Healthwatch England
Committee Meeting
Hilton Blackpool
Promenade, Blackpool FY1 2JQ
Public Committee Meeting  
25 April 2018 - Starting with tea, coffee, pastries at 08.30-09.00

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<tr>
<td>1.1 Welcome and apologies</td>
<td>JM</td>
<td>To open the meeting</td>
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<td>1.2 Declarations of interests</td>
<td>JM</td>
<td>Committee Members to declare any interests</td>
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<td>1.3 Minutes of the last meeting, action log, review of agenda and matters arising</td>
<td>JM</td>
<td>To confirm the minutes and discuss the matters arising</td>
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<tr>
<td>1.4 Chair’s Report</td>
<td>JM</td>
<td>For discussion</td>
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<td>1.5 National Director’s Report</td>
<td>IR</td>
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<td>1.6 Committee Members Update</td>
<td>Committee</td>
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<tr>
<td>1.7 Mental Health Paper</td>
<td>LS</td>
<td>For information</td>
</tr>
</tbody>
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Questions from the public

10.45 - Coffee/Tea Break

<table>
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<tr>
<th>AGENDA ITEM</th>
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<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 2017/2018 Delivery and Performance Report</td>
<td>IR</td>
<td>For discussion</td>
</tr>
<tr>
<td>2.2 Audit, Finance and Risk Sub Committee Meeting Minutes including 2018/19 budget</td>
<td>DF</td>
<td>For discussion and APPROVAL</td>
</tr>
<tr>
<td>2.3 Intelligence Report 2017/2018</td>
<td>IR</td>
<td>For discussion</td>
</tr>
<tr>
<td>2.4 Business Plan</td>
<td>IR</td>
<td>For discussion and APPROVAL</td>
</tr>
<tr>
<td>2.5 KPIs</td>
<td>IR</td>
<td>For discussion and APPROVAL</td>
</tr>
</tbody>
</table>

Questions from the public

2.6 Standing Orders | JM | For discussion and APPROVAL |

Public Participation Session

Including presentation from:

Healthwatch Darlington

Close of business and lunch 13.15
### Item 1.3

**Healthwatch England Committee Meeting**

**Minutes of meeting No. 22**

**Location:** Yarnfield Park Training & Conference Centre, Yarnfield Lane, Stone, ST15 0NL

**Date:** Wednesday 31 January 2018

**Attendees**

- Jane Mordue - Chair
- Amy Kroviak - Committee Member
- Andrew Barnett - Committee Member
- Andrew McCulloch - Committee Member
- Danielle Oum - Committee Member and Chair of Healthwatch Birmingham
- Deborah Fowler - Committee Member and Trustee of Healthwatch Enfield
- Helen Horne - Committee Member and Chair of Healthwatch Cumbria
- Helen Parker - Committee Member
- Jenny Baker - Committee Member and Chair of Healthwatch Bucks
- Lee Adams - Committee Member
- Liz Sayce - Committee Member
- Pam Bradbury - Committee Member and Chair of Healthwatch Dudley
- Phil Huggon - Committee Member
- Ruchir Rodrigues - Committee Member

**Apologies**

- None

**In attendance:**

- Imelda Redmond - National Director
- Neil Tester - Deputy Director
- Joanne Crossley - Head of Operations
- Jacob Lant - Head of Policy & Partnerships
- Ben Knox - Head of Communications
- Leanne Crabb - Committee Secretary (minute taker)

## Introduction

### 1.0 Agenda Item 1.1 - Welcome and apologies

The Chair welcomed everyone to the meeting, with a special greeting to the seven new Committee members who were appointed in January 2018 and were attending their first Committee Meeting. There were no apologies.

### 2.0 Agenda Item 1.2 - Minutes, action log and agenda review

The Chair presented the minutes of 25 October 2017. It was noted by Deborah Fowler (DF) that one amendment was needed: 2.2 stated Pam Bradbury (PB) reported on work with Health Education England, this will be added to 3.0 as a declaration of interest.
2.1 The Committee approved the minutes.

2.2 Matters arising from the minutes - it was agreed that full names would be used in minutes in the first instance and initials to be used thereafter.

2.3 Helen Horne (HH) asked for an update on the mental health project asking that we give local Healthwatch enough time to plan their work streams in support. Liz Sayce (LS) responded the project is being scoped and once that’s completed clear communications will go to Local Healthwatch.

2.4 The Committee confirmed the agenda

3.0 Agenda Item 1.3 - Declarations of interests

3.1 The Committee noted that there were no real, perceived or potential conflicts of interest experienced by any member in relation to the items on the agenda.

4.0 Agenda Item 1.4 - Chair’s Report (Jane Mordue - JM)

4.1 JM presented the Chair’s report, highlighting the good work local Healthwatch have done as reflected in HWE Annual Report and stressed that we want to get better at evidencing the impact we have. She noted the power of the hundreds of changes made annually by HW and their cumulative effect. We need to be confident and have positive messages/evidence to talk about our expertise in engagement.

4.2 JM talked about the planned new strategy for HWE. She also noted and commended the letters sent to Government advising on the NHS Mandate and state of local Healthwatch funding.

4.3 Lee Adams (LA) asked if we know if we’re talking to people from protected characteristic groups. IR responded that we gather that information and will report in July and it will be incorporated into the strategy and business plan.

4.4 Phil Huggon (PH) asked for timescale regards to response from Secretary of State re local Healthwatch funding. IR reported that this is being chased up.

4.5 There was a discussion on NHS performance measurements and whether HWE can influence this, if there is appetite for change, and if engagement could be included as a measurement. IR advised we are working with the NHS on this.

4.6 Jenny Baker (JB) raised the point that every surgery should have a Patient Participation Group (PPG) but these groups can range from very strong and effective to a notional online group that never meets. JB would like to see this reviewed across the network due to the important role they have in giving patients a voice. IR advised we will consider this issue later in the year.

4.7 The Committee noted the report

5.0 Agenda item 1.5 -National Director’s Report (Imelda Redmond - IR)
<p>| 5.1 | Before presenting her report Imelda Redmond reflected on her first year with Healthwatch and thanked the Committee, colleagues and the network. She commented that there is real potential in us all working together to become part of the fabric across the whole country with the future strategy. |
| 5.2 | IR stated that more resources would go into stakeholder relationships. Healthwatch has a lot of potential as we are in a unique position of being in every Local Authority area and on every Health &amp; Wellbeing Board. |
| 5.3 | IR reported that HWE has nearly a full complement of staff. Andy Payne has left and will be replaced by Gavin MacGregor as Head of Network Development in early March. |
| 5.4 | IR informed the committee that the annual conference has been moved to 3 and 4 October this year and will be used to promote the HWE Annual Report and 70th anniversary of the NHS. It will be held in Stratford-Upon-Avon. |
| 5.5 | IR has been asked to join the Advisory panel on the Green Paper on Social Care and has established an advisory group made up of local Healthwatch who are helping put the reality checks into our work. IR also said she is on an advisory group for STP (sustainability &amp; transformation plan) for NHSE. |
| 5.6 | IR talked through the Intelligence Summary report. Danielle Oum (DO) noted that the Intelligence Summary talks of quantity not quality. IR acknowledged this and stated we will be more proactive with templates and toolkits to support the local Healthwatch in sharing good quality reports including Enter &amp; View. There was a discussion about the Intelligence Summary and suggested that it be sent to local Healthwatch and be given a slot on the agenda. |
| 5.7 | Andrew Barnett (AB) asked for an update on engagement and research. IR informed the Committee that we have commissioned a literature review. AB also asked if we reuse previous research. IR confirmed that we do. |
| 5.8 | Ruchir Rodrigues (RR) queried how feedback from local Healthwatch had increased by 85% compared to the same period last year, and asked for the top three challenges were for HWE and local Healthwatch. IR responded that the increase was due to an investment of resources and time, and that the top three challenges could be added to the Intelligence Summary in the future. |
| 5.9 | The Committee noted the report |
| 6.0 | <strong>Agenda item 1.6 - Committee Members update - verbal</strong> |
| 6.1 | HH advised that she had attended a conference in Manchester on devolution and stated that she was pleased to see the ten authorities are working well together. |
| 6.2 | Pam Bradbury (PB) stated that as a volunteer of a Leadership Academy she was approached to ask if Healthwatch wanted to be involved in apprenticeship’s planning &amp; training. Four of her local Healthwatch are interested and the apprentices will go into NHS or Social Care. |
| 6.3 | DF reported on a recent commission to work with Healthwatch Enfield’s local A&amp;E talking to patients to understand why they need to use the services. She will keep the Committee informed. |
| 6.4 | Danielle Oum (DO) talked about a play called ‘Phyllis’ which has been commissioned by an STP and explores the perspective of having dementia from the patient and family’s viewpoint. During the play the audience, many of them providers, were consulted. The play gave a very powerful message. DO will find out if the play can be shown elsewhere. |
| 6.5 | Andrew McCulloch (AM) advised he had gone to the King’s Fund event called Community Health Services, and that they had produced a worthwhile report. AM noted that community health doesn’t often feature highly in local Healthwatch reports and it would be good to see more. |
| 6.6 | JB advised that she attended an MEP breakfast meeting on behalf of the European Neurological Alliance and there was a presentation on Brexit. |
| 7.0 | <strong>Agenda item 1.7 - Audit, Finance and Risk Sub Committee (AFRSC) (Deborah Fowler - DF)</strong> |
| 7.1 | DF informed the Committee that the AFRSC had met on 22 January 2018 and gave an overview of the finances: there is a predicted underspend of 18%. This has been caused partly by the time taken to recruit but also by procurement issues, caused by both internal and CQC system issues. DF stated the internal problems were disappointing as we thought the issue of the underspend had been improving. DF reassured the Committee that we are not expecting to be penalised for the underspend in the next budget. |
| 7.2 | There was a discussion regarding the underspend and procurement process, with Committee Members asking for further information. JC advised she would send out procurement log to the Committee. IR gave reassurance that the internal underspend issues have been dealt with and that there are plans in place to improve procurement. |
| 7.3 | The Committee noted the report. |
| 8.0 | <strong>Agenda item 2.1 - Sustainability Challenges of the Healthwatch network (Jacob Lant - JL)</strong> |
| 8.1 | JL went through the presentation. He noted in particular a graph comparing the levels of award for local Healthwatch comparing actual funding and the funding for our predecessor, LINks. Noting the Staffordshire correspondence, he reiterated that HWE will write to Local Authority leaders to emphasise steps we’ll take if proposed funding cuts prevent them carrying out their statutory duties. |</p>
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<tr>
<th>Section</th>
<th>Description</th>
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<tr>
<td>8.2</td>
<td>LA asked if some local Healthwatch funding is too low to run a service on. JL confirmed there was a big variation in network funding and the headline figures. IR advised in future Committee Meetings there will be a risk matrix so we know which local Healthwatch to focus on regarding low funding.</td>
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<tr>
<td>8.3</td>
<td>There was a discussion on the issues raised in the paper including how we know the minimum needed to run a local Healthwatch, and also conflation of additional income with core funds, key components of a local Healthwatch, what caused over 30 local Healthwatch to get an increase in funding; also to look at prior data on funding. It was agreed to consider these and identify levers we could use to safeguard local Healthwatch funding. IR confirmed that this would be part of our strategy. As a first step, given the importance and urgency of stopping the downward trend, it was agreed to have a sub group to consider and report back to the next meeting. The Chair asked Phil Huggon (PH) to lead.</td>
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<td>8.4</td>
<td>The Committee noted the report</td>
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<tr>
<td>9.0</td>
<td>Agenda item 2.2 - Delivery Report (Neil Tester - NT)</td>
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<tr>
<td>9.1</td>
<td>NT introduced the delivery report and explained it is a snapshot of how HWE deployed its resources. He highlighted that HWE is heading up one strand of the NHS70 celebrations and will be supporting network activity.</td>
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<td>9.2</td>
<td>Amy Kroviak (AK) suggested HWE take the opportunity of the NHS70 celebrations to highlight HWE being the voice of the people. She noted the increase of mentions, and asked for further breakdown. NT to share figures on media coverage.</td>
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<td>9.3</td>
<td>Pam Bradbury (PB) questioned if signposting figures have been published. NT will check and advise.</td>
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<td>9.4</td>
<td>Committee members underlined the importance of a strong communications strategy to further raise the profile of HWE. IR confirmed that this would be considered as part of the business planning process.</td>
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<tr>
<td>9.5</td>
<td>The Committee noted the report</td>
</tr>
<tr>
<td>10.0</td>
<td>Agenda item 2.3 - Quarter 2 2017/18 - Financial update (Joanne Crossley - JC)</td>
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<tr>
<td>10.1</td>
<td>JC summarised the financial update report, highlighting procurement issue. She advised that HWE are looking increasing the number of staff to reduce the need to procure external suppliers.</td>
</tr>
<tr>
<td>10.2</td>
<td>The Committee noted the report</td>
</tr>
<tr>
<td>11.0</td>
<td>Agenda item 2.4 - Quarter 3 2017/18 - Performance Report (Imelda Redmond - IR)</td>
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<tr>
<td>11.1</td>
<td>IR presented the Quarter 3 performance report, stating that in future we will have a new way of reporting, to align with the new strategy. The top line is there are no concerns regarding outputs.</td>
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<tr>
<td>11.2</td>
<td>The Committee queried how effective the current KPIs were. IR advised that these were a stop gap and that there will be new ones with the new strategy.</td>
</tr>
<tr>
<td>11.3</td>
<td>The Committee noted the report</td>
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<tr>
<td>12.0</td>
<td><strong>Agenda item 2.5 - Summary of audit completed by PricewaterhouseCoopers (Deborah Fowler - DF)</strong></td>
</tr>
<tr>
<td>12.1</td>
<td>DF compared the 2015 audit where HWE had 14 recommendations to the 2017 audit in which it was confirmed all previous 14 recommendations had been dealt with and HWE were given only two new ones, both low priorities. DF congratulated Joanne Crossley (JC) and Sandra Abraham (SA) and the Operations Team.</td>
</tr>
<tr>
<td>12.2</td>
<td>The Committee noted the report</td>
</tr>
<tr>
<td>13.0</td>
<td><strong>Agenda item 2.6 - Strategy (Imelda Redmond - IR)</strong></td>
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<tr>
<td>13.1</td>
<td>IR introduced the final version of the new strategy. This has been developed over the past nine months working with a wide range of stakeholders. She thanked all involved for their input. She recognized that new Committee members were coming to this without prior involvement but with fresh eyes. A Business Plan would be developed for the March Committee workshop where there would be ample opportunity to consider how we will actually deliver.</td>
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<tr>
<td>13.2</td>
<td>The Committee agreed the three aims: 1. Support you to have your say 2. Provide a high-quality service to you and 3. Ensure your views help improve health and care. They explored what was meant, under 1. by ‘We want more people to get the information they need to make decisions about their wellbeing, care and the services that support them.’ Did this give us an active role in improving public health? With our seats on Health and Wellbeing boards this is clearly something that is important to us but our role, as the Chair reminded members, is to ensure ‘public involvement in decision-making about health and care’. JM confirmed that major work on public health had been put out of scope. Members also commented on some use of language in the strategy. JM welcomed the opportunity for Committee members to email tweaks to the language used to IR. Leanne Crabb (LC) to email out the strategy to all members of the Committee to look at the wording of the document. JM asked if the Committee were happy to agree to sign off of the document now. The Committee all agreed they were.</td>
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<tr>
<td>13.3</td>
<td>The Committee discussed strategy, the need to track impact and quality, and HWE media presence. IR advised that this would form part of the future performance report.</td>
</tr>
<tr>
<td>13.4</td>
<td><strong>Decision</strong> The Committee approved the Strategy document</td>
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<tr>
<td>14.0</td>
<td>Agenda 3.0 - Public Participation</td>
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<tr>
<td>14.1</td>
<td>Comments were made from members of the public audience regarding difficulties in hearing all the discussions, and not enough hard copies of the papers being available. LC to provide microphones at the next meeting and will make more hard copies of papers available.</td>
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<td></td>
<td>LC</td>
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| 14.2 | Other questions/comments from the public: |
|      | It was suggested HWE work with Diabetes UK as they have a huge amount of knowledge HWE can plug into. IR confirmed HWE has approached charities that are keen to work with us; we will be going back to them to work out the specifics. |
|      | - There was another recommendation to see the play ‘Phyllis’ as mentioned in 6.4 |
|      | - It was expressed that the meeting was useful and that resources should be used to ensure all local Healthwatch understand the priorities, especially volunteers who often have underused skills we could tap into. |
|      | - A request was made for a group to be set up to work with organisations to improve communication with public, family and carers regarding care packages, discharge from hospital, and understanding the planned needs for surgery. |
|      | - A comment was given that people should be encouraged to explore and learn about the illness they have so they can be better informed about decisions. |
|      | - A couple of suggestions were made regarding cutting down the duplication in the reports given today. |
|      | - A request was made for the public to be able to make comments after each section rather than at the end of the meeting. JM to consider this. |
Presentations about the work the local Healthwatch are doing were made by:

Simmy Akhtar - Chief Officer of Healthwatch Stoke-on-Trent; the presentation talked about work Healthwatch Stoke-On-Trent did some work with homeless people’s access to GP services locally. Their work highlighted the impact not having easy access to medical services has on the health of the homeless population. As a result of their report a working group was created to tackle the problem, the Clinical Commissioning Group wrote to all GP practices, and a GP Access card was produced and distributed.

Simon Adams - Chief Operating Officer of Healthwatch Worcestershire; the presentation focused on ‘care in the corridor’ at Worcestershire Royal Hospital. As part of their work Healthwatch Worcestershire undertook 44 unannounced Enter & View visits over a six week period, surveying 119 patients, 51% of whom had been on a trolley for over four hours. This led to 38 recommendations in five main areas:

- Information for patients
- Patient Care
- The Environment
- Privacy & Dignity
- Waiting times

This report was welcomed by the Trust who took forward nearly all the recommendations.

Both presentations were well received.

15.0  Any Other Business and close of session

There being no further business, the meeting in public was ended. The Chair thanked everyone for their time and contribution.

Next meeting

Meeting 23 is scheduled for Wednesday 25 April in Blackpool
<table>
<thead>
<tr>
<th>NUM</th>
<th>REFERENCE</th>
<th>LEAD</th>
<th>ITEM</th>
<th>ACTION</th>
<th>DEADLINE</th>
<th>STATUS</th>
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<tbody>
<tr>
<td>1.</td>
<td>CM170202</td>
<td>Imelda Redmond</td>
<td>6.6</td>
<td>To include local Healthwatch leadership development as part of the strategy consultation. In addition, this was discussed at the People and Values Sub Committee meeting (SCM170405), AP (Head of Engagement) continues to lead the work on business analysis as well as leading on the leadership of the network as part of the strategy review.</td>
<td>December 2017</td>
<td>Completed</td>
</tr>
<tr>
<td>2.</td>
<td>CM170524</td>
<td>Imelda Redmond</td>
<td>9.1</td>
<td>To update the risk tolerance statement</td>
<td>April 2018</td>
<td>Ongoing</td>
</tr>
<tr>
<td>3.</td>
<td>CM170524</td>
<td>Imelda Redmond</td>
<td>13.2</td>
<td>To review and update the Equality and Human Rights plan</td>
<td>July 2018</td>
<td>Ongoing</td>
</tr>
<tr>
<td>4.</td>
<td>CM170731</td>
<td>Esi Addae</td>
<td>3.2</td>
<td>To update the previous minutes confirming the dissolution of the Audit and Risk Sub Committee</td>
<td>October 2017</td>
<td>Completed</td>
</tr>
<tr>
<td>5.</td>
<td>CM170731</td>
<td>Imelda Redmond</td>
<td>8.1</td>
<td>To work with CQC colleagues on how to reduce the time period for recruitment</td>
<td>June 2018</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>CM180131</td>
<td>Imelda Redmond</td>
<td>4.3</td>
<td>To gather information about whether we are speaking to people from protected groups and issue a report in July and then it will be incorporated into the strategy and business plan.</td>
<td>July 2018</td>
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<td>7.</td>
<td>CM180131</td>
<td>Imelda Redmond</td>
<td>4.5</td>
<td>Chase response from Secretary of State</td>
<td>February 2018</td>
<td>Completed</td>
</tr>
<tr>
<td>8.</td>
<td>CM180131</td>
<td>Imelda Redmond</td>
<td>4.6</td>
<td></td>
<td>December</td>
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<tr>
<td></td>
<td>CM180131</td>
<td>Name</td>
<td>Number</td>
<td>Description</td>
<td>Action</td>
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<tr>
<td>9</td>
<td>CM180131</td>
<td>Amie McWilliam-Reynolds</td>
<td>5.8</td>
<td>The top three challenges facing local Healthwatch/HWE to be added to the Intelligence Summary in future meetings</td>
<td>April 2018</td>
<td></td>
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<tr>
<td>10</td>
<td>CM180131</td>
<td>Danielle Oum</td>
<td>6.4</td>
<td>To explore whether the play ‘Phyllis’ can be shared more widely</td>
<td>February 2018</td>
<td>Completed</td>
</tr>
<tr>
<td>11</td>
<td>CM180131</td>
<td>Joanne Crossley</td>
<td>7.2</td>
<td>To send out procurement log to the Committee</td>
<td>April 2018</td>
<td>Taken to April AFRSC</td>
</tr>
<tr>
<td>12</td>
<td>CM180131</td>
<td>Jacob Lant</td>
<td>8.1</td>
<td>Write to Local Authority leaders to emphasise steps we’ll take if proposed funding cuts prevent them carrying out their statutory duties.</td>
<td>April 2018</td>
<td>Completed</td>
</tr>
<tr>
<td>13</td>
<td>CM180131</td>
<td>Imelda Redmond</td>
<td>8.2</td>
<td>In future Committee Meetings there is to be a risk matrix so we know which local Healthwatch to focus on regarding low funding</td>
<td>July 2018</td>
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<tr>
<td>14</td>
<td>CM180131</td>
<td>Jane Mordue</td>
<td>8.3</td>
<td>A sub group be formed to look at the funding of local Healthwatch</td>
<td>February 2018</td>
<td>Completed</td>
</tr>
<tr>
<td>15</td>
<td>CM180131</td>
<td>Neil Tester</td>
<td>9.2</td>
<td>To share figures on media coverage at next public Committee Meeting</td>
<td>April 2018</td>
<td>Included in performance report</td>
</tr>
<tr>
<td>16</td>
<td>CM180131</td>
<td>Neil Tester</td>
<td>9.3</td>
<td>Check and advise Committee if advice, information and signposting figures have been published</td>
<td>April 2018</td>
<td>Completed</td>
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<td></td>
<td>CM180131</td>
<td>Neil Tester</td>
<td><strong>9.4</strong> Communication strategy, stakeholder mapping, NHS70 opportunities and what we do will be considered at the March Committee workshop.</td>
<td>April 2018</td>
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<td></td>
<td>CM180131</td>
<td>Leanne Crabb</td>
<td><strong>13.2</strong> Email out the strategy to all members of the Committee to look at the wording of the document</td>
<td>February 2018</td>
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<td></td>
<td>CM180131</td>
<td>Leanne Crabb</td>
<td><strong>14.1</strong> At next public Committee Meeting HWE will provide microphones for better sound quality and more hard copies of the papers</td>
<td>April 2018</td>
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AGENDA ITEM: Chair’s Report

PRESENTING: Jane Mordue

PREVIOUS DECISION: N/A

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

EQUALITY AND DIVERSITY: My aim is to support the organisation in fulfilling its statutory obligations in respect of equality and diversity. My activity over the quarter has sought to ensure that we are drawing on the full range of experiences from the widest possible group of people.

AGENDA ITEM: Chair’s Report 1.4

1. Healthwatch - our unique role

In January, we met at Stafford, where Healthwatch was ‘born’ out of the tragedy of Mid Staffs. We are five years old, a stripling compared with the 70th anniversary of the NHS, but a good time to review achievements and plan future direction. We approved our new strategy ‘We want health and social care the works for you’, which sets out our ambitions for 2018-2022 and today we consider our business plan.

We have focussed on what is it that Healthwatch, uniquely, can do?’ We are clear that we will not alone solve all the challenges facing health and social care. Our unique role is to provide the oxygen for those debates, relaying what people tell us about those services. But this is not just ‘customer feedback’. The ambition of the 2012 Health and Social Care Act was ‘to involve people in decision-making about health and social care’. Healthwatch England, and the 152 Healthwatch organisations, one in each local authority area, have brought people’s voices to the table at all levels. This ranges from the GP practice to the new integrated care structures and, crucially, at Health and Wellbeing Boards. Often, Healthwatch provides the safe space which enables those discussions to actually take place.

2. Healthwatch England strategy and business plan - our ambition

Our strategy is now translated into the business plan which is on the agenda today for agreement.

Our dream is that telling your experience to Healthwatch becomes a reflex action for anyone who wishes. Our business plan is geared to do more, exponentially more ideally, to make that dream a reality. We have initiatives to build more profile, both for ‘brand’ Healthwatch and the power of the public’s voice. We want to double our contacts with people to more than 1 million a year. We want to be able to tell everyone who has shared their experience, the impact that their feedback has had. We want to strengthen the Healthwatch network and the links with Healthwatch England at the centre to ensure that people’s experiences are heard and understood wherever. We will continue to address
inequality and ensure that the most vulnerable and those who don’t usually have a voice are heard. We shall have a sharper digital offering. We will develop more responsive information and advice systems.

Key areas of our work are driven by and for local Healthwatch. We have achieved much over the past five years and we look forward to working together to implement our shared vision for the future. Our strategy reinforces our offer of support and our business plan details what we offer and how, together, we can build a stronger collective voice. We are keen to demonstrate the value of the engagement delivered locally, both for the benefit of people and the public purse.

**Local authorities’ statutory duty to fund their Healthwatch**

The Health and Social Care Act 2012 gives the statutory duty to local authorities to commission a Healthwatch for their residents. This has turned out to be an unexpectedly big ask, given the huge challenges they themselves face. The original central government funding of £40m is now down to £27m reaching local Healthwatch. This equals that given to our predecessor LINKs, which had fewer statutory duties. Some local Healthwatch are paréd to the bone. Many undergo disproportionately complicated re-commissioning processes. Local Healthwatch were already playing David to the Goliaths of their local health and care economy. We must and will work with everyone in the chain of funding and delivery to seek a solution. Our business plan shows our commitment to doing even more to support local authority commissioners to fulfil their statutory duties.

3. Work with strategic partners

We shared our strategy with the Department of Health sponsor team and this was well received. They acknowledged their role in ensuring that the statutory duties of Healthwatch should not be imperilled by pressures on local authority funding.

The All Party Parliamentary Group on the Arts, Health and Wellbeing met at the House of Lords in March. Chaired by Lord Howarth of Newport, he asked participants to offer their practical ideas for how to persuade providers of the value of the arts and creativity in improving health and wellbeing. They had specifically mentioned Healthwatch as a conduit for their message. I was able to refer to several local Healthwatch programme involving the arts to find out people’s views, including HW Wiltshire’s 1950s themed tea party and HW Hampshire’s work with disabled people.

I noted that our statutory role is to ensure the involvement of people in decision-making about health and social care. Thus, whilst we can signpost, we have no role in advocacy.

Lord Howarth welcomed our comments and strongly agreed with the point I had also made about the power of the myriad of individual changes on the ground to add up and lead to more system wide change. Jayne Howard, former chair of HW Cornwall, spoke and was supportive of us and the power of Healthwatch. She said arts organisations should be encouraged to think of approaching their local Healthwatch - to share stories and think of them as part of the spectrum. She suggested we might consider a session on this at our national conference even. It was also agreed that the APPG should ask health systems, an audit really, the extent of arts in their plans?
I also participated in a visit with members of the board of the Care Quality Commission to a care home in Birmingham, for the Jewish community. Rated outstanding, it was inspiring to hear the leadership team talking about their journey from poor performance to the current rating. They cited the need to have values led leadership; supported by rigorous values led recruitment, support and retention processes. Achieving a cadre of permanent staff had proved crucial to their success.

4. Committee

January was the first meeting for our new members, followed by a workshop in March to discuss the business plan. I am currently meeting with each member to discuss performance review and objectives.

List of meetings and events (February 2018- March 2018)

- Committee member recruitment
- Healthwatch England Committee workshop
- CQC Board meeting February
- Department of Health sponsor team
- CQC Board meeting, March, and visit to Andrew Cohen Care Home, Birmingham
- APPG Creative Arts and Health
- Committee performance reviews
AGENDA ITEM: National Director’s report

PRESENTING: Imelda Redmond

PREVIOUS DECISION: N/A

EXECUTIVE SUMMARY: This report updates the Committee on some of the main activities that we have worked on since the last meeting in October

RECOMMENDATIONS: Committee Members are asked to NOTE this report

AGENDA ITEM: National Director’s report 1.5

1. Update on activities

This report gives the committee a general update on the activities that we have been focused on since our last meeting in January. The senior team have been very focused on ensuring that at Healthwatch England we are ready to move forward with the new strategy. Following the approval of the strategy we have given the Business Plan, including the budget, performance indicators and setting objectives for all staff considerable amount of attention. I am grateful to the Leadership Team for their work on this. It has been time consuming for a small team not only to deliver the work of the organisation but also to put the time and effort into doing some through planning. This year it has been particularly time consuming because not only do we have a new strategy but we have introduced new ways of working and new systems. Later in this meeting we will discuss the Business Plan and Performance indicators.

2. Staffing

We continue to build a strong team with clear accountabilities and methods of working. Since February we have welcomed 3 new members of staff including Gavin Macgregor, Head of Network Development.

In March, we conducted the annual staff survey. The findings will be shared with Audit, Finance and Risk Sub Committee on the 18th April. Over all we are pleased with the findings of the survey. We had an excellent rate with all staff responding. Staff were very positive about working for Healthwatch England, with many questions scoring over 90%. The leadership is carrying out a detailed analysis of the survey result including the detailed comments. We are not complacent, there is a lot of learning from the survey and there are examples of staff experiencing that not all senior leaders demonstrate the Healthwatch values and behaviours at all times. There is work that we need to do on improving staffs access to learning and development and their knowledge of the Healthwatch Committee. We are working on a plan to put into action the improvements
that staff want to see. I suggest that this action plan is monitored by the Finance Audit and Risk Committee.

The Staff Engagement Group (SEG) continues to meet and has been a very useful source of feedback and morale building. The SEG played a role in encouraging staff to undertake the annual survey.

3. Annual Conference
Planning for the annual conference is continuing, with Danielle Oum and Helen Parker providing strategic input and oversight and on behalf of the committee.

The Healthwatch network has been invited to submit nominations for awards across seven categories with nominations closing on 4 May 2018. The seven categories are:

- Giving people the advice and information they need
- Volunteering
- Helping people have their say
- Improving health and social care
- Championing diversity and inclusion
- #itstartswithyou

We also have an award this year that will celebrate the work that others have done to improve the engagement of people and communities. This will be under the title of celebrating 70 years of the NHS.

Thank you to Committee members who have agreed to judge the awards; we will keep you informed as we progress. If you see any work that you think is outstanding as you meet with local Healthwatch, do encourage them to submit a nomination.

The Healthwatch network has also been invited to submit proposals to run agenda sessions at the conference that may be of interest to the broader network. Submissions close on 11 May 2018.

4. Network
Over the past few months I have had the opportunity to go to a number of network meetings across the country. I was pleased to be invited to an event by Wessex Healthwatch on the Isle of Wight, they have done very powerful training of professionals from across health and social care to build their skills and confidence in engaging and involving people in the design and delivery of care. The group has set up an action learning set to continue the work. I also spent some time in the North East attending a Board meeting of Healthwatch County Durham and the North east regional network meeting. The senior leadership team are attending all network meetings to discuss the finding situation of local Healthwatch. These presentations have been well received and there has been a fruitful discussion within the networks. Unfortunately it remains challenging times financially for the network. Over the past few months a number of risks have been identified where a either a Healthwatch holds more than one contract and loses their primary contract as has been the case in Wiltshire, Lancashire and Lewisham. This puts the other Healthwatch at risk. We are also carry out a due diligence exercise on
organisations that host one or more Healthwatch as we are currently not sighted on the risk they might pose if they lose contracts or have poor reserves.

4.1 GDPR
We are working with the network to help them achieve GDPR compliance. The legal responsibility for compliance sits with the local Healthwatch not with Healthwatch England. We have produced a range of products to help them plan including regular information updates and webinars. We have been working with them to find solutions on how to meet the Data Protection Officer requirement which is of ongoing concern to Healthwatch organisations and other smaller health and social care service providers.

4.2 Digital
We have held a number of events with the network to understand their future digital requirements. We are aiming to engage with every Healthwatch to ensure that we move towards the provision of a universal solution for them in the most cost effective way. This important work programme will continue throughout quarter one of this year to inform our procurement plan for 2019/20.

Major progress was made in Q4 in developing Endeca which is an information search tool that enables us to make sense of our library of Healthwatch publications. This will change the way we store, use and report on our data through the creation of theme based dashboards and adoption of data visualisation software.

5. Influence and Policy and Public Affairs

5.1 Governmental news
Following her appointment as Minister of State for Social Care, Caroline Dinenage has been confirmed as the lead minister for the adult social care green paper. In February I met with the Minister to discuss how the Healthwatch network can help to inform the Social Care Green Paper, in my capacity as an expert advisor.

As we understand things, Caroline Dinenage is also the sponsor minister for Healthwatch England through her sponsorship of the CQC. The sponsorship arrangements for local Healthwatch fall under Jackie Doyle-Price, the Under Secretary of State (Mental Health and Inequalities), as part of her broader remits around use of feedback in health and social care.

Following the acknowledgement of our concerns via the department regarding the state of local Healthwatch funding in March, we met with our sponsor team within the Department of Health and Social Care. We have subsequently raised the issue more firmly with both our sponsor ministers and with the Parliamentary Health Select Committee Chair, Dr Sarah Wollaston MP.

On 27 March Prime Minister Theresa May appeared in front of the Parliamentary Liaison Committee. During the hearing the PM committed to bringing forward plans for long-term funding of the NHS before next year, in honour of the service’s 70th anniversary. We are offering our help to NHSE to define priorities.
5.2 Key health and social care announcements

In March an agreement was reached between Ministers, NHS Employers and union leaders regarding pay rises for NHS staff. The agreement covers all staff on the Agenda for Change contract - about 1.3m across the UK - which is the entire workforce with the exception of doctors, dentists and senior leaders, and will cost £4.2bn, with the expenditure being covered by the Treasury. Staff will now be asked to vote on the deal, with rises backdated to April if they agree by the summer. However the social care workforce were not covered by this. The recruitment and retention crisis in social care continues.

NHS England and NHS Improvement announced their intention to create seven “single integrated regional teams” and will decide by September which national roles and functions will be combined. This will include the “functional integration of NHS England and NHS Improvement regional teams, to be led in each case by a single regional director working for both organisations. The exact regions are still to be decided but they will include the current London, South West and South East patches. The existing North of England and Midlands and East patches will both be split in two.

The Public Accounts Committee report on the CQC recommended that they set out how they plan to reduce the variation in relationships with Healthwatch at a local level. We are working with CQC to see how we can improve local relationships. They are of course undergoing major change as a result of the change in their funding base.

In April the Department of Health and Social Care announced a consultation in the expansion of those eligible for personal budgets. The proposals would allow hundreds of thousands of people with physical disabilities and mental health conditions access to a personal NHS budget that will pay for treatment. Health secretary Jeremy Hunt and the NHS chief executive Simon Stevens, have both backed the initiative, which would potentially allow up to 350,000 extra people to take up a personal health budget.

Performance data published by NHS England in April revealed that more than 76,000 people waited over four hours on trolleys to be admitted to hospital in March, just five hospitals met the four-hour A&E waiting target - and overall performance on four-hour A&E waits was the worst in 15 years.

5.3 NHS Mandate

In our submission to this year’s NHS Mandate refresh we focused on six areas that we felt could be improved, namely improving public involvement in changes to local services; Using people’s experiences of leaving hospital as a way of measuring how well services are working together; Demonstrating how learning from feedback is improving care; Increasing focus on the evaluation of mental health services; Shifting the focus of NHS targets to take greater account of people’s experiences; and Tackling access issues in NHS dentistry.

In March we received a response from the Minister outlining in more detail how the Government is addressing each of the six issues. Some key areas highlighted include the NHS doing more to demonstrate what it has learnt from complaints and feedback, and greater evaluation of the progress being made in mental health. In the letter the government has confirmed they are now actively working with NHS England to bring back
‘emergency readmissions’ as key measure of how well health and care services are doing. (see below for more)

We will continue to work with the department to review the NHS’ progress against the existing Mandate commitments, and will be sharing our insight with them across the year to inform this process.

5.4 Hospital Discharge

The failure of health and social care services to meet the target to reduce the number of delayed transfers of care (DTOC) from hospital to 3.5% of available beds has not led to a loss in focus amongst sector stakeholders on the issue. On the contrary, efforts have been galvanised by continued falls in the number of DTOCs, on behalf of both the NHS and local authority partners. Unfortunately the situation continues to be divisive and more remains to be achieved.

Following the release of our reports into hospital discharge and emergency readmissions in October 2017, a number of other organisations have explored the same issues. These include the British Red Cross, whose report into hospital discharge credited our research, and appeared on the BBC News at 10; the National Audit Office, who looked at emergency admissions to hospital; and Marie Curie. I attended their launch and will continue to work with them on this issue.

The National Audit Office’s report into emergency admissions to hospital credited our report into emergency readmissions, and supported our call for the government to strengthen the data that NHS Digital collects on readmissions, and to reinstate the publication of national statistics on emergency readmissions.

Subsequently, the Parliamentary Public Accounts Committee announced a one-off session into the NAO’s report. We submitted evidence to the inquiry, which heard oral evidence from NHS England Chief Executive Simon Stevens, DHSC Permanent Secretary Chris Wormald, NHS E Chief Medical Officer Steve Powiss and Urgent and Emergency Care director Pauline Philip.

Through this activity we have identified an opportunity to bring together a roundtable on this issue, to prospectively involve the NAO, British Red Cross, Marie Curie, Department of Health and Social Care, NHS England, NHS Digital and the Local Government Association.

5.5 Social care

As the Green Paper on Social Care is being developed, we have undertaken a range of actions in order to contribute to the discussion.

In particular, we have pulled together a group of local Healthwatch chairs and Chief Executives to act as an advisory group to our participation. We have also undertaken some deliberative work on people’s attitudes to social care, which will soon be reinforced by a piece of public polling around the same issue.
The Green Paper has been given a bit more direction by seven key principles outlined by the Secretary of State Jeremy Hunt MP in a March speech to social care workers.

Those key principles are:

- **Quality:** while 81% of social care services are rated as ‘Good’ or ‘Outstanding’ by CQC, the Secretary of State acknowledged that too many people still receive unacceptable poor care and variation in quality. He said that the CQC’s local system reviews had shown up high levels of local variation in quality, and so he said that the Green paper would take views on expanding the role of CQC to inspect local commissioning practice.

- **Integrating the NHS and social care around the individual:** too many people with long-term care needs experience a disconnect between the NHS and social care. To address this the Secretary of State announced three pilot sights for new joint assessments for health and social care, where people would have one joint assessment shared between the NHS and social care.

- **Control:** the Secretary of State accepted that the uptake of direct payments has been too slow, so he promised to ‘turbo charge’ the progress on developing integrated personal budgets. As such he announced that his department will be consulting on Personal Health Budgets, with the aim of ensuring that people with long-term health and care needs experience personalised and integrated care and support.

- **Nurture the workforce:** the social care workforce are ‘modern day heroes’, though their contribution is often overlooked and undervalued according to the Secretary of State. To address this he committed to developing a workforce strategy for the social care workforce alongside the NHS.

- **An action plan for carers:** carers make an invaluable contribution to our society. Their contribution is massive and their reward minimal. The Secretary of State acknowledges this and will publish an Action Plan to support carers better in the future.

- **A sustainable future:** this is essentially the issue of paying for social care, ensuring that it is well resourced and vibrant. Part of the answer according to the Secretary of State lies in innovation and new technology, including housing, aids and adaptations.

**Security from catastrophic costs:** the Secretary of State acknowledged that the current system does not adequately protect people from costs associated with some long-term conditions and that some people face unfair, catastrophic care costs. As such the Green Paper will look at options for better protecting people from these costs, and to find a way to share the costs of care more fairly between the population, and the state.

Following the Competitions and Market Authority (CMA)’s report into the UK care homes market we will be holding discussions with the DHSC policy team around complaints advocacy in April. In the interim, we have responded publicly to the Government’s response to the report.
More widely in the social care sector, conversations around a potential hypothecated tax for health and social care services have grown louder, although how this would fit with the Prime Minister’s long term funding proposal is yet to be explored.

5.6 Public Engagement in Service Change

In January we submitted evidence to the Health Select Committee’s inquiry into Sustainability and Transformation Partnerships. Reflecting the change in name of STPS, the inquiry formally looked at Integrated Care Systems (ICSSs), Accountable Care Systems (ACSs) and Accountable Care Organisations (ACOs) as well as STPs.

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

Our submission led to me appearing in front of the to give evidence in mid-February, alongside National Voices’ Don Redding, the Richmond Group’s Dr Charlotte August and Ipsos MORI’s Kate Duxbury.

We told the committee about the experiences of Healthwatch working with STPs at a local level. She highlighted that while there is variation out there, the best examples are where STPs have emerged out of pre-existing initiatives to create better integrated services.

We used the evidence session to call for the introduction of a new metric that tracks the progress of each STP in engaging their communities. We also highlighted the need for independent STP Board Chairs to be appointed to overcome vested interests in the STP process.

The inquiry has also heard from a range of other stakeholders, including NHS England’s Simon Stevens, Health Minister Stephen Barclay MP and Chief Nursing Officer Professor Jane Cummings.

Elsewhere on service change, a consultation on contracting arrangements for Accountable Care organisations has been scheduled to take place following local elections. The ACO process was also going through a process of judicial review, following concerns that they have no basis in law, and have not been subject to parliamentary scrutiny.

5.6 Mental Health

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

The report found that too many children and young people find themselves at ‘crisis point’ before accessing mental health services because health care, education and other public services are not working together as effectively as they could to protect and support their best interests.

We also responded to the Government’s green paper on transforming children and young people’s mental health provision. In our submission we supported the aims of the green
paper, which reflects many of the comments people have shared with local Healthwatch over the last few years. We raised comments made by LHW about a need for mental health support in primary as well as secondary education, and also stressed the valuable role the network can play in providing insight into how services are meeting the needs of local young people.

Following our intention to make mental health a major policy work, the work programme for this topic has been scoped out, with a literature review undertaken and gaps in understanding identified. We have met with a number of stakeholders to discuss this work and explore our initial findings further, in order to inform this activity over the coming year.

5.7 Technology

As part of our continuing work on the topic of patient data, we have recently undertaken a piece of public polling to understand how people’s thoughts on the handling of personal and patient data have been affected by various positive and negative news stories.

Whilst our polling took place before the recent news regarding the handling of data by social media companies such as Facebook and political consultancies such as Cambridge Analytica, the topicality and prominence of the debate highlights how integral it is for the NHS and other organisations to hold data securely, and for people to consent to how their data is handled.

As mentioned in the last update, from May 25th 2018 people will be able to exercise a single opt-out to prevent their personal identifiable data being used to support medical research and future planning of service delivery. We will be supporting communications around this development.

In March we responded to the CQC’s review of online GP practices. The review found that although the quality of care has improved over the past 12 months, more needs to be done to ensure patient safety with a significant proportion of providers still found not to be providing ‘safe’ care in accordance to the relevant regulations.

In our response, we recognised the attractions of online services, and acknowledged is an appetite for people to make better use of technology, with services like web consultations and online prescriptions. They offer convenience and accessibility, particularly for those who struggle to make a face-to-face appointment with their GP. However, people also need to have confidence in the safety, quality and reliability of those providing these services.

Latest figures from NHS Digital show that nearly 14m patients are now using online services to book appointments, order repeat prescriptions and view their records. This represents 24% of all patients. NHS England said that figures from February 2018 show that an average of 1m appointments are being made or cancelled online every month and nearly 2.3m prescriptions are ordered online.
5.8 Key Appointments / Resignations

In January Care Quality Commission Chief Executive Sir David Behan announced his intention to stand down from the role in Summer 2018, after six years in the role. Recruitment for his successor is on-going.

In February it was announced that Dr Simon Eccles was to become the new Chief Clinical Information Officer for Health and Care to spearhead NHS use of technology and data to drive improvements in patient care in NHS England. Dr Eccles is a practicing hospital consultant in Emergency Medicine at Guy’s and St Thomas’ NHS Foundation Trust, and will succeed Professor Keith McNeil.

In March the chief executive of the King’s Fund, Professor Chris Ham, announced his intention to step down. He is expected to leave the position by the end of this year after holding the role since 2010, when he replaced NHS Confederation boss Niall Dickson.

Meetings for Imelda during last quarter:

- JUSTICE, the Ombudsman Association and the UK Administrative Justice Institute
- Department of Health and Social Care
- ADASS - Association of Directors of Adult Social Services
- Westminster Health Forum
- NHS Health System Transformation
- Health Select Committee
- Aylesbury Vale District Council
- Speak Up Guardian
- NHS
- NHS England
- NHS Right Care
- British Red Cross
- National Voices
- Diabetes UK
- Wessex Voices (Healthwatch Isle of Wight)
- HW North East Network (County Durham)
- Care Opinion
- Pioneering Care Partnership
- Valdani Vicari & Association
- St James Place
- The Good Governance Institute
- The Kings Fund
- Alzheimer’s Society
- Equality and Diversity Council (NHS England)
- Citizen’s Assembly
- Local Healthwatch Webinar - Strategy
- Stakeholders Healthwatch Webinar - Strategy
AGENDA ITEM: Mental Health Programme Update

PRESENTING: Liz Sayce, Committee Member

EXECUTIVE SUMMARY: This paper summarises the progress to date on the mental health programme including:

- A recap of the programme scope
- Objectives and how the programme will support delivery of the five year strategy
- Short summary of activity to date and findings from the 224 local Healthwatch reports on mental health produced to date (compiling views from more than 30,000 people).
- Outline of activity plan for 2018/19

RECOMMENDATIONS: Committee Members are asked to NOTE this report.

AGENDA ITEM: Mental Health Programme Update 1.7

Introduction:

Mental health has been the people’s number one health and social care issue according to local Healthwatch for the last three years.

In 2016/17 a total of 6,360 people shared their experiences of mental health services with us - with very little in the way of positive feedback. It therefore stood out from the other areas of health and care as priority for further work.

Recap of what the committee has agreed to date:

In October 2017 the Committee agreed to the creation of a multi-year programme of activity on mental health.

A committee advisory group was then formed to agree the top level objectives and scope of the programme, with Committee Member Liz Sayce agreeing to chair the group and provide oversight of the work on behalf of the committee.

Objectives:

We aim to make a significant contribution to the objectives in the new Strategic Plan, in particular to:
• Ensure people’s views help improve health and care - both locally and nationally - contributing to our aim to double the number of Healthwatch recommendations implemented by 2023.
  o We expect to see impact on the specific issues selected, starting with maternal mental health and the transition from adolescence to adulthood (see below).
  o We also aim to create a robust evidence base of user experience and user-informed solutions, to inform the development of the next mental health forward view. We are currently two years in to the implementation of the current five year forward view for mental health.

• We will also use the mental health programme to support people to have their say - we will help more people living with mental health issues to access the information they need to take control of their health and care, make informed decisions and shape the services that support them.

• We will test new methods of working as an organisation and with the Healthwatch network to deliver the programme. In particular the mental health work will provide an opportunity to explore our approach to two of the strategy enablers:
  o **Insight:** Trialling new ways of capturing people’s experiences including direct engagement with the public at a national level, coordinated local Healthwatch activity and greater analysis of data held by others. We will collect examples of solutions flowing from leadership or engagement by people using services and turn this insight into effective story-telling to stimulate change.
  o **Partnerships:** To develop relationships with key voluntary sector partners that extend our reach, enhance our evidence base and build our credibility. This to be supported by involving user led researchers to ensure our work is people focused rather than service oriented.

        We will also model new ways of working together with local Healthwatch on nationally led projects.

**Scope:**

The scope agreed by the committee advisory group was for the programme to **take a birth to death look at mental health and wellbeing**, looking at the support people receive and whether they are getting help that they value, that supports them in their lives, and that comes at the right time.

The intention is to also cut our intelligence by specific groups, including those identified under the protected characteristics, to assess variation in people’s experiences; and to identify a few key intersection issues, for instance where people face multiple challenges.

It was agreed that we would undertake an initial phase to analyse all the data Healthwatch currently holds on mental to help identify and prioritise areas for activity.
In line with the new strategy, 2018/19 is about trialling new ways of filling the gaps in our intelligence, how we work with the network and partners, and how we share interim findings as the programme progresses.

It will also be vital to have ‘early wins’ in line with our objective to ensure people’s views help improve health and care. We expect to be able to showcase at least one national influencing achievement by March 2019.

The end product will provide a series of user journeys through life and their different experiences accessing support in the current system. This will be designed to highlight best practice as well as illustrating gaps not currently being addressed by national policy and clinical practice.

**Timeline for current phase of activity:**

- **Nov 2017** - Committee advisory group agreed top level scope for the programme.
- **Dec 2017** - Announced the scope via our communications channels - website, social media, press, yammer, newsletter etc.
- **Jan - Feb 2018** - Reviewed local Healthwatch intelligence on mental health, including analysis of 224 local reports published by the network to date compiling the views and experiences of 33,390 people.
- **Mar - Apr 2018** - Stakeholder engagement with DHSC, NHSE, CQC, NHSCC, Royal College of Psychiatrists, NAO, key national charities, service user researchers.
- **Apr - May 2018** - Literature review of 109 key academic and policy documents completed and an initial three deliberative research sessions delivered.
- **May 2018** - Share with local Healthwatch the programme of activity and how they can get involved.
- **May 2018** - Publish background briefing on our existing evidence and outlining programme of activity for 2018/19.

**What the analysis of local Healthwatch intelligence told us:**

From what people have shared with local Healthwatch we found the following high level key messages:

- There is a desire for more accessible information about the range of mental health services available to people.
- People want mental health support to be more coordinated with other health, care and wider services (e.g. education for young people).
GPs are seen by people as the first port of call when trying to access mental health support, with people reporting that they often have to go back to the GP as they find navigating the mental health system confusing.

However, others reported feeling that their GP did not listen to them or take their concerns about their mental health seriously.

People report that there is variation in the consistency and quality of mental health support within local areas as well as across the country as a whole.

People talked about experiencing long waiting times to access mental health support in general, with access in times of crisis featuring prominently.

The length of time it takes to receive a diagnosis was also perceived by a significant number of people to take too long, leading to symptoms deteriorating.

People who moved to a different area of the country during the referral process or whilst receiving treatment reported having to restart the process causing frustration and further delay in treatment.

The analysis of the reports also helped identify five areas where we already have a good understanding of user experience of mental health and wellbeing.

- Child and Adolescent Mental Health
- GPs and mental health
- Crisis care
- Community support
- Dementia*

The analysis also highlighted a number of areas where we have comparatively little insight despite there being high volume of service users or high levels of anticipated need (volume and/or severity of condition) based on research by other organisations. For example, we currently hold limited user experience information on:

- Maternal mental health
- Transitioning from adolescence to adulthood
- Anxiety and depression in women
- Social isolation

*There is a question over whether or not Dementia itself should be considered in scope of our work on mental health but we are keen to understand more about the experiences of people with both Dementia and a mental health condition. It is therefore useful to know we have a solid understanding of the experiences of people with Dementia from our existing evidence base.
- Mental health and learning disabilities
- Psychosis

In May we aim to publish a baseline report that provides a more detailed look at the evidence outlined above.

**Initial feedback from Stakeholders:**

Throughout March and April we have been engaging with a number of key stakeholder organisations and individuals.

This series of meetings suggests there is appetite for us to use the insight we gather to help identify the gaps which the current MH Forward View is not addressing. In particular they would like to know more about the experiences of the groups with pre-existing or more severe mental health conditions where there is perhaps less current policy focus.

Stakeholders engaged so far have also suggested that using our insight to test the effectiveness of the early interventions prioritised by the MH Forward View would be useful, but cautioned that the new initiatives introduced will take time to have impact.

Stakeholder feedback on how they wish to feed into the programme has led us to revise our initial plans around the establishment of an external advisory group. Given the breadth of the programme stakeholders suggested that we would be better off organising one-off topic specific round table events to inform specific workstreams within the programme. This would likely give us more useful insight to inform our investigations. These could be supported by a smaller advisory group including Healthwatch England Committee members and two external advisors who would focus on keeping our research user focused.

**Next steps:**

As part of this initial phase of the programme we have developed the following criteria for prioritising areas for further investigation / activity:

- **Scale and severity:** We will consider the proportion of the population that are being impacted by an issue, as well as the severity of the impact on affected groups and individuals.
- **Intelligence gaps:** We will look to fill gaps in our own intelligence and broader gaps in systems insight into user experience of mental health support.
- **Opportunities to influence:** We will prioritise areas where we identify real potential to influence change, in particular where stakeholders are actively looking for insight to help shape their thinking.
Our unique contribution: We will prioritise areas where Healthwatch insight and our approach to gathering and analysing intelligence provides a unique look at an issue.

Person focused: We will concentrate our efforts on targeting impact that will make a real and direct difference for people, rather than system focused changes unlikely to change people’s experience.

Feasibility: We will consider how feasible it is for Healthwatch England and the network to explore an issue in a way that will add value to the national policy conversation.

Is anybody else doing it: We will concentrate on issues not currently being covered by other organisations, or where we identify suitable partnership opportunities to that satisfy the rest of the criteria outlined above.

With these criteria in mind, and the review of existing Healthwatch insight completed, we have identified two areas of work as key topics to collaborate on with the Healthwatch network over the next year.

These two areas are also in line with the development of the overall birth to death approach to understanding people’s mental health user journeys.

1. Maternal mental health services

Quarter 2: Host a roundtable session with key stakeholders / experts to identify and shape priority areas for further investigation.

Launch a call for evidence from stakeholders and the public.

Conduct analysis of existing national data sets to map against the insight we gather.

Encourage local Healthwatch to share with us any insight captured on the issue they may not have shared with us previously - we would do this via a structured form for Healthwatch to fill out.

Quarter 3: Produce a survey for local Healthwatch to share via social media platforms which will explore some of the issues identified in Q2.

Pre-load the new Healthwatch research toolkits with materials for interested local to carry out focus groups with local people.

Arrange coordinated enter and view activity to test out findings.

Quarter 4: Produce short interim report on key findings re maternal mental health.
2. Transition between adolescents and adulthood

Quarter 3: Initial date capture phase
Quarter 4: Testing phase
Quarter 1 2019/20: Report phase

We will look to evaluate this approach as we go and test out different approaches to work with local Healthwatch and potential partners.

In addition to these broad topics of work with the Healthwatch network as whole, Healthwatch England will look to produce a number of products throughout the year to share more detail from the existing insight and to explore specific topics in more detail, such as the experience people with learning disabilities in accessing support around their mental wellbeing: this appears to be a problematic intersection where we may be able to make a difference. These will allow further opportunities to test the ways we share insight, from blogs and media activity to detailed policy briefings, that can be used locally and nationally to engage with policy and system decision-makers.
AGENDA ITEM: 2017/18 Delivery, Performance and Finance Report

PRESENTING: Imelda Redmond

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

EXECUTIVE SUMMARY: This paper provides a summary of delivery and performance during 2017/18 and lessons learned. It also provides the year-end finance and HR position.

RECOMMENDATIONS: The Committee is asked to NOTE the report.

1. 2017/18 business plan priorities

1.1 The Committee determined that in 2017/18 we would continue to focus on three key priorities, described as follows:

1. Support local Healthwatch to be a powerful advocate
   - To support the network to engage their communities and encourage greater use of the views people share to drive improvements to care.
   - To help local Healthwatch comply with legislation.
   - To support the network to be sustainable.

2. Bring the public’s views to the heart of national decisions
   - To improve the way we gather and understand the experiences the public share with local Healthwatch.
   - To develop a clear system for ensuring that those with the power to change services hear people’s views.

3. Develop an effective Healthwatch England
   - To continue to develop ways of working that deliver value for money.
   - To develop a new long-term strategy for Healthwatch England.
   - To support our Committee to deliver its statutory functions.
   - To continue to build and maximise the capacity of our organisation.

2. Activity, outcomes and learning

2.1 We supported the network by:
   - Providing training, development and networking opportunities throughout the year but centred upon quarterly regional network meetings and the July annual conference. Principal training delivered covered Enter and View activity; communications skills and techniques; media and influencing skills; and CRM training.
   - Delivering a social care complaints scrutiny toolkit; call handling and signposting guidance; communications guidance on audience insight and awareness; communications planning calendar; improved and expanded range
of materials and templates on the online brand centre; template media releases; campaign guide, tools and templates for the #ItStartsWithYou and #SpeakUp campaigns.

- Introducing our research helpdesk, providing advice and quality assurance to 48 Healthwatch on 78 issues and projects.
- Undertaking substantial analysis of the structure of the network and the state of its financial support. Introducing a Scheme of Delegation to enable more effective use of the Committee’s power to advise councils. Providing advice to a wide range of Healthwatch and commissioners and reducing or reversing funding reductions as a result.

![Local Healthwatch downloads of promotional materials from our communications centre](image)

We updated and broadened the range of promotional materials we provide for Healthwatch to raise their local profile, and made it easier for them to produce print and online images and publications specific to their areas, audiences and projects. 3,294 of this year’s 5,399 downloads from the online communications centre where we share promotional materials for our network to use were tailored resources, created from our templates by 441 users in local Healthwatch.

### 2.2 We learned:

- We need to provide a single, clear, comprehensive training and development offer for the network, based on its identified needs and making use of e-learning to maximise reach. The organisational and staff churn within the network means we will need to continue to provide entry-level training alongside more advanced development.
- This needs to sit within a wider support framework so that we and the network are clear about what we will deliver and how.
- Working with the network to plan publicity campaigns increases the numbers involved and delivers higher take-up of our support resources.

### 2.3 We developed the Healthwatch profile and shared our messages by:
Increasing visibility and engagement with our website and social channels.
Focusing our media efforts on developing new professional audiences through trade media.
Running 2 public awareness campaigns together with our network.

Digital reach and engagement

We have doubled our social media audience reach in two years. It expanded more slowly this year than in 2016-17 but still saw almost 28% growth (up to 3,261,842). We have not seen similar rates of growth in visits to our website and our updates to the site, together with our wider promotional plans for 2018-19, are intended to address this. We continued to increase people’s active engagement with our web and social media content. People took action on our website, such as downloading documents, clicking to read more content or sending an email, 86,817 times (up by 15% on the previous year). Growth in the numbers of people sharing, commenting, replying to or visiting our website through our social media content was more than double that, at 35% (up to 47,359). Social media engagement has almost doubled over two years.

Social media reach and unique visits to our website

Active engagement with our online content
Media audience reach and volume of mentions

The following two charts illustrate, in percentages, how the numbers of people we reached through the media and the number of times we put our stories in front of them changed this year compared to the previous year’s direction and rate of change. The first chart shows national audience numbers declining much more slowly than the previous year and regional coverage increasing substantially, reversing the previous year’s decrease. We reached slightly more professionals through trade media than in 2016-17 but as the second chart shows; we reached a wider range of professional audiences by placing far more stories and authored articles. We gave every adult in England 25 opportunities to see our media stories. Our national and regional stories ran 3,160 times and we secured 170 pieces of trade coverage, in a year when General Election purdah ruled out new launches and announcements in Q1 and we had no dedicated media staff until July.

**Percentage change in media audience reached**

<table>
<thead>
<tr>
<th></th>
<th>2016-17</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>-5.4</td>
<td>50</td>
</tr>
<tr>
<td>Regional</td>
<td>-20</td>
<td>0.7</td>
</tr>
<tr>
<td>Combined Regional + National</td>
<td>-32.8</td>
<td>-57.3</td>
</tr>
<tr>
<td>Trade</td>
<td>-33.3</td>
<td>-50</td>
</tr>
</tbody>
</table>

**Percentage change in volume of media mentions**

<table>
<thead>
<tr>
<th></th>
<th>2016-17</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>-10.4</td>
<td>4.25</td>
</tr>
<tr>
<td>Regional</td>
<td>-5.6</td>
<td>-5.6</td>
</tr>
<tr>
<td>National + Regional</td>
<td>4.25</td>
<td>153.7</td>
</tr>
<tr>
<td>Trade</td>
<td>-10.4</td>
<td>4.25</td>
</tr>
</tbody>
</table>
2.4 *We learned:*

- Reintroducing a dedicated member of staff to focus on media from July enabled us to focus successfully on widening the range of professional audiences we could reach - in relation to our reports but also regarding our broader corporate messages about the value of embracing people’s feedback.
- There is increasing overlap between our media and digital work - the increase in regional reach is due in substantial part to the shift of regional media online.
- Our focus on enabling people to find their local Healthwatch online continued to increase the traffic to this page but worked best when people could use a direct online link.
- Our increasingly targeted approach to online promotion enabled us to grow online reach and engagement, despite changes in the structure of some key external websites that reduced their referrals to us.
- That we need to encourage Healthwatch to plan communication from the outset of engagement and research projects, so there are stories of real people and real impact to tell at the end.

2.5 *We shared our insight and helped people to drive improvement by:*

- Developing our annual report to Parliament to include our first overall assessment of the intelligence the network had gathered about people’s experiences.
- Working with a range of statutory and other organisations, including through national boards and collaborations, to share our new findings and to help others make constructive use of our previous work.
- Delivering 2 key pairs of reports - on social care, and on discharge and readmissions - and supplementing this with additional research.
- Speaking at a wide range of national and specialist conferences and events to share our findings and make our wider points about public engagement and involvement.
- Developing our role in relation to the NHS Mandate to include informing the Secretary of State’s assessment of delivery.

![Reports and briefings published](chart.png)
2.6 *We learned:*

- That our “back catalogue” continues to have value as context for our own and others’ current work.
- That being constructively engaged with other organisations’ thinking and planning enables us to challenge appropriately without damaging relationships, and that our demonstrably independent focus on what people really experience provides an incentive for others to work with us.
- That we have more to do this year to expand our relationships with and influence within local government and the voluntary sector.
- How to begin to develop a more nimble approach to intelligence analysis to inform the next phase of our policy and communications work.

2.7 *We developed our organisation by:*

- Implementing our new staff structure, recruiting to fill a substantial number of vacancies during the year, and identifying the additional roles necessary for 2018/19 and beyond.
- Introducing, reviewing and improving our programme management framework.
- Securing improvements in the speed of some elements of the procurement process.
- Recruiting and inducting 7 new members of the Healthwatch England Committee.
- Developing our strategy for 2018-2023 and planning the activity for our transitional year in 2018/19.

2.8 *We learned:*

- What will be most important to people, to our network, to our new Committee and to our external stakeholders as we implement the strategy.
- What makes for an effective relationship with commercial and contracts staff in relation to procurement; and the importance of beginning and concluding procurement early.
- That we need to have a flexible approach to procurement and planning to make best use of our resources.
## 3 Key Performance Indicators

<table>
<thead>
<tr>
<th>KPI</th>
<th>KPI achieved?</th>
<th>Comments on performance achieved</th>
<th>Reasons for under-performance, learning and next steps</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Support for local Healthwatch</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over 80% of delegates agree that the Annual Conference workshops improved their Knowledge and skills</td>
<td>Yes</td>
<td>88% against target of 80%</td>
<td>Positive and negative evaluations of conference workshops are subject to the substantial caveat that problems with last year’s online evaluation system reduced response rates to very low levels. Open invitations were offered to local Healthwatch to run workshops of their choice, without a national steer on themes based on identified needs. 2018 workshops are based on the strategic themes developed in consultation with local Healthwatch and our conference app will enable instant evaluation, which has been built into session timings.</td>
</tr>
<tr>
<td>Over 80% of delegates agree that the Annual Conference workshops will help them run their organisations better.</td>
<td>No</td>
<td>67% against target of 80%</td>
<td></td>
</tr>
<tr>
<td>Over 70% of LHW staff and volunteers agree or strongly agree that the information we provide is useful and valuable</td>
<td>No</td>
<td>Not measured</td>
<td>The original intention was to undertake these measurements as part of our annual survey of local Healthwatch staff and volunteers, due in Q4. This survey was not undertaken in Q4 in order to enable us to focus on development, introduction and evaluation of 2018-19’s new network support offer. The proposed KPIs for 2018-19 include a target satisfaction level covering each dimension of this support.</td>
</tr>
<tr>
<td>Over 80% of LHW agree that Healthwatch England support (a) enhanced their ability to engage effectively (b) helped them use their intelligence to influence stakeholders.</td>
<td>No</td>
<td>Not measured</td>
<td></td>
</tr>
<tr>
<td>Over 65% of local Healthwatch use the support we provide to produce their annual reports.</td>
<td>Yes</td>
<td>79% against target of 65%</td>
<td></td>
</tr>
<tr>
<td>95% of local Healthwatch are aware of our quality standards for research, evaluation and information sharing.</td>
<td>No</td>
<td>Quality standards not completed.</td>
<td>Working with a network reference group, we developed the first element of this work, our research quality assurance framework. Before proceeding to the next stage - consulting the full</td>
</tr>
</tbody>
</table>
network - we decided to bring this work within the scope of our wider quality framework as set out in the strategy and 2018-19 plan.

Every adult in England has at least 10 opportunities to see or hear messages about how and why to share experience with local Healthwatch.

<table>
<thead>
<tr>
<th>Yes</th>
<th>12 opportunities to see delivered against target of 10</th>
</tr>
</thead>
</table>

Planning these messages into all media and digital activity across the year enabled us to exceed what was intended as a stretch target for opportunities to see these messages. The increase of 15% in visits to our Find Your Local Healthwatch page built upon the previous year’s 38% increase but we did not fulfil our ambition to exceed this in absolute and relative terms. Our approach was based on converting opportunities to see messages about how and why to contact Healthwatch. This was the first time that we had attempted this approach. We learned that we were better able to direct people to this page of our site when we could put links directly in front of them - 42% of visitors to this page followed direct links in emails, online content and social media messages. As the majority of opportunities to see came from media coverage which did not include direct links, the large number of opportunities to see did not translate into an equivalent increase in relevant traffic. This learning is informing our planning for 2018-19 and our new strategic aims provide more concrete calls to action for our audiences.

Numbers visiting “Find Your Local Healthwatch” up 40% to 80,000.

<table>
<thead>
<tr>
<th>No</th>
<th>Visits increased by 15% to 65,888</th>
</tr>
</thead>
</table>

No 40% against target of 100%

Corporate delivery

<table>
<thead>
<tr>
<th>No</th>
<th>40% against target of 100%</th>
</tr>
</thead>
</table>

This KPI concerns Healthwatch sharing individual feedback, not published reports. The number of Healthwatch using the CRM increased from 87 at 87
end 2016-17 to 100 at end 2017-18. Of these, 55 were sharing feedback via the CRM. A further 6 Healthwatch were sharing feedback by supplying us with the data separately, bringing the total to 61. A further 30 Healthwatch hold data in a system provided by a single supplier and we had reached agreement with them about how to import this data. However, a delay in handover between contractors for CRM development delayed implementation. We will be able to bring these 30 Healthwatch on stream during the first half of 2018-19. Our digital work during 2018-19 also focuses on improving usability and skills to enable CRM sites not supplying data to do so.

| Network business analysis delivered in Q3 to shape strategy | Yes |
| A clear audit exists of when and why the Committee exercises its advisory functions. | Yes |
| Publish Healthwatch England strategy. | Yes |
| Publish the Healthwatch England annual report to Parliament on time. | Yes |
| 100% of FOI's responded to within 20 days of receipt | Yes |
| 100% of completed programmes evaluated for impact | Yes | Only 1 programme reached this point during 2017/18 |
| We introduced, piloted and reviewed our programme management framework during the course of the year, meaning that most projects |
and programmes had not been planned in a way that enabled this evaluation. The Committee received a number of evaluation reports during the course of the year, on individual policy and communications projects and the annual conference. The revised programme framework now in place includes a mechanism to ensure we plan for, measure and can report on the realisation of a range of strategic benefits including impact.

| 90% of staff to respond to the staff survey | Yes | 97% against target of 90% |
4 Financial performance and position 2017/18

The financial position at the end of Q4 and end of Financial Year is summarised below:

<table>
<thead>
<tr>
<th></th>
<th>2017-18 Annual Budget total</th>
<th>Spend as at Year End*</th>
<th>Variance</th>
<th>% of annual budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAY*</td>
<td>£1,926,640</td>
<td>£1,819,154</td>
<td>£107,486</td>
<td>94%</td>
</tr>
<tr>
<td>NON PAY</td>
<td>£958,000</td>
<td>£764,878</td>
<td>£193,122</td>
<td>80%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>£2,884,640</td>
<td>£2,584,032</td>
<td>£300,608</td>
<td>90%</td>
</tr>
</tbody>
</table>

Our funding allocation for the year was £2.884m, which is a reduction on our budget envelope of £3m in 2016-17

We spent 90% of the Annual Budget as at end of March 2018.

5 Annual HR report

As at end March 2018 we have 35 roles in the organisation, made up of 33 members of staff and two vacancies. Three members of staff are on maternity leave.

*Please see details of our organogram attached separately*

During the course of year we had the following staff movements:

<table>
<thead>
<tr>
<th>Number of New Starters</th>
<th>16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Leavers</td>
<td>5</td>
</tr>
<tr>
<td>Number of Redundancies</td>
<td>3</td>
</tr>
</tbody>
</table>

All vacancies were subject to first refusal for staff across CQC who were at risk of redundancy due to restructures across the CQC Directorates. We were unable to avoid the redeployment process.
Summary of Diversity of Staff and Committee Members

CQC are unable to share data on all the protected characteristics due to numbers being less than 10. However, we are able to summarise the following characteristics:

<table>
<thead>
<tr>
<th>Gender</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>33</td>
</tr>
<tr>
<td>Male</td>
<td>18</td>
</tr>
<tr>
<td>Grand Total</td>
<td>51</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>BME</td>
<td>11</td>
</tr>
<tr>
<td>Not Declared</td>
<td>7</td>
</tr>
<tr>
<td>White</td>
<td>33</td>
</tr>
<tr>
<td>Grand Total</td>
<td>51</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age Band</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 30</td>
<td>10</td>
</tr>
<tr>
<td>31 - 45</td>
<td>13</td>
</tr>
<tr>
<td>46 - 54</td>
<td>15</td>
</tr>
<tr>
<td>55 +</td>
<td>13</td>
</tr>
<tr>
<td>Grand Total</td>
<td>51</td>
</tr>
</tbody>
</table>
AGENDA ITEM No: 2.2

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

PRESENTING: Deborah Fowler

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

RECOMMENDATIONS: Committee Members are asked to NOTE this report

Report to be sent separately after the AFRSC meeting on 18/04/2018
AGENDA ITEM: 2017/18 Annual Intelligence Report

PRESENTING: Amie McWilliam Reynolds

EXECUTIVE SUMMARY: This paper provides a summary of intelligence gathered from the local Healthwatch Network over the last year.

RECOMMENDATIONS: The Committee is asked to NOTE the report.

The below report sets out the insight we have received from the local network both in terms of the records of feedback from individuals and the reports they have produced through 2017/2018.

Annual Intelligence Report
2017/18

Key Messages

- In 2017/18, Healthwatch England received 16% more reports from the Healthwatch network compared to 2016/17.
- However, the number of Enter and View reports that we have received has decreased by 2%.
- In 2017/18, Healthwatch England received twice (207%) more individual feedback from the local Healthwatch network compared to 2016/17.
- The majority of our feedback relates to primary care in particular GP services.

In Summary, what we hear about....

| Primary Care | People have continued to tell us that they have issues making appointments with GPs. This includes problems using telephone appointment systems, waiting too long for appointments and difficulties registering with new GP services when moving area. We also received feedback from people struggling to find and access dental services as well as those disputing the cost of dental services. |
### Primary Care

<table>
<thead>
<tr>
<th>Emerging Themes</th>
<th>In 2017/18 we have heard more concerns about prescriptions and a lack of co-ordination and communication between pharmacies and GP practices, which could be a result of changes in the prescription processes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy context</td>
<td>The GP Forward View has recommended increasing the number of appointments available and increasing the use of online patient systems; CQC has also published its review into online primary care services.</td>
</tr>
<tr>
<td>What are we doing</td>
<td>• We currently sit on the GP Patient Survey Steering Group.</td>
</tr>
</tbody>
</table>
| Opportunities   | • There is an opportunity to map the evidence we gather against these national statistics on access to help provide a view on progress.  
 • There is an additional opportunity for collaboration with General Medical Council who are keen to expand role of patient experience during the revalidation process. |

### Secondary Care

| Key Themes | People have continued to tell us about poor quality of care provided in A&E departments as well as concerns about long waits when arriving at appointments and poor communication between staff and those in attendance at A&E.  
We have also heard about missed hospital appointments due to poor administrative processes. This includes people not being told of their appointments or correspondence being in the wrong language.  
We also heard about discharge from hospital, which can be unclear and uncoordinated across services involved. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Emerging Themes</td>
<td>We have received more feedback this year on the poor communication between hospital staff and patients.</td>
</tr>
</tbody>
</table>
| Policy context | 4hr A&E and 18 week referral to treatment targets are being missed, with major emphasis to fix the problem being placed on improving the ‘delayed transfers of care’.  
The number of DTOCs is falling but the 3.5% target set in the NHS Mandate was missed. Our concern is that feedback from people suggests the experience of being discharged is not improving. |

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1 Across England, more and more GP practices are changing the way repeat prescriptions are ordered. Repeat prescriptions will no longer be able to be ordered on a person’s behalf by a pharmacy or a company and instead the responsibility is now with the patient to order their repeat prescription directly from their GP surgery which is causing issues for some. Here’s an example of the changes in Cheshire: [http://www.oaklandsmiddlewich.nhs.uk/important-changes-repeat-prescription-ordering-cheshire](http://www.oaklandsmiddlewich.nhs.uk/important-changes-repeat-prescription-ordering-cheshire)
### Secondary Care

#### What are we doing
- Published a report about discharge from services,
- Insight on A&E shared with Department of Health and Social Care (DHSC)
- Insight on missed appointments shared with Chief Nursing Officer and NHSE,
- Emergency readmissions work resulted in DHSC/National Health Services England (NHSE) agreeing to publish this data again.

#### Opportunities
- Develop insight further alongside the 4hr target to show impact of winter pressures,
- Use this insight to inform Healthwatch view of NHS performance against Mandate
- Continue sharing insight with CQC to feed into their Local System reviews.

### Social Care

#### Key Themes
People told us they have issues accessing appropriate home care services. Despite hearing positive experiences about the care provided in peoples’ homes, we have also heard that sometimes services can be of poor quality and inconsistent.

Since our care home report, we continued to hear feedback regarding the variation in the quality of care delivered across care homes. People told us about a lack of the information needed to make informed decisions about which care homes best meet their requirements.

#### Emerging Themes
This year we have received an increase in requests for information about social care services, particularly questions about assessments, access to care at home, care home entry and equipment services.\(^3\)

#### Policy context
The Government is currently developing a green paper on the long term plans for social care. We are feeding our insight into this process, picking up specifically around the need for better information and advice to help people plan their care.

#### What are we doing
- Home Care Services’ and ‘Care Homes’ reports published, met with Minister of State for Health to discuss quality of information available,
- Healthwatch England National Director is acting as an independent advisor on the Social Care Green Paper.
- Conducted research specifically exploring people’s information needs to be shared with DHSC team for Green Paper.
- Leading Quality Matters priority one in partnership with the LGO - looking to improve complaints handling in social care.

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\(^3\) This comparison is between financial year 2017/18 and 2016/17; the data used for 2016/17 is from Jun 2016. However, proportionality has been considered.
<table>
<thead>
<tr>
<th>Social Care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Opportunities</strong></td>
<td>Work with DHSC to discuss complaints advocacy review as part of broader health and social care feedback strategy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Health</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key Themes</strong></td>
<td>People told us that they need more accessible information about the services that are available to them. We also heard that services need to be better coordinated and that long waits for appointments lead to delays in diagnosis, care planning and delivery.</td>
</tr>
<tr>
<td><strong>Emerging Themes</strong></td>
<td>We have started to see an increase in positive feedback about how GPs are tackling mental health issues. Over half of the people who talked to us about GPs and mental health told us that GPs management of mental health has improved and they are the ‘go to place’ when seeking help.</td>
</tr>
<tr>
<td><strong>Policy context</strong></td>
<td>Stakeholders are increasingly interested in using user feedback to inform service change in this area. On Child and Adolescent Mental Health Services (CAMHS) specifically the role local Healthwatch can play in providing insight on user experience to inform decision making was highlighted by the CQC in their recent report.</td>
</tr>
<tr>
<td><strong>What are we doing</strong></td>
<td>Our mental health insight underpins our mental health priority work programme for 2018/19 and beyond. We plan to publish our first report on what people have told us in May 2018. Linking with organisations that focus on support and advocacy for people with mental health problems. This will be a theme at the national conference.</td>
</tr>
<tr>
<td><strong>Opportunities</strong></td>
<td>We will be beginning our mental health programme of work (info to be shared).</td>
</tr>
</tbody>
</table>
Annual Intelligence Report 2017/18

Where does our data come from?

Healthwatch England provides insight into people’s views of health and social care using two key sources of information from the local Healthwatch network:

1. Research reports produced by the local Healthwatch network;
2. Records of individual feedback collected by the network and passed to Healthwatch England.

In 2017/18 we received 910 local Healthwatch reports from 141 local Healthwatch. This was an increase of 16% compared to 2016/2017. Just under half of these reports (37%) relate to the area of social care, the majority of which (75%) are as a result of ‘Enter and View’ visits to Care Homes.

Last year Enter and View visits have been conducted across GP surgeries (80), hospitals (19) and mental health units (13). However, overall, there has been a fall (2%) in the number of Enter and View reports received4.

FIGURE 1. VOLUME OF HEALTHWATCH INSIGHT COLLECTED IN 2017/18 COMPARED TO 2016/17.

<table>
<thead>
<tr>
<th>Service Area</th>
<th>LHW Reports 16/17</th>
<th>LHW Reports 17/18</th>
<th>% of LHW Reports 16/17</th>
<th>% of LHW Reports 17/18</th>
<th>Individual Feedback 16/17</th>
<th>Individual Feedback 17/18</th>
<th>% of Individual Feedback 16/17</th>
<th>% of Individual Feedback 17/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>174</td>
<td>194</td>
<td>22%</td>
<td>21%</td>
<td>1052</td>
<td>3071</td>
<td>41%</td>
<td>39%</td>
</tr>
<tr>
<td>Secondary Care</td>
<td>128</td>
<td>115</td>
<td>16%</td>
<td>13%</td>
<td>830</td>
<td>2330</td>
<td>32%</td>
<td>30%</td>
</tr>
<tr>
<td>Social Care</td>
<td>296</td>
<td>335</td>
<td>38%</td>
<td>37%</td>
<td>242</td>
<td>1224</td>
<td>9%</td>
<td>16%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>58</td>
<td>98</td>
<td>7%</td>
<td>11%</td>
<td>117</td>
<td>423</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Other Care</td>
<td>138</td>
<td>191</td>
<td>18%</td>
<td>21%</td>
<td>327</td>
<td>1473</td>
<td>13%</td>
<td>19%</td>
</tr>
</tbody>
</table>

Please note: a.) Some reports/individual pieces of feedback cross multiple service areas, b.) Our processes for coding and collecting our insight has changed since16/17 such as improved collection of reports and increased uptake in CRM usage which will contribute to the increase in numbers seen from 16/17 to 17/18, c) in 2016/17 we began pulling individual feedback through the CiviCRM system partway through the year therefore the figures included are not for the entire year.

4 We are currently further investigating the reasons for the decrease in Enter and View visits. We are assessing a number of causes for the decrease, including: 1) The number of ‘must-do’ Enter and View visits stated by local authorities could have changed since 2016/17, 2) A local Healthwatch may have carried out numerous visits in 2016/17 to one type of provider and therefore decide the next year not to return to these and focus on another type of provider instead (e.g. GP surgeries vs. care homes - a programme of primary care visits equates to more visits than care homes as there tends to be more GP surgeries than care homes in local areas), 3) Some local Healthwatch may be making visits not using the power of entry thus not calling it Enter and View, 4) Some local Healthwatch may have decided to stop using the power of entry due to resource constraints and the time it takes to plan and deliver one visit.

5 In 2017/18 the taxonomy changed which resulted in secondary care services being broken down into A&E and Urgent Care and Hospitals. This means for the majority of the year we can measure the level of feedback or reports on these two areas of Secondary care, but for the beginning of the year they have been combined into a single figure, this relates to 6 reports and 263 pieces.
We received 7895 individual pieces of feedback from 54 local Healthwatch networks. This was an increase of 207% compared to the same period last year.

Around two thirds (63%) of the feedback that Healthwatch England has received from the network is unsolicited\(^6\). The remaining third is solicited\(^7\).

Unsurprisingly our solicited insight is more positive than our unsolicited insight and there is little difference in the topics that people volunteer information about and the topics Healthwatch proactively captures.

This financial year, we have seen increases in both solicited and unsolicited feedback.

Overall, just under half of our feedback (39%) related to primary care services, the majority of which was specifically about GP services. A further 30% of individual feedback received related to secondary care, notably about hospital care outside of A&E and urgent care.

Only 5% of individual feedback related to mental health. However, there has been a slight increase compared to the previous year, which may be a result of mental health being a priority for many members of the local Healthwatch network.

**What are people asking us about?**

Last year Healthwatch received around 1,260 requests for information as identified through the individual feedback collected by the Local Healthwatch network and passed to Healthwatch England via CRM. Additional requests for information, around 50,000, are also reported in the annual return.

Over a quarter of the requests relate to social care, in particular:

1. The process for moving into a care home
2. Transitioning from residential to nursing homes
3. Costs and funding availability

And domiciliary care:

1. How to get care/help at home
2. How to get needs assessments and equipment
3. What services are available once discharged from hospital

We have also received information requests from carers asking about what support is available for them.

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\(^6\) Unsolicited feedback refers to feedback that is predominantly collected through people contacting their local Healthwatch unprompted, e.g. via the telephone or email, to share their experiences or to ask for information.

\(^7\) Solicited feedback refers to feedback that is actively sought from people through local Healthwatch engagement events
A large proportion of requests for further information are also about GP services. The majority of people were asking about how to register to or change to a GP practice and what GP services are available in their local area.
What are people telling us about?

Primary Care

During the last financial year, 194 local Healthwatch reports were published covering primary care. In addition, we received 3,071 individual pieces of feedback from members of the public about primary care through the Healthwatch network. This accounts for 39% of the all individual feedback received.

The following services are included in the primary care category; General Practice, Dentistry, Pharmacy, NHS 111 and Opticians. The majority (71%) of our primary care feedback relates to GP services.

General Practice

We have received 149 reports from local Healthwatch about GP services, 94 of these were Enter and View reports. In addition, around a third of our information that relates to individual experiences of health and social care is about GP services.

The primary issue we hear about is accessing GP services. This includes the following themes:

1. Issues with booking appointments, particularly via the telephone appointment system
2. Waiting too long for an appointment once it has been booked
3. Issues registering at different GP practices, whereby local Healthwatch are asked to provide a signposting role to local GP services.

Another important issue we hear about is the variation in staff attitudes and their communication with patients. In some areas, people gave positive feedback about the staff at their local GP practice. However, of the feedback we received about staff attitudes and communication around half was negative. People would have told us that they would like to see greater empathy from receptionists and GP’s and more communication with patients, particularly about their appointment and follow-up.

Case Study

Healthwatch Redbridge\(^8\) completed a large scale Enter and View project visiting all 45 GP surgeries in their borough. The aim was to look at communication and review how well practices were implementing changes from the accessible information standard. Practice managers, staff and patients were engaged during the visits and the work has resulted in more than 10 actions from local surgeries such as training for staff and installing hearing loops.

\(^8\) [http://healthwatchredbridge.co.uk/sites/default/files/ais_summary_report.pdf](http://healthwatchredbridge.co.uk/sites/default/files/ais_summary_report.pdf)
**The policy context:** In recent years there has been an effort through the GP Forward View to address access issues in primary care, both in terms of how people are making appointments (attempts to increase use of the ‘Patient Online’ booking system) and the availability of appointments (increase in evening and weekend slots). The most recent figures suggest 14 million patients now use the online system to book appointments, order repeat prescriptions and view their records - this is about a quarter of all patients, albeit more still needs to be done to reach those who are hard to reach or vulnerable groups.

**Possible action:** It would be worth us considering mapping the evidence we gather against these national statistics to help provide a view on progress. This could potentially form part of our submission to the Secretary of State on NHS England’s performance against the NHS Mandate (due in May).

As of March 2018, we now have a seat on the GP Patient Survey Steering Group - attended by the Head of Intelligence. We suggest feeding our evidence in through this forum to help shape the future of the GPPS to focus more on feedback, particularly around staff attitudes and communication.

In the autumn of 2017 we launched phase two of #ItStartsWithYou focusing on raising the importance of GPs using patient feedback to improve the service they provide. This has led to increased engagement with practice managers and patient participation groups through the trade press and their national associations.

There may also be an opportunity to form a closer working relationship between Healthwatch England and the General Medical Council as they are looking to expand the role patient feedback plays during the professional revalidation process.

**Other Primary Care**

This financial year, 45 reports were received from local Healthwatch about dentistry, pharmacy, NHS 111 and opticians. In addition around 14% of our individual feedback has been focused on how these services are delivered.

Common themes we hear about are;

1. Issues accessing dental services, particularly finding and registering at a dentist
2. Difficulty getting timely dental treatment
3. Questions and disputes over the cost of dental services.

More recently we have heard about issues with prescriptions including the collection of medication, the availability of medication and errors made, and the lack of co-ordination and communication between pharmacies and GP practices. We hear that there is low awareness of the additional health services that pharmacists can provide.
Healthwatch Enfield, Islington and Buckinghamshire all found that people mostly attend to collect a prescription but would be open to having quicker access to the medical advice pharmacists can give.

The policy context:

We have continued to engage with dentistry in 2017/18, picking up mostly on the recommendations we made in our November 2016 report around access to dentistry for specific groups.

Through our position on the Regulation of Dental Services Programme Board we have pushed for the issue of access to dentistry in care homes to be looked at. We understand the CQC is now exploring this over the next year and although the full scope of the CQC’s work is not yet clear but we will look to support the activity where possible - resource has been allocated in this year’s business plan which we will be looking to support.

More broadly on access, we have escalated our concerns regarding the information available on NHS Choices around accessing an NHS Dentist to the DHSC. As of October 2017 we identified that more than half of dentist surgeries on NHS Choices have no information about whether or not they are taking on new NHS patients, with 24 areas having no surgeries with open lists. We will continue to monitor feedback provide on this issue and share it with relevant parties to encourage the DHSC to make updating NHS Choices data a mandatory element of the new dental contract.

Secondary Care

A&E and Urgent Care

Local Healthwatch have produced 11 reports about A&E departments during the last financial year. We also received 211 pieces of individual feedback from members of the public relating to A&E departments through the CiviCRM system. This represents 3.5% of all individual feedback received.

The prominent themes emerging from the feedback relate to:

1. The quality of care and treatment people receive when attending A&E,
2. The attitudes and level of staffing in A&E departments,
3. Long waiting for those attending A&E.

The majority of feedback we receive involves people sharing their experiences about the poor quality of care and treatment that they or a relative/friend receives while attending A&E. This theme accounts for the majority (72%) of all individual feedback.

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9 20171114_Bucks_Making the most of your pharmacy, 20170921_Islington_Pharmacy in Islington: Awareness of additional services, 20180331_Enfield_ A&E One stop shop for everyday healthcare needs
Another key theme relates to staffing, primarily concerning issues around how staff communicate with patients together with people commenting on poor staff attitudes and the quality of staff within A&E departments generally. This accounts for the majority (60%) of all individual feedback received on this area.

Waiting times for people who present at A&E are also a key concern. This is mainly about people waiting to be seen once they have arrived at A&E. There are also issues with people waiting to receive treatment once they have been seen by a healthcare professional.

**Case Study**

Leicestershire Royal Infirmary opened a new purpose-built emergency department and Healthwatch representatives from Rutland, Leicester City and Leicestershire spent 12 hours talking to people about the new service. Overall, people experienced no delays in waiting to speak to reception, and relatively short waiting times to be assessed by clinicians.

Healthwatch found that the new check in process seemed to be working well, with a few areas for improvement such as ensuring text size and colour is more accessible as well as having an audible source of information for people in the waiting room.

Healthwatch Leicestershire has worked with the Trust on this and other service developments.  

**The policy context:** There has been interest from the DHSC to package up the insight we are gathering on A&E, with specific reference to what patient experience is telling us around winter pressures. Top lines were shared at an initial meeting in March.

**Possible action:** That we develop our evidence into something more formal specifically looking at urgent care and people’s experiences alongside the 4hr A&E target. This would help to paint a more accurate picture for the system on what the real impact of winter pressures is on people using services.

**Hospitals**

Over the last year we identified 98 local Healthwatch reports that were published which talked about peoples experiences when attending hospitals. In addition, we received 1,856 individual pieces of patient feedback.

Common themes we hear about are;

1. People experiencing long waiting times when attending,
2. More understandable information needed following appointments or discharge,

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10 20170621_Leicestershire_Emergency department check in report
3. Coordinating services following discharge,
4. Improved administration processes to reduce missed appointments.

We heard that people experienced **long waits** when arriving for appointments, but then had a good experience with the staff. Others have told us that their appointment was efficient but they were **not given information that was easy to understand** afterwards.

This was also a common theme from the reports on hospital discharge - especially when there was a change in the medication being given. Feedback about communication with staff is more negative than we have heard previously; this could be due to pressures in hospitals or the reduced number of staff as suggested by external research\(^\text{11}\).

**Hospital admission and discharge** is a key area of work for many Healthwatch. This is a point in care when services from secondary, primary, and sometimes social care and mental health, all need to work together to get the best experience for the patient. We’ve seen good examples of impact in this area of work for Healthwatch and have highlighted the significance of the issue in two briefings in the autumn of 2017.

**Missed appointments** are a rising issue for the NHS, and **Healthwatch Doncaster** has investigated this at Doncaster Royal Infirmary. They spoke to 1630 people, and found that the administration process should be reviewed for accuracy, efficiency and accessibility. People with disabilities and from non-English communities said hospital documentation needs to be more accessible. Both working age people and young people wanted more appointments outside normal working hours as this would increase their ability to attend hospital appointments.

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**Case Study**

**Healthwatch Northamptonshire**\(^\text{12}\) conducted a two part study of 89 people in hospital (survey) and interviewed (a smaller set - 7) them about their post hospital experience. The key message from their work coincides with what we’ve heard nationally; people want to be better informed about their conditions and need to be able to contact key healthcare professionals in case of problems after time in hospital. Clear communication that is strengthened by coordination between GPs and hospitals would be something that improves people’s experiences of care in hospital and reduce the chance they will be readmitted.

As a result of Healthwatch Northamptonshire’s work, Kettering General Hospital has implemented an admission and discharge information pack to support hospital staff to improve experiences of hospital care. The hospital will also involve the community with engagement events to gain feedback about what services need to be included in the discharge process.

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\(^{11}\) [https://www.kingsfund.org.uk/blog/2017/10/falling-number-nurses-nhs-paints-worrying-picture](https://www.kingsfund.org.uk/blog/2017/10/falling-number-nurses-nhs-paints-worrying-picture)

\(^{12}\) 20171231_Northamptonshire_Discharge from hospital and follow up support
**The policy context:** On hospital discharge we continue to explore options to help the system use our insight into people’s experiences to gauge progress on reducing delayed transfers of care and what the impact has been on patients. Most notably this work will continue in the year ahead around emergency readmissions.

Our report in October 2017 identified that figures on emergency readmissions rates had not been published since 2012/13 because of concerns over the methodology and the definition of what constitutes an emergency readmission. However, our research revealed the number of emergency readmissions has increased by 22.8% in the last five years, significantly higher than the overall increase in admissions.

Our concerns have since been picked up on by reports from the British Red Cross and the NAO. In March the DHSC wrote to us and outlined that they will now be working with NHSE to start publishing the data again but have outlined the need for time to get the methodology right. We have extended an offer to convene a roundtable to help develop the methodology.

We will also continue to highlight how developing a better understanding of patient experience transferring between services is a good indicator of how well integration is working in a local area. In particular we will continue to share our findings with CQC to feed in to their Local System Reviews which are making a similar point.

On long waiting times it may be worth us considering gathering our evidence in the same way as proposed for urgent care. We could assess people’s experiences alongside the 18 week referral to treatment target and use patient insight to explore the impact of system pressures on people.

On missed appointments we have shared our insight with the Chief Nursing Officer and an offer extended to help NHSE use our evidence over time to understand why people are missing appointments. We await a response.

**Social Care**

During the last financial year, **335** local Healthwatch reports were published on services relating to social care. We also received **1,224** pieces of individual feedback from members of the public through the Healthwatch network, representing a 16% of our total individual feedback during this same period. The majority of our feedback involves people talking to us about domiciliary care, followed by care homes and social care assessments, mostly about older people.
Domiciliary Care

Last summer, we shared what people told us about home care - this was based on feedback from 52 local Healthwatch. Continuing from the report, we’ve had high levels of feedback about care at home. People still tell us they have trouble accessing the most appropriate home care services, or are receiving poor quality of care, and having issues with carers visiting their home at the wrong time or not staying long enough to properly fulfil their caring role.

Common themes we heard about were;

1. Care planning - a process that helps to ensure care is focused on what people need
2. Skills and qualifications for care staff to improve care and reduce staff turnover
3. Choice and consistency - this means including family in the assessments, communication and feedback between providers, families and the people who use the services needed better attention.

Care Homes

In August 2017, we published our briefing ‘What’s it like to Live in a Care Home?’ Following the publication of that report, we’ve received a further 70 reports about care homes. We continue to receive a mix of feedback on care homes, including residential and nursing, largely focuses on people questioning the dignity or quality of care that they or their family member receives combined with issues relating to the quality of staffing.

Common themes we heard about were;

1. Variation in the quality of care within and between care homes
2. Good practice happens when people needs are met and services work together
3. The best care homes let people live as similarly as they would have in their own home.

Case Study

Healthwatch Wokingham Borough identified key features that can be applied to the environment of a care home to encourage someone with dementia to live well and experience more independence. After a targeted walk through, recommendations were made around the 9 key areas of focus in the home. Dementia Friendly improvements made to the home that improved the experience of people with dementia living here. Healthwatch has been invited back by the provider in a year to see the progress.

13 https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/20171002_-_home_care_-_what_people_told_local_healthwatch.pdf
14 https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/20170815_whats_it_like_to_live_in_a_care_home_findings_from_the_healthwatch_network.pdf
Information about assessments and care

People commonly ask us for information on accessing social care assessments as well as information around their eligibility to receive allowances or funding for social care services. Any kind of assessment can be stressful, and this is especially true if you are vulnerable and needing extra support at home. Healthwatch Brighton and Hove\textsuperscript{15} heard from people who’d had different support assessments and found a lack of consistency in the process, with some assessors having poor knowledge of hidden needs (such as mental health or multiple conditions) and showed a lack of empathy towards people when they asked questions.

We hear a lot from informal carers - 1425 comments from carers in the last year - with information coming from across the country with 58 Healthwatch contributing. Carers tell us they need easier access to information to support their role and their own wellbeing, respite care, or help with having a carer’s assessment.

The policy context:

Following our two reports on social care last summer, Healthwatch England National Director has been invited to act as one a number of independent advisors to the Government’s social care green paper - due for publication in the summer.

As part of this work we had a positive meeting with the Minister of State for Health, Caroline Dinenage MP, in February picking up on the poor level of information available to help people judge the quality of care and find services that are right for them.

We have conducted two deliberative focus groups sessions and some national polling activity to explore people’s needs/wants in this area and will be sharing this insight with the DHSC team working on the Green Paper.

Last year the Competition and Market’s Authority’s report on care homes picked up on the concerns we submitted around the lack of complaints advocacy in social care. The Government’s response to the CMA has agreed to take forward a review of this to put complaints in social care on an equal footing with the NHS.

On 11 April we met with the DHSC takes the review of this issue forward as part of their broader health and social care feedback strategy which is being developed. We will continue to make our long-standing point that there should be the same offer of advocacy support to help raise complaints regardless of the health or social care service used.

We are also on schedule to publish our work with the LGO on a ‘single complaints statement’ as part of the Quality Matters initiative which aims to help provide some consistency in complaints handling in social care.

\textsuperscript{15} 20180215_Brighton and Hove_Vulnerable People Need Help With Assessments
Mental Health

During the last financial year, we received 98 local Healthwatch reports on mental health. In addition, we received 423 individual pieces of feedback from members of the public about mental health care. This accounted for 5% of our total feedback received by Healthwatch England.

A number of cross-cutting themes\(^\text{16}\) have been identified from the reports and feedback we have received. These include:

1. Information about mental health services available and how to access them
2. The management of mental illness by GPs
3. Long waiting times for appointments leading to delays in diagnosis and receiving necessary support
4. Staff shortages in Community Mental Health Teams
5. Lack of coordination between mental health and other health and social care services.

A quarter of the feedback we receive is about the lack of information on available mental health services. People have told us that they have difficulties understanding and navigating the health care system to locate the most appropriate mental health support.

Of those people who have some knowledge about mental health services, they often do not know how they can be accessed. For example, a small number of people that spoke to us did have knowledge of some mental health support that was available such as talking therapies but again did not know how to access them.

Many people’s first point of call is with their GP. Historically, we receive largely negative feedback about the way GPs deal with people with mental health conditions. Whilst we still hear some negative experiences, we have also started to hear more positive experiences of GPs especially in relation to dealing with mental health conditions, around half of our feedback in the last year relating to mental health and GP services is positive. This was particularly prevalent for parents of children with mental health conditions who told us that they often turned back to their GP or schools to support them in navigating the appropriate services after experiencing difficulties accessing CAMHS.

20% of our mental health feedback relates to people having long waits to see a specialist which can often lead to delays in diagnosis. We heard that the delay ultimately means support and treatment is not given as early as possible. This is leading to worsening mental health conditions and causes additional stress, anxiety, depression and social exclusion. The issue about waiting times appear to be across the board affecting all areas of mental health services but particularly children’s mental health services, community mental health teams and perinatal services.

\(^{16}\) An in depth report which breaks down the key themes for each service and condition, from childhood through to older age will be published in May 2018.
People told us that waiting times were being made worse by staff shortages. We heard that services are overstretched and are experiencing high levels of staff turnover particularly with Community Psychiatric Nurses.

Another key theme that people tell Healthwatch about is that the gaps between health services need to be dealt with. 15% of feedback relates to the lack of coordination with and between mental health services, for example, CAMHS and learning disability services could be better coordinated to meet the needs of children who have a learning disability, such as autism, and mental health issues.

In addition to this, people with a diagnosis of two or more mental health conditions often felt that their care was disconnected and it was harder for them to get support which can result in service provision not being tailored to specific needs, therefore ineffective support and treatment is given. We heard this particularly in feedback received on substance misuse and learning disabilities. People believe that when services are better joined up they tend to have more positive experiences of using them.

Case Study

Healthwatch Suffolk\(^7\) was commissioned through Suffolk’s Emotional Wellbeing Transformation Plan to understand what the state of mental health among young people. After surveying 6800 students from age 11-18, they were able to highlight concerns and good practice in Suffolk. Healthwatch discovered that the number of young people who said they got less than six hours of sleep on a school night increased with age – from one in ten at age 11 to six in ten at age 16. Girls rated their self-esteem as poor or very poor more often than boys (1/3 compared to 1/10), and school pressure was found to be the most common stressor by age 17.

Healthwatch Suffolk worked with pupils, commissioners and schools when creating recommendations. In an update on progress, Suffolk will now have a new Emotional Wellbeing hub to help young people, parents, carers, or professionals get information and support when they need it. On top of this, a pilot of a 7 day crisis service is due to begin in April 2018\(^8\).

The policy context: Recent stakeholder meetings in support of the development of the Mental Health Programme suggest there is appetite for us to use the insight we gather to help identify the gaps which the current Mental Health Forward View is not addressing. In particular they would like to know more about the experiences of the groups with more severe mental health conditions as there is perhaps less policy focus on support for these groups at the moment.

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\(^7\) 20171101_Suffolk__My health, Our future
Stakeholders engaged so far have also suggested that using our insight to test the effectiveness of the early interventions prioritised by the MH Forward View would be useful.

Also worth noting the CQC CAMHS review published in March made three recommendations specifically referencing the importance of services and professionals working with local Healthwatch to gather insight on current user experience, to help design new services, and as a way of scrutinising whether improvements are driving the desired impact. This is really positive position and marks an important first step in recognising the contribution of Healthwatch to the mental health sector at a national level.

**Possible Action:** The scope of the mental health programme and its focus on the experience of different groups of service users should enable us to spot those who not having their poor experiences addressed by the mental health forward view.

This feedback from stakeholders should be used to help us prioritise the individual issues we explore further over the course of the programme.
Healthwatch England Business Plan 2018-19

About this document

In March 2018, we published our strategy which set out our aims and the difference we want to make by 2023 in partnership with local Healthwatch.

This business plan explains what we intend to do during the first year of the strategy towards achieving our aims.

Contents

- Foreword
- Introduction
- Summary of our strategy (vision, purpose approach and aims)
- Summary of our annual business plan
- How we will measure progress
- Budget
- Risks
Foreword

Jane Mordue, Chair of Healthwatch England

This spring the Healthwatch network celebrated our fifth anniversary. We also published our new strategy, setting out what we want to achieve over the next five years.

The run up to these events provided us with an opportunity to reflect on our progress and our ambitions for the future. They also gave us the chance to think about our role in making change happen, how this fits with what local Healthwatch organisations are focussed on and how we can work together to achieve our shared vision for the future.

Our unique offer

Our society faces big challenges when it comes to making sure people have the health and care support they need. And, as our new strategy makes clear, we believe we can play a unique role in helping to solve them.

People know that the traditional approach to providing care and support needs to change. By finding out what really matters to people and making sure these views are heard we can the oxygen for the debates that need to take place.

But this is not just ‘customer feedback’. The ambition of the 2012 Health and Social Care Act was to put people's views at the heart of decision-making about health and social care. And since Healthwatch England and the 152 local Healthwatch across England were established we have worked hard to make sure people's voices are heard.

From the changes people want to see at their GP practice, to discussions over long-term health and care strategy, we aim to be at the table. We help to provide a safe space where often difficult discussions can take place and above all we help ensure that decisions are shaped by what really matters to local people.

Big and small changes that matter

From a standing start in 2013, we have developed considerable experience when it comes to how best to help people have their say. As a result we now have a catalogue of powerful evidence, covering a spectrum of views that have been used across England to achieve positive change.

For example, nationally, the experiences that thousands of people shared with us about hospital discharge helped kick-start work across the NHS to improve how people in the most vulnerable circumstances are supported after leaving hospital.

While locally, countless residents of care homes, nursing homes, mental health wards and other care environments have had their daily lives improved by the implementation of recommendations made after visits by our staff and volunteers.

Our ambition

So, we have proof of concept but we now need to go further.

People tell us that they want to be in control of their own health, care and wellbeing, to make more decisions and to shape the services that support them. While health and care workers tell us that they value our evidence for its honesty and practicality, we know its use needs to be more widespread.
As our strategy makes clear, we aim to do more, exponentially more ideally, to support people to have their say and ensure their views are heard and have an impact on health and care policy.

To move us towards achieving our aims, our business plan includes:

- Initiatives to build more profile, both for Healthwatch and the power of the public’s voice, so we double our contacts with people to more than one million a year by 2023;
- Work to continue to understand and address inequality and ensure that the most vulnerable and those who don’t usually have a voice are heard;
- The sharper use of digital systems to capture people’s views and provide a more responsive information and advice service;
- Research to help health and care professionals understand the value of listening to their communities in both quality and monetary terms; and
- Activity to strengthen the structure of the Healthwatch network, the service we provide and improve the skills of our staff and volunteers.

Challenging environment

If we are to achieve our vision, we also need to work with funders to ensure that sufficient resources are in place.

Local authorities have a statutory duty to commission a local Healthwatch for their residents and, since we were established, we have seen funding for local Healthwatch fall by over a third.

Given the challenges local government funding faces, this situation may not be surprising but it does mean that some local Healthwatch are now pared to the bone.

This is why our business plan sets out how we will work with everyone in the chain of funding and delivery to seek a solution. At a time of significant changes to local health and care services, it has never been more important to make sure that a strong local voice for people remains in place and that communities are involved in the big decisions that will affect them.

At Healthwatch England, we are passionately committed to deliver on our vision, purpose and statutory duties for the public, local Healthwatch, local government and the taxpayer.

With a new strategy and business plan in place, I firmly believe we will move a step closer to helping to achieve health and care that works for everyone.
Introduction

*Imelda Redmond, National Director of Healthwatch England*

To help achieve our vision of ‘health and care that works for you’, our business plan for the year ahead will focus on delivering our strategic aims to:

1. **Support you to have your say**
   
   We want more people to get the information they need to take control of their health and care, make informed decisions and shape the services that support them.

2. **Provide a high quality service to you**
   
   We want everyone who shares their experiences or seeks advice from us to get a high quality service and to understand the difference their views can make.

3. **Ensuring your views help improve health and social care**
   
   We want services to use your views to shape the health and care support you need to day and in the future

**A year of transition**

The first year of the strategy will be a transitional year, where we will ensure that we have the right systems and structures in place to ensure we can deliver our ambitions for the next five years.

In particular we will focus, in partnership with local Healthwatch, on:

- Ensuring we are better known and understood so more people engage with us;
- Increasing the amount of evidence we get from our communities and the research we undertake;
- Developing strong partnerships to hear and share what people want from care;
- Investing in our digital infrastructure for gathering, understanding and communicating people’s views;
- Improving our how we measure our impact and encourage quality and innovation; and
- Ensuring that we use our limited resources well and build the skills of our people.

We know that our relationship with local Healthwatch is key to our success. This is why throughout the year ahead we will focus on improving the support we offer, creating an environment where innovation is celebrated, learning is shared and our impact is greater than the sum of our parts.
## Healthwatch England - Strategy Business Plan 2018 - 2023

### Aim 1
Support you to have your say.

We want more people to get the information they need to make decisions about their wellbeing, care and the services that support them.

<table>
<thead>
<tr>
<th>Activities for Year 1</th>
<th>Delivery Date 2018/19</th>
<th>KPIs</th>
<th>Outcomes Resulting from all Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
</tr>
<tr>
<td>Content strategy: Map current content providers, identify gaps and establish partnerships. Trial content syndication.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Digital development: Roll out refreshed website to local Healthwatch. Establish user requirements for future investment case.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Involvement Index: Establish public awareness levels, attitudes and experience of involvement in care. Audience targeting: Put in place tools to improve targeting of engagement.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review Healthwatch intelligence on advice, information and sign posting to establish common questions the public want answered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard approach to advice, information and signposting: Develop and roll out common Healthwatch approach to meeting people’s information needs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communications and engagement strategy: Establish single campaigns calendar. Map potential community partners and intermediaries. Establish engagement model and baseline effective approaches.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Publish literature review on engagement methodologies; identify relevant collaborative partnerships and design engagement tool kits.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empowering young people: Scope project to empower more young people and encourage them to volunteer.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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*68*
### Key Partners

- Existing health and care information providers (e.g. NHS, CQC)
- Community services (community health teams, fire service, schools, housing etc.)
- Volunteer intermediaries (Volunteer Centre, Do-It, V-Inspired)
- Professionals who act as peer-to-peer advocates of involvement

### Dependency

- Common Healthwatch approach to impact measurement
- Strategic partnership approach
- Network wide forward planning
- Digital system
- Shift in professional attitudes Healthwatch staff and volunteers skills & development

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**Aim 2**

*Provide a high quality service to you.*

*We want everyone who shares experiences or seeks advice from us to get a high quality service and to understand the difference their views make.*

<table>
<thead>
<tr>
<th>Activities for Year 1</th>
<th>Delivery Date 2018/19</th>
<th>KPIs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
</tr>
</tbody>
</table>
| Create and articulate a clear offer to the network for 2018/19 to include
  - Training offer
  - Support
  - Data sharing
  Licence/Network agreement |     |    |    |   |
| Scope and run a programme of work on improving the funding base of LHW. |     |    |    |   |
| One Healthwatch: Programme of engagement to formalise and agree shared vision, purpose and strategy which is understood by staff and volunteers |     |    |    |   |
| Complete training needs assessment for the network. Develop a skills framework including a core skills framework for Healthwatch volunteers, staff and leaders. Explore accreditation of training. |     |    |    |   |
| Develop a plan for engaging with commissioners and local stakeholders
  - Establish quality key performance indicators.
  - Provide guidance on Commissioning LHW
  - Regularly communicate with these key stakeholders. |     |    |    |   |
| Network collaboration: Review regional network activities. Establish new methods of providing support to network on a regional basis |     |    |    |   |
| Single digital platform: Scope and develop new area for local Healthwatch to access resources, data and to collaborate. |     |    |    |   |

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**Outcomes Resulting from all Activities**

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 3</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>We have a shared vision and purpose in place, which staff and volunteers understand</td>
<td>More health and social care stakeholders understand our role</td>
<td>Rise in % of staff and volunteers say Healthwatch is good place to work.</td>
<td></td>
</tr>
<tr>
<td>We have created the offer to the network for 2018/19 and then communicated, delivered and evaluated it</td>
<td>Everyone in Healthwatch can access training and guidance designed to support their role. Satisfaction with our support has increased.</td>
<td>95% of Healthwatch meet agreed quality standards. Rise in % of people reporting a good quality experience</td>
<td></td>
</tr>
<tr>
<td>We have a common set of impact measures and quality KPIs in place. We understand the wider social impact of our work.</td>
<td>80% of Healthwatch and commissioners use our impact framework and quality KPIs. Rise in % of people reporting a good quality experience.</td>
<td>Every person who shares an experience with us, gets told how this has made a difference if they want to know</td>
<td></td>
</tr>
<tr>
<td>We have the tools in place to offer staff and volunteers an induction and they can access training and support.</td>
<td>We use a single digital platform to engage and serve our communities used by the entire Healthwatch network with an intelligence hub that brings together our insight.</td>
<td>Our skilled staff and volunteers are representative of the communities we represent</td>
<td></td>
</tr>
<tr>
<td>We have established the core skills and competencies staff and volunteers need at different levels. We have baselined satisfaction levels.</td>
<td>80% of local Healthwatch meet the agreed quality standards</td>
<td>Health and social care stakeholders increasingly contact us and commission involvement, advice and other activities</td>
<td></td>
</tr>
<tr>
<td>An agreement is in place with every Healthwatch, setting out our offer and agreed requirements</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Key Partners
Wider voluntary sector - in particular those with links to specific groups.
Local Authorities, CCG’s, STP’s, Department of Health and Social Care
Existing health and care information providers (e.g. NHS, CQC)
Local government professional bodies (e.g. LGA and ADASS)

Dependency
Digital systems and single working IT platform
Funding rates for Healthwatch at a local level

Aim 3
Ensure your views help improve health and care.
We want more services to use your views to shape the health and care support you need today and in the future.

<table>
<thead>
<tr>
<th>Activities for Year 1</th>
<th>Delivery Date 2018/19</th>
<th>KPIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expanding our support base: Automated process established for identifying and engaging broad patient and public involvement (PPI) workforce across health and care.</td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>Evaluation of networks contribution to date completed and current status of the network mapped out.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual tracker survey set up to establish professional and stakeholder attitudes to public involvement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Value of engagement: Strong economic case for public engagement established and engagement matrix developed to help stakeholders identify the ROI for different engagement methods.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current NHS targets assessed against patient experience intelligence to make strong case for change in focus.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 3</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>We have proved the economic case for public involvement and can articulate the return on investment for taxpayers.</td>
<td>We will have a single intelligence hub used by the entire Healthwatch network which brings together our insight with data from key ALB partners and major third sector contributors.</td>
<td>Rise in the numbers of externals - policy makers, academics, commissioners, providers, professionals and media - accessing the Healthwatch evidence service.</td>
</tr>
<tr>
<td>We have established a network of involvement advocates with health and care services.</td>
<td>We have developed strong relationships with health and social care education, CPD and revalidation bodies to make the case for using people’s experiences to inform improvement</td>
<td>Twice as many recommendations we make are implemented by services.</td>
</tr>
<tr>
<td>We have a common set of quality &amp; impact measures and KPI in place</td>
<td>We can tell people the impact of our work using a single set of national, regional and local measures.</td>
<td>NHS and social care services increasingly feeding back to people about how their views have shaped decisions.</td>
</tr>
<tr>
<td>We have established the reach and impact of the Healthwatch network</td>
<td>We have a common evidence based approach to influencing and achieving change.</td>
<td>Rise in % of recommendations that lead to changes in care</td>
</tr>
<tr>
<td>We have baselined professional and stakeholder perceptions of involvement and the Healthwatch network.</td>
<td>Rise in % of professionals reporting positive perceptions of involvement and Healthwatch.</td>
<td>Key NHS and social care performance measures focus on improving people’s experience of care.</td>
</tr>
</tbody>
</table>

Evaluation of networks contribution to date completed and current status of the network mapped out.
We have a common set of quality & impact measures and KPI in place
We can tell people the impact of our work using a single set of national, regional and local measures.
We have established a network of involvement advocates with health and care services.
We have developed strong relationships with health and social care education, CPD and revalidation bodies to make the case for using people’s experiences to inform improvement
We have a common set of quality & impact measures and KPI in place
We can tell people the impact of our work using a single set of national, regional and local measures.
We have established the reach and impact of the Healthwatch network
We have a common evidence based approach to influencing and achieving change.
We have baselined professional and stakeholder perceptions of involvement and the Healthwatch network.
Rise in % of professionals reporting positive perceptions of involvement and Healthwatch.
Key NHS and social care performance measures focus on improving people’s experience of care.
Partnership programme developed to embed benefits of PPI in education, CPD and revalidation.

Healthwatch Evidence Service: Requirements fully scoped, technology required mapped out and necessary procurement completed. This will also include setting of realistic targets for information sharing over the lifetime of the strategy.

Robust impact measures in place including methodology for recording and analysing metric around % of recommendations accepted + % recommendations which led to change.

<table>
<thead>
<tr>
<th>Key Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing health and care data holders - NHS Digital, NHS England, CQC</td>
</tr>
<tr>
<td>Other patient / public engagement organisations - Patients Association, Care Opinion etc.</td>
</tr>
<tr>
<td>Wider voluntary sector - in particular those with links to specific groups.</td>
</tr>
<tr>
<td>Health and social care education, graduate training, CPD and revalidation bodies</td>
</tr>
</tbody>
</table>

We have an evaluation matrix which enables partners to identify the best methods for engagement to support their initiative.

Dependency
Digital systems
AGENDA ITEM No: 2.5

AGENDA ITEM: 2018/19 Year 1 Key Performance Indicators (KPIs)

PRESENTING: Imelda Redmond

PREVIOUS DECISION: N/A

EXECUTIVE SUMMARY: Following the process of developing a Business Plan for 2018/19. A set of KPIs have now been identified for Aims 1, 2, 3 and the organisation as a whole. This paper provides a list the KPIs for our first year of activity within our new strategy.

RECOMMENDATIONS:
The Committee is asked to APPROVE this paper

Background

The Committee approved the strategy in their January meeting and discussed the draft Business Plan and enablers their March workshop. Here now is a paper that outlines KPIs for discussion and approval.

This is a DRAFT - final copy will be presented at the meeting
## Aim 1 - Support you to have your say.

*We want more people to get the information they need to make decisions about their wellbeing, care and the services that support them.*

<table>
<thead>
<tr>
<th>KPI Description</th>
<th>Method used to collect Data</th>
<th>Baseline</th>
<th>Frequency Of Reporting</th>
<th>Responsible Head</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. We will see a 5% increase in public recognition of Healthwatch</td>
<td>Annual Tracker</td>
<td>33% recognition</td>
<td>Annual</td>
<td>Benedict Knox</td>
</tr>
<tr>
<td>2. We will see a 5% increase in public understanding of the purpose of Healthwatch</td>
<td>Annual Tracker</td>
<td>11%</td>
<td>Annual</td>
<td>Benedict Knox</td>
</tr>
<tr>
<td>3. We will see 35% increase in engagement with Healthwatch England via digital media</td>
<td>Google analytics Sprout social</td>
<td>Web visitors 167,264 Unique visitors 86,817 Social media reach 3,261,842 Engagement with social media 47,359</td>
<td>Quarterly</td>
<td>Benedict Knox</td>
</tr>
</tbody>
</table>

Composite KPI:
A. Website visitors
B. Actions taken
C. Number of engagements on social media
<table>
<thead>
<tr>
<th>Aim 2 - Provide a high quality service to you.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>We want everyone who shares experiences or seeks advice from us to get a high quality service and to understand the difference their views make.</strong></td>
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</table>

<table>
<thead>
<tr>
<th>KPI Description</th>
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<th>Baseline</th>
<th>Frequency</th>
<th>Responsible Head</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. We will see a new agreement in place with 80% of the Network</td>
<td>CRM</td>
<td>0</td>
<td>Quarterly</td>
<td>Gavin Macgregor</td>
</tr>
<tr>
<td>8. 80% of Local Healthwatch will report with good or outstanding satisfaction with the service from Healthwatch England</td>
<td>Composite KPI: Events, Training Annual Return</td>
<td>67%</td>
<td>Quarterly</td>
<td>Gavin Macgregor</td>
</tr>
</tbody>
</table>
9. 30 Local Healthwatch will take up the new digital offer

<table>
<thead>
<tr>
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<th>Baseline</th>
<th>Frequency</th>
<th>Responsible Head</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. We will develop an involvement/contact index to track how engaged Healthwatch England and each Local Healthwatch are with each other</td>
<td>To be developed</td>
<td>0</td>
<td>Quarterly</td>
<td>Gavin Macgregor</td>
</tr>
</tbody>
</table>

Aim 3 - Ensure your views help improve health and care.

_We want more services to use your views to shape the health and care support you need today and in the future._

<table>
<thead>
<tr>
<th>KPI Description</th>
<th>Method used to collect Data</th>
<th>Baseline</th>
<th>Frequency</th>
<th>Responsible Head</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. We will develop a new benchmark professionals understanding of the role of Healthwatch</td>
<td>Annual Tracker to be established</td>
<td>0</td>
<td>Annual</td>
<td>Jacob Lant</td>
</tr>
<tr>
<td>12. We will see the development of measurements to show impact</td>
<td>Annual Tracker to be established</td>
<td>0</td>
<td>Quarterly</td>
<td>Jacob Lant</td>
</tr>
<tr>
<td>13. We will see at least three strategic partnerships formed</td>
<td>Regular tracking via CRM</td>
<td>0</td>
<td>Quarterly</td>
<td>Jacob Lant</td>
</tr>
<tr>
<td>14. We will develop the methodology for tracking the use of Healthwatch England and Local Healthwatch findings by national organisations</td>
<td>Regular Tracking</td>
<td>0</td>
<td>Quarterly</td>
<td>Jacob Lant</td>
</tr>
</tbody>
</table>
**Year 1 Organizational KPIs**

We are a well-run organization that develop its resources well

<table>
<thead>
<tr>
<th>KPI Description</th>
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<th>Baseline</th>
<th>Frequency</th>
<th>Responsible Head</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. We will see 100% of the staff completing the staff survey</td>
<td>Staff Survey</td>
<td>98%</td>
<td>Annual</td>
<td>Joanne Crossley</td>
</tr>
<tr>
<td>16. The survey to show a 90% positive response</td>
<td>Staff Survey</td>
<td>90%</td>
<td>Annually</td>
<td>Joanne Crossley</td>
</tr>
<tr>
<td>17. We will see 100% of the budget spent on agreed priorities</td>
<td>Finance Reports</td>
<td>89%</td>
<td>Quarterly</td>
<td>Joanne Crossley</td>
</tr>
<tr>
<td>18. 80% or more of our work programmes will have delivered or are on track to deliver the agreed programme and strategic benefits.</td>
<td>Leadership Papers</td>
<td>0</td>
<td>Quarterly</td>
<td>Joanne Crossley</td>
</tr>
<tr>
<td>19. We will see the Committee discharge its statutory responsibilities under Health &amp; Social Care Act and Equality &amp; Human Rights Acts</td>
<td>Composite KPI: Annual report Quarterly report to AFRSC on discharge of statutory duties</td>
<td>0</td>
<td>Quarterly</td>
<td>Neil Tester</td>
</tr>
</tbody>
</table>
The Standing Orders and Accountability Framework for Healthwatch England were last updated in 2012. They have had minor amendments made to reflect changes such as The Department of Health now being called The Department of Health and Social Care. None of the amendments change the fundamental duties of the Committee. The Committee is being asked to approve the updated versions of the Standing Orders and the Accountability Framework which are both below. Any changes/insertions that have been made are highlighted in yellow.

HEALTHWATCH ENGLAND STANDING ORDERS

1. INTRODUCTION

1.1 The Healthwatch England (HWE) Committee Standing Orders set out the basic rules and procedures by which HWE will conduct its business. They should be read in conjunction with the HWE Accountability Framework which sets out the purpose of HWE, its legal powers and duties, its accountability to the Department of Health and to the Board of the Care Quality Commission, of which HWE is a statutory Committee.

1.2 It is the duty of the HWE Chair to ensure that HWE Committee Members, any Independent members co-opted to HWE or a subcommittee, and HWE Officers are notified of and understand their responsibilities in the HWE Accountability Framework and HWE Standing Orders. These Committee Standing Orders, as far as they are applicable, apply with appropriate alteration to meetings of any subcommittee or working group established by the HWE Committee.

1.4 The Committee’s Accountability Framework, and Standing Orders, will be in line with the CQC Governance Framework.

2. INTERPRETATION AND DEFINITIONS

These Committee Standing Orders are made pursuant to the Health and Social Care Act 2012. Any expression to which a meaning is given in the Health and Social Care Act or in Regulations made under it shall have the same meaning in these Standing Orders, unless the context requires otherwise. In addition:
• “Accounting Officer” is the Officer responsible and accountable for funds entrusted to Healthwatch England. This person is responsible for ensuring the proper stewardship of public funds and assets. For HWE, the Chief Executive of the Care Quality Commission is the Accounting Officer.

• “Committee” means the Healthwatch England (HWE) Committee, which consists of a Chair and between six to twelve Non-Executive members appointed in accordance with the Commissioner for Public Appointments’ Code of Practice on behalf of the Secretary of State for Health.

• “Committee member” means any person appointed as a member of the HWE Committee.

• “Budget” means a resource, expressed in financial terms, proposed by the Committee for the purpose of carrying out, for a specific period, any or all of the functions of HWE.

• “Chair” is the person appointed as a Care Quality Commission Commissioner by the Secretary of State, to chair Healthwatch England and its Committee and to ensure that the Committee successfully discharges its overall responsibility for the work of HWE. The Committee may also choose to elect a Deputy-Chair. Where appropriate the expression “the Chair” shall be taken to refer to the Deputy-Chair, if the Chair is absent from the meeting or otherwise unavailable.

• “HWE Director” is the senior HWE employee accountable to the Chair and to the CQC Chief Executive for the range of HWE business. The HWE Director is invited to sit with the Committee and has the right to participate in, but not vote on, Committee proceedings.

• “Independent members” are persons formally appointed by the Committee as members of the Committee itself or of a specific HWE sub-committee. They will be persons to whom the Committee Standing Orders and all HWE policies will apply.

• “Members” refers to both HWE Committee members and Independent members.

• “Officer” means any person who is an officer of Healthwatch England.

• “Sub-Committee” means a committee that has been established with delegated advisory authority from the Committee. The sub-committee’s chair must be a member of the HWE Committee, as must the majority of the sub-committee members. The terms of reference of the sub-committee must be approved by the HWE Committee.

3. **COMPOSITION of the COMMITTEE**

3.1 **Membership of the HWE Committee**

3.1.1 The Committee will comprise:
- The Chair; and
- Between six to twelve Non-Executive Committee members appointed on behalf of the Secretary of State for Health by the HWE Chair.

3.1.2 The Chair of HWE is appointed by the Secretary of State for Health as a Commissioner of the Care Quality Commission and as the Chair of Healthwatch England. Their appointment is for four years in the first instance, renewable once.

3.1.3 In appointing the members to the HWE Committee, the Chair is responsible for:
- Ensuring that a majority of the Committee is not CQC Commissioners
- Ensuring as far as possible that the Committee members have relevant skills and knowledge in order to discharge the Committee’s functions under section 45A of the Health and Social Care Act 2008
- Ensuring that the process of appointment is transparent and in accordance with criteria laid down by the Commissioner for Public Appointments’ Code of Practice for Ministerial Appointments to Public Bodies of 1st April 2012
- Having regard to the need to encourage diversity in the range of people appointed
- Ensuring that up to four members represent directors (i.e. the most senior representation) of local Healthwatch organisations.

3.1.4 Appointments of the Committee Members, as laid out in the Care Quality Commission (Healthwatch England Committee: Membership) Regulations 2012, are made for a period not exceeding four years. The term of appointment of each Committee member will be confirmed in the letter of appointment. Members may be reappointed for a further term but are not eligible for further reappointment until a term has elapsed.

3.1.5 The HWE Committee may recruit additional Independent Members on a time-limited basis to add to its expertise. They may co-opt up to a maximum of one third of the total number of members of the Committee. Co-opted members may not vote.

3.2 Termination of Committee Membership

3.2.1 A member may resign at any time by giving notice in writing to the Secretary of State in the case of the Chair and to the Chair in the case of Committee Members.

3.2.2 If the HWE Chair ceases to be a member of the Commission, their tenure as HWE Chair will cease immediately.

3.2.3 The Secretary of State may revoke the appointment of the HWE Chair by giving notice in writing.

3.2.3 The HWE Chair may revoke the appointment of a Committee member in writing if the Chair is satisfied that the Committee member is unable or unfit to carry out the duties of a Committee Member, is failing to carry out the duties of a Committee Member or is disqualified from holding office in accordance with Schedule 2 of the Regulations.
3.2.4 The Chair may suspend a Member from office by giving notice to the member in writing, where the Chair has grounds for believing that the Committee member may be unable or unfit to carry out the duties of a Committee Member, may be failing to carry out the duties of a Committee Member or may be disqualified from holding office in accordance with Schedule 2 of the Regulations.

3.2.5 The appointment of a local Healthwatch director will be terminated if they cease to be the director of a local Healthwatch organisation, if they become the director of a different local Healthwatch organisation, or become a member of the Care Quality Commission.

4.0 CONDUCT OF COMMITTEE MEMBERS

4.1 Individual Committee members must act in accordance with the provisions of the Accountability Framework with particular reference to acting in the best interests of HWE.

4.2 Members are required to comply with the Cabinet Office’s Code of Conduct (2011).

5. MEETINGS OF HEALTHWATCH ENGLAND COMMITTEE

5.1 Admission of the Public and the Press
5.1.1 Meetings of the Healthwatch England Committee will normally be held in public. The Committee will operate as far as possible in an open and transparent fashion, except where confidentiality requirements are concerned.

5.1.2 The HWE Committee is covered by the Public Bodies (Admission to Meetings) Act 1960. Members of the public and press are not admitted to private meetings of the Committee, except by specific invitation.

5.2 Convening Meetings

5.2.1 Ordinary meetings of the Committee will be held at such times and places as the Committee may determine.

5.2.2 The Chair may call a meeting of the Committee at any time, provided ten clear working days’ notice is given. If a request for a meeting, signed by at least one-third of the whole number of HWE Committee members, is presented to the Chair, then s/he must call a meeting within ten clear working days of receiving this request. If the Chair refuses to call a meeting, or if, without so refusing, does not call a meeting within ten working days of receiving the request, those members who requested may call a meeting themselves.

5.2.3 All Meetings of the Committee and its sub-committees will be held in line with the requirements of the Equality Act 2010 to make reasonable adjustments regarding

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19 The Members’ Code of Conduct is attached as an appendix to this document.
the access needs of members, which include making papers available in accessible formats, holding meetings in accessible venues and providing communication support where needed.

5.3 Notice of Meetings
5.3.1 Before each meeting of the Committee, a notice of the meeting, specifying the business proposed to be transacted at it, must be delivered to every Committee member or sent by post, electronically or fax to the correspondence address supplied by them, at least five clear working days before the day of the meeting. Supporting papers will, wherever possible, accompany the agenda.

5.3.2 The business of the meeting will not be invalidated where any member fails to receive notification.

5.3.3 In the case of a meeting being called by Committee members in default of the Chair, the notice must be signed by those Committee members and no business can be transacted at the meeting other than that specified in the notice.

5.3.4 Before each public meeting of the Committee, a public notice of the time and place of the meeting, and the public part of the agenda, must be displayed on the HWE website at least five clear working days before the meeting.

5.4 Chairing Meetings
5.4.1 At any meeting of the Committee, the Chair, if present, will preside.

5.4.2 If the Chair is absent, or is disqualified from participating, the Deputy-Chair will preside or, in his/her absence a Committee member chosen by the Committee members will preside.

5.4.3 The decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters will be final.

5.5 Quorum for Meetings
5.5.1 No business can be transacted at a meeting unless at least half of the whole number of the Chair and Committee members are present.

5.5.2 If at any time during a meeting, a quorum of Committee members is not present then the business will, at the discretion of the Chair, be discussed by the Committee members present and the decision deferred to the next meeting of the Committee, unless the Chair of the meeting indicates an earlier date or is able to conduct the business under the urgent action provision.

5.5.3 If the Chair or any Committee member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest s/he will no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon.
at that meeting. Such a position must be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

5.5.4 In such a situation, Members may apply to the HWE Chair for a dispensation prior to the meeting to enable them to take part in the discussion and vote at the next meeting.

5.6 Voting
5.6.1 The Chair and all Committee Members may vote. Co-opted Members may not vote.

5.6.2 When necessary, if there is no consensus, a question at a Committee meeting must be decided by the majority of the votes of the Chair and the Committee members present voting on the question.

5.6.3 In the case of the number of votes for and against a motion being equal, the Chair of the meeting will have a second or casting vote.

5.6.4 All questions put to the vote will, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper or electronic ballot may also be used if a majority of the Committee members present request it.

5.6.5 If at least one-third of the Committee members present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Committee member present voted or abstained.

5.6.6 If a Committee member so requests, their vote will be recorded in the minutes of the meeting by name upon any vote (save those by paper ballot).

5.6.7 Committee members absent from a meeting will not have the right of a proxy vote although their written views may be entered in the debate. Absence is determined as at the time of voting on a motion.

5.7 Notices of Motion
5.7.1 Any motion proposed must be seconded before it is considered.

5.7.2 A Committee member desiring to move or amend a motion must send written notification, seconded by another member, to the Chair at least 10 clear working days before the meeting. The Chair will insert this notice in the agenda for the meeting, subject to the notice being permissible under the appropriate regulations and within HWE’s statutory remit. This does not, however, prevent any motion or amendment being moved without notice during the meeting on any business mentioned on the agenda.

5.7.3 Subject to the agreement of the Chair, and subject also to the provisions below, a Committee member may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed
for the meeting. The notice must state the grounds of urgency. If in order, it will be declared to the Committee at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item will be final.

5.7.4 A motion, once moved and seconded, may be withdrawn by the proposer with the agreement of the seconder and with the consent of the Chair.

5.7.5 The mover of a motion has a right of reply at the close of any discussion on the motion or any amendment thereto.

5.7.6 When a motion is under discussion or immediately prior to discussion, it is open to any Committee member to move:

- An amendment to the motion;
- The adjournment of the discussion or the meeting;
- That the meeting proceed to the next business;
- The appointment of an ad hoc committee to deal with a specific item of business;
- That the motion be now put; or
- A motion under Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960 resolving to exclude the public (including the press).

5.7.7 No amendment to any motion will be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

6. AGENDAS, MINUTES AND PAPERS

6.1 Setting the Agenda
6.1.1 The Chair will set the agenda for each meeting, in consultation with the HWE Director.

6.1.2 Committee members wishing to put forward agenda items should notify the Chair at least 15 clear working days before the meeting. The request must state whether the item of business is proposed to be transacted in the presence of the public and must include appropriate supporting information. Requests made less than 10 clear working days before a meeting may be included on the agenda at the discretion of the Chair.

6.1.2 In the event that the Chair is not willing to include an item on the agenda of a meeting, any Committee member will be entitled to have a notice of motion included on the agenda (see 4.7.1).

6.1.3 The agenda will be sent to Committee members at least 5 clear working days before the meeting and supporting papers will accompany the agenda, but will certainly be dispatched no later than three clear days before the meeting, save in emergency.
6.1.4 It is within the discretion of the Chair of a meeting to allow urgent items not on the published agenda to be discussed at the relevant meeting. The reasons for allowing such action should be indicated by the Chair.

6.2 Record of Attendance
6.2.1 The names of the Chair and Committee Members present at the meeting must be recorded in the minutes.

6.2.2 Where a Committee member is not present for the whole of the meeting the minutes must indicate for which items the Committee member was present at the time of determination of the item.

6.3 Minutes
6.3.1 The minutes of the proceedings of a Committee meeting will be drawn up by the HWE Director and Committee Secretary (or his/her representative) and submitted for agreement at the following Committee meeting. Once confirmed as a correct record by the Chair of the meeting, they will be signed. Any amendment to the minutes must be agreed and recorded in the minutes of the Committee meeting at which they are submitted for agreement.

6.3.2 The minutes of Committee meetings, other than minutes containing confidential information will be available to the public. The Committee will also receive the minutes of its advisory sub-committees for information. Any Committee member not on a sub-committee will have a right to consult any confidential minutes of that sub-committee.

7 APPOINTMENT OF SUB-COMMITTEES

7.1 Appointment of Sub-Committees
7.1.1 Subject to such directions as may be given by the Secretary of State, the HWE Committee may, and if directed by the Secretary of State must, appoint advisory sub-committees of the Committee, with Terms of Reference approved by the Committee.

7.1.2 Any sub-committee of the HWE Committee will be an advisory sub-Committee (not an executive sub-Committee) only. It must be chaired by a member of the HWE Committee.

7.1.4 The constitution and terms of reference of any sub-committee must be approved by the Committee at any meeting where at least four Committee members are present.

7.1.5 The Committee may delegate authority to the sub-Committee to propose appointments to the sub-committee but the Committee must approve all appointments to its sub-committees. Sub-Committees are able to co-opt members to the sub-committee, subject to the approval of the HWE Committee.
7.1.6 The Committee will keep under review the structure and remit of any sub-committees.

8 ARRANGEMENTS FOR THE EXERCISE OF HEALTHWATCH ENGLAND FUNCTIONS BY DELEGATION

8.1 Reserved Matters Reserved to the Committee
8.1.1 HWE and CQC have agreed to work as strategic partners. However, as HWE is a statutory Committee of the Care Quality Commission, the CQC Board must agree the matters relating to HWE’s operation which it reserves to itself for decision, taking due account of HWE’s independence.

8.1.2 The HWE Committee must agree those matters within its legal powers which it reserves to itself for decision and which matters it will delegate to the HWE Director.

8.1.3 Notwithstanding 8.1.2, the Committee, in full session, may decide on any matter it wishes that is within its legal powers.

8.1.4 Those advisory functions of the Committee which have not been expressly reserved to the Committee or delegated to a formally approved sub-committee of HWE shall be exercised on behalf of the Committee by the HWE Director.

8.1.5 The HWE Director will determine which executive functions s/he will perform personally and will nominate Officers of HWE to undertake the remaining functions for which s/he will still retain accountability to the Chair and the CQC Chief Executive. The scope of responsibility entrusted to any individual Officer or Appointee of HWE shall be described in their job description or task based terms of engagement with any limits on their powers described within the Scheme of Delegation.

8.1.6 The HWE Director may periodically propose amendments to the Scheme of Delegation which will not have effect unless considered and approved by the HWE Committee as indicated above. The Audit, Finance and Risk Sub Committee must receive a report of every decision to suspend Committee Standing Orders.

8.2 Emergency Powers
8.2.1 The functions exercised by the Committee may, in an emergency, be exercised by the HWE Chair after they have consulted one other Committee member and the HWE Director.

8.2.2 The exercise of such powers by the Chair must be reported to the next formal meeting of the Committee in public session for ratification, with reasons why an emergency decision was required clearly stated.

9. DUTIES OF MEMBERS TO REGISTER INTERESTS

9.1 Register of Interests

20 The Policy on Registering Interests is available in full as a separate annex to this document.
9.1.1 The HWE Director will arrange for the establishment and maintenance of a Register of Members’ Interests to record the interests of the HWE Committee Members. It will be published on the HWE website.

9.1.2 The types of interests to be registered are set out in the Policy on Registering Interests.

9.2 Declaring an Interest at a meeting
9.2.1 In addition to registering an interest, HWE Committee Members must declare any interest:
   a) At any proceedings of the HWE Committee or its committees, where a matter affecting a declarable interest is considered, or;
   b) At meetings of any outside body to which they are appointed or nominated by HWE, or;
   c) In other circumstances where they are active in a role for HWE.

9.2.2 Where there is an interest that must be declared under the Committee Standing Orders, it should be declared:
   a) At the commencement of the proceedings in response to the formal request from the Chair for the declaration of interests; or
   b) If unaware of the interest at the commencement of the proceedings, as soon as s/he becomes aware of the interest.

9.2.3 When an interest is declared, the Member is required to make an oral statement declaring the nature of the interest if requested to do so by the Chair.

9.2.4 Where such a disclosure is made, the disclosure shall be recorded in the Minutes of the Committee Meeting.

9.2.5 A Committee Member will generally be allowed to speak, but not vote, on non-financial matters in which they have an interest that needs to be declared. However, the Chair may consider the interest to be of such a nature as to disqualify him or her from speaking on the matter, and must be reported to the meeting and recorded in the minutes.

9.2.6 The HWE Director will, at least annually, in March of each year, ask Members to confirm their interests for inclusion on the Register of Interests maintained by them. Nevertheless, Members should inform the Director of any changes in their interests as they occur, both for the purposes of updating the Register and, if necessary, for formal reporting to the Committee.

10. SUSPENSION, VARIATION, AMENDMENT AND APPROVAL OF COMMITTEE STANDING ORDERS

10.1 Suspension of Committee Standing Orders
10.1.1 Except where this would contravene any statutory provision or any direction made by the Secretary of State, any one or more of the Committee Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Committee are present, and that a majority of those present vote in favour of suspension.
10.1.2 A decision to suspend Committee Standing Orders will be recorded in the minutes of the meeting.

10.1.3 No formal business may be transacted while Committee Standing Orders are suspended.

10.1.4 A separate record of matters discussed during the suspension of Committee Standing Orders must be made and must be available to the Chair and Committee members.

10.1.5 The Audit, Finance and Risk Sub Committee must receive a report of every decision to suspend Committee Standing Orders.

10.2 Approval, Variation and Amendment of Committee Standing Orders
10.2.1 Any amendment to these Committee Standing Orders can only be approved if:

- A notice of motion has been given (i.e. at least 10 working days in advance)
- A quorum of Members is present at the time of the vote and no fewer than half the total of the Committee members present vote in favour
- The variation proposed does not contravene a statutory provision or direction made by the Secretary of State

10.2.2 Any amendment must be reported to the Audit, Finance and Risk Sub Committee.

August 2012
Updated: April 2018 (if agreed at April Committee)

HEALTHWATCH ENGLAND ACCOUNTABILITY FRAMEWORK

Introduction

Healthwatch England (HWE) has operated from 1st October 2012 as the new national consumer champion for anyone who uses health and social care services. HWE has an important role in driving improvement in the health and social care system, at national and local level, for the benefit of users and the public. This document sets out how HWE will operate and how it will be held to account for the delivery of its objectives.

The operating principles in the Department of Health and Social Care (DHSC)/Care Quality Commission (CQC) have been agreed jointly by the Department of Health and Social Care, the Care Quality Commission (as HWE’s “host” organisation) and Healthwatch England itself to ensure that HWE has the best chance of success. Each of the parties involved agree to work together to build a constructive and collaborative relationship of trust and respect, in the interests of users of health and social care services and the public. The principle of “no surprises” will operate between them.
1 PURPOSE OF HEALTHWATCH ENGLAND
1.1 Healthwatch England (HWE) has been established under the Health and Social Care Act 2012 to be the new consumer champion for health and social care in England. Its purpose is to strengthen the collective voice of patients and users of health and social care services and of the general public.

1.2 Healthwatch will exist in two distinct forms - local Healthwatch organisations at local level, funded by and accountable to the public via local authorities; and HWE at national level, funded by the Department of Health and Social Care, to enable the collective views of the people who use NHS and social care services to influence national policy.

1.3 HWE is a statutory committee of CQC, supported by CQC’s infrastructure and with access to CQC expertise. CQC is therefore legally accountable for HWE. However, CQC and HWE have agreed that they will work together as strategic partners, with HWE operating as independently as possible within the legal constraints. This document sets out the legal arrangements between DHSC, CQC and HWE. There are Memorandums of Understanding (MoU) which describe in more detail the nature of the strategic partnership between CQC and HWE and how it will operate on a day to day basis.

1.4 HWE will set its own strategic objectives after appropriate consultation. It will share drafts of its plans and proposed expenditure with the Department of Health and Social Care before its plans are published and formally approved by Secretary of State. HWE will have its own identity and will speak with an “unedited voice”. HWE will be able to analyse and interpret intelligence and data and come to its own judgement on these; and will be able to produce and publish its own reports, independent of CQC.

1.5 The HWE Committee will not have executive powers itself but will have an executive arm, staffed by dedicated HWE staff, recruited for the purpose of enabling the Committee to deliver its priorities and work plan, and reporting to the HWE Director.

2 GOVERNANCE AND ACCOUNTABILITY
2.1 The legal origins of HWE’s powers and duties
2.1.1 Healthwatch England’s powers and duties stem from the Health and Social Care Act 2012 Part 5 Chapter 1 and the Care Quality Commission (Healthwatch England) Regulations 2012.

2.1.2 HWE’s main statutory objective is to be the new consumer champion for health and social care in England. By enabling the views and experiences of users and of the general public to be heard and identifying how services can be improved, HWE will provide a platform for making the NHS and local government more accountable to their local communities for the health and social care services they commission and/or provide. HWE’s scope is wider than that of CQC’s and includes commissioning, public health, health inequalities and social care arrangements for children and young people.

2.1.3 Its specific statutory functions are to:
- provide leadership, guidance, support and advice to local Healthwatch organisations
- escalate concerns about health and social care services which have been raised by local Healthwatch to CQC. CQC will be required to respond to advice from its Healthwatch England subcommittee
- provide advice to the Secretary of State, NHS England, NHS Improvement and to English local authorities, especially where HWE is of the view that the quality of services provided are not adequate. The bodies to whom advice is given are
required to respond in writing. The Secretary of State for Health will be
required to consult Healthwatch England on the mandate for NHS England.

2.1.4 Healthwatch England is required to make an annual report and lay a copy before
Parliament.

2.2 Ministerial responsibility
2.2.1 As a statutory committee of the Care Quality Commission, HWE is accountable to
the Secretary of State for Health for discharging its functions, duties and powers
effectively and economically. The Secretary of State for Health will account for
HWE’s business in Parliament.

2.2.2 HWE will account to Parliament for the proper, effective and efficient use of
resources and operation of the committee through the Accounting Officer, who in
turn accounts to the Permanent Secretary of the Department of Health and Social
Care for the proper use of HWE resources.

2.3 The Department of Health and Social Care’s Principal Accounting Officer’s
responsibilities for HWE
2.3.1 The Department of Health and Social Care’s Principal Accounting Officer (PAO) is
the Permanent Secretary. He has designated the Care Quality Commission’s Chief
Executive as Healthwatch England’s Accounting Officer. However, the
Department of Health and Social Care’s PAO remains accountable to Parliament for
the issue of any grant in-aid to HWE and is required to assure himself that HWE is
delivering its strategic objectives in a way that delivers value for money and has
appropriate governance, risk management and internal controls in place.

2.3.2 The DHSC’s PAO is responsible for ensuring that the budgetary allocation to HWE is
set out in a separate line in DHSC’s budget letter to CQC and for ensuring that
arrangements are in place within the Department to monitor HWE’s activities on a
regular basis.

2.3.3 The PAO will ensure that there is a Departmental Sponsor (also to be the
Departmental Sponsor for CQC) to manage the Department’s relationship with
Healthwatch England on behalf of Ministers. The Department of Health and Social
Care’s HWE Sponsorship Team is the primary contact for Healthwatch England with
the Department on a day-to-day basis. The Sponsorship Team will be in regular
contact with HWE to address any issues arising and will be the main source of
advice to the Principal Accounting Officer and the Secretary of State on the
discharge of their responsibilities in respect of Healthwatch England.

2.4 The CQC Chief Executive’s responsibilities as Accounting Officer for HWE
2.4.1 The responsibilities of the Chief Executive of the Care Quality Commission, as
Accounting Officer, to the Department of Health and Social Care’s Principal
Accounting Officer and to Parliament are set out in the DHSC/CQC Framework
Document and in HM Treasury’s Managing Public Money.

2.4.2 The CQC AO’s responsibilities extend to HWE for:
• safeguarding the HWE public funds for which he has charge and ensuring propriety
  and regularity in the handling of those public finds;
• ensuring that HWE’s resources are used economically, efficiently and effectively
  for the purposes intended;

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21 The respective responsibilities of the AO and Accounting Officers for Non-Departmental Public bodies and other arm’s length
bodies are set out in Chapter 3 of Managing Public Money, available on the HM Treasury website at www.hm-
treasury.gov.uk/psr mpm idex.htm
• ensuring that HWE as a whole is run on the basis of standards set out in Box 3.1 of *Managing Public Money* in relation to governance, decision-making and financial management.

2.4.3 The Care Quality Commission’s Chief Executive is HWE’s Consolidation Officer for the purposes of Whole Government Accounts. The CQC CEO will give evidence, normally with the PAO of the Department of Health and Social Care, when summoned before the Public Accounts Committee on HWE’s stewardship of public funds.

2.4.4 The responsibility for managing HWE’s resources effectively on a day-to-day basis will be delegated by the CQC Chief Executive to the HWE Director. The Director will ensure that timely forecasts and monitoring information on HWE’s performance and finance are available to the AO to enable him to notify the Department promptly of any likely over- or under-spends or any significant problems, whether financial or otherwise, which have been detected.

2.4.5 The CQC AO has responsibility for ensuring that HWE’s proposed plan and expenditure are appropriate and within the budget allocated. It is expected that any differences of view about HWE’s proposals will be resolved as the plan and budget are developed. However, as AO, the CQC CEO retains the ultimate right to veto HWE’s plan and proposed expenditure if he considers it to be inappropriate. The AO would be required to notify the PAO of his reasons for so doing.

2.4.6 The CQC CEO will be the Principal Officer for handling cases involving the Parliamentary Commissioner for Administration in relation to HWE and will ensure that effective procedures for handling complaints about Healthwatch England are established and made widely known.

2.5 The responsibilities of the HWE Chair to DHSC and Parliament

2.5.1 The HWE Chair has particular responsibilities to Parliament and the Department of Health and Social Care in relation to HWE including for:

• establishing, in agreement with the Department of Health and Social Care, HWE’s strategic priorities and business plans, in the light of the Department’s wider strategic aims and current PSA(s) and HWE’s functions as defined in legislation;
• reporting annually to Secretary of State and to Parliament on the overall performance of HWE compared with its aims and objectives
• meeting regularly with CQC and DHSC to report on HWE’s progress

3 ROLE AND RESPONSIBILITIES OF THE HWE CHAIR AND THE COMMITTEE

3.1 Role of the HWE Chair

3.1.1 The Chair of HWE has specific responsibilities for providing leadership to the HWE Committee, ensuring that it meets its statutory obligations and discharges its responsibilities efficiently and effectively; for developing strong links with stakeholders in order to be able to influence national policy; and for overseeing the activity of the HWE Director to ensure that the HWE staff implements the business plans of HWE efficiently and effectively.

3.1.2 The Chair of HWE, who is appointed by the Secretary of State for Health, will also be a Non-Executive Commissioner of the CQC Board. That is, they will be a non-executive member of the CQC Board, with equal status and responsibilities to other Board members, and will be expected to contribute fully to the business discussions and decisions at the CQC Board. The HWE Chair is accountable to the CQC Chair as a Board Member, as are all of CQC’s Board members.

3.1.3 When the CQC Board is considering how to respond to HWE advice, the HWE Chair should declare an interest and refrain from discussion.

3.1.4 In relation to HWE, the HWE Chair has responsibility for:

• Setting and monitoring the delivery of HWE’s strategic priorities, objectives and budget in line with relevant statutory guidance
• Determining the business priorities of HWE Committee meetings, ensuring that all members are able to contribute effectively to the Committee’s discussions
- Ensuring that the HWE Committee, in reaching decisions, takes proper account of HWE’s responsibilities set out in the Framework Document, of any relevant statutory guidance and the requirements of the CQC corporate governance framework;
- Promoting the efficient and effective use of staff and other resources, reporting on the performance and finances of HWE to the Department of Health and Social Care;
- Providing information to key strategic partners, including the CQC Board, on HWE’s performance and providing them with the opportunity to contribute to the proceedings of HWE;
- Delivering high standards of regularity and propriety and ensuring that members of the Committee also deliver these standards; and
- Representing the views of the Committee to the general public.

3.1.6 The Chair also has an obligation to ensure that:
- The work of the HWE Committee is reviewed and the Committee is working effectively;
- The Committee has a balance of skills appropriate to directing HWE business, as set out in the Government Code of Good Practice on Corporate Governance;
- HWE Committee members are fully briefed on their terms of appointment, duties, rights and responsibilities;
- She, together with the other Committee members, receives appropriate training on financial management and reporting requirements and on any differences that may exist between private and public sector practice;
- She assesses the performance of individual Committee members when they are being considered for re-appointment;
- There is a code of practice for Committee members in place consistent with the Cabinet Office model code.\(^\text{22}\)

3.1.7 Under the HWE Committee’s Standing Orders, the Committee may nominate a member as Deputy-Chair for a set period (although s/he can be re-appointed). The duties to be undertaken by the Deputy-Chair are: to chair Committee meetings in the absence of the Chair and otherwise deputise for him/her in his/her absence; to act as a “sounding board” for the Chair on important matters which require reflection and a second opinion; and to represent HWE at public events or other meetings, as agreed by the Chair.

3.2 Role of the HWE Committee

3.2.1 The HWE Committee will consist of a maximum of 12 Members plus the Chair. The Committee Members will have a balance of skills and experience appropriate to directing HWE and will include up to 4 members who are directors of local Healthwatch organisations.

3.2.2 The HWE Committee will be responsible for:
- acting as the national consumer champion for people who use, or may use, health and social care services, ensuring that their views and experiences are reflected in all of its considerations;
- taking forward the strategic aims and objectives of HWE consistent with its overall strategic direction in its Business Plan and Strategy and within the policy and resources framework determined by the Secretary of State;
- ensuring that the Secretary of State and the CQC Board are kept informed, via the HWE Chair, of any changes which are likely to impact on the strategic direction of HWE or on the attainability of its targets, and determining and implementing the steps needed to deal with such changes;
- ensuring that any statutory or administrative requirements for the use of public funds are complied with; that the Committee operates within the limits of its

\(^{22}\) The HWE Members’ Code of Conduct is included in the HWE Standing Orders.
statutory authority and delegated authorities from the Department of Health and Social Care and the Care Quality Commission, and in accordance with any other conditions relating to the use of public funds; and that, in reaching decisions, the Committee takes into account guidance issued by the Department of Health and Social Care.

- ensuring that the Committee receives and reviews regular financial information concerning the management of HWE; that it is informed in a timely manner about any concerns about its activities; and provides positive assurance to the Department and CQC that appropriate action has been taken on such concerns;
- ensuring that effective arrangements are in place to provide assurance on risk management, governance and internal control of HWE’s business. The Committee is expected to assure itself of the effectiveness of the internal control and risk management systems, including by using CQC’s Audit and Risk Assurance Committee to help HWE to address key financial and other risks.

3.2.3 Individual Committee Members should:
- comply at all times with the HWE Conflict of Interest policy, which sets out the rules relating to conflicts of interests;
- not misuse information gained in the course of their public service for personal gain or for political profit, nor seek to use the opportunity of public service to promote their private interests or those of connected persons or organisations;
- comply with the HWE Committee’s rules on the acceptance of gifts and hospitality, and of business appointments;
- act in good faith and in the best interests of HWE.

3.3 Terms of HWE Committee Appointments

3.3.1 The HWE Chair is appointed for a period of up to four years by the Secretary of State.

3.3.2 The HWE Committee Members will be appointed by the HWE Chair in accordance with the requirements of the Code of Practice of the Officer of the Commission on Public Appointments and requirements set out in Regulations. Four of the Committee Members will represent local Healthwatch. The HWE Chair will be responsible for ensuring that, in accordance with the Regulations, the membership of the HWE Committee is diverse, with members having the expertise and knowledge necessary to deliver the statutory functions of Healthwatch England.

3.3.3 The term of Committee appointments will be specified in the letter of appointment issued to individual Committee Members, each appointment will be for no longer than four years. Members may be reappointed for a further term but are not eligible for further reappointment until a term has elapsed.

3.3.4 The HWE Chair is able to remove a Committee member if the Chair believes they are unable or unfit to carry out the duties of that office; or are failing to carry out their duties, or are disqualified under the Regulations.

3.3.5 The Committee will also be able to co-opt members to ensure that the Committee has access to specialist expertise when needed.

3.3.6 The HWE Chair will notify the CQC Board and the Secretary of State once the appointments have been decided.

3.4 Dispute resolution

3.4.1 The HWE Committee and CQC Board have agreed to work together openly and positively. Should any difficulties arise e.g. the HWE Chair believes they are unable to deliver the HWE business plan or the Chief Executive has concerns that the HWE plans are undeliverable within budget, a resolution to any difficulties should be sought as close to the “source” of difficulty as possible through open and frank discussion.

3.4.2 In the unusual event that this does not happen, the issue can be raised with the Minister of Health who can meet with the various parties concerned. The Minister
for Health will ultimately be responsible for securing a resolution and their decision will be final.

3.4.3 The Health and Social Care Act 2012 makes provision for Secretary of State to issue conflicts guidance if needed.

3.5 Lobbying Parliament or Government
3.5.1 HWE will not use public funds to employ external public affairs or consultants to lobby Parliament or Government with the principal aim of altering Government policy or to obtain increased funding.

4 HWE’s COMPLIANCE RESPONSIBILITIES

4.1 Annual Report and accounts
4.1.1 HWE’s audited accounts will be published within CQC’s audited accounts after the end of each financial year. The rules governing the external audit of CQC, as set out in the DHSC/CQC Framework Document, will apply to HWE and CQC’s Governance Statements will also make reference to HWE.
4.1.2 HWE is required to publish its own annual report which outlines its main activities and performance during the previous financial year and sets out in summary form forward its plans. A draft of the report should be submitted to the Department and to the CQC Board at least 10 working days before the proposed publication date.
4.1.3 The report and accounts will be laid in Parliament and made available on HWE’s website.

4.2 Corporate Governance
4.2.1 HWE is expected to comply with the principles of good corporate governance, set out in the CQC Corporate Governance Framework. A key purpose of the Corporate Governance Framework is to provide assurances and evidence, when required, that the right things are being done in the right way at the right time. These include: arrangements for business planning; budgeting principles; risk management; internal audit; and performance reporting.

4.3 Strategic and Business Planning
4.3.1 HWE will prepare and publish a strategic plan and an annual business plan which reflects HWE’s statutory duties, has regard to DHSC policy and includes a budgeted work programme for that year. The HWE plan will be produced in accordance with the Department’s business planning guidance and Managing Public Money and will demonstrate how HWE is contributing to the achievement of the Department’s objectives.
4.3.2 The Accounting Officer will confirm that the proposed plan and budget are within approved funding provision for HWE, meet HWE’s statutory role and contribute to the achievement of DHSC’s objectives. The AO may veto anything in HWE’s business plan which he believes is not a proper use of HWE’s funds.

4.4 Budgeting Procedures
4.4.1 Unless agreed by the Department of Health and Social Care and, as necessary, HM Treasury, HWE shall follow the principles, rules, guidance and advice in Managing Public Money. The HWE Director will refer any difficulties or potential bids for exceptions in the first instance to the CQC Accounting Officer and then to the Sponsorship Team for CQC in the Department of Health and Social Care.
4.4.2 Each year the Department will send the Care Quality Commission a formal statement of the annual budgetary provision allocated by the Department for HWE in the light of competing priorities across the Department and any forecast income approved by the Department. Any grant-in-aid provided by the Department of

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23 How HWE will comply with its requirements is set out more fully in the HWE Standing Orders, Standing Financial Instructions and Policy Handbook which covers business planning, business continuity, communications, managing complaints, risk management and information governance.
Health and Social Care for the year in question will be voted in the Department of Health and Social Care's Supply Estimate and be subject to Parliamentary control.

4.4.3 Once the budget has been approved by the Department of Health and Social Care and subject to any restrictions imposed by statute, HWE shall have authority to incur expenditure approved in the budget as long as HWE remains within its delegated authorities.

4.4.4 At the start of the financial year, HWE will profile expected expenditure and drawdown of any Departmental funding/other income over the year. HWE will comply with the general principle that there is no payment in advance of need. Cash balances accumulated during the course of the year from grant-in-aid or other Exchequer funds shall be kept to a minimum level consistent with the efficient operation of HWE. Grant-in-Aid not drawn down by the end of the financial year shall lapse. Subject to approval by Parliament of the relevant Estimates provision, where grant-in-aid is delayed to avoid excess cash balances at the year-end, the Department will make available in the next financial year any such grant-in-aid that is required to meet any liabilities at the year end, such as creditors.

4.4.5 In the event that the Department of Health and Social Care provides HWE separate grants for specific (ring-fenced) purposes, it would issue the grant as and when HWE needed it on the basis of a written request. HWE would provide evidence that the grant was used for the purposes authorised by the Department. HWE shall not have uncommitted grant funds in hand, nor carry grant funds over to another financial year.

4.5 Internal Audit
4.5.1 The CQC has entered into arrangements for internal audit which satisfy HM Treasury’s requirements (set out in the DHSC/CQC Framework Document). As a statutory Committee of CQC, HWE will be subject to review by CQC’s internal audit. Any internal reports relevant to HWE will be submitted to the HWE Committee to decide action and monitor progress against agreed actions.

4.6 Risk Management
4.6.1 In accordance with HM Treasury requirements, HWE must ensure that the risks it faces are identified and dealt with in an appropriate manner. Risks will be identified as part of its strategy setting and business planning processes and monitored on a regular basis. The HWE Committee will be able to seek advice from CQC’s Audit and Risk Assurance Committee which also has responsibility for scrutinising the internal controls operated by HWE to provide assurance to the HWE Committee and to the Accounting Officer that HWE is managing risk effectively.

4.6.2 HWE will also adopt and implement CQC policies and practices to safeguard itself against fraud and theft.

4.7 Performance Reporting
4.7.1 HWE will operate management, information and accounting systems that enable it to review in a timely and effective manner its financial and non-financial performance against the budget and any targets set out in the corporate and business plans.

4.7.2 HWE will provide financial and non-financial performance information to the Audit and Risk Assurance Committee who will have a role in scrutinising HWE’s performance and providing assurances to the HWE Committee.

4.7.3 HWE will also be required to provide financial and non-financial performance information to the Department of Health and Social Care. Officials of the DHSC Sponsorship team will liaise regularly with HWE officials to review HWE’s financial performance against plans, achievement against HWE targets and HWE expenditure. The Sponsorship Team will also take the opportunity to inform HWE of any wider policy developments that might have an impact on HWE and actions the team has taken or plans to take in respect of those.
4.7.4 HWE’s performance will be discussed as necessary at the CQC’s Quarterly Accountability Reviews with the Department, attended by the CQC Chief Executive in his capacity as Accounting Officer for both CQC and HWE.

4.8 Information Governance
4.8.1 HWE will comply with CQC’s policies on Information Governance which ensure that:
- Patient, personal and/or sensitive information within HWE’s care is well managed and protected through all stages of its use
- HWE’s compliance with good information governance practice will be included as part of CQC’s compliance statements
- HWE meets its legal obligations for records management, accountability and public information by complying with relevant standards on confidentiality, security and records management.

4.8.2 CQC’s Senior Information Risk Owner will be HWE’s SIRO. The Committee will appoint an HWE officer to act in the capacity of Caldicott Guardian.

5 HEALTHWATCH ENGLAND STAFF
5.1 HWE staff will be formally employed by CQC on the same terms and conditions as CQC’s staff. A detailed statement of terms and conditions is set out in the CQC Employee Handbook.

5.2 CQC HR policies apply to HWE staff including the requirement to undertake training which is mandatory for CQC staff. The policies and training materials are available to all staff via the CQC intranet.

5.3 The code of conduct for staff in place for CQC staff, based on the Cabinet Office’s Model Code for Staff of Executive Non-department Public Bodies, in Chapter 5 of Public Bodies: A guide for Departments, will apply to HWE staff.

5.4 Subject to its delegated authorities, HWE shall ensure that the creation of any additional posts does not incur forward commitments that will exceed its ability to pay for them.

6 DELEGATED AUTHORITIES
6.1 The delegation from Department of Health and Social Care to HWE will be included in the CQC budget notification. This cannot be altered without prior approval from the Department.

6.2 CQC’s Scheme of Delegation includes a delegation from the CQC Chief Executive to the HWE Director of the HWE budget.

September 2012
Updated: April 2018 (if approved by at the April Committee)