and early action can be taken as needed.

With the Senior Management Team now in place, the plans for the remainder of the financial year are now taking final shape and a full list of activities for Q3 and Q4 will be presented at the next meeting. Our basic measures of reach as reflected in the metrics for Q1 remain steady. We hope that they will receive a boost to these following the publication of the annual report.

Budget

At the beginning of August, we received written confirmation from the Department of Health for the allocation of £825,000 non-recurrent programme funding in 2013-14, in addition to the £3 million baseline funding. This programme funding supports the delivery of the local Healthwatch support programme, elements of which will be delivered jointly with the Local Government Association.

Our actual spend in the four months to end July was £1,714,371 compared to a budgeted spend of £1,624,539, resulting in an overspend of £89,832.

Subjective	In month (£)			Year to date (£)		
Class	Budget	Actual	Variance	Budget	Actual	Variance
PAY	204,522	147,035	(57,487)	785,231	891,695	106,465
NON-PAY	167,862	93,092	(74,770)	839,309	822,676	(16,633)
Grand Total	**372,384**	**240,127**	**(132,257)**	**1,624,539**	**1,714,371**	**89,832**

The overspend was previously higher (£222,089 by the end of June) and was driven largely by having temporary staff filling some of the vacant staff positions. This was necessary in order to have the organisation up and running quickly. There was also an intense amount of activity and resulting direct costs in this quarter – including the launch and conference. With further recruitment of permanent staff underway, the deficit position will continue to reduce.

Cost centres for each of the major projects have now been established with a nominated budget holder for each. Each cost centre is being carefully reviewed to ensure deliverables can be achieved in the most cost effective way. This will be the basis of a full mid-year re-forecast which will provide an accurate position for the remainder of the financial year and ensure that we secure the maximum impact for the £3,825,000 budget assigned.

Staffing and Recruitment

I announce with pleasure the final senior management appointment, the new Head of Operations, Sarah Armstrong. Sarah joins Healthwatch England from Community Service Volunteers where she was Operations Director. She is an experienced operational manager who has worked in a variety of settings for the last fifteen years.

We continue our campaign to recruit the remaining 20 vacancies within the overall 31 staff agreed as part of the Healthwatch England organisational structure.

In early September, recruitment started for the vacancies within the policy team and we will soon undertake recruitment for the next four vacancies in the Communications and Development teams.

Activity

National Conference

Healthwatch England held its inaugural national conference on 20th June 2013 in Birmingham. Overall attendance was 215 people (including exhibitors, speakers and staff); the number of local Healthwatch represented on the day was 108. We had cross-party support, with both Norman Lamb MP, Minister of State for Care and Support and the Rt Hon Andy Burnham MP, Shadow Secretary of State for Health delivering keynote speeches. Anna Bradley spoke of her vision for Healthwatch and the future, I delivered a short presentation on Healthwatch England's support offer for local Healthwatch moving forward, and also participated in a question and answer session with the Rt Hon Andy Burnham MP.

Complaints Report

At the national conference we launched our video report on complaints and survey work which showed that almost 1 in 2 people lacked confidence in the current system. The link to the video report is available here: http://www.healthwatch.co.uk/complaints.

On the day of launch, we wrote to our statutory partners to express our concerns about how the current complaints system in health and social care was failing consumers and asked for their engagement in delivering improvements. We are testing this as a form of strategic engagement with partners, in anticipation of formal recommendations which we will be developing over the course of the year.

We have also begun to engage with local Healthwatch to understand more about what is working, and what is not working, in their local complaints systems. We have been impressed with the energy and knowledge they bring to bear on this issue. The rich and detailed examples of problems, and good practice, existing at a local level are giving us an early indication of the potential power of the network. We will be working with them in the next few weeks to gather evidence of what is happening locally so that we begin to build a picture of both the quality of complaints handling from a consumer point of view.

Annual Report

Healthwatch England will lay its first annual report before Parliament on the 8th October, followed by launch events, including a parliamentary reception on the 9th October 2013. This report will establish a mandate for the Healthwatch network and will set out a framework for consumer rights in health and social care.

To develop this report, we started with consumers and hosted a deliberative event on 20th July 2013 to explore experience of health and social care and perceptions of consumer rights. This event included people with long-term physical or mental health conditions, unpaid carers, young people, and people from across the socio-economic spectrum. This work has been supplemented with representative polls to give us a baseline of views and experiences of rights in health and social care as well as discussions with a group of experts.

Following the publication of the annual report, we will conduct a consultation on the proposed framework and its implications for the work of the network. We will also develop specific events to test out the proposed framework with mental health service users and children and young people.

Local Healthwatch

I have attended a number of local Healthwatch launches, including Lambeth, Sutton, Southwark, Merton and, most recently, Cumbria. These have been informative and positive events, and I have been heartened to see the broad community engagement and public support for these new organisations.

A detailed update on the Healthwatch network follows at Agenda Item 9.

Influencing

We continue to engage with reviews that address particular consumer concerns and panels that are aimed at driving improved design that delivers consumer benefit.

Clwyd/Hart Review

We have actively engaged with the Clwyd/Hart review of complaints in hospitals as part of the Key Partnership Group and by submitting evidence to the review.

We share with the Review team a concern to ensure that patients are supported in raising concerns and complaints and have them resolved fairly and transparently. We also share the view that consumers need to be made aware of the standard of service to expect when they raise a concern or complaint and that consumer and local pressure to improve the complaints system will be a critical part of reform going forward. We also know from our own work that complaints are a major issue right across health and social care and we hope that the review will include recommendations that are transferable to primary care and social care as part of its work.

The Keogh Review

The Keogh Review report was released on 16th July. I represented Healthwatch England on the National Advisory Group established by Sir Bruce Keogh to help guide the overall review process and to advise on how to ensure a robust and consistent approach was taken to conducting the individual investigations.

The report revealed worrying concerns about a range of hospitals with higher than expected mortality rates. Alongside our own media release, Healthwatch England provided support to

local Healthwatch and in particular those in an area of a Keogh hospital, by providing specific information about the findings in the report as well information on dealing with media scrutiny and enquiries that may have arisen from the Keogh Review. This is a new and important support role of Healthwatch England to the Healthwatch network.

Of particular interest to Healthwatch England was the fact that the review teams found that focus groups with patients and staff were "the single most powerful aspect of the review process". One of the review panel Chairs explained, the process of sitting in a room with patients and asking "How is it for you?" gave a unique insight not only into delivery but into the culture of the hospital under review. What is frequently labelled as "soft intelligence" turned out to be some of the sharpest insight into achievements and failure of the hospitals under review.

The Keogh Review further confirms our belief that there needs to be a profound change in how the NHS listens to the feedback, concerns and complaints of the patients.

The Health and Wellbeing System Improvement Programme Leadership Board

This Leadership Board, hosted by the Local Government Association, aims to ensure that the new local Health and Wellbeing System is delivered effectively between multiple partners, including local authorities, Public Health England and NHS England. Our role is to provide input, oversight and challenge in order that local Healthwatch can play the most influential role on the Health and Well Being Board and in the new local Health and Social Care landscape.

Metrics Quarter 1

	Quarter 1		
	April	**May**	**June**
Unique website visitors	14,574	12,274	11,327
Twitter followers	1,271	1,590	1,670
Media Opportunities to read/see			
National	3,749,577	3,547,000	3,542,000
Regional	5,506,544	5,180,000	5,160,000
Newsletter			
Subscribers	2,556	2,751	3,063
Open rates	42%	45%	No newsletter sent in June
Service Centre Enquiries			
Calls	322	245	211
Emails	390	177	242
Paper correspondence	20	10	7

AGENDA ITEM 7 – STRATEGIC PARTNERSHIPS

STRATEGIC PARTNERSHIPS

This agenda item will provide:

- An update on the development of our strategic partnership with NHS England and the CQC; and
- A copy of the Memorandums of Understanding between Healthwatch England and the Department of Health and Healthwatch England and the Care Quality Commission.

Members are invited to:

- DISCUSS the approach to our strategic partnership with NHS England;
- APPROVE Memorandum of Understanding with the Department of Health.

NHS England

Healthwatch England has consistently worked to develop a constructive working relationship with NHS England. This is a difficult relationship given the operational capacity of Healthwatch England and the scale and complexity of NHS England.

We can highlight a number of positive outcomes from our engagement to date, including Sir David Nicholson, Chief Executive of NHS England, attendance at the July Healthwatch England Committee workshop, from which we are in negotiation to further engage with him for video training for local Healthwatch.

We still have much on-going work to do to enhance the operational effectiveness of our relationship:

- Joint engagement of Healthwatch England with both the policy and commissioning directorates of NHS England;
- Engagement with Healthwatch England on NHS England's major guidance consultation; and
- Ensuring appropriate and effective engagement between NHS England's local area teams and local Healthwatch.

In cooperation with NHS England, we are developing a Partnership Agreement which sets out our shared vision, objectives and values and the key areas where we will work closely together. Members are invited to comment on the Shared Goals and Values and Behaviours of the draft Partnership Agreement (see slides).

A full draft of the Partnership Agreement is attached.

Department of Health Memorandum of Understanding

The Chief Executive of Healthwatch England and the Director of People, Communities and Local Government, have signed the Memorandum of Understanding between DH and Healthwatch England which is now to be formally approved by the Committee which had input into the draft and approach at the last meeting.

There have been a number of team changes within the DH Healthwatch England sponsorship team which was reflected in our operational risk register. I am pleased to note that the

transition has been smooth, and our relationship continues to be positive with a successful accountability meeting held on 27th August 2013.

CQC Memorandum of Understanding

The Memorandum of Understanding between CQC and Healthwatch England is directly based upon the strategic alliances and benefits and accountability arrangements noted at the previous Healthwatch England Committee meeting.

The Chief Executives of CQC and Healthwatch England are in the process of agreeing on the Memorandum of Understanding between CQC and Healthwatch England, which was informed by the strategic alliances and benefits and accountability arrangements noted at the previous Healthwatch England Committee meeting.

Work to operationalise this is underway, and further policies are in preparation including amended Standing Financial Instructions for Healthwatch England. Both the signed Memorandum of Understanding and the Standing Financial Instructions will be presented as a package to the Healthwatch England Committee.

Appendix available separately

- PDF of Department of Health/Healthwatch England MOU
- PDF of Draft Partnership Agreement with NHS England

AGENDA ITEM 8 – TRANSITIONAL MEMBERS

TRANSITIONAL MEMBERS

Purpose

To agree an approach on the recruitment of transitional and co-opted members to the Healthwatch England Committee.

Transitional Members

We currently have four members on the Healthwatch England Committee – Christine Vigars, Dag Saunders, David Rogers and Jane McFarlane appointed on a transitional basis either as representatives of LINks or on the basis that they were leading local authorities' arrangements for the set-up of local Healthwatch organisations. They were appointed to fulfil the regulatory requirement that the experience of local Healthwatch should be present within the Committee, at a time when local Healthwatch did not exist.

Like all the Healthwatch Committee members, the transitional members were recruited and selected according to standard Nolan rules, with open advertisement and clear selection criteria. The intention was always that these four members would be holding places for individuals who were Chairs (or similar) of local Healthwatch, once the local Healthwatch network was established. I have always been clear that these permanent members would be recruited and selected in the same way as the transitional members.

Under the original terms of appointment, these members conclude at the end of September. This date was set particularly because we had hoped that by this stage local Healthwatch Chairs would be all appointed and have made some progress in establishing their own organisations and Boards, making it possible for them to consider taking on additional responsibilities by putting themselves forward for the Healthwatch England Committee.

In practice, however, local Healthwatch establishment has been uneven. We estimate that there are currently around 120 permanent Chairs in post now, but some of these are very recent and many are still working on establishing their own Boards and organisations.

To allow the best possible chance of a large and strong field for these four Healthwatch Committee member posts, we have decided to extend the terms of the existing transitional members for a further six months and recruit for new Members from January 2014. In making this decision, we have consulted with the existing members (who are content) and with the Department of Health, who say this is a decision for the Healthwatch England Chair and Committee.

To allow this time, and ensure continued representation of the regions, the proposal is for transitional members to be co-opted for a short extension in order that we recruit in a proper and timely manner. It should be noted that co-opted members have slightly different rights and cannot cast a vote at Committee. In reality, this is unlikely to have an operational impact as there has yet to be a vote at the Committee but a contingency needs to be made for this and it is proposed that if a vote were to occur, co-opted members views would also be recorded separately in the minutes.

For DISCUSSION and DECISION by the committee:

- The committee is asked to approve the decision to keep the transitional members on as co-opted members for a term of six months.

AGENDA ITEM 9 – LOCAL HEALTHWATCH

LOCAL HEALTHWATCH ENGAGEMENT TO DATE AND NEXT STEPS

Purpose

This report provides the Committee with an update on our engagement with local Healthwatch and proposals for working over the next 6 months based on our learning to date.

An analysis of local Healthwatch media coverage is attached in a separate note. It is pleasing to see the impact already being made, with over 1,000 separate pieces of media coverage since launch.

Context

Our business plan states that one of our objectives is to develop a vibrant Healthwatch network and provide support and leadership to local Healthwatch which we will do by:

1. Developing and delivering a vibrant Healthwatch network
2. Providing leadership and support to local Healthwatch on priorities including: governance, commissioning, Health and Well Being Boards and their responsibility for children etc.
3. Establishing standards of good practice among local Healthwatch and ensuring local Healthwatch have the powers and functions they need to do their job effectively
4. Creating a clear route for local Healthwatch to escalate concerns to Healthwatch England, the Care Quality Commission and other bodies
5. Gathering data and intelligence from local Healthwatch to spot emerging issues and help them understand how their local environment compares to the national picture.

A review of the last 6 months

Our work supporting the Healthwatch network over the past 6 months has consisted of:

<u>Regional, national and contact with individual Healthwatch</u>

To date, we have run a series of regional and national events as well as contact with individual Healthwatch.

These are:

- The national launch event in April and the national conference in June. Together these 123 Healthwatch.

- After the launch we hosted or attended 10 introductory regional meetings of the Healthwatch network and currently there are 7 on-going network meetings in the North East, North West, East & West Midlands, Eastern region, London and South Central.
- Support of individual Healthwatch through speaking at over 20 launch events or where specific issues or concerns have been flagged.

There is a diversity of approaches in the set up and functioning of these with some are being supported by legacy funding to voluntary sector organisations which will shortly come to an end, and some are already self-sustaining. Our approach has been to support and attend so that we are aware of the status of this variety of networks and so that we can be clear where we add value to what is pre-existing.

Specific support in set up

We have also recognised the particular needs of set up and have supported this through:

- Advice and guidance, posted on the Hub, about set up issues;
- Support for website development through the provision of Website in a box, and website in a box II;
- The provision of a communications centre where Healthwatch can develop branded materials – 142 local Healthwatch are signed up for the comms centre.

In addition to this, three webinars were hosted with local Healthwatch to garner feedback and raise awareness of the support offer.

Training

We have run a training programme dedicated to supporting local Healthwatch to exercise their 'enter and view' powers and to train their volunteers about how to conduct good 'enter and view'. So far this training has been delivered to 99 local Healthwatch.

Developing standards of delivery among local Healthwatch

A major contribution to this work is currently live with an outcome and impact tool that has been developed jointly with LGA currently in test with local Healthwatch. This is taking the form of 4 events currently taking place in Taunton, London, Birmingham and Leeds. The new tool is being distributed to local Healthwatch and Local Authorities attending the events in September and will be available to the whole network in October. This will be followed with the opportunities for implementation meetings and then a review of the development tool.

The Hub

We now have 149 local Healthwatch signed up as users of the Hub, but the number of active members is lower at 86 users. Two successful webinars were hosted by Abdel Elsheikh in August to form a 'Hub super user group' and have been very helpful in identifying issues local Healthwatch are experiencing in using the Hub as well encouraging their further engagement with the Hub.

Local Healthwatch engagement with us

We have been tracking the degree of engagement among local Healthwatch and a representation of this will be presented to the Committee.

This table below provides a summary of these approaches, what has worked well and what needs to change in the future.

Method	What is working	Less successful	Future plans
Newsletter	Very well received	None	To continue the weekly letter
Helpline	Well received	Direct local Healthwatch calls are reducing; the number is now available more widely and we are receiving some other calls on the line.	People are now coming directly to the website and their regional link. An information officer is being appointed who will support all of Healthwatch enquiries so that we have a more efficient system overall.
Regional network events	Well received	Purpose needs further refinement and we need to work towards a consistent format, recognising that other organisations engagement may diminish over time.	Healthwatch England now needs to provide and support a diary of network events planned for the year, mostly held on a bimonthly basis. These are a vital source of feedback about our support offer.
Regional training	Very well received. The audience liked the local contact for all staff and a more informal opportunity to engage with Healthwatch England	People said that they needed more help with training skills and how to support volunteers.	To undertake a training needs analysis to scope out the needs of the network and identify some training opportunities by various methods but including some face to face.
Events	Well received	Healthwatch staff would like the opportunity to engage with Healthwatch England. Events have been too exclusive and need to be publicised well in advance.	Plan an annual event open to all Healthwatch staff with a social event to promote networking.
Data gathering	Response rates have been lower than expected. Maps will be shared and there will be a focus on building interest and motivation.	In advance of Healthwatch annual returns, further work is required to build a comprehensive picture of the status of the network.	To test alternate forms of information gathering in order to understand what works best for local Healthwatch organisations and to complete our picture for the network.
Sharing good practice		Limited to date because of the newness of the network.	This is an area needing greater focus. We need to demonstrate the benefit of improved information flows to local Healthwatch.

Developing common standards	An outcome and impact tool has been developed jointly with the LGA and is currently being tested with local Healthwatch.		The roll out of this tool will need to be supported and fuller feedback from the Healthwatch network secured. The impact of the tool on practice will need to be evaluated.
Partnership working and information sharing	Has worked well with DH, LGA and CQC. HIT team has been helpful in this set up phase.	Managing some of the challenges of differing priorities.	Relationships with local stakeholders will require further development. This could be a specific focus for regional events.
Attending events	This has been well received e.g. at CQC events		To hold and/or attend regional events on subjects that involves the network and other stakeholders to influence strong partnership working.
Comms via the Hub	149 Healthwatch are now signed up to the Hub.	Active use of the Hub is more limited with 86 users.	A popular and successful hub super user group has been established. Further effort to engage the network in the Hub will be required and should be enabled by the provision of a shared CRM platform for Healthwatch England and local Healthwatch.

Next steps: activity in the current financial year

Engagement

A key piece of learning from this period is that the process of engaging effectively and efficiently with the diversity of Healthwatch is taking time to develop and will require us to be adaptive in our approach. We will continue our newsletter and hub communication, and begin more detailed monitoring of its reach and impact. We will also pilot one to one engagement with selected local Healthwatch with whom we have had less engagement in order to provide support and encouragement.

We hope that Committee members will be part of this process. We will balance this with support to emerging leaders willing to share good practice. Alongside the engagement, this offers us a further opportunity to gather data on the status of each Healthwatch as we experiment with ways of simplifying and incentivising this data sharing with us in advance of local Healthwatch supplying us their annual return.

Network meetings

We propose to continue to support and attend the pre-existing network meetings and also facilitate subject focused network events identified through feedback from local Healthwatch.

We are currently scoping 8 regional events on the effective sharing of information with partners collected from various channels. The events aim to identify the most effective

pathways for sharing/escalating information at a local, regional and national level, including directly with Healthwatch England. The events will present a variety of test scenarios to explore how the information gathered via different channels will be shared with the other system players.

Training

In terms of training, we will be delivering further Enter and View training so that all organisations have received the recommended package these will take place in small groups' and one to one sessions.

To further our work on standards of delivery among local Healthwatch, we will be providing facilitation on the use of the Outcomes and Impact Tool developed with the Local Government Association at four regional events and one to one sessions where required.

Complaints campaign and engaging with vulnerable communities

This next period also provides us with an opportunity to focus the work of local Healthwatch on issues of importance to their local communities. A critical element of this is to ensure they develop engagement with vulnerable communities or those who are seldom heard within their existing work. We will be providing support and encouraging learning across the network on this issue.

We will also be working with local Healthwatch to establish our first network campaign on complaints and to enable them to work with local providers to secure improved services.

All of these pieces of work will give us a further opportunity to explore how virtual communities of interest develop. By testing the Chairs and Chief Executives network at the same time as developing communities of interest around specific topics we will be able to establish the appetite and impact of these networks.

Implications for our future work with the Healthwatch network

The above suggests that we will need to consider adopting a refreshed programme of engagement next financial year using the learning from this year. It also raises challenges around the amount of resource available to us to invest in the network.

The network needs to feel supported by us and we will need to continue to be clear about the boundaries around our support for them. It is important that we are demonstrating that we have heard and considered what the local Healthwatch have told us they need.

This means that Healthwatch England needs to have:

- strong trusting relationships that demonstrate that the local organisations believe that we add value
- a comprehensive data set on the set up and of each organisation and a baseline assessment of their ability to function stored in a shared database
- an understanding of their local issues and pressures
- an understanding of how they are working with partners and therefore able to influence locally
- an understanding of where best practice exists and can be shared - particularly engagement techniques and using information effectively to influence
- feedback on how local organisations are functioning from partners like CQC and LGA/commissioners

- a system of support that can be applied quickly where an organisation is struggling
- strong and clear lines of communication that enable us to hear what they are telling us
- principles of engaging that demonstrate that we are inclusive, fully consultative and can be trusted
- relationships with partners that allows timely information sharing and the identification of issues that need our support
- IT systems that local organisations will use to enable the two way flow of information essential for our ability to discharge our statutory function for people
- An understanding of the regions to provide context and perspective to issues that we might want to campaign about.

We will return to these issues in more detail at the October Committee Workshop and bring recommendations for the longer term network back to the November Committee meeting.

Appendix available separately

- Local Healthwatch media Coverage PDF

AGENDA ITEM 10 – PUBLIC POLICY UPDATE

USING OUR ADVISORY POWERS

This paper sets out the proposed approach to using our statutory powers to give advice to statutory bodies and the Secretary of State. It proposes a new approach to undertaking in-depth investigation and publishing reports into health and social care, as set out under the Health and Social Care Act 2008 s.45C(3)(4)(5) as amended by the Health & Social Care Act 2012.

For those who prefer a diagram, one is attached to the end of this paper summarising the thinking.

1. Using our powers

1.1 How can we advise decision makers on consumer concerns and policy solutions?

The Health & Social Care Act 2012 gives us the power to provide advice, information or assistance to any statutory body covered by the Act (s. 181 (1)(a)(b)).

In particular, we have the power to give information or advice to the Secretary of State, NHS England, Monitor, the Care Quality Commission or local authorities about the views of people who use health or social care services, and the wider public on their need for, and experiences, of health and social care services.

We can also give information and advice which comes from the experiences, views and opinions of local Healthwatch about whether, and/or how, standards in health and social care could be improved (Health and Social Care Act 2008 s. 45A (5)(6) as amended).

If we give the Secretary of State, NHS England, Monitor, Care Quality Commission or local authorities any advice, they must provide us with a written response or proposed response to the advice.

And, if we write to a local authority to express concern (Health and Social Care Act 2008 s. 45A (4) as amended) if, in our opinion, they are not (Local Government and Public Involvement in Health Act 2007, s. 221):

- Promoting, and supporting, the involvement of people in the commissioning, provision and scrutiny of local care services;

- Enabling people to monitor and review the standard of provision in local care services, whether, and how, local care services could be improved, whether, and how, local care services ought to be improved and this affects the commissioning or provision of local care services.

- Obtaining the views of people about their needs for, and their experiences of, local care services and using this to improve commissioning, provision, managing or scrutinising local care services.

This informational and advisory activity will supplement the influencing, policy and communication activities of Healthwatch England.

When we use our powers, we have to have regard to the direction of Government policy as laid out by the Secretary of State (Health and Social Care Act 2008, s. 45A (10) as amended).

All of this means it is down to us to decide when we want to just draw decision makers' attention to a concern or solution we have, and when we are using our statutory powers and require a written response.

1.2 How might we capture our policy concerns and recommendations for national decision makers?

There might be a number of activities we undertake to give decision makers advice on changing policy and practice to improve the experience of consumers of health and social care.

These are:

- Policy briefings: to identify a specific policy concern that we want to highlight and draw decision makers' attention to solutions we have developed to address it. This would be based primarily on publically available data, policy analysis and intelligence we have collected through the network. We would make specific recommendations to each relevant statutory body and/or the Secretary of State.

- Healthwatch annual report: to report on our priority policy activities, and people's realisation of rights to health and social care. This would be based on our intelligence, policy analysis and organisational activity over the financial year. We would use this to identify and make specific recommendations to improve the rights of consumers in health and social care.

- Special reports: to investigate a collective concern of consumers in health and social care and develop tangible policy solutions. To do this we will undertake our own, or commission, research and write policy reports into thematic priorities. We would make specific recommendations to each relevant statutory body and/or the Secretary of State.

- Special inquiries: to undertake inquiries into areas of substantive concern to consumers or threats or abuses of consumers rights that has been identified by Healthwatch England. Using an expert panel, we would take oral and written evidence from witnesses and draw on available existing data to make specific recommendations to each relevant statutory body and/or the Secretary of State.

To progress the recommendations laid out in these publications, information or advice could be given through the use of an open letter, an advisory meeting directly with the appropriate representative from a statutory body, or an advisory note setting out our concerns and solutions, or those of local Healthwatch.

Importantly, irrespective of the approach we take, when we make any recommendations to statutory bodies or the Secretary of State we are evoking our statutory powers to give information and advice.

1.3 Where will the data come from?

We will draw together data, intelligence and insight from local Healthwatch, statutory bodies and informed third parties, like charities or academics.

- Local Healthwatch: we will consider the trends arising from data in the Healthwatch hub and infobank, feedback from the informal conversations we have with them, the cases that they escalate to us and the reports or recommendations they make to us about national policy decisions.

- Statutory bodies: we will analyse national health and social care data sets, regulatory, value for money or market reports, and additional intelligence we can access through our national relationships with statutory.

- Third parties: we will consider trends being captured by charities providing advice and support to people who use health and social care services, and any recommendations relating to national policy they or academics make in research or policy reports, and in particular if they make a direct recommendation to Healthwatch England.

In line with our statutory obligations we will have a particular regard to the ideas and recommendations of local Healthwatch.

1.4 How are our special reports and inquires different to the other approaches?

The special reports and inquiries are examples of us implementing the powers that Healthwatch England has been given in the Health & Social Care Act 2012 to publish reports into to health and social care.

When we publish these special reports or inquires we must have regard to the recommendations made by local Healthwatch, and when we publish them - as far as is practicable - we must exclude information about individuals that may or will seriously and prejudicially affect their interests (Health and Social Care Act 2008 s.45C(3)(4)(5) as amended).

We want to use our power to create s.45C reports to look at the thematic concerns of consumers that require in-depth exploration or investigation. We may choose to develop further formats for these reports in the future.

1.5 How will we decide if the concern warrants an in-depth exploration?

At each committee meeting we will give an update on the thematic concerns of consumers and local Healthwatch about health and social care.

We propose that twice a year the committee decide on a substantive thematic concern that requires a deeper exploration and investigation.

Previously the committee had agreed to undertake a special report on a quarterly basis, however on reflection Healthwatch England staff suggest that without an adequate period of inquiry (at least six months) the quality of this work could be compromised, and so we are suggesting a change to twice-yearly.

The committee will use a set of criteria to assess whether an in-depth investigation is necessary or whether we should be taking a different approach.

The **criteria** below are a proposed operationalisation of the criteria agreed upon at the previous committee discussion in June 2013 and the committee strategy workshop in August 2013.

The agreed criteria for determining our strategic priorities are:

- Does it fit with our role, strategy and statutory responsibilities?
- How much does it matter and to whom?
- Is change feasible?
- Can Healthwatch England make a significant difference as the national consumer champion?
- Does it contribute to a balanced set of priorities?
- How does it build the network?

These have been operationalised for this activity as follows.

The issue being raised is:

- A threat or breach of a consumer right in health and social care (based on the forthcoming Healthwatch Consumer Rights framework).
- Seen by consumers a priority for change or action.
- Has been raised by local Healthwatch informally, through the hub or through report recommendations.
- A growing or changing trend in national statistics.
- Can be resolved by a policy or practice intervention by Healthwatch England or local Healthwatch.
- Something Healthwatch England has the capacity and/or resource to address.
- Something Healthwatch England adds value to as another organisation is not adequately covering the issue.

The committee has also agreed previously to ensure a balance of the following factors when deciding on priorities. A proposed operationalisation of these are listed below:

- National with local concerns.
- Issues faced by all ages with children and young people, working age adults or older people.
- Issues that apply to health or social care with both health and social care.
- Issues faced by the greatest volume of consumers with smaller groups of consumers with greater levels of need.
- Issues that can be addressed reactively with proactively and prospectively.

We propose that the Healthwatch England SMT bring the committee a pre-scored short and long list of the thematic concerns of consumers based on the data we collect. Each shortlisted priority will contain a rationale setting out how the SMT believe it meets the criteria above. The same will be done for the longlisted themes, but instead explaining the areas in which they did not meet the criteria above.

Committee members would then have an opportunity to discuss both the short and longlisted themes and can chose to escalate a longlisted theme into the shortlist if the Chair is satisfied that there is a clear rationale for doing so.

The Chair of the committee would facilitate a discussion about the shortlisted themes and ask the committee to agree upon the priority area for investigation.

If the committee decide to undertake in-depth work on any of the themes, we then need to decide how deep the exploration needs to be.

1.6 What activity might we undertake?

When we have decided to undertake in-depth activity we might decide to undertake research into an area, commission an expert organisation (like a charity or a research institute) or undertake a full inquiry into the issue ourselves.

If we chose to undertake a special report we will use existing evidence and new primary research with consumers (in house or commissioned). We will use this evidence to inform a policy report which will contain specific advice and recommendations to the appropriate statutory body or to the Secretary of State.

We propose that a special report would be overseen by an advisory group which would draw on experts by experience, at least one Healthwatch England committee member, at least one local Healthwatch and experts in the related field of inquiry.

If we chose to undertake a special inquiry we could convene an inquiry panel made up of at least two committee members, at least two local Healthwatch and experts in the related field of inquiry.

We propose that the special inquiry be chaired by the Chair or committee members nominated of Healthwatch England and will take written and oral evidence from witnesses with both consumer and issue-specific expertise. If appropriate, we may call on our statutory partners to provide us with additional information or act as a witness to help inform the inquiry. Inquiry session will be open to the public. In addition to this we recommend that all inquiries will last least 6 months and the findings will be written up into an inquiry report by Healthwatch England.

We would intend for any findings from this work to be published, shared with stakeholders and presented formally to the committee at a public meeting.

1.7 What happens to the options we do not pursue?

If an options is part of the shortlist, but is not pursued, Healthwatch England staff will continue to monitor the concern and we may use another approach to give information or advice to national decision makers. We will do this in recognition that many consumers will continue to have a concern, even if we are unable to prioritise it for in-depth activity.

When we bring the committee a new shortlist we will also provide an update of the progress we have made on the themes that were previously shortlisted, and if they continue to be on the shortlist ask the committee to reconsider them for future activity.

2. Priorities for September 2013

2.1 Where has the suggested in-depth work for September 2013 come from?

Not all the mechanisms we need to undertake a comprehensive assessment of potential in-depth options are in place because the Healthwatch network and Healthwatch England has been in the set-up phase.

Our Intelligence strategy, which will be shared with the Committee for discussion in November 2013, will set out how we will be building the infrastructure we need to access, analyse and apply data from different sources.

To ensure the committee can still have a meaningful discussion about the priority for the first special report we have drawn the data we currently have access to. This includes:

- Issues escalated to Healthwatch England from local Healthwatch
- Informal feedback from local Healthwatch on the Hub or in person
- Research reports undertaken by local Healthwatch reports and recommendations
- Concerns and priorities set out in the final annual reports of LINKs
- Data and insight from Mind, the Citizens Advice Bureau and the Carers Fed
- Recent parliamentary inquiry reports

We recognise that these sources produce an imperfect list, and as such suspect that very different priorities will emerge in future lists.

2.2 What are the options for a deep dive in September 2013?

Below are the options that have been shortlisted by the Healthwatch England SMT for consideration by the committee. As explained previously, in this first shortlist we are not able to give full metrics and descriptions behind the rationale for this shortlist.

Option A: consumers outside the safety net

Description: concerns have been raised about the cumulative impact of welfare, education, health and social care reforms on consumers, and in particular the increasing numbers of disabled people who are / or will not be no longer eligible for either adult social care or disability benefits. Stakeholders have suggested that there will be an increasing burden on universal and preventative health and local authority services as a result. There is a concern that this will lead to escalation of need and associated cost. There is a similar concern about the numbers of disabled children and young people who will be reliant on universal health and social care services because they do not receive a new Education, Health & Social Care Plan.

Criteria score: High

Criteria	Rationale	High / Mid / Low
A threat or breach of a consumer right in health and social care (based on the forthcoming Healthwatch Consumer Rights framework).	Yes - a breach of the right to access and a threat to the right to essential services and the right to safe, dignified and quality services.	High
Seen by consumers a priority for change or action.	Yes – primarily those affected by the changes (individuals and families) and being advocated for by consumer and	High

	representative groups	
Has been raised by local Healthwatch informally, through the hub or through report recommendations.	Yes – through the hub and informally through conversations with local Healthwatch	High
A growing or changing trend in national statistics.	Yes – change in the demographics of people receiving support	High
Can be resolved by a policy or practice intervention by Healthwatch England or local Healthwatch.	Partially – Welfare Reform Act and associated regulations have been enacted. Yes – the Department of Health is currently consulting on introduction of a national eligibility threshold Yes – the Care Bill is currently passing through the House of Lords (prevention clauses) Yes – the Children & Families Bill is currently passing through the House of Lords (EHCP and local offer clauses)	Mid
Something Healthwatch England has the capacity and/or resource to address.	Yes – internal / committee expertise and sufficient networks	High

Balance score: Mid

Balance	**Assessment**	**High / Mid / Low**
National with local concerns.	National and local	High
Issues faced by all ages with children and young people, working age adults or older people.	Primarily children, young people and working age adults	Mid
Issues that apply to health or social care with both health and social care.	No – welfare Yes - both, but primarily social care	Mid
Issues faced by the greatest volume of consumers with smaller groups of consumers with greater levels of need.	Smaller groups of consumers with greater levels of need	Mid
Issues that can be addressed reactively with proactively and prospectively.	Reactively	Mid

Option B: unsafe discharge

Description: concerns have been raised that people are being discharged from hospital unsafely without adequate assessment of their on-going needs or arrangement of sufficient support in their own home or community. Stakeholders are concerned that this increase the risk of emergency re-admission into hospital and have particularly highlighted issues facing older people, those with mental health conditions or who are homeless.

Criteria score: High

Criteria	Rationale	High / Mid / Low
A threat or breach of a consumer right in health and social care (based on the forthcoming Healthwatch Consumer Rights framework).	Yes - a breach of the right to essential services and the right to safe, dignified and quality services.	High
Seen by consumers a priority for change or action.	Yes – primarily family members of those affected and has been highlighted by representative groups	High
Has been raised by local Healthwatch informally, through the hub or through report recommendations.	Yes – through the hub, through our complaints work, through reflections on Keogh review, and informally through conversations with local Healthwatch	High
A growing or changing trend in national statistics.	Yes – increasing emergency readmission rates for significantly for stroke, fractured proximal femur, hysterectomy and other conditions.	High
Can be resolved by a policy or practice intervention by Healthwatch England or local Healthwatch.	Yes – local solutions with providers Yes – national policy on emergency readmissions	Mid
Something Healthwatch England has the capacity and/or resource to address.	Yes partially – internal expertise and networks	Mid

Balance score: Mid

Balance	Assessment	High / Mid / Low
National with local concerns.	National and local (especially post-Keogh)	High
Issues faced by all ages with children and young people, working age adults or older people.	All ages	High
Issues that apply to health or social care with both health and social care.	Both – but primarily health	Mid
Issues faced by the greatest volume of consumers with smaller groups of consumers with greater levels of need.	Smaller groups of consumers with greater levels of need	Mid
Issues that can be addressed reactively with proactively and prospectively.	Reactively	Mid

Option C: the true cost of care

Description: concerns have been raised about the lifetime cost of care to an older person and their family. Stakeholders have suggested that the proposed £72,000 cap on care costs to be introduced in 2016 will not cover the true cost of care, nor people's assets, because of the need to contribute £12,000 towards their daily living costs and an increasing dependency on third party top ups. People have also suggested that rising adult social care eligibility, the use of Resource Allocation Systems and the inclusion of disability benefits in financial assessments are creating a widening gap between the money available to meet need and the market cost of this provision.

Criteria score: High

Criteria	Rationale	High / Mid / Low
A threat or breach of a consumer right in health and social care (based on the forthcoming Healthwatch Consumer Rights framework).	Yes - a breach of the right to access and a threat to the right to essential services and the right to safe, dignified and quality services.	High
Seen by consumers a priority for change or action.	No – primarily being advocated for by consumer and representative groups, but current concerns about the cost of residential care for older people if a significant concern for consumers. This area of focus was also recommended for Healthwatch England in a recent cross-house Parliamentary Inquiry.	Mid
Has been raised by local Healthwatch informally, through the hub or through report recommendations.	Yes – informally through conversations with local Healthwatch about the reform of adult social care	Mid
A growing or changing trend in national statistics.	Yes – increasingly ageing population living longer, with care and support needs. Yes – councils increasing eligibility at a local level and taking wider resources into account in financial assessments	High
Can be resolved by a policy or practice intervention by Healthwatch England or local Healthwatch.	Yes – the Department of Health is currently consulting on a cap on care costs and the introduction of a national eligibility threshold Yes – the Care Bill is currently passing through the House of Lords Yes – the Children & Families Bill is passing through the House of Lords	High
Something Healthwatch England has the capacity	Yes – internal / committee expertise and sufficient networks	High

and/or resource to address.		

Balance score: Mid

Balance	Assessment	High / Mid / Low
National with local concerns.	National and local	High
Issues faced by all ages with children and young people, working age adults or older people.	Primarily older people and only some working age adults	Low
Issues that apply to health or social care with both health and social care.	Just social care	Low
Issues faced by the greatest volume of consumers with smaller groups of consumers with greater levels of need.	Both	High
Issues that can be addressed reactively with proactively and prospectively.	Proactively	High

Option D: rights to independent advocacy

Description: concerns have been raised about the lack of general statutory right to independent advocacy in social care meaning that some are unable to be meaningfully involved in decisions that affect their life and care. Some stakeholders have also raised concerns about the adequacy and sustainability of independent advocacy provision under the Mental Capacity Act and the Mental Health Act.

Criteria score: High

Criteria	Rationale	High / Mid / Low
A threat or breach of a consumer right in health and social care (based on the forthcoming Healthwatch Consumer Rights framework).	Yes – a threat to, and potentially breach of the right to be listened to and the right to be involved.	High
Seen by consumers a priority for change or action.	Yes – particularly those requiring support and their families. Also been advocated for by representative groups	High
Has been raised by local Healthwatch informally, through the hub or through report recommendations.	Yes – through the hub and informally, but primarily from those with previous / additional experience of providing advocacy	Mid
A growing or changing trend in national statistics.	Yes – decreased funding for advocacy, IMHA and IMCA services reported	Mid
Can be resolved by a policy or practice intervention by Healthwatch England or	Yes – House of Lords Committee on the Mental Capacity Act 2005 currently sitting	High

local Healthwatch.	Yes – Care Bill is currently passing through the House of Lords (information and advice clauses) Yes – CQC thematic review of emergency mental health care Yes – No 10. Dementia challenge	
Something Healthwatch England has the capacity and/or resource to address.	Yes – internal / committee expertise and sufficient networks	High

Balance score: High

Balance	Assessment	High / Mid / Low
National with local concerns.	National and local	High
Issues faced by all ages with children and young people, working age adults or older people.	Primarily working age and older people	Mid
Issues that apply to health or social care with both health and social care.	Both	High
Issues faced by the greatest volume of consumers with smaller groups of consumers with greater levels of need.	Smaller groups of consumers with greater levels of need	High
Issues that can be addressed reactively with proactively and prospectively.	Proactively	High

Option E: young people and the secure estate

Description: concerns have been raised about the health, care and wellbeing of young people in the secure estate (secure children's homes, secure training centres and young offender institutions), given that these young people have higher levels of unmet need and mental health problems than others. Stakeholders are concerned about the effects of admission, their treatment during their stay and the continuity of care after discharge.

Criteria score: Mid

Criteria	Rationale	High / Mid / Low
A threat or breach of a consumer right in health and social care (based on the forthcoming Healthwatch Consumer Rights framework).	Yes – a threat to the right to a safe, dignified and quality service, the right to be listened to, the right to be involved and the right to live in a healthy environment	High
Seen by consumers a priority for change or action.	No – primarily advocated for by representative groups	Low

Has been raised by local Healthwatch informally, through the hub or through report recommendations.	No – but was contained in LINK reports previously and has partially been raised in informal conversations with local Healthwatch	Low
A growing or changing trend in national statistics.	Not identified	Low
Can be resolved by a policy or practice intervention by Healthwatch England or local Healthwatch.	Yes – practice at a local level Yes – engagement with the Youth Justice Board	Mid
Something Healthwatch England has the capacity and/or resource to address.	Yes – internal / committee expertise and sufficient networks	High

Balance score: Mid

Balance	**Assessment**	**High / Mid / Low**
National with local concerns.	Primarily national, but some local	Mid
Issues faced by all ages with children and young people, working age adults or older people.	Children and young people	Low
Issues that apply to health or social care with both health and social care.	Both	High
Issues faced by the greatest volume of consumers with smaller groups of consumers with greater levels of need.	Smaller groups of consumers with greater levels of need	Mid
Issues that can be addressed reactively with proactively and prospectively.	Proactively	High

Below are the thematic concerns longlisted by the Healthwatch England SMT:

- **Impact of the reconfiguration of health and social care services at a local level on the continuity of treatment and care**: raised by many local Healthwatch, however we will be addressing this through a new project to bring together local Healthwatch to identify how local services are affected by reconfiguration and develop best practice in engaging in it.

- **Lack of communication and joint working between different health and social care agencies at a local level:** the consequences of which are frequently raised by consumers and local Healthwatch, however Anna Bradley now sits on the board of the Integration Transformation Fund and can ensure the experience and engagement of people using health and social care is at the heart of the implementation.

- **Access to, and availability of, GP services:** frequently raised by local Healthwatch, consumers and strong theme from our deliberative event.

- **Adequacy of staffing levels in NHS hospitals:** frequently raised by consumers and local Healthwatch. This concern was captured in the Francis, Keogh and Berwick reviews, the

Government is expected soon and we anticipate that other organisations will be focusing on address this in the future.

- **Adequacy of communication and English-language skills in health and social care:** frequently raised by consumers. This concern was captured in the Francis, Keogh and Berwick reviews, the Government is expected soon and we anticipate that other organisations will be focusing on address this in the future.

- **Lack of, or delayed, access to talking therapies for people with mental health conditions:** raised by consumers, advocacy groups and previous LINKs groups.

2.3 What happen next?

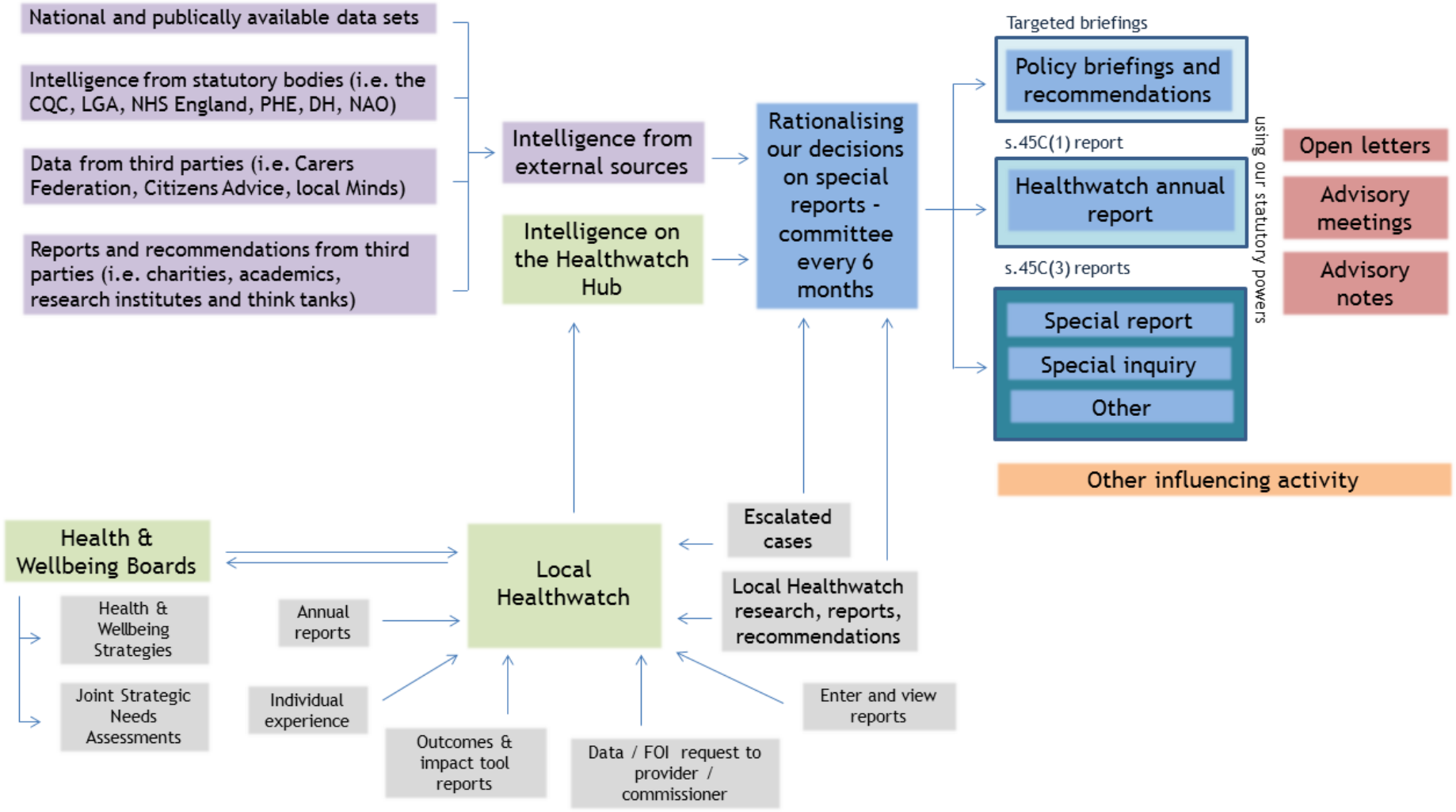
Once the committee has chosen a thematic priority, Healthwatch England staff will develop a proposed specification for this work that will brought back to the next committee meeting for further discussion and agreement.

For DISCUSSION and DECISION by the committee:

- The Committee are asked to APPROVE this approach to using our information and advisory powers.

- The Committee are asked to DISCUSS and APPROVE which of the thematic issues Healthwatch England should pursue as first priority

Deciding priorities for our special reports



AGENDA ITEM 10 – PUBLIC POLICY UPDATE

RESPONDING TO THE RECOMMENDATIONS OF FRANCIS, KEOGH AND BERWICK

Below is a paper proposing Healthwatch England's positions on the recommendations made by Sir Robert Francis QC and the proceeding independent reviews by Professors Don Berwick and Sir Bruce Keogh, ahead of the next stage of the Government's official response.

This paper gives and overview of our proposed positions to the recommendations made around:

- The duty of candour
- Complaints handling
- Position of the Healthwatch network

It also includes an update on the complaints campaign the Healthwatch network is currently developing.

1. Duty of Candour

Sir Robert Francis QC proposed a new statutory duty of candour, meaning that health and social care providers who believe or suspect that their treatment or care has caused death or serious injury have to inform and give an explanation to the person affected and / or their family.

The debate surrounding the duty of candour centres around three core questions:

1.1 Should it be placed in statute? (Francis recommendation 181)

Prior to the Francis review, there had been a number of calls[i] for a statutory duty of candour; however these had not been acted upon by previous administrations. Francis proposed a statutory duty of candour[ii], which was accepted by the Government[iii] and would extend the contractual duty that had initially been proposed.

Professor Berwick (recommendation 10), in his review[iv] of patient safety, agreed that if a 'serious incident' occurred a patient and/carer should be notified, however said that an automatic duty of candour - where patients are told about 'every error or near miss' - would increase defensiveness and bureaucracy in the system. He recommended further research to understand disclosure of incidents to patients could best be balanced.

Our proposed position:

The public tell us that they are told about mistakes in their treatment and care, or that their loved ones', too late and too many patients and families have to battle with professionals and providers to find out what went wrong and why this happened. They are worried that this lack of openness, transparency and candour results in small mistakes quickly escalating and more serious ones being repeated time and time again.

These concerns were recognised and repeated by Francis, Keogh[v] and Berwick in their independent reviews of healthcare in England. A statutory duty will act as an impetus for change and help to rebuild public confidence that was lost in the crises that occurred at Mid Staffs, Morecombe Bay and Winterbourne View. But only if it operates across both health and social care services.

We believe that patients, people who use care services, and their families have a right to know when things have gone wrong with their treatment or care. They should be told about these errors in a prompt and sensitive manner, have questions answered, be offered support to help them come to terms with the consequences of these mistakes and if necessary, be signposted to organisations that can help them seek redress.

We support a statutory duty of candour, as anything weaker than this (i.e. a contractual duty) would not act as a deterrent to poor practice. However, we recognise both the Government and Professor Berwick's concerns that a duty will not be the full resolution, and agree that there is a wider culture intervention that is needed to promote greater openness, transparency and candour in both health and social care.

We also agree that exposure to, and the development of skills in, candour should feature as a core part of training for health and social care professionals. This should be in collaboration with people who use these services to ensure professional's gain a greater insight into the value people place on open and transparent conversations about when things go right and go wrong with their treatment or care.

Healthwatch England is committed to supporting the health and social care system players to establish a new culture of openness and transparency, where candour is a normative way of working, and where the statutory duty and any proposed criminal sanctions are only used as a backstop for the enforcement of candour.

1.2 Should it be placed on both organisations and individuals? (Francis recommendation 181)

The Government has suggested that the statutory duty of candour only applies to organisations, as extending it to individuals would create a culture of fear amongst professionals in the system. Rt. Hon. Jeremy Hunt did, however, say that he would review this decision once the review, led by Professor Don Berwick, on patient safety was completed.

Our proposed position:

We agree with the Government's intention to introduce at duty of candour on organisations and with the recognition that this duty must cover all health and social care providers to ensure consistency of improvement across the system. However, we believe that the Government must extend the duty of candour to cover both organisations and individual professionals, and therefore disagree with the Government and Berwick's conclusions.

Organisations can only comply with a duty of candour, if they are told about an incident or understand the context in which an incident took place. If the incident was actively hidden from the organisation by staff and the organisation could not have reasonably known about the incident, then accountability must also lie at the individual level.

Few of the professional standards for health and social care professionals (expect those of the General Medical Council and Nursing and Midwifery Council) explicitly mention candour. We agree with Professor Berwick that embedding this into the standards would be a useful starting point in breeding a culture of candour within the health and social care professions.

However, like the public, patient's groups and some professional bodies, do not think professional standards and codes of practice act as an adequate safeguard as they do not prompt the openness, transparency and candour in the moment of an incident. However, in applying this duty to individuals, we believe that the Government, professional bodies, regulators and providers must ensure that professionals are aware that complying with this duty will not prejudice any criminal or civil act taken against them.

1.3 Should it lead to criminal sanctions? (Francis recommendation 183)

Francis recommended that, as a last resort, the Care Quality Commission should be able to prosecute both organisations and individuals in cases of 'serial non-compliance' with this duty or 'serious and wilful deception'. Similarly, Professor Berwick concluded that criminal sanctions should only be used rare cases of 'neglect or wilful misconduct' or obstruction. He stopped short of calling for criminal sanctions for candour, instead focusing (recommendation 10) on a new 'general offence of wilful or reckless neglect or mistreatment applicable both to organisations and individuals'.

Our proposed position:

We recognise that Professor Berwick poses an important question about what the threshold (i.e. level of seriousness) of an incident would be that would lead to a criminal sanction.

Establishing a criminal liability will be important, as failure to comply with a duty of candour could mean that individual crises unnecessarily escalate, resulting in further abuse, neglect and preventable death, which could have otherwise been prevented. It also gives better protection to those professionals who speak up about serious incidents in the face of bullying, pressure of obstruction from their managers or colleagues.

We hope that a criminal sanction would incentivise organisations and professionals to cultivate and promote a culture of openness and transparency and have conversations about neglect, abuse and unnecessary death at an earlier stage with patients, people using care services and their families.

We do, however, recognise the Government's concerns that criminal sanctions could perversely incentive a culture of blame in health and social care and would welcome the opportunity for the Healthwatch network to support new ways of working and engaging with people who use these services that would safeguard against this.

In reality, we also recognise that the practice of candour may take different forms depending on the seriousness of the incident. For example, in a low level incident of neglect, the practice of candour might be an acknowledgement from the professional involved to the patient, an meaningful apology, a quick resolution to ensure the incident does not occur again to that patient or other on the ward and a recognition of the incident and resolution by management. However, in serious cases, where mistakes, neglect or abuses have taken place we believe criminal sanctions may need to be applied, although we recognise there may be difficulties in establishing whether or not the organisation or professional is jointly liable.

We acknowledge that there is a mixed public appetite for criminal sanctions, and whilst we see a case for applying criminal sanctions to organisations, we are currently seeking legal advice on whether extending criminal sanctions to individual would incentivise a more open and transparent system for people using it or whether adequate redress is available in existing legislation.

2. Complaints handling

The issue of candour, openness and transparency go hand in hand with discussion about patient safety, feedback and the handling of people's complaints. Francis, Keogh and Berwick all place a significant emphasis on the importance of listening and responding to feedback and complaints in improving quality and safety in the NHS. For example, Keogh wrote in his independent review of 14 failing NHS Trusts that the '*very best consumer-focused organisations, including some NHS trusts, embrace feedback, concerns and complaints from their customers as a powerful source of information for improvement*' (ambition 3).

Importantly, they all pointed to need for a stronger complaints system, whilst support people to pursue a local resolution and be supported to make their complaint. Similarly, they raised concerns about providers not using feedback and complaints to give an insight into concerns in performance and suggestions for improvement.

Francis, Berwick and Keogh specifically recommend greater visibility of patient feedback and complaints at all levels of healthcare or as Berwick out it, '*from the ward to the board*'. Additionally, he recommends that patients, families and carers should place a more active role on board to ensure that the voice of people using the services is present in decision making and to ensure that proper discussion is had about concerns and ideas for improvement. Similarly, Francis argues that more emphasis must be placed on discussion complaints as they arise (in real-time) and looking at the narrative contained in feedback and complaints, rather than boards relying on statistical data (recommendations 36 and 40). This will enable decision makers to identify thematic concerns that should be addressed in improvement activity.

Our proposed position:
We agree that patient safety and experience must be at the heart of decision making in the NHS. However to make this a reality, we are going to need a fundamentally different relationship between patients and professionals in the future. For too long, too many patients have had their safety put at risk, and people's feedback and complaints have not been listened to and acted upon.

The reviews of Francis, Keogh and Berwick are wake-up calls about the importance of overhauling the health complaints system. But, we must not forget social care and believe that any improvement in health complaints must be complimented by one in the social care system.

Consumers tell us that they want to see action and to know how professionals will be held to account for their decisions, attitudes behaviours. Currently, people are angry, frustrated and lost in the cracks of a creaking and complex system.

Polling by YouGov for Healthwatch England in March 2013 found that over half of the public who had a problem with a health or social care service in the last three years did nothing to report it, and almost half did not have any confidence that their complaints would actually be dealt with. A new complaints system must be simplified, transparent

and responsive to their needs. As such, we support Berwick's suggestion of an independent national complaints management system (recommendation 3) that simplifies the navigation of the complaint system for consumers.

Similarly, we agree that there needs to be a greater representation of patients and carers on NHS committees and boards. The Francis, Keogh and Berwick reviews showed how senior managers rarely heard directly from patients. Having greater representation on decision making tables would improve transparency and ensure that their concerns and ideas for change are listened and acted upon.

Ultimately people have told us that they don't want to make a complaint. Many have said that when it gets to a complaint it feels like communication has broken down and they can't find another way of having their concerns heard and responded to. People have told us that they are looking for an acknowledgment of what went wrong, a timely and adequate response and an assurance that it won't happen again. This is why cultivating a culture of candour in health and social care is so important to people. People should not have to raise a concern in the form of a formal complaint for it to be taken seriously and for the provider to take action, and in this we agree with Francis (recommendation 112).

People have raised concerns about the sufficiency and coverage of local Independent Complaints Advocacy Services (ICAS) and the extent to which they are supporting individual cases in to find and local resolution to their concern or complaint. Some ICAS have been commissioned to the same organisation that runs the local Healthwatch. In these areas we are starting to see effective work to support individual complainants as well as using this intelligence to pursue collective feedback and concerns about a local provider. There could be a viable opportunity to co-commission ICAS with local Healthwatch to create a better offer to consumers who have a concern about their local health or social care service. In this respect we

Further, to strengthen the ability of local Healthwatch to ensure improvements are made to local services, we fully support Francis' suggestion (recommendation 119) that they should have access to detailed information about complaints about providers in their local area and would encourage the Government to support us in taking action to implement this.

2.1 What is Healthwatch England doing on complaints?

Building on our initial video report into people's experiences of making complaints in health and social care, we are working towards a new consumer campaign, which ensured that people's concerns and complaints are received, acted up and responded to.

The campaign will aim to:

- To influence the direction of national legislation, policy and guidance to ensure the health and social care complaints systems are redesigned to benefit consumers.

- To create positive improvements to local complaints systems and demonstrate best practice to system players.

- To educate the public and consumers about their rights around complaints in health and social care.

To make this a reality we will run a programme of campaign activity with partners across the consumer and patients' rights movement. This will include:

- ***A national policy focus:*** bringing together consumers, advocacy groups, commissioners and to co-design a new national system for complaints, underpinned by tangible policy asks. This element would draw on people's experiences, international insight and intelligence about system used in other policy areas. It will demonstrate, through co-design, the value of having people / consumers as equal partners in reforming the system.

We agree with Berwick (recommendation 3) that providers should continually improve their local complaints systems and to this end we would:

- ***A local practice focus:*** bringing together local Healthwatch, consumer groups, patient groups, commissioners and providers at a local level to resolve problems with the complaint systems in their own community. Through joint working they would co-design (in real-time) practical solutions to improve their local complaints systems for the better. These trailblazers would help us create good practice resources and campaign materials that can be used across the partnership.

- ***A consumer rights focus:*** producing a range of materials that enable consumers to navigate their way through the reconfiguration of health and care services, understand their rights and use complaints systems. It would include the creation of information and advice products, and targeted interventions to 'at risk' consumer groups (this might include people with mental health conditions, limited mental capacity, and children and young people).

3. Commentary on Healthwatch England and local Healthwatch

3.1 Local Healthwatch settlement

Francis asserted in his review that the 'resources supplied to local Healthwatch must be sufficient to reflect what is needed for its duties'. He also highlighted concerns from witnesses that if the settlement was not ring-fenced, some of the money might not reach local Healthwatch operations and be used to address other financial pressures in local authority budgets.

Our proposed position:

We recognise the concerns about the money not being ring-fenced, but think this is more of an issue of transparency. Like Francis and the public we also want reassurance that the full local Healthwatch allocation is being spent on local Healthwatch operations and governance. To this end, we will be working to map the difference between the settlement for local Healthwatch and the level of funding that has been given to local Healthwatch.

3.2 Consistency of local Healthwatch

Francis agreed with witnesses that there should be a consistent basic structure for local Healthwatch.

Our proposed position:

It is right that local Healthwatch are commissioned and structured to reflect the needs of their local community, and their focus should be driven by the concerns and experiences of people using health and social care services in their area.

We believe that the consistency in the outcome and impact of local Healthwatch activity is more important than the structure. To this end we are working with the Local Government Association on an impact and outcomes tool to help local Healthwatch better monitor the impact of their work, and Healthwatch England to better understand where to put in addition resource to support local Healthwatch to increase the impact of their work.

At present, we are concerned about the inconsistencies in the commissioned length of contract for local Healthwatch meaning that people could have moments of inconsistency and lack of representation on a yearly basis. We are discussing this with our contacts at the Department of Health and the Local Government Association to ensure there is continuity for people in these communities at times of transition.

3.3 Effectiveness of the Healthwatch network

Berwick highlighted concerns of some witnesses that the Government should consider returning to earlier models of representation, such as Community Health Councils (CHCs).

Our proposed position:

The health and social care system are going through a significant period of changing and it is important that consumers' voices are championed in the reform.

The Healthwatch network is still young, but we have new statutory powers that our predecessors did not. Rather than throwing things up in the air, now is the time to test our statutory powers and use them to ensure that local patient voices are at the heart of decisions about the design, commissioning and delivery of health and social care services. We may find that our powers of intervention need to extended, and we will make the case for this if/when the time comes.

In addition to our own monitoring and evaluation of our performance, and that of local Healthwatch, we have begun to work with the Department of Health's Health Reform Evaluation Programme team to ensure that the Healthwatch model is adequately captured in this evaluative work.

Notes

[1] For example see:

Department of Health (2003) Making Amends: A consultation paper setting out proposals for reforming the approach to clinical negligence in the NHS (A report by the Chief Medical Officer):
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4060945.pdf

Health Select Committee (2009) Patient Safety: Sixth Report of Session 2008–09:
http://www.publications.parliament.uk/pa/cm200809/cmselect/cmhealth/151/151i.pdf

[1] Mid Staffordshire NHS Foundation Trust Public Inquiry team (2013) Reports of the Mid Staffordshire NHS Foundation Trust (Francis) Public Inquiry:
http://www.midstaffspublicinquiry.com/report

[1] Department of Health (2013) Patients First and Foremost: The initial government response to the report of The Mid Staffordshire NHS Foundation Trust Public Inquiry:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170701/Patients_First_and_Foremost.pdf

[1] National Advisory Group on the Safety of Patients in England (2013) A Promise to Learn – A Commitment to Act: Improving the safety of patients in England (Berwick Review):
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

[1] Professor Sir Bruce Keogh (2013) Review into the quality of care and treatment provided by 14 hospital trusts in England: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf

AGENDA ITEM 11 - INFORMATION GOVERNANCE UPDATE

INFORMATION GOVERNANCE UPDATE

Context update

On 26th April 2013, Dame Fiona Caldicott published the findings of her second Independent review of how information about patients is shared across the health and care system. This new report builds upon her first independent review in 1997.

Healthwatch England has welcomed the report, recognising that the new proposals will help to build people's confidence and trust in health and social care services. In particular, we welcome the revised list of Caldicott principles and their extended application to both health and social care.

Because of their importance to people's experience and engagement in the system we include them in full below for the committee's information.

1. Justify the purpose(s): Every proposed use or transfer of personal confidential data within or from an organisation should be clearly defined, scrutinised and documented, with continuing uses regularly reviewed, by an appropriate guardian.

2. Don't use personal confidential data unless it is absolutely necessary: Personal confidential data items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).

3. Use the minimum necessary personal confidential data: Where use of personal confidential data is considered to be essential, the inclusion of each individual item of data should be considered and justified so that the minimum amount of personal confidential data is transferred or accessible as is necessary for a given function to be carried out.

4. Access to personal confidential data should be on a strict need-to-know basis: Only those individuals who need access to personal confidential data should have access to it, and they should only have access to the data items that they need to see. This may mean introducing access controls or splitting data flows where one data flow is used for several purposes.

5. Everyone with access to personal confidential data should be aware of their responsibilities: Action should be taken to ensure that those handling personal confidential data — both clinical and non-clinical staff — are made fully aware of their responsibilities and obligations to respect patient confidentiality.

6. Comply with the law: Every use of personal confidential data must be lawful. Someone in each organisation handling personal confidential data should be responsible for ensuring that the organisation complies with legal requirements.

7. The duty to share information can be as important as the duty to protect patient confidentiality: Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.

We also welcome the proposed extension to the NHS Constitution, which makes more explicit the informational rights of people using health and social care services and the corresponding pledges:

- You have the right of access to your own personal records within the health and social care system.
- You have the right to privacy and confidentiality and to expect the health and social care system to keep your confidential information safe and secure.
- You have the right to be informed about how your information is used.
- You have the right to request that your confidential data is not used beyond your own care and treatment and to have your objections considered, and where your wishes cannot be followed, to be told the reasons including the legal basis.

As we continue to develop and strengthen our own consumer rights framework we propose that these be used as part of our investigation.

Information governance update

Healthwatch England is embedding good information governance in its own work with people who use health and social care, and cultivating good practice and behaviours by local Healthwatch.

To this end, over the summer Healthwatch England has begun to put in place measures to improve our information governance.

These activities include:

1. Creating and launching an Information Sharing Agreement (ISA)

As part of the launch of the Hub we published the Hub's Terms and Conditions, Privacy Statement and Copyright statement in May 2013. When a local Healthwatch registers for the Hub, they are asked to read a guidance document on information governance and issues relating to Hub usage.

We published a draft Information Sharing Agreement (ISA) in June 2013, and announced that we will be developing an information governance program to ensure we adhere to the Caldicott principles. Local Healthwatch were given the opportunity to comment on, or query, this draft ISA. The final ISA went live on Monday 9 September and the committee are asked to review and approve the final ISA that is included in the annex to this paper.

2. Improving the compliance of the Info Bank

We are commissioning in November 2013 changes to Info Bank that will improve information governance by alerting the person inputting data of values that have been entered that could potentially violate the ISA (including people's names, patient I'd numbers or full postcodes). These values will then need to be addressed before the form can be submitted.

The Info Bank will also be equipped with a check box, for the person entering the data, to confirm that s/he has reviewed the entire form in light of the agreed information governance principles and related guidance.

The Intelligence team regularly extracts data from the Info Bank and examines fields for the presence of information that violates the ISA, and have reminded local Healthwatch of agreed practice when this happened.

The Intelligence, Digital and Operations teams are working together to ensure this compliance is maintained as we design and migrate to the new Customer Relationship Management (CRM) system.

3. Compliance of the hub

We have also checked the compliance of the hub with information governance best practice.

We can confirm that the data on the hub is hosted in Europe (Dublin and Amsterdam).

The SharePoint side of the Hub is compliant with world-class industry standards, including ISO 27001, EU Model clauses, HIPAA BAA, and FISMA, and it is verified by third-party auditors.

The Info Bank side which is built on the Azure platform is in compliance with key industry standards, including ISO/IEC 27001:2005.

ISO 27001 is the international standard for information security. The standard is reflected in the requirements of the Information Governance Toolkit (which NHS bodies are required to comply with), and the Security Policy Framework (which government departments and Arms-length Bodies are required to comply with).

4. Next steps

To ensure we continually improve our information governance:

The Intelligence and Operations team will be working together to produce an Information Governance protocol for Healthwatch England for the committee to discuss and agree in December 2013. This protocol will specify all of the activities, procedures and behaviours needed to ensure we improve our information governance.

Once the protocol has been finalise, the Intelligence and Development teams will be working together to design and deliver information governance training and resources for local Healthwatch to ensure they are compliant with the legislation and the new Caldicott principles. We anticipate that this training and associated resources would be tied to our new offer around CRM and data collection.

The intelligence team will continue to provide insight from the hub on people's experience of information governance and security in health and social care to John Carvel (committee member) who represents Healthwatch England on the Care Quality Commission's National Information Governance Committee and in his position on the new Independent Information Governance Oversight Panel chaired by Dame Fiona Caldicott.

Appendix available separately

- PDF of Information Sharing Agreement

AGENDA ITEM 12 – ORGANISATIONAL DEVELOPMENT

ORGANISATIONAL DEVELOPMENT

We have undertaken an organisational review to consider the achievements gained so far during the first delivery phase, to capture the learning from this phase, to understand more about where we are currently as an organisation, and to be able to think more about the direction of the organisation going forward with a view to identify what the immediate and longer term needs are.

The review took two forms; an initial one-day session led by the Senior Management Team followed with a half day review involving the full staff team. Both sessions began with reviewing the key achievements that have enabled the organisation to grow so far. It was agreed that achievements include;

- Developing the Healthwatch brand, being clear about what we are here to do, and taking this clear message into communities
- Building good relationships with Local Healthwatch
- Growing a diverse, skilled team who are also flexible and support one another
- Being able to develop the organisation whilst being 'open for business' at the same time
- Understanding and working within the CQC support frameworks relating to finance, HR, IT and information sharing

The key learning points gained so far include;

- Understanding the responsibility of being able to provide expertise and guidance in both the health and social care arenas with limited capacity
- Using the valuable learning from Local Healthwatch as it arises
- The value of relationships with others
- Accepting there is still so much more to do

In summary, it was agreed that the Healthwatch journey so far (and going forward) could be demonstrated in three distinct phases;

- The **recognition** phase – by reviewing the journey so far we were able to recognise the hard work, dedication and commitment from staff members to grow the organisation during the initial setting up period. This phase has ended but we felt it was essential that the learning was captured.
- The **investment** phase – from acknowledging the input from staff it enables us to now think about what else is needed to continue to successfully grow and develop the team and the organisation. It was agreed that this is the current phase.
- The **vision** – this is summarised as being the next phase of the journey, being the place where the organisation consistently performs well.

The diagram below demonstrates this:

Recognition	Investment	Vision
Recognising the achievements so far Considering the learning Saying thank you to everyone who made this happen Admiring the individual and collective energy, sense of fun and informality	Building on the achievements Using the learning Strengthening the team Stabilising the team Asking questions of the team… what would you like?	Consistently achieving Constantly fresh with new learning Continue to invest in the team Growing capacity Reaching and realising potential
The energising phase	**The stabilising phase**	**The performing phase**

Moving forward from the **investment** phase to achieving the **vision,** the following development needs have been identified and prioritised;

- To continue the recruitment of the Healthwatch team so all vacancies are filled by permanent members of staff by the end of quarter 3.
- To understand more about staff development needs – understanding what further learning/support needs they have to undertake their role well. An initial staff development plan will be created in quarter 3 and then tested in quarter 4.
- To continue to build relationships with Local Healthwatch and support their development and growth - this work will be on-going.
- To capture the learning through the development of a robust CRM system. This will be developed and tested in quarter 3.
- To develop processes that support Healthwatch England and Local Healthwatch development such as data sharing protocols and how to responds to DPA and FOI requests. This work will be on-going but has begun during quarter 2.

There is strong commitment to focus on activities that benefit Healthwatch England and Local Healthwatch jointly. For example, by developing a CRM system at Healthwatch England it can be shared with Local Healthwatch enabling them to have use of developed system saving them time, energy and resources. It also enables us to have a consistent information gathering approach across all Local Healthwatch.

The Next Steps

The Senior Management Team will continue to review the progress towards the priorities and there is a further development day planned for October 2013. The next full staff team meeting takes place in October (and continues monthly beyond then) to update the team of the continuing progress made and to gain their input and commitment to moving towards the **vision** phase.

END OF PAPERS