Healthwatch England 1 August 2018
Public Meeting Agenda

11.30-14.00 – Public Committee Meeting Agenda		
1.1 Presentation from Healthwatch Camden	Frances Hasler	(30 min)
1.2 Welcome and apologies	JM	To open the meeting
1.3 Declarations of interests	JM	Committee Members
1.4 Minutes of the last, action log, review of agenda and matters arising	JM	To confirm the minutes and discuss the matters arising
1.5 Chair's Report	JM	For discussion
1.6 National Director's Report including Conference update	IR	For discussion
1.7 Committee Members Update	Committee	For discussion
1.8 Q1 Delivery and Performance Report including Management Framework	IR	For discussion
1.9 Audit, Finance and Risk Sub Committee Meeting Minutes	HP	For discussion
2.0 Intelligence Report Q1	AMR	For discussion
2.1 Standing Orders	JM	For approval
2.2 Dates for 2019	JM	For approval
Questions from the public		

MEETING REFERENCE: CM180801
AGENDA ITEM: 1.4

AGENDA ITEM: Minutes and Actions from Previous Committee Meeting

PRESENTING: Jane Mordue

PREVIOUS DECISION: N/A

EXECUTIVE SUMMARY: This report updates the Committee on the minutes and actions from the previous Committee meeting – 25/04/2018

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

Healthwatch England Committee Meeting
Minutes of meeting No. 23
Location: Hilton Blackpool, North Promenade, Blackpool

Date: Wednesday 25 April 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 Board Member 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

Apologies
- Ruchir Rodrigues – Committee member

In attendance:
- Imelda Redmond –National Director
- Neil Tester – Deputy Director
- Gavin MacGregor – Head of Network Development
- Leanne Crabb – Committee Secretary (minute taker)

	Introduction	

1.0	**Agenda Item 1.1 - Welcome and apologies** The Chair welcomed everyone to the meeting. Apologies: Ruchir Rodrigues	
2.0	**Agenda Item 1.2 - Minutes, action log and agenda review** The Chair presented the minutes of 31 January 2018.	
2.1	It was noted by Deborah Fowler that her role with Healthwatch Enfield should be recorded as a Board Member, not a Trustee. Deborah Fowler also noted that in 2.2 it was suggested first and last names be used throughout the minutes rather than full names then initials.	
2.2	Danielle Oum raised the point that her name had been incorrectly noted as Deborah Oum.	
2.3	The Committee **APPROVED** the minutes.	
2.4	Pam Bradbury commented on Action 16; it should state 'Guidance for Call Handling' not 'signposting figures'. Neil Tester responded that guidance was produced but not disseminated as it was in the process of being matched with the call handling training. Gavin MacGregor added that the training will take place between June and September and will be on e-learning in quarter 4, it has all been commissioned.	
2.5	Helen Horne questioned Action 9 -*The top three challenges facing local Healthwatch /HWE to be added to the Intelligence Summary in future meetings*, and if it had been established what the top three issues facing local Healthwatch are in sharing information via Customer Relationship Management (CRM). Imelda Redmond replied that they are capacity, systems (the complexity of what we have in place) and capability. Helen Horne then asked how the system would be improved to make reporting on CRM more functional. Jenny Baker commented that CiviCRM is being piloted but there is frustration that some things are not being seen through. Imelda Redmond responded that CRM reporting would be looked at in the June Committee workshop.	IR
2.6	Deborah Fowler asked for an update on Action 14 - *A sub group be formed to look at the funding of local Healthwatch*, Phil Huggon responded that the working group has evolved with the executive group led by Gavin MacGregor working on getting local Healthwatch more involved in funding discussions and north/south groups are being considered. An update on the work being done regarding local Healthwatch funding will be brought to the June Committee workshop. Jenny Baker added that previously work had been done on alternative funding and that it would be good for Healthwatch England to give local Healthwatch advice on this. Gavin MacGregor replied that work was being done to understand different ways of generating funds and that there was future plans to undertake horizon scanning.	GM
2.7	The Committee confirmed the agenda	
3.0	**Agenda Item 1.3 - Declarations of interests**	

3.1	The following interests were declared at the meeting: Helen Horne - agenda items discussing local Healthwatch funding – Director of People First Independent Advocacy Liz Sayce – agenda item 1.5, National Director's Report, Key health and social care announcements - Board Member of the CQC	
4.0	**Agenda Item 1.4 – Chair's Report (Jane Mordue)**	
4.1	Jane Mordue presented the Chair's report, highlighting the unique role of Healthwatch and the statutory duty of local government to commission and fund the service.	
4.2	Jane Mordue commented on the Committee appraisals she has undertaken and how they highlighted the great talent amongst Committee members. Imelda Redmond asked how to take plans from the appraisals forward. A general discussion followed on how best the Committee could add value and make decisions, and how they could better understand the Non-Executive Director (NED) boundaries of a Healthwatch Committee member. It was requested that part of the June Committee workshop be dedicated to this.	**IR**
4.3	The Committee noted the report	
5.0	**Agenda item 1.5 –National Director's Report (Imelda Redmond)**	
5.1	Imelda Redmond presented her report adding that the Healthwatch conference planning was well under way. She advised that the network were starting to send in nominations for the conference awards; a play called 'Phyllis' was being presented; the Alzheimer's Society would be delivering training to over 250 conference attendees; and speakers are being arranged including the National Health Service's recently appointed National Medical Director, Professor Stephen Powis.	
5.2	Imelda Redmond advised that there would be a lot of work done towards the NHS 70th Anniversary and that this would involve some Committee members. She requested that Amy Kroviak joined in the preparation for this. Pam Bradbury commented that we should be mindful that most local Healthwatch are already involved in NHS 70th Anniversary work. A paper will come back to the next meeting to update the Committee on work relating to NHS70 across the local and national Healthwatch.	IR
5.3	Andrew McCulloch questioned the purpose of the report on hospital discharge. Neil Tester advised the Committee that this related specifically to emergency readmissions and that we want to bring people together who had picked up previous work we have done on this. Phil Huggon asked if NHS Providers were engaged in this discussion. Imelda Redmond confirmed that they could be brought in.	NT
5.4	Liz Sayce commented that feedback from the staff survey sounded good and requested that once an action plan on how to respond to it is produced, that the headlines be shared with the Committee. Danielle Oum advised that the AFRSC would be meeting with the Staff Engagement Group (SEG).	**JC**

5.5	Jenny Baker welcomed the fact that Imelda Redmond had attended meetings with the voluntary sector. She advised she would like a clear strategy regarding the voluntary sector so that local Healthwatch can get clarity on where they fit in with that sector. Imelda Redmond agreed that partnerships within the voluntary sector were key to delivery in the new strategy. Phil Huggon asked when the Committee could get a better look at planned future partnerships. Neil Tester responded that this information would be brought to the next Committee meeting.	**NT**
5.6	Helen Parker asked if Healthwatch had any response to their offer of support in 5.1 - *Governmental news*, of the National Director's Report. Imelda Redmond responded that we have done deliberative work around the country to see what the public knows about social care and what their needs are regarding accessing high quality information to make decisions. As part of the Green Paper for Social Care we are talking about access, services, money and workforce. She advised that our submissions will be shared with the Committee in the near future.	**IR**
5.7	Liz Sayce asked how Endeca will help enhance intelligence. Neil Tester reported that it is designed to improve the richness of the qualitative intelligence and help with large volumes of information. The software reads freetext and filters what we are looking for. A demonstration was suggested for the next Committee meeting.	**NT**
5.8	The Committee noted the report	
6.0	**Agenda item 1.6 – Committee Members update - verbal**	
6.1	Helen Horne advised that when attending her local Health and Wellbeing Board she highlighted the story of a 90 year old man's lack of support in his home. Helen Parker commented that it would be good to do some work around how to land stories for the network. Jane Mordue responded that we could consider doing some work around this at the conference or at a future Committee workshop.	**JM**
6.2	Jenny Baker shared that she has been pressing her local Health and Wellbeing Board to have a metric on patient engagement. Healthwatch England has been supporting NHS England to develop a similar metric for Clinical Commissioning Groups (CCGs) on patient engagement as part of the CCG Improvement and Assessment Framework. The Healthwatch policy team have agreed to look at how learning from the two can be brought together to help support further development.	
6.3	Deborah Fowler updated on Healthwatch Enfield's commissioned work with their A&E: in January they spent one week there and spoke to 630 people. 75% of people had not tried to see their GP before attending A&E. Of those who did see their GP, 50% didn't trust their GP's diagnosis. 30% of people were advised to attend A&E by various other health professionals. The most common reason for attending was convenience for a quick diagnosis. The visit also highlighted a few pathway issues. Deborah Fowler also advised that she is involved with the RSA who have set up a health and wellbeing network. They have no clear focus yet. Imelda Redmond responded that she will consider how we could work together, potentially on the NHS 70th Anniversary project.	**IR**
6.4	Danielle Oum attended a regional meeting. Gavin MacGregor responded that he is working with his team to work out how we get maximum impact out of these meetups.	**GM**
7.0	**Agenda item 1.7 – Mental Health Research Programme(Liz Sayce)**	

7.1	Liz Sayce presented the paper. She explained that the research project was still at the planning stage. She reported that: So far we have commissioned- • A literary review • Deliberative events We are carrying out- • Detailed analysis of the local Healthwatch reports • Detailed the analysis from the feedback from members of the public • Stakeholder engagement meetings Two priorities have emerged as the most likely to be pursued during the early phase of this work. These are *maternal mental health* and *children and young people's mental health*. The Committee asked that at every stage there was detailed consideration given to people from specific groups as set out in protected characteristics. Also the work should consider prevention, especially for children and young people. The Committee also asked the research programme to consider ensuring that we don't just look at mental health issues from a narrow medical model perspective. The Committee wanted to know what the dedicated resources for this piece of work were. Liz Sayce, Andrew McCulloch and Andrew Barnett will lead for the Committee.	**NT**
7.2	The Committee agreed there had been excellent work started on this. A general discussion took place encompassing various aspects of the project. It was mentioned that Terms of Reference (ToR) would be useful for the group. There was a request for a sense of scale and maternal mental health numbers. Imelda Redmond responded that we need to be realistic about what resources are provided for this, we need to understand our resources and prioritise appropriately. Lis Sayce responded to comments made by the Committee and advised they would be taken into account. She confirmed a holistic approach was crucial. Jane Mordue applauded the work that has already been done.	
7.3	The Committee noted the report.	
8.0	**Questions from the Public** Q - Regarding funding for local Healthwatch, is it based on population size? A – Imelda Redmond replied there is no formula for that at present and advised it was something that could be looked at as we carry out a thorough review of local Healthwatch funding. Q – If you're part of a local Healthwatch it can be hard to challenge commissioners regarding funding. A – Gavin MacGregor responded that Healthwatch England is planning a detailed programme of work with local commissioners and including Cabinet members to help them commission well.	**IR**
9.0	**Agenda item 2.1 – 2017/2017 Delivery and Performance Report (Imelda Redmond)**	
9.1	Imelda Redmond presented the report. She explained it was a brief overview of the previous financial year and was being used to help with future planning. She added not all targets were met as there were points last year where we were understaffed. This has now improved. She commented that the paper sets out activity, learning and how we supported the network.	

9.2	Amy Kroviak mentioned the measurements relating to media such as newspapers. She commented that 'opportunities' doesn't always mean someone saw the media item so she feels it doesn't add value as a measurement. She also wanted to ensure we are collecting information about media coverage of the local Healthwatch. Imelda Redmond confirmed we are already doing this. Neil Tester advised that he could share this information with Amy Kroviak and any other Committee members who were interested.	**NT**
9.3	Danielle Oum asked that in future reports when talking about percentages actual figures were also included to make the data more meaningful.	**NT**
9.4	Danielle Oum also felt it would be useful to see what percentage of local Healthwatch were not drawing down material offered by Healthwatch England, and to look at why that was the case. Phil Huggon added that it was good to see an upward trend in downloads by local Healthwatch, and it would be great to see it increase further.	
9.5	Helen Horne questioned the high trade media figures and wanted to understand their added value. Neil Tester responded that we have been focusing on trade publications as previously we hadn't been able to embed ourselves with policy audiences as we as we had wanted to. The value of these trade publications is they get seen by a wide audience such as care home managers and GP practice managers. Amy Kroviak commented that trade publications could be easily adapted for a different audience.	
9.6	Deborah Fowler noted that it was a helpful report with a good focus on learning points. She mentioned that she would have liked to have seen a bit more data, for example regarding training for the network, which local Healthwatches didn't take up the offered training, and evaluations of training that did take place.	
9.7	Deborah Fowler also commented that regarding the research helpdesk the report didn't give a feel for if the local Healthwatch used it more or less than predicted. She added it would be useful for the helpdesk to build up a list of frequently asked questions (FAQs). She also felt that examples of learning about impact would be useful.	**AMW**
9.8	Liz Sayce raised the issue of CRM and the alternative systems and wanted to know if there were frustrations in the network regarding CRM and how close Healthwatch is to getting everyone on one system. Imelda Redmond responded that we are looking at this. She confirmed this topic would be looked at in a workshop.	**IR**
9.9	There was a general discussion regarding the diversity statistics. It was mentioned that sexuality doesn't feature in the findings. It was also noted that seven members of staff didn't disclose their ethnicity and it would be good to see them being encouraged to do so in future. Imelda Redmond replied that information was provided by the CQC and that we do not know why sexuality wasn't included.	
9.10	Jenny Baker commented that there were lots to commend in the report and she especially wanted it mentioned that Enter and View initiatives and the delivery and setting strategies involved good work. She added that it would be useful to see a parallel delivery report showing a snapshot from a local Healthwatch point of view summarising what is coming through from the network.	
9.11	The Committee noted the report	
10.0	**Agenda item 2.2 – Audit, Finance and Risk Sub Committee (Deborah Fowler)**	

10.1	Deborah Fowler presented the minutes from the April 18 2018 AFRSC meeting including the proposed 2018/19 budget. She highlighted the final underspend which was better than anticipated. She pointed out that at the end of quarter 3 we had a 18% underspend with a projected underspend of 13% by the end of the financial year. The actual underspend ended up as 10%. She commented that this was a great achievement. She advised the Committee that the AFRSC had revised the proposed KPIs (agenda item 2.5) and risk register. She wanted the Committee to note that the proposed budget involved an increase in staff to reduce the need to procure, that the budget required permission to procure more than we have a budget for, and that spend had been switched into different columns. She advised that the AFRSC had agreed to commend the proposed 2018/19 budget to the Committee and asked them for approval. Deborah Fowler also mentioned that she had concerns over the timings of papers, and that due to Committee meetings being brought forward, it was hard to get data and reports out in time. She proposed that Committee meetings are moved back by three weeks and AFRSC to be moved a week back. Imelda Redmond responded that this would be looked at. Deborah Fowler also notified the Committee that Danielle Oum would be taking over as Chair of the AFRSC as of the next meeting and that a new member for the Sub Committee would be needed.	**IR**
10.2	Pam Bradbury said that when Healthwatch England had a People and Values Sub Committee they worked hard at ensuring staff had regular appraisals and Professional Development Plans (PDPs) and she would like to see this given as a responsibility to a Committee member to concentrate on. Imelda Redmond responded that this is now the responsibility of the new AFRC	**IR**
10.3	The Committee **APPROVED** the 2018/19 budget.	
11.0	**Agenda item 2.3 – Intelligence Report 2017/2018 (Imelda Redmond)**	
11.1	Imelda Redmond introduced the paper and explained it was a full year of information gathered from local Healthwatch. She commented that from gathering the intelligence there is clearly a lot of opportunities for us to influence services. She also stated that there is a disconnect between what local Healthwatch say the public are commenting on and what they say our priorities should be. She drew attention to the large volume of reports as a positive. She clarified that the majority of solicited feedback is positive whereas the majority of unsolicited feedback is negative.	
11.2	Danielle Oum mentioned the merits of lived experience case studies being included and challenged how we know about engaged communities.	
11.3	Deborah Fowler pointed out that mental health is often mentioned as people's number one topic to talk to us about but that the report shows otherwise. She also questioned whether local Healthwatch are involved with their area's Pharmaceutical Needs Assessments (PNAs) and whether Healthwatch England is involved in them. Imelda Redmond responded that we are not involved in PNAs at present.	
11.4	Lis Sayce suggested that it would be good to see whether key issues in Enter and View reports have been actioned and what changes have occurred as a result of them. Imelda Redmond agreed and reminded the meeting that the "What's it like to live in a care home?" report does cover this but it can sometimes be hard to gather follow up information about what changes were made. Gavin MacGregor added that our Quality Statement being drafted will have a focus on recording impact.	
11.5	Phil Huggon commented that in future reports it would be useful to see if there are any geographical differences in the data we receive showing how engaged local Healthwatch are in their engagement.	

11.6	Helen Parker commended the key themes and structure of the report. She added that it may be useful to provide templates of the ideal output and impact and take that out to the network.	
11.7	Jenny Baker commented that there would be value in sharing the report with the network and Boards of local Healthwatch. Imelda Redmond agreed this would be beneficial.	**IR**
12.0	**Agenda item 2.4 – Business Plan (Imelda Redmond)**	
12.1	Imelda Redmond introduced the paper by reminding the Committee they had previously approved the Strategy (January 31 2018) and that Enablers had been looked at in the March workshop. The next stage is to approve the Business Plan, and KPIs (agenda item 2.5).	
12.2	A general discussion was had about the plan. Comments were made regarding how crucial strong leadership across the network is and also that identifying impact needs to be a high priority in everything we do. Some Committee members expressed a wish for more detail about what is coming up. It was proposed that there be a deep dive into some aspects of the plan at some future Committee meetings. A mention was made of the aims and how ambitious they were. Imelda Redmond will draft a plan for future workshops.	**JM/ IR**
12.3	Imelda Redmond addressed the Committee's concerns by giving assurance that the Business Plan purposely didn't have too much detail as these were covered in the staff work plans. She advised that each quarter the Committee would be given a retrospective look at what had been done and a forward view of the coming quarter. She advised that she would give updates in a Word format rather than a table for six months as a trial and then the Committee could reconsider how they receive the updates. She asked that the Committee approve the Business Plan so that work could commence on implementation.	**IR**
12.3	The Committee **APPROVED** the Business Plan	
13.0	**Agenda item 2.5 – KPIs (Imelda Redmond)**	
13.1	Amy Kroviak stated that she felt the baseline of 33% recognition was misleading as although people recognise the name Healthwatch they may not know what Healthwatch does. She also felt there was more work to be done to encourage people to share information on a much larger scale. Amy Kroviak let the Committee know she would like a further opportunity to look at media and how we are tracking it. Imelda Redmond responded she would discuss it with Amy Kroviak.	**IR**
13.2	Liz Sayce commented that the KPIs were a big improvement on previous ones, especially regarding how involved Healthwatch England and local Healthwatch are with each other.	
13.3	A general discussion was had regarding Aim 3 questioning what esteem Healthwatch is held in by professionals and how our reputation is perceived. Also there were comments on whether the KPI's impact was talking about local Healthwatch or Healthwatch England and whether it related to local work or national policy. Neil Tester reminded the Committee that this year is a transitional year.	
13.4	Helen Parker suggested that in Aim 2 (the difference your views have made) there needed to be a year one aspiration and we need to understand the impact.	
13.5	Imelda Redmond requested the Committee send any further suggestions to her as soon as possible after the meeting. Imelda then asked the Committee to approve the KPIs with the understanding that they would be reviewed in six months, so that data could be collated immediately.	

13.6	The Committee **APPROVED** the KPIs.	
14.0	**Agenda item 2.6 - Standing Orders (Jane Mordue)**	
14.1	It was agreed that due to time constraints agenda item 2.6 would be carried over to the next Committee meeting.	**JM**
15.0	**Public Participation**	
15.1	A presentation was made by Michelle Thompson – Chief Executive Officer at Healthwatch Darlington. The presentation was entitled *Great North Care Record Engagement*. The presentation explained that the end purpose aims to produce a platform to join up records in front line care with an analytics platform to be shared by the NHS, Local Authorities, Universities and other health and care related organisations. Healthwatch Darlington led a group of 12 local Healthwatch in engaging with the public to get their views and concerns on data sharing. The presentation included feedback from a range of sources complimenting Healthwatch Darlington on the professional way they led the project. More information on the work undertaken can be found at the website of Healthwatch Darlington. The Committee congratulated Michelle on her successful joined up work with 11 other neighbouring local Healthwatch.	
16.0	**Any Other Business and close of session**	
16.1	Andrew McCulloch wanted the Committee to consider the benefits of a forward work plan and expressed the wish to see safeguarding the public and staff in the work we do. Imelda Redmond responded that this could be considered.	**IR**
16.2	There being no further business, the meeting in public was ended. The Chair thanked everyone for their time and contribution.	
	Next meeting	
	Meeting 24 is scheduled for Wednesday 1 August in London	

ACTION LOG						
NUM	**REFERENCE**	**LEAD**	**ITEM**	**ACTION**	**DEADLINE**	**STATUS**
1.	CM170202	Imelda Redmond	6.6 To include local Healthwatch leadership development as part of the strategy consultation	Local Healthwatch leadership support will be explored as part of the strategy consultation. In addition, this was discussed at the People and Values Sub Committee meeting (SCM170405), AP (Head of Engagement) continues to lead the work on business analysis as well as leading on the leadership of the network as part of the strategy review.	December 2017	Completed
2.	CM170524	Imelda Redmond	9.1 To update the risk tolerance statement	The risk tolerance statement has been reviewed by the Audit, Risk and Finance Sub Committee	April 2018	Completed
3.	CM170524	Imelda Redmond	13.2 To review and update the Equality and Human Rights plan	The Equality and Human Rights plan will be updated in line with other supporting documents when the strategy is finalised. An update is shared in the National Directors report - agenda item 1.5	July 2018	Ongoing
4.	CM180131	Imelda Redmond	4.5 Chase response from Secretary of State	Response received	February 2018	Completed
5.	CM180131	Imelda Redmond	4.6 Review Patient Participation Groups and their effectiveness		December 2018	
6.	CM180131	Amie McWilliam-Reynolds	5.8 The top three challenges facing local Healthwatch /HWE to be added to the Intelligence Summary in future meetings	Full quarterly report is now included in committee papers	April 2018	Completed
7.	CM180131	Imelda Redmond	8.2 In future Committee Meetings there is to be a risk matrix so we know which local Healthwatch to focus on regarding low funding	Reviewed by AFRC and at this meeting for Committee	July 2018	Completed
8.	CM180131	Neil Tester	9.4 Communication strategy, stakeholder mapping, NHS70 opportunities and what we do will be considered at a future Committee workshop.		October 2018	

9.	CM180425	Imelda Redmond	2.5 CRM reporting to be looked at in a future Committee workshop.		October 2018	
10.	CM180425	Gavin MacGregor	2.6 Look at different ways of generating funds and consider future plans to undertake horizon scanning on this.	Engagement team undertaking this work	July 2018	Completed
11.	CM180425	Imelda Redmond	4.2 At June Committee workshop look at how best the Committee can add value and make decisions, and how they could better understand the Non-Executive Director (NED) boundaries of a Healthwatch Committee member.		June 2018	Completed
12.	CM180425	Imelda Redmond	5.2 A paper to come back to the next meeting to update the Committee on work relating to NHS70 across the local and national Healthwatch.		August 2018	Completed
13.	CM180425	Neil Tester	5.3 NHS Providers to be engaged in discussions regarding hospital.		July 2018	Completed
14.	CM180425	Joanne Crossley	5.4 AFRSC to meet with the Staff Engagement Group (SEG) to discuss plans to address points raised in the staff survey.	SEG have been invited to next AFRSC	July 2018	Completed
15.	CM180425	Neil Tester	5.5 Information regarding planned future partnerships with the voluntary sector to be brought to the next Committee meeting.		August 2018	
16.	CM180425	Imelda Redmond	5.6 HWE Green Paper for Social Care submission to be shared with the Committee.		August 2018	Completed
17.	CM180425	Neil Tester	5.7 A demonstration of Endeca to be presented to the Committee.		October 2018	
18.	CM180425	Jane Mordue	6.1 The Committee to focus on how the network		October 2018	

			can land local stories.			
19.	CM180425	Imelda Redmond	6.3 To consider how to work with RSA's health and wellbeing network		June 2018	completed
20.	CM180425	Gavin McGregor	6.4 Maximise impact from regional meetings		July 2018	Completed
21.	CM180425	Neil Tester	7.1 Give Committee regular briefings regarding the mental health research programme	Committee being updated at every Committee Meeting	Ongoing	Completed
22.	CM180425	Imelda Redmond	8.0 As part of the review of local Healthwatch funding look at the appetite for a population size related formula.	This will be dealt with as part of the Funding Crisis Taskforce	July 2018	
23.	CM180425	Neil Tester	9.2 Share with HWE Committee media coverage information for local Healthwatch.		June 2018	Completed
24.	CM180425	Neil Tester	9.3 Future Delivery & Performance Report with percentages also include actual figure to help give context.		August 2018	
25.	CM180425	Amie McWilliams -Reynold	9.7 Build a FAQ list from the questions coming into the research helpdesk.		October 2018	
26.	CM180425	Imelda Redmond	9.8 To look at the CRM system and the consistency in its use across the network.		September 2018	
27.	CM180425	Imelda Redmond	10.1 Timings of future AFRSC and Committee meetings to be looked at to ensure papers can be prepared and sent out in good time.		June 2018	Completed
28.	CM180425	Imelda Redmond	10.2 To consider giving a member of the AFRSC responsibility for staff personal development.		December 2018	
29.	CM180425	Imelda Redmond	11.7 To share the HWE intelligence report with the network and Boards of local	The HWE intelligence report is diarised to be released on Yammer and in the HWE newsletter in July and this will happen on an	June 2018	Completed

			Healthwatch.	ongoing basis.		
30.	CM180425	Imelda Redmond	12.2 To draft a forward plan for future workshops.		September 2018	
31.	CM180425	Imelda Redmond	12.3 To give a Word update on the Business Plan for six months as a trial for the Committee to reconsider how they receive the updates.		August 2018	Completed
32.	CM180425	Imelda Redmond	13.1 To speak to AK regarding how media coverage is tracked.		June 2018	Completed
33.	CM180425	Jane Mordue	14.1 Standing Orders Update to be carried over to 1 August Committee meeting.	Added to agenda	August 2018	Completed
34.	CM180425	Imelda Redmond	16.1 To set up a forward plan for future Committee meetings.		August 2018	

MEETING REFERENCE: 20180801
AGENDA ITEM No: 1.5

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.

1. Healthwatch England strategy

The committee has focussed on three topics during this past quarter, as we head into our new 5 year strategy:

Local Healthwatch sustainability
Mental Health
Committee and leadership team working

2. Local Healthwatch sustainability

The whole point of Healthwatch is that it is open to whatever the public wish to tell us. As a result we receive real time information on what people think about health and social care and are able spot changes as they happen. We may build on this calling on other sources but the unadulterated voice of the public is crucial. Any threat to the ability of local Healthwatch to do this is an existential threat to our common purpose. The energy, initiative and honesty of local Healthwatch in seeking out the true voice of the public is inspirational to all who encounter its work. To sustain local Healthwatch, we have always worked closely with them individually and their commissioners, providing much welcomed training for the latter.

How dispiriting then to find at our January meeting that funding for local Healthwatch had reached an all-time low. It was just over half of the original funds dispatched to local authorities by the then Department of Health and was on a downward trajectory.

This, despite the fact that Parliament, through the Department of Health and Social Care, requires local authorities to fund Healthwatch to carry out their statutory duties. But how to identify the tipping point when funding falls below this level has been a persistent bugbear – how to identify the 'so far and no further' point? The chart presented to us in January showing that funding had now reduced to the level given to the former LINKs, which had fewer responsibilities, showed us that the time had come to act.

To combat this, we set up a Committee sub group, led by Phil Huggon, to look, with local Healthwatch, at what can be done. The good news is it became clear from our review that it is not through lack of appreciation for the work of Healthwatch that local authorities are cutting funding. Many simply face extreme funding pressures. Some, but it is now a minority, are maintaining funding levels.

The challenge for the sub group was to map the situation, find levers for change and get the message out there both about the plight of local Healthwatch and the difference that a properly supported activity can make.

The committee at its June workshop heard back from the sub group. As we knew already, there are no magic fixes, but it was clear that this work was already resulting in a more systematic, less case by case approach. We now have a complete map of funding and risk. Working with

local Healthwatch, all avenues for tackling this issue, at local or national level are being addressed. Having a clear definition of quality to hold up to local commissioners is also key and this is being tackled. We have campaigned at both local and national level. Nationally, we have met with Ministers, officials at the Department of Health and Social Care and enlisted the support of the Care Quality Commission. We had an extensive and widely welcomed presence at the recent Local Government Association conference.
In response to the Committee's call for continued and urgent focus, the National Director set up a task force which she chairs and reports on elsewhere on this agenda. May I thank everyone who has contributed so many hours and so much thinking to this work throughout the year. There have been some successes but we have to recognise that there are no quick fixes. We will not give up!

3. Mental Health

Mental health has regularly come high as a priority in the work of local Healthwatch and last year, the committee decided to give it a special focus. The challenge was how to differentiate 'business as usual' from doing something which would bring special value to the national debate. The committee set up a programme group, led by Liz Sayce and with a mix of staff and of committee members with an expertise in this area. They are taking a thoughtful approach to ensuring that they truly make a difference and this is starting to bear fruit with a series of studies of mental health issues facing people at different stages of their lives.

4. Committee

4.1 Committee

I have appointed Phil Huggon as my vice-chair. He brings both energy and clarity of thought as well as in-depth knowledge of how the NHS works. He has a background in marketing and transformation and is currently chair of the NHS Transformation Unit in Manchester.
Andrew Barnett was elected as Senior Independent Member by the Committee, following a process agreed and used previously. He brings a wealth of senior experience – he leads the Gulbenkian Foundation's work in the UK on improving wellbeing for the most vulnerable, and moral authority – being recently appointed Chair of the Church of England's Church Urban Fund.

4.2 Committee and National Director appraisals

I have completed the programme of appraisals which produced some very interesting conversations and led *inter alia* to the workshop below. Each appraisee now has a short set of objectives and roles based on their expertise and offers of help. Particular strengths are in the areas of bringing the voice of local Healthwatch, relations with local government, mental health, health inequalities, diversity, engagement itself, profile and reputation, prevention and research methodology. All are keen to have ambassadorial responsibilities.

4.3 Committee and leadership team working

The arrival and introduction of 7 new committee members in January followed by the departure of 3 long standing members in May, presented both opportunities and challenges.
In any Committee's work there is a balance between their strategic and their governance role. We at HWE are fortunate in that much of our practical governance is taken care of by the Care Quality Commission. We do monitor performance closely at committee level and through the work of our Audit Finance and Risk sub-committee, chaired by Danielle Oum. However, there is more time to focus on using committee members' experience and expertise to guide and support the work of the National Director and her team.

In June, the leadership team and committee members held an excellent workshop to learn about each other and weld ourselves into an effective group where lines of communication are open and constructive challenge is welcomed.

5. Work with strategic partners

Our new strategy will bring its own programme of meetings with strategic partners. In the meantime, opportunities are being taken as offered. I attended the launch of a publication by the Institute of Government, 'The World's Biggest Quango: The First Five Years of NHS England'. The former Secretary of State, Jeremy Hunt, spoke. This was at the time that an announcement was expected about an uplift in Government funding for health and care. The question of whether prevention would be supported was raised.

Imelda and I met the new Chair of the Human Tissue Authority, Nicola Blackwood. They operate mainly in the world of high science but recognise the need to learn how best to communicate with the public about what is on the horizon. They were seeking our advice.

As part of the NHS 70th anniversary, Neil Tester and I attended the launch of a piece of work by The King's Fund, 'What do the Public think?' The results of a MORI survey it chimed with all our findings. The retiring chief executive, Professor Sir Chris Ham, was also keen to encourage a 'deal' between the professions and patients/the public.

Most recently, I was invited to the first reception of its kind by the University of the Third Age, at the Houses of Parliament. They are keen to raise their profile and diversify their membership. They presented their report, 'Living Life, Extending Horizons, Challenging Conventions'. The tagline was, 'The exceptional impact of the U3A movement on wellbeing in later life. They invited Healthwatch as they claim a role in reducing social isolation, helping prevent mental health problems. They would like Healthwatch to help get the word out.

List of meetings and events (April to June 2018)

Committee member and National Director appraisals
CQC Board meetings April, May and June
Launch of publication, 'The World's Biggest Quango: The First Five Years of NHS England' May
Chair, Human Tissue Authority, June
King's Fund launch of 'What do the Public Think?' as part of the NHS at 70 celebrations, June
Royal College of GPs Summer Reception June
CQC Diversity and Inclusion project June
Healthwatch England workshop June
House of Commons U3A reception

MEETING REFERENCE: CM180801
AGENDA ITEM: 1.6

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 April

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

1.0 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 April. Following the approval of the strategy, Business Plan, including the budget, performance indicators objectives have been established for all staff. We have now turned our attention to the implementation of the new five year strategy, mindful that this first year is a transitional year and we continue to create new ways of doing things as we begin to deliver on the strategy. I am grateful to the Leadership Team for their work on this.

1.1 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 closed 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

1.2 #itstartswithyou

We have received the highest number of nominations this year with 173 nominations from 97 different Healthwatch. The agenda for the two days is finalised and we are delighted that the Minister Caroline Dinenage will be joining us.

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. The judging is now complete and the finalist notified.

1.3 Network

Over the past few months I have continued to visit Healthwatch around the country had the opportunity to go to a number of network meetings and events. I was pleased to be invited to an event hosted by Healthwatch Portsmouth. I also spoke at a conference organised by The East of England Healthwatch at Duxford Cambridge. I also spent some time in the North East attending a Board meeting of Healthwatch County Durham and the North east regional network meeting. I recently also spent a couple of very interesting days with Healthwatch Brighton and Hove which included a tour of the local hospital, an event hosted by the Mayor of Brighton and Hove to launch the Brighton and Hove annual report which gave me the opportunity not only to meet many of the great local volunteers and Committee, but also many of the key stakeholders from

local government and health. The Chief Officer and a Committee member arranged for me to do a couple of TV interviews and a radio interview and finally I got to spend time with the young Healthwatch volunteers who do a lot of work to ensure that the voice of young people is heard. There is no doubt that the funding situation across the network is the biggest challenge we all face, this remains a high priority both for the Committee with the work led by Phil Huggon, and for the staff team. We are taking actions on a number of fronts:

- We have established a funding crisis task force from across the organisation to make sure we are pulling together to help
- We continue to make sure all our data is up to date so we can accurately analysis and identify the challenges
- We are supporting individual Healthwatch in conversations with their local commissioners.
- We are building the case for support and building relationships across local Government with senior officials and politicians.
- We have established a series of four seminars for local authority Commissioners. The response to these has been very positive.
- We committed a considerable amount of time and resource to the Local Government Association's annual conference. We had a stand and offered meetings to all key local authority partners. We will be attending National Children's and Adult Social Services conference in the autumn to continue this work.
- We have of course raised the issue with Ministers and they were very supportive of our position. We are expecting a response in the next day or so.

We are working closely with the network to deliver a training and support offer, and developing a new agreement and quality standards. We have organised a number of webinars including an introduction to the NHS and introduction to Social Care. These have been incredibly popular with over 50 people signing up and so we will be repeating them again in September. We have also produced a range of new resources for local Healthwatch to use such as posters, videos and booklets.

Our work on building our reputation as experts in engagement continues. We have commissioned Plymouth University to undertake a literature review including the value of Healthwatch activity. Again this might well be a useful conversation at a future workshop for the Committee. From this piece of work we want to build a set of 'engagement tools' both for the network but also for the wider sector too.

Likewise we are beginning work to establish impact and ways of measuring it across the network. We are beginning by analysing all 152 annual reports. Later this year we will commission an external agency to develop impact tools for the network to use.

1.4 Digital

There is a considerable amount of work underway to improve our digital offer both to the network and to the public. We are almost at the end of a programme of work to find out from the network what their digital requirements are and how we can meet them within our limited budget.

We have been testing the new website which will go live on 29th July. The new website has video capability and is mobile friendly unlike our old one so our communications will improve.

We have built the first prototype of the APEx Reports Library. This will eventually allow much great opportunities for the network to share reports, good practice and data with each other.

We are working on ways to reduce the burden of local healthwatch when it comes to data inputting by having new import functions within CiviCRM. We are also piloting a new platform which will allow local healthwatch to quickly analysis their data.

If there is time on a future workshop agenda it might be useful for the Committee to have a closer look at the digital capacity.

1.5 Campaigns

We launched our campaign #Itstartswithyou; a campaign to raise awareness of the importance of sharing stories and experiences to bring about improvements. We also launched a video which has been extensively shared via twitter and facebook. The campaign was kicked off with a twitter Thunderclap that reached 2 million people, up 115% from last year.

#Itstartswithyou will also provide the vehicle for our campaign as part of #NHS70 where we will be asking the public to think about what they want from health and social care in the future.

Influence and Policy and Public Affairs

2.0 Governmental engagement

Following Jeremy Hunt's move to become Foreign Secretary, Matt Hancock (former Secretary of State for Digital, Culture, Media and Sport) has been appointed as the new Health and Social Care Secretary. I understand that his special advisors from DCMS, Lottie Dominiczak and Jamie Njoku-Goodwin, have moved with him. There may well be additional appointments to the team made in the coming weeks.

On 23 May I, along with the Vice Chair and the Deputy Director, met with the sponsor minister for the Healthwatch Network, Under Secretary of State (Mental Health and Inequalities) Jackie Doyle-Price. The purpose of the meeting was to discuss the significant and growing pressures on local Healthwatch funding and the risks this is posting to the future sustainability of the network. The minister was receptive to our concerns and recognised the need to send clear messages to local government leaders about the importance of Healthwatch and that understanding people's experiences will be a crucial measure of assessing the effectiveness of current health and social care transformation programmes. The minister instructed her officials to work with us on finding solutions, and specifically asked them to also work with the LGA to ensure local authorities understand their obligations. The letter following up on the meeting is included in your papers – **Appendix i.**

In June the Prime Minister announced a five year funding plan for the NHS, which promised the health service an increase of £20.5 billion per year by 2023, with £4.1 billion extra next year. This represents a 3.4% a year real-terms increase which is higher than was initially suggested but lower than the 4% many system commentators including NHS Providers, a number of key think-tanks and the former Secretary of State for Health and Social Care said would be needed. This extra money is designed to give the NHS the financial security to develop a 10-year plan to be published in the autumn. In return for the money the Government set out a number of top-line conditions:

- Getting back on the path to delivering agreed performance standards – locking in and further building on the recent progress made in the safety and quality of care.
- Transforming cancer care so that patient outcomes move towards the very best in Europe.
- Better access to mental health services, to help achieve the government's commitment to parity of esteem between mental and physical health.
- Better integration of health and social care, so that care does not suffer when patients are moved between systems.
- Focusing on the prevention of ill-health, so people live longer, healthier lives.

There have been questions raised over how this extra investment will be funded. The PM had suggested that the Brexit dividend would contribute to the cost but a report in July by the Office for Budget Responsibility suggested that this will not be possible. Therefore it looks likely the vast majority of additional funding will need to be raised through taxation.

In addition to the 5-year funding settlement, the government also set out their intention to:

- Come forward with proposals to reform social care later this year.
- Ensure that adult social care doesn't impose additional pressure on the NHS.
- Consider any proposals from the NHS for legislative changes that will help it to improve patient care and productivity.
- Consider proposals from the NHS for a multi-year capital plan to support transformation and a multi-year funding plan for clinical training places.
- Ensure that public health helps people live longer, healthier lives.

This means that the Government's Green Paper on Social Care, which had been expected before summer recess, has now been pushed back to the autumn to align with the NHS long-term plan. Both are likely to be published in November to tie in with the budget.

2.1 Key health and social care announcements

Much of the quarter was dominated by the run up to NHS 70 with significant focus across the sector on celebrating the NHS and the hard working staff who keep it running. As mentioned above, the PM took the celebrations as an opportunity to announce increased funding for the NHS and the development of a 10 year plan.
In July Simon Stevens, Chief Executive of NHS England, set out in more detail his five priority areas for the plan. The first two are a continuation of priorities under the Five Year Forward View.

1. Mental health – in particular services for children and young people, and potentially crisis care.
2. Cancer – including an overhaul of screening services.

The other three are new areas:

3. Cardiovascular diseases – including heart attacks and strokes. Simon Stevens said the NHS has ground to make up in this area.
4. Renewed focus on children's services and prevention
5. New objectives around reducing health inequalities – e.g. the differential life expectancy of people with learning disabilities.

As part of the NHS long term plan it was announced an NHS Assembly would be set up to enable the voluntary sector and the public to inform the plan. We understand that more concrete details will be announced in the autumn suggesting that the Assembly will be more focused on informing the implementation and ongoing evaluation of the plan, with the initial development of the plan being informed by existing engagement and insight. We have published our view on the NHS Assembly alongside a collection of think-pieces from across the sector on the long-term plan.

In the run up to the NHS 70th Birthday celebrations the King's Fund published an interesting report on public attitudes towards the NHS. Much of what they heard is echoed in the views people share with Healthwatch. The top line findings suggest people are still committed to the founding principles of free at the point of use. They have realistic expectations of what the NHS can deliver with existing resource but would be happy to pay more. They also recognise they have a role to play in keeping themselves healthy. There was a strong message that if they are going to play their part and contribute more than the NHS needs to do more to tackle waste and inefficiency. If they are asked to pay more in tax then they want to see this as a dedicated pot for the health service. Read the report here.

In social care there was a flurry of publications in the run up to July, which was when we initially expected it to be published. The most relevant for the Committee was the work carried out by the King's Fund and the Health Foundation looking at the public's views on potential funding models. It looks at the various merits of different possible models including the likely 'cap and floor' model and the option for implementing free personal care as is provided in Scotland. Read the report here.

Their findings closely match the findings of our research on public attitudes towards social care. You can read more about this under the social care section of the report. A copy of our research has been included in your committee papers as **Appendix ii.**

The delay to the Green Paper was greeted with a mixed response. On the one hand many in the sector feel the issue has dragged on long enough already, however the logic of aligning it with the NHS long-term plan placated many. The Local Government Association has responded by announcing their intention to publish their own green paper. I expect this to be published before the end of July with it drawing on our research.

Following on from their review of the care home market last year, the Competition and Markets Authority has issued draft guidance setting out what the public should expect from care homes and what providers must do to comply with consumer law. Our research has identified considerable gaps in the information and advice available around choosing a care home, and so this draft guidance is welcomed. The key issue will be around implementation of the guidance. To help this we have recommended a number of ways the CMA could make the guidance easier for providers to understand and use.

At the beginning of July the CQC published their end of programme report on the Local System Reviews. This is the series of 20 reviews that have been conducted at a local authority level looking at how services are working together to help older people continue to live well in the community, and get home quickly and safely from hospital when they do need treatment. Healthwatch England and local Healthwatch have been very supportive of this work as it looks at services in the way people experience them rather than as individual organisations. We therefore supported the CQC's recommendations including the call to extend their powers to routinely be able to look at areas in this way. You can read the report here.

2.2 NHS Mandate

For the second year in a row we were invited by the Department of Health and Social Care to submit evidence to the Secretary of State's review of NHS England's performance against the Mandate.

In our meetings with officials we highlighted:

- The positive work around the development of the patient engagement metric introduced as part of the CCG Improvement and Assessment Framework. This process has highlighted a number of areas for attention at a local level which are now being worked on through individual improvement plans. However, we also raised concerns that the metric only accounts for around 1% of the CCG IAF score.
- On service change we highlighted the evidence submitted earlier in the year to the Health Select Committee which set out a clear need for the NHS to step up engagement in the STPs.
- Reiterated the point we made in our submission to the NHS Mandate this year, that the current 18 week RTT target is not sensitive enough to understand real patient experience and is therefore not a good indicator of the impact of pressures on the system.

We understand that each of these points was picked up on in the review process but the publication of the annual assessment has been delayed due to the appointment of the new

Secretary of State.

2.3 Hospital Discharge

Since the last Committee meeting, delayed transfers of care have continued to fall on behalf of both NHS and local authority partners. However, the reductions in the delays attributed to social care have been far more significant. This is in part because reducing the delays was made a condition for councils in order to access money through the Better Care Fund. However, this has raised questions as to whether councils are being forced in to prioritising individuals in hospital above the needs of those in the community in order to keep them out of hospital in the first place.

Emergency readmissions continued to be a policy issue last quarter. Following the work done by the British Red Cross and the National Audit Office (both of which referenced our findings) on emergency admissions there was a one off Public Accounts Committee hearing. We submitted written evidence which led to emergency readmissions being highlighted as a key issue. In June the Nuffield Trust and the Health Foundation, as part of their joint QualityWatch initiative, ran a very similar piece of analysis on emergency readmissions using Hospital Episode Statistics data. They found a very similar trend to us. Following the level of interest in this issue we are currently re-running the analysis we did last year and have convened a round table meeting with the above organisations as well as NHS England, NHS Digital and the Department of Health and Social Care.

2.4 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 further qualitative and quantitative research to understand what can be done to help people plan better for their future care needs.

- Two deliberative research sessions in March 2018, one in Watford and one in Leeds
- A representative poll of 2,106 adults in England.
- Analysis of a Freedom of Information request, submitted to every council in England requesting information on waiting times for assessments and care services.

This insight was compiled into a briefing that was shared with the Department of Health and Social Care in early May. Over the last few months we have been sharing it more widely with stakeholders, with the findings broadly welcomed.

Headline findings are:

- Respondents to the national poll and those who took part in the deliberative research highlighted huge uncertainty over how care is funded; with those in the focus groups also expressing a clear sense of resentment about the lack of clarity around current funding mechanisms.
- There is a lack of understanding among the public about where to go for reliable information and advice about social care. Our polling showed that GPs are often seen as the most reliable and trusted source of information, with 78% respondents reporting high levels of trust in GPs. The deliberative research confirmed this, though for the purpose of

this briefing we should bear in mind that when the public refer to a 'GP' they tend to mean the practice as a whole, not an individual medical professional;
- People are clear on what they would want from social care. The most important factors are the ability of the service to meet individual needs (65%) and the safety of the service (66%). The ability to compare cost of service between local providers was equally important (66%);
- However, people are reluctant to think about or plan for potential future care needs. Only 5% of survey respondents said they were fully prepared to meet their future or urgent care needs, while 27% said they did not think people should plan at any particular time, and should just 'wait and see';
- As people get older they are less likely to think that they should plan for their future care needs, the over 55 years of age group were most likely to say that people should just 'wait and see' what happens (38%);
- Attendees at our deliberative events suggested that the best way to encourage more people to plan and consider their care needs earlier in life would be to simplify and streamline current advice. They wanted to see the development of an independent, single point of contact, like an online portal or dedicated telephone service, which could advise and guide people through the current system. In order for this to succeed people said it would be vital to have a well-resourced and prolonged awareness-raising campaign.
- Our deliberative events have led us to conclude that the information and advice needs of the public stem from two key questions that for the most part people do not know the answer to: how is care funded and what is the standard of care?
- Finally, it was clear from speaking to people that while they spoke of a single point of contact for information, equivalent to NHS 111, they also want localised guidance to explain what care options are available in their area.

A full copy of the briefing has been included in the papers – **Appendix ii**.

We have also published a new single complaints statement for social care, developed in partnership with the Local Government and Social Care Ombudsman as part of the cross-sector Quality Matters initiative. The statement creates a single understanding of how the complaints system in social care works and has been designed to help both professionals and the public. You can read more here.

2.5 Public Engagement in Service Change

In June the Health and Social Care Select Committee published their report into Integrated Care Organisations, Partnerships and Systems. We had previously submitted evidence to the inquiry, and I had given oral evidence to the committee in February. Among the key recommendations made in the report was the need for NHS bodies to do more to communicate what the changes mean to the public, and to explain why they were taking place. In response, we called for extra funding for public engagement, so that the case for change is built on people's experiences of care and their ideas for improvement. We also highlighted the need for the Government and NHS England to continue to evaluate the impact of these changes on people to ensure they achieve the intended outcomes. We look forward to working with them to develop this idea further as part of the NHS long-term plan discussions.

The two judicial reviews brought against the plans to create Accountable Care Organisations in England both found in favour of NHS England. This means plans to consult on the ACO contract are likely to go ahead but timelines are still to be defined.

2.6 Mental Health

It was positive to see both the Department of Health and Social Care and Simon Stevens make clear in their communications around the NHS long-term plan that mental health will remain a top priority.

A poll by Ipsos Mori published in May showed that mental health has now risen to number two on the list of health issues that concern the public. Whilst cancer retained the top spot, the proportion quoting mental health as a concern jumped from 16% to 32% in the last 12 months.

At the last meeting the Committee was informed that our first area of research for the mental health programme would be on maternal mental health. It is therefore worth noting that in May NHS England announced an extra £23 million for perinatal mental health services to provide access to specialist services nationwide by April 2019. This means we have an opportunity to evaluate patient experience as the services are changing and help the NHS target their investment effectively. This funding forms part of a package of measures, worth a total of £365m by 2021, to transform specialist perinatal services so that at least 30,000 additional women can access evidence based treatment that is closer to home and when they need it, through specialist community services and inpatient mother and baby units.

2.7 Health Service Safety Investigations Bill

On 18 June I gave evidence to the Parliamentary Joint Committee on the Draft Health Service Safety Investigations Bill. The Bill looks to establish the Health Service Safety Investigations Body ("HSSIB") as an independent statutory body, with powers to conduct investigations into incidents or accidents within the NHS which appear to evidence risks affecting patient safety.

It also proposes to create a 'safe space' within which participants can provide information for the purposes of an investigation by imposing a prohibition on the disclosure of information held by the HSSIB in connection with an investigation. Finally, the Bill makes provision for the accreditation of NHS trusts and foundation trusts to carry out investigations into patient safety with the benefit of 'safe space'. In the session I was joined by Peter Walsh, Chief Executive, Action against Medical Accidents and Scott Morrish, a patient safety campaigner.

In the session I outlined the importance of ensuring that investigations were seen to be transparent by patients and their families involved in the complaints; the need to make sure that 'safe spaces' work as a concept at a national level before trusts are accredited to use the power; and the importance of HSSIB's role in setting the right expectations for open and transparent investigations across the health and social care sector.

2.8 Technology

On the 25 May the NHS patient data opt-out came in to force. This follows four years of persistent involvement from Healthwatch, but the end result is a policy which largely reflects what people want to see in terms of how their data is used by NHS and social care services.

Shortly before the opt-out website went live we published our latest briefing on the issue. The main message was that people trust the NHS with their data but it is vital that services do not become complacent with this trust.

- Overall, most people are positive about sharing their patient data. 73% of adults told us they would be happy for the NHS to use their information to improve the healthcare treatment of others.
- When compared with other sectors including banking, retail and government, the health sector is also seen as the most trusted in terms of keeping people's data safe and the most likely to use data appropriately.
- Just over half of the people we polled (53%) said they were more aware of data security issues than they were three years ago. Similarly, 57% also said they were more concerned about how their data generally is being used.
- Yet greater awareness does not directly link to greater concern. The research showed that whilst younger people in particular were more likely to be aware of data security issues, they were also less likely to be concerned about how their data is used.
- The majority of respondents (85%) said they had heard of the hacking scandal that hit the NHS in May last year. Interestingly, more than half (53%) of people who had heard about this told us it made them less confident in the ability of the NHS to protect their data.
- So whilst overall confidence in the NHS remains high, it is clear that specific crises run the risk of eroding public trust over time.
- In contrast, positive data initiatives like the ground breaking Genomics programme, which is seeking to map 100,000 genomes of people with rare diseases, had much lower levels of awareness. They also seemed to have less impact in terms of improving people's perceptions of how data is used.

Elsewhere on the technology agenda, as members of the DHSC's National Information Board Social Care Advisory Group we provided input to that group's work on influencing the Social Care Green Paper and NHS long-term plan, focussing on digital solutions that providers and commissioners could use to address quality challenges across the sector. This will be submitted to the teams who are working on the green paper and the long-term plan to influence their work.

2.9 Key Appointments / Resignations

In July, Sir David Behan stood down as Chief Exec of the CQC. He will be replaced by Ian Trenholm, current Chief Executive of NHS Blood and Transplant, who is due to start at the end of July. In the meantime Andrea Sutcliffe, Chief Inspector of Social Care, is acting up in to the role on a temporary basis. A new CQC Director of Procurement is currently being recruited.

3.0 Meetings I attended during the last quarter:

A P R I L	Follow up meeting with North East Network	Healthwatch Sunderland; Healthwatch County Durham; Healthwatch Darlington; Healthwatch Middlesbrough; Healthwatch Redcar & Cleveland; Healthwatch Stockton on Tees; Healthwatch South Tyneside
	The Pioneering Care Partnership Board meeting	Healthwatch County Durham Board meeting
	Adult social care trade associations meeting	To keep trade association stakeholders informed and engaged with changes CQC is making
	Introduction - Tony Müdd/Imelda Redmond	Tony Müdd - Divisional Director, Development & Technical Consultancy | St. James's Place Wealth Management - Social Care Green Paper
	Caring for people with learning disabilities: the importance of support in the right place	Kings Fund Online Event
	Alzheimer's Society	Follow up meeting - Imelda Redmond / Dr Doug Brown, Chief Policy and Research Officer
	Meeting with Simon Stevens	NHS England
	Introduction meeting with Kirsty Shaw	CQC
	Catch Up meeting with Jill Morrell	CQC
	EDC April 2018 meeting	Equality and Diversity Council NHS ENGLAND
	Visit to the South West Clinical Senate - Citizens' Assembly meeting	NHS England South, South West Region
	Aylesbury Vale District Council	Imelda Redmond and Neil Tester from Healthwatch to meet with Maryvonne Hassall and Andrew Grant
	Phone call with James Kent, Special Adviser to the Prime Minister	To plan agenda for roundtable on 26/04/2018
	Number 10 Roundtable Invitation on NHS long term plan - PM in attendance	To give Imelda's perspectives on the priorities and opportunities for the PM plan to develop a long term plan for the NHS over the course of this year
	Anchor	Discussion re Green Paper on Social Care - Imelda Redmond & Jane Ashcroft

M A Y	Healthwatch Torbay	Neil Tester on behalf of Imelda Redmond attending event launching a project supporting the community to Financial Advice, Information & Resilience Service (FAIR) in a fast changing landscape.
	NHS at 70 debate: How can the NHS survive and thrive for another 70 years?	NHS ENGLAND
	Good Governance Institute Annual Leader's Forum (Leeds)	This year we'll be tackling risk management, challenges presented by accountable care systems, and new principles of good governance among others
	NHS Confed: breakfast roundtable on future funding	Host - Naill Dickson CEO
	Expert Group Meeting DHSC	Update on process and emerging reform package anddiscussion of outline reform proposals
	LGA Conference	Imelda speaking 'Securing the voice of people who use services'.
	Care Home Parliamentary Reception 2018	Attended reception as opportunity to share our work on understanding people experiences of living in care homes
	Integration Partnership Board work shop	Jacob Lant attending on behalf of Imelda Redmond - group discussion on the big issues surrounding the future of integration, ahead of the forthcoming Green Paper
	Nursing and Midwifery Council (NMC) Event	Publication event for the NMC's new education standards
	Nursing and Midwifery Council	Coffee meeting with Jessie Cunnett
	Meeting with Ministers - Jackie Doyle-Price, Parliamentary Under Secretary of State for Mental Health and Inequalities and Caroline Dinenage, Minister for Social Care	In regards to Imelda Redmond's letter to Jackie Doyle-Price and Caroline Dinenage regarding funding of local Healthwatch organisations and requesting a joint meeting.
	Alzheimer's Society Annual Conference	Jacob Lant attending on behalf of Imelda Redmond - invitation to speak and to join the panel, sharing knowledge and experience of being on the Green Paper panel and highlighting the importance of user voice to shape how services work and develop.
	Meeting to discuss NHSE / Involvement in value interventions programme	Jacob Lant on behalf of Imelda Redmond meeting with Nicola Stewart - NHS ENGLAND
	STP Advisory Group Meeting	NHS ENGLAND
	Developing People Improving Care - Third Sector Organisations Roundtable	NHSI

J U N E	Meeting with NHSE (Neil Churchill)	Quarterly HWE meeting - Gavin attending with Imelda
	Meeting with Kevin Rotero	CQC
	CQC horizon scanning – call for insight and invitation to a roundtable event	CQC
	NHS Confederation Parliamentary Funding Report Launch	Launch of the report 'Securing the future: funding health and social care to the 2030s'.
	Meeting re NHSLA - Leadership Academy Support to Healthwatch UK	Mike Chitty / Imelda Redmond/Gavin Macgregor
	Teleconference - CQC key stakeholder - request for an interview to collect feedback	Colin Penning - Senior Public Campaigns Officer, Engagement, Care Quality Commission (CQC)
	Quality Matters Board meeting	DHSC
	House of Commons Health and Social Care Committee invite to our launch event, *Integrated care: putting patients and communities at the centre*	Joshua Edwards attending on behalf of Imelda
	Help Force	Meeting with Sir Thomas Hughes Hallett Help Force CIC Director
	NHS Confed18: Celebrating the past, shaping the future	
	Great Manchester chairs/officers review meeting	
	Healthwatch England & HTA Meeting	Imelda meeting with Jane Mordue and Nicola Blackwood (HTA Chair)
	Peter Walsh / Imelda Redmond meeting prior to evidence session	Peter Walsh is CEO of Action against Medical Accidents
	Joint Committee on Draft Health Service Safety Investigations Bill	House of Lords and House of Commons
	Conference Call - Imelda Redmond, Tom Whiting and Alex Dewsnap	Harrow council about funding for Harrow Healthwatch
	Healthwatch Portsmouth Annual General Meeting	Imelda to provide update on the implementation of the Healthwatch England new strategy 2018-23
	System Engagement, NICE - QUALITY IMPROVEMENT ROUNDTABLE MEETING National Institute for Health and Care Excellence -Invite from Professor Gill Leng, Professor Steve Powis and Adam Sewell-Jones	Roundtable meeting to consider future requirements for quality improvement across the health system.

HEALTHWATCH ENGLAND – PUBLIC COMMITTEE MEETING

Wednesday 1st August 2018
151 Buckingham Palace Road, SW1W 9SZ

AGENDA ITEM No.1.8

AGENDA ITEM: Q1 Delivery and Performance Report

PRESENTING: Imelda Redmond

PREVIOUS DECISION: The Committee agreed the 2018-19 business plan, budget and KPIs in April 2018.

EXECUTIVE SUMMARY: This paper summarises delivery and performance against KPIs during Q1 and provides an update on the financial position as at end June 2018. It reviews progress against the programme management framework and sets out the approach we will be taking to tracking impact and the realisation of strategic benefits.

RECOMMENDATION: Committee Members are asked to NOTE the contents of this report.

The paper covers:

1. Programme management framework
2. Impact and evaluation
3. Q1 delivery highlights and Q2 look-ahead
4. Budget summary
5. Performance against KPIs

1. Programme management framework

For management purposes we have consolidated all our activity into the following overarching programmes:

- Digital Development
- Network Development
- Research, Evidence and Impact
- Engagement
- Awareness and Influence
- Organisational Development

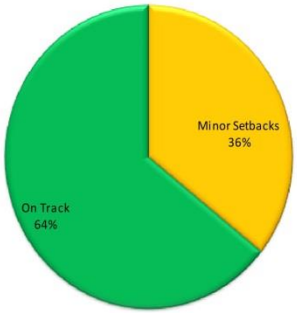
We apply a RAG rating to each activity within each programme and to the programmes overall, to enable close performance management. The Committee is asked to note that a Red rating within this framework denotes that substantial action is required to return a programme to its planned trajectory but does not imply that the programme activity will not be delivered. Table 1 below summarises the overall status for each programme.

Table 1 – overall programme status

Programme	Overall Q1 delivery status	Commentary
Awareness and Influence	**Amber**	Some planned Q1 schedules for external activity shifted due to changing plans in other programmes. Programme is still expected to achieve Green status as revised plans are now in place.
Digital Development	**Amber**	Major elements of programme successfully delivered in Q1 but some schedules affected by a key staff vacancy, meaning that a minority of activity is rated amber. There remains sufficient time within the overall programme to return to schedule and for the programme to achieve Green status.
Engagement	**Amber**	New programme being developed to cover the life of the strategy. Initial activity underway, with first output due by October Committee meeting.
Network Development	**Red**	Substantial delivery undertaken. This programme is Red for Q1 due to the need to develop our integrated response to the network funding crisis. The Funding Taskforce, initiated following the Committee workshop and bringing together staff from across the organisation for focused and sustained activity, will ensure this programme is not Red at end Q2.
Organisational Development	**Amber**	This programme is expected to achieve Green status. Progress has already been made during Q23 on the 2 activities rated Amber.
Research, Evidence and Impact	**Green**	All activities on track or delivered.

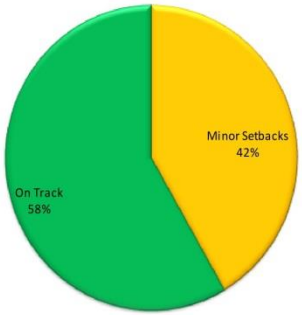
The Audit, Finance and Risk Sub-Committee has considered a more detailed breakdown of progress within each programme and has provided feedback to enable us to develop the following dashboard reports, indicating the activities making up each programme and their status.

Awareness & Influence



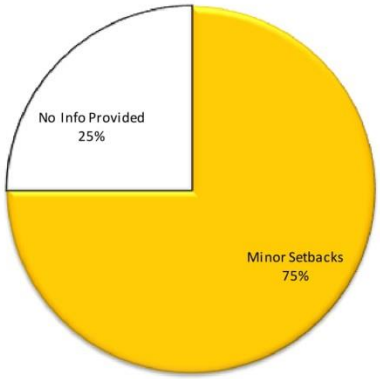
64% On Track	36% Minor Setbacks
Run national #ItStartsWithYou campaign timed with NHS70	Support communication of Healthwatch insight
Develop, design and publish Healthwatch annual reports and plans	Mental Health Programme
Develop Healthwatch marketing and communications materials	Expanding our professional support base
Marketing the role and impact of Healthwatch	Developing Healthwatch England's Approach to Partnerships
Social Care Programme	Regional stakeholder engagement
Additional Insight Sharing Activity	
Stakeholder perceptions survey	
Political Engagement	
Horizon Scanning	

Digital Development



58% On Track	42% Minor Setbacks
Develop local Healthwatch website design and navigation	Develop Healthwatch use of email and social media marketing
Develop Healthwatch England website design and navigation	Healthwatch Feedback Centre
Intelligence System (CRM Development): Improve user functionality	Systems Information and Signposting
Intelligence System (CRM Development): Integrate APEx	Intelligence System Procurement (including web)
Intelligence System (CRM Development): Data Import Function	Data Interface (Architecture): Endeca development
Support, Maintenance and Hosting (CRM and Web)	
Data Warehouse (Store): SQL development	

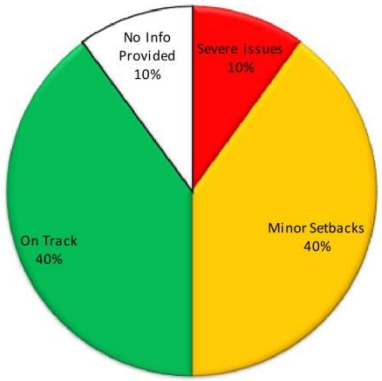
Engagement



75% Minor Setbacks
Building the Academic Case
Evaluation of the network's contribution to date
Making the economic case

25% No Information Provided
Supporting stakeholder engagement with the network

Network Development



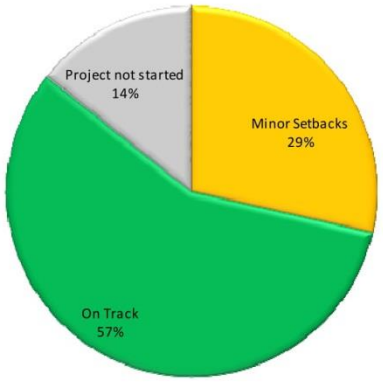
40% On track
Develop Network Model
Sustainability (Commissioner Engagement)
Network Research and Intelligence Support
Network Information Governance

40% Minor Setbacks
Review of Regional Networks and Collaboration
Learning and Development
Provide communications training and support for local Healthwatch
Network Digital Support

10% Not Available
Sustainability (Healthwatch Network)

10% Severe Issues
Advice and guidance

Organisational Development

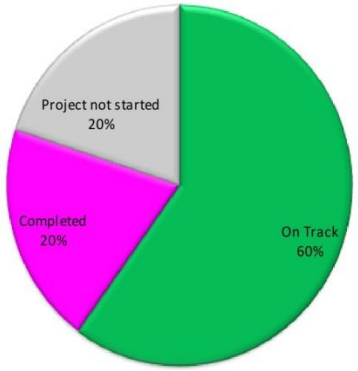


57% On Track
National Directors Meeting
Collaborative operational working with CQC
Healthwatch England Committee
Programme Management Framework (including EDHR)

14% Project not started
Procurement Support

29% Minor Setbacks
Internal Staff Training, Development and Recruitment
Developing Key Performance Indicators and Impact Measurements

Research, Evidence and Impact



60% On Track
Information Sharing
Intelligence Reporting
Primary Research

20% Not Started
Business Intelligence Collection

20% Completed
Healthwatch Knowledge Provision and Signposting

2. Impact and evaluation

The Leadership Team has identified 23 strategic benefits that we are seeking to realise across our programmes, and have grouped them into four themes, as follows (distribution of number of strategic benefits is indicated by the figures in brackets).

1. Network relationships, resources and infrastructure (9)
2. Impact and influence (8)
3. Culture change (3)
4. Range and reach (3)

The performance and delivery report to the October Committee meeting will update the Committee on our early learning about building this approach into planning and delivery, and on any benefits already identified as realised or impacts achieved. These reports to subsequent Committee meetings will then serve as the vehicle to update the Committee on examples of impact.

We will now be working to embed benefits realisation into our assessment of performance, so that we are able to take account of both delivery to schedule and the outcomes of the activity. Building on this approach we also plan to develop a framework for strategic evaluation, bringing options to the October Audit, Finance and Risk Sub-Committee and Committee meetings.

3. Q1 delivery highights and Q2 look-ahead

2018-19's planned activities focus upon making a number of significant transitions in what we do and how we do it to enable us to deliver our strategic aims by 2023. This means that this year we are trialling new ways of working while ensuring key deliverables are achieved. The tables below highlight key delivery in Q1 in support of each aim. They also indicate the areas on which we will be focusing in Q2.

Aim1: Support you to have your say	**Q1 delivery highlights**	**During Q2 we will focus on:**
	• The successful launch of our network-wide #ItStartsWithYou campaign, integrated with our awards activity and our involvement with the NHS70 aniversary celebrations. The launch Thunderclap had a social media reach of well over 2 million people, increasing last year's reach by 115%. The campaign was also a key driver of the Healthwatch media profile over the quarter. • The release of our new video, using 3 real stories to show how people can make a difference by sharing their experiences wirh	• Completing our switch to the new look for the website. • Working with partner organisations and the network in preparation for the autumn's NHS70 National Conversation. • Building collateral and content to enable the network to make the most of the annual showcase of conference. • Preparing the Annual Report for launch in October.

	Healthwatch. This has been our most successful videoo to date, with more than 11,000 views across all of our channels. • The development, user testing and Beta launch of our refreshed website, which also forms the basis for our web offer to the network.	
Aim 2: Provide a high quality service to you	**Q1 delivery highlights**	**During Q2 we will focus on:**
	• Developing our analysis of risk and resourcing across the network, to facilitate the Committee's recent workshop discussion and our revised plan of action on network funding. • Engaging with the network and commissioners to shape our approach to the forthcming network agreement. • Developing our learning and development offer for the network, including final conference planning to enable a successful opening of registrations in Q2. • Promoting the value of local Healthwatch to senior local government audiences at the Local Government Association Conference.	• Further accelerating our activity on network funding. • Conducting our annual State of Support analysis. • Promoting attendance at our conference and working to ensure Healthwatch attendees can use every opportunity it offers. • Further developing the Quality Framework and network agreement. • Delivering our events for commissioners of Healthwatch, which have drawn an early and enthusiastic response. • Implementing a range of usability improvements to the CRM.
Aim 3: Ensure your views help improve health and care	**Q1 delivery highlights**	**During Q2 we will focus on:**
	• Worked closely with key stakeholders in the run-up to the May launch of the national patient data opt-out to ensure that our 4 years of policy effort continnued to shape the launch and roll-out, as it has the development of the policy and	• Making our social care findings more widely available to inform debate in the run-up to the Green Paper. • Further developing our work to influence the NHS Plan

	processes. • Seen the research we conducted to inform the development of rhe Social Care Green Paper welcomed by stakeholders including the Department of Health and Social Care, the LGA, ADASS, the King's Fund and NHS Digital. • Updated our influential analysis of emergency hospital readmissions. • Made the case for effective engagement and the use of existing insight in thr development of the NHS Plan, and argued that new transformaiton funding must include suffciciwent resource for effective engagement.	and its implementation. • Moving our mental health programme on to the next stage. • Working with key stakeholders to explore how they can make use of our updated emergency readmissions findings. • Managing our engagement literature review and using its emerging findings to shape our longer-term programme.

4. Budget summary

	2018-19 Annual Budget Total	2018-19 Spent to date	% of Annual Budget spent
PAY	1,976,578	£462,784	23%
NON PAY	809,464	£164,929	20%
TOTAL	**2,786,042**	**627,713**	**22%**

We are reviewing our headcount for 2018-19 to see where further support will be needed. This will mean that our non-pay expenditure may reduce further, with pay costs increasing accordingly. We have spent 22% of our annual budget as at end Quarter 1. We expect to spend all of our budget allocation for 2018-19.

The non-pay element of our budget allocation has been profiled to cover our three Aims and six programmes of work, enabling management and the Audit Finance and Risk Sub-Committee to maintain effective oversight.

We have continued to build effective ways of working with procurement colleagues and are beginning to benefit from some process improvements arising from improved flexibility and delegated financial authority.

5. Performance against KPIs

The Committee approved a new set of key performance indicators for 2018-19 at its April meeting, recognising the developmental and transitional natire of much of our activity in the first year of the strategy. The following tables describe performance against these KPIs after the first quarter.

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.

No.	KPI Description	Data Collection Method	Baseline	Reporting Frequency	Target	Status	Notes
1	We will see a 5% increase in public recognition of Healthwatch	Annual Tracker	33%	Annual	38%	Green	Due to be measured Q4
2	We will see a 5% increase in public understanding of the purpose of Healthwatch	Annual Tracker	11%	Annual	16%	Green	Due to be measured Q4
3	We will see 35% increase in engagement with Healthwatch England via digital media. Composite KPI:	Google analytics; Sprout social; number of Twitter followers; Facebook likes; number of Twitter retweets and Facebook shares; unique visitors; click rate; content downloads; how visitors arrived at site	Web visitors Unique visitors Social media reach Engagement with social media	Quarterly	+ 5%	Green	All indicators showing increase Q1 2018-19 from Q1 2017-18, with overall increase at 42%, driven by substantial increase in social sharing.
	A. Social following		18,230		24,611		19,037 (+24% vs Q1 2017-18)
	B. Social Sharing		3,126,153		4,220,307		899,100 (+61% vs Q1 2017-18)
	C. Website visitors		167,264		225,806		42,708 (+9% vs Q1 2017-18)
	D. Actions taken		18,258		24,648		20,010 (+10% vs Q1 2017-18)
	E. Number of engagements on social media		44,713		60,363		8,751 (+1% vs Q1 2017-18)

4	We will see 15% increase in media reach of Healthwatch England and Local Healthwatch	Regular tracking of opportunities to see and mentions by national regional and trade, and online	24.75 Opportunities To See	Quarterly	28.46	Amber	14% of annual target delivered in Q1 but Q1 performance up on Q1 in previous year. 4.27 OTS (3.85 national and 0.42 regional/local).
5	We will see increase of 20% in the number of people who share their views with the network	Regular Tracking / Annual Return	341000 sharing views	Annual	409,200	Amber	Annual return currently being compiled.
6	We will see increase of 20% in the number of people who seek information across the network	Regular Tracking / Annual Return	176,000 seeking information	Annual	211,200	Amber	Annual return currently being compiled.
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.							
No.	**KPI Description**	**Data Collection Method**	**Baseline**	**Reporting Frequency**	**Target**	**Status**	**Notes**
7	We will see a new agreement in place with 80% of the Network	CRM	0	Quarterly	80%	Amber	Agreement in development stage.
8	80% of Local Healthwatch will report with good or outstanding satisfaction with the service from Healthwatch England	Composite KPI Events, Training Annual Return	0	Annually	80%	Green	Assessment due in Q4.
9	20 Local Healthwatch will take up the new digital offer	Regular tracking	0	Quarterly	20	Green	3 pilot sites on board and interest from 20+ additional Healthwatch.
10	We will develop an	To be developed.	0	Quarterly	Yes/No		

	involvement/contact index to track how engaged Healthwatch England is with Local Healthwatch and Local Healthwatch with each other.	(Show variances as well as averages)				Green	Approach to index development agreed.
11	In order to let people know the difference their views have made, in year 1, we will analyse all local Healthwatch annual reports and extract the outputs and outcomes to provide a baseline	Local Healthwatch annual reports	0	Annual	100%	Green	Analysis on track for completion in Q3.
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.							
12	We will develop a new benchmark showing professionals' understanding of the role and effectiveness of Healthwatch. (We will commission a piece of work that will establish a baseline on a range of professionals' views and understanding of Healthwatch at a national and local level.)	Annual Tracker to be established. (Show variance as well as averages)	0	Annual	Yes/No	Green	In procurement and on track for delivery in Q4.
13	We will develop measures to show impact by category at national level and at	Annual Tracker to be established	0	Annual	Yes/No	Green	On track for delivery in Q4.

	local level; and report on the volume, nature and source of the impact captured.						
14	We will see at least three strategic partnerships formed	Regular tracking via CRM	0	Quarterly	3	Green	Discussions in progress with a range of organisations.
15	We will develop the methodology for tracking the use of Healthwatch England and Local Healthwatch findings by national organisations	Regular Tracking	0	Annual	Yes/No	Green	Work planned but not due for delivery until Q4.
Year 1 Organisational KPIs							
We are a well-run organisation that develops its resources well.							
16	We will see 100% of the staff completing the staff survey	Staff Survey	98%	Annual	100%	Green	Survey due in Q4.
17	The survey to show a 90% positive response	Staff Survey	90%	Annually	90%	Green	Survey due in Q4.
18	We will see 100% of the budget spent on agreed priorities	Finance Reports	90%	Quarterly	100%	Green	22% of annual budget spent in Q1 and procurement in hand.
19	90% of programmes on track	Leadership Papers. (Show variance as well as average)	80%	Quarterly	90%	Amber	Most programmes rated amber in Q1 but delivery expected to be achieved by year-end.

20	The Committee discharges its statutory responsibilities under Health & Social Care Act and Equality & Human Rights Acts	Composite KPI: Annual report Quarterly report to AFRSC on discharge of statutory duties	0	Quarterly to Audit, Finance and Risk Sub-Committee from Q2; Annually to Committee	Yes/No	Green	Reporting to begin from Q2.

MEETING REFERENCE: CM180801
AGENDA ITEM: 1.9

AGENDA ITEM: Audit, Finance and Risk Sub Committee Minutes

PRESENTING: Helen Parker

PREVIOUS DECISION: N/A

EXECUTIVE SUMMARY: This report updates the Committee on the minutes and actions of the last AFRSC meeting held on 18072018

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

AUDIT, FINANCE AND RISK SUB COMMITTEE MEETING

Audit, Finance and Risk Sub Committee (AFRSC) Meeting
Minutes of meeting No. 4
Meeting Reference: AFRSC180718

Minutes of the Audit, Finance and Risk Sub Committee (AFRSC) July 18, 10:30am – 12:30pm

Attendees:
Helen Parker (HP) – Chair
Andrew McCulloch (AM) – Sub Committee Member
Phil Huggon (PH) – Sub Committee Member – attended via phone

In Attendances:
Imelda Redmond (IR) – National Director
Joanne Crossley (JC) – Head of Operations
Sandra Abraham (SA) – Strategy, Planning and Performance Manager
Leanne Crabb (LC) – Committee Secretary (minute taker)

No.	Agenda Item	Action and Deadline
1.1	**Welcome & Apologies:** Helen parker (HP) welcomed everyone to the Audit, Finance and Risk Sub Committee meeting (AFRSC) and advised she would be Chairing on behalf of Danielle Oum (DO). Apologies had been received from Danielle Oum	
1.2	**Draft Minutes of Meeting of 18 April 2018:**	

	Minutes of the last meeting were agreed	
1.3	**Matters Arising** From the actions of the previous meeting the new members of the AFRSC suggested inviting the members of the Staff Engagement Group (SEG) along to the next AFRSC to be introduced to the sub committee. Phil Huggon (PH) requested an update on concerns over GDPR. Imelda Redmond (IR) advised that since GDPR came in there have been no reported concerns by the network. **ACTION** • **LC to send invite for next meeting to the members of SEG.**	LC
2. 1	**Finance and Procurement** Joanne Crossley (JC) gave a report on finance. She highlighted that we have spent 22% of budget so far this financial year and confirmed that the executive believes we are on track to spend the whole budget this financial year. JC advised that procurement needs are being reviewed and that we will begin to see activities being undertaken. JC informed the sub committee that procurement for training for HWE staff and local Healthwatch is going through at the moment. IR advised that the Committee previously approved budget for five new members of staff, this is still happening but may take longer than planned but we are able to use the staffing costs in other ways so are looking at bringing temporary people with skills into the team. HP asked if we can easily get interim staff in. IR responded that we are looking at this and it does require Department of Health and Social Care (DHSC) sign off. PH commented that it would be good to make use of the skills in the network by paying them to do interim work for us. IR advised this was another possibility being looked at as it had now been confirmed that HWE could give grants to local HW, as long as they were set up as a charity. JC presented the Programme Management Framework and Dashboard to the sub committee. AM commented that it was very good. PH added that he liked it and that it addressed previous concerns. IR advised that it is now easier for the Executive Team to have a clear overview of all the work we are doing. She said that there needed to be a discussion about what information regarding the Framework goes to future AFRSC and full Committee meetings. A general discussion followed covering whether a dashboard with additional commentary regarding key risks would be sufficient for the full Committee meetings. HP found the dashboard dials useful and AM	

	felt it was important for the information to cover "what is bothering the senior management". PH added that if there was a particular concern then that could require a more detailed report about that risk. It was agreed if a dial on the Dashboard turned red it should be escalated to the AFRSC by email if in between AFRSC meetings. HP suggested that the team asks Ruchir Rodrigues (RR) to review the plans and progress for the Digital Development programme. IR concluded that on the Dashboard most of the dials were where we'd expect them to be at this relatively early stage. She also confirmed that, in reviewing progress, the leadership team were reviewing procurement progress in particular - to avoid delays later in the year. **ACTION** • **IR and JC to use above feedback to create a Programme Management Framework report for future Committee meetings.** • **LC to arrange for RR to look at Digital in the Programme Management Framework.**	IR/JC LC
3.1	**Risk Registers** Sandra Abraham (SA) introduced the Strategic Risk Register and advised that it had been reviewed at the Leadership Meeting on 17/01/2018. IR advised that our Strategic Risk Register had been presented to the Care Quality Commission (CQC) Audit and Corporate Governance Committee (ACGC) in June 2018. There was strong engagement from the ACGC and they have requested we return to report to them again in October 2018. HP added that the ACGC had observed that there were a large number of risks on the register, and a significant number of red/black risks – even after mitigations, and in areas where the Committee had a low risk tolerance. ***EXTRACT FROM DRAFT ACGC MEETING NOTE – 6 JUNE 2018*** ***Item 11 – Healthwatch England (HWE) update (ACG/06/18/11)*** 1. *IR and HP presented the annual update to ACGC from Healthwatch England as set out in the written report and related appendices.* 2. *In discussion, the Committee discussed whether the corporate risks to HWE could be defined in a different way, to better reflect the impact of the failure of local healthwatch on HWE. The Committee acknowledged the challenge around the current funding climate and funding model for local healthwatch that represented an "existential" threat to the Healthwatch network. The Committee noted that it was difficult for HWE to put effective mitigation in place. It was noted that a number of local healthwatch had taken on multiple contracts in order to increase funding but, this could potentially impact on their ability to function*	LC

	effectively as a local healthwatch. It had been identified that some of those organisations with the most contracts were some of those at greatest risk of failure. While it was difficult to mitigate against such risk, it was nevertheless important that HWE took action to ensure the risk was highlighted at the right levels. Work was underway to consider this and IR would report back to the next meeting of ACGC on progress. 3. *The Committee thanked IR, HP and colleagues for the report and its assurance that HWE had effective procedures and controls in place around governance and the effective identification of risk.* IR advised that the Leadership Team has already begun to look at re-evaluating risks. A general discussion followed regarding how to present the risks to the AFRSC. It was suggested that risks related to the same issue are clustered, and that the AFRSC focuses on just the three or four most significant risks. IR and SA will work together on what to bring to the next AFRSC. SA presented the Information Risk Register. AM suggested changing the Impact on HWE of a data breach in the network from very high to high. Although it carries clear reputational risk for HWE, the legal responsibility would sit with the local HW, so the impact would be relatively less. HP asked that, although the CQC required there to be a separate Information risk register, any relevant information risks be included among the top 3 or 4 risks overall if their rating was ever raised to this level. **<u>ACTIONS</u>** • **LC to confirm we are on the agenda for the CQC's next ACGC meeting and to ensure we prepare a paper for it** • **IR and SA to prepare a simpler Strategic Risk paper for the next AFRSC** • **SA to change Impact from very high to high on Information Risk Register**	IR/SA SA
3.2	SA introduced a paper on Internal Audit. She confirmed our actions from the previous audit had been completed. She advised that the previous AFRSC had requested to be more involved in future planning of Internal Audits (which are conducted by the CQC). SA confirmed that this planning will start in Q4 and needs to be added to the AFRSC Forward Plan to discuss in October. A general discussion took place regarding possible inclusions in future	LC

	audits. HR was suggested. IR also raised the concern over people contacting our enquiries number to 'whistleblow' but it not being understood by the staff answering the call that action needs to be taken. Our calls are taken by CQC staff in Newcastle. IR and SA are visiting them to discuss what they do on our behalf and will bring a report back to the next AFRSC. To be added to forward plan. The sub-committee noted that a review of procurement was part of the CQC audit plan for 18/19. **ACTIONS** • **LC to add Internal Audit to the Forward Plan for October 2018** • **LC to add feedback and actions from visit to Newcastle to Forward Plan for October 2018**	LC
4.1	**Forward Agenda** No comments	
5.0 **5.1**	**Any other issues** It was agreed that dates for next year be sent out to the full Committee **ACTIONS** **LC to send 2019 meeting dates to full Committee**	LC
	Date of next meeting – 16 October 2018 at 10:30am	

SUMMARY OF ACTIONS (LAST UPDATED MARCH 2018):						
NUM	DATE	LEAD	ACTION	UPDATE	DEADLINE	STATUS
1.	22/01/18	Leanne Crabb	LC to put the action for the Sub Committee to have a meeting with the Staff Engagement Group (SEG) once members join on April's agenda.	SEG has no forward date for next meeting - once there is a date an invite will go to all members of the AFRSC. Now updated - see action 18.	July 2018	Update - see Action 18
2.	22/01/18	Leanne Crabb	Invite Danielle Oum to the April meeting.		March 2018	Completed
3.	22/01/18	Leanne Crabb	IR to send Sub Committee recent briefing on GDPR.		March 2018	Completed
4.	22/01/18	Sandra Abraham	SA to make risk in OR07 higher.		Feb 2018	Completed
5.	22/01/18	Sandra Abraham	SA to improve the definition of SR04.		Feb 2018	Completed
6.	22/01/18	Sandra Abraham	SA to find out when next audit is.		Feb 2018	Completed

7.	22/01/18	Leanne Crabb	LC to update budget on Forward Agenda in October and January		April 2018	Completed
8.	18/04/18	Leanne Crabb	LC to send ToR to all members of the Sub Committee.		May 2018	Completed
9.	18/04/18	Danielle Oum	DO to discuss potential fourth Sub Committee Member with the Healthwatch England Chair.	Helen Parker joining AFRSC	May 2018	Completed
10.	18/04/18	Leanne Crabb	LC to get updates regarding the Action Log before the next AFRSC meeting.		July 2018	Completed
11.	18/04/18	Leanne Crabb	LC to discuss with DO a more appropriate numbering system for the July meeting agenda.	Each item now individually numbered	June 2018	Completed
12.	18/04/18	Sandra Abraham	SA and IR to re-evaluate risks on the Operational Risk Register.		July 2018	Completed
13.	18/04/18	Imelda Redmond	IR to arrange for some analysis of local Healthwatch risk registers be done.		July 2018	

14.	18/04/18	Leanne Crabb	LC to add Risk Register to July Committee agenda		July 2018	Completed
15.	18/04/18	Imelda Redmond	IR to bring to a future workshop: How Healthwatch England is supporting public bodies, such as Health and Wellbeing Boards, to engage with the public, and the impact we are having.		December 2018	
16.	18/04/18	Leanne Crabb	LC to reassess timings of the AFRSC and Committee Meetings.	Completed for 2019	July 2018	Completed
17.	18/04/18	Leanne Crabb	LC to add discussed items to forward agenda		July 2018	Completed
18.	18/07/18	Leanne Crabb	LC to send invite for next meeting to the members of SEG	Invite for October AFRSC sent to SEG on 20/07/18	October 2018	Completed
19.	18/07/18	Imelda Redmond Joanne Crossley	IR and JC to use sub committee feedback to create a Programme Management Framework report for future Committee meetings.		October 2018	
20.	18/07/18	Leanne Crabb	LC to arrange for RR to review plans and progress on at Digital on the Programme Management Framework.		October 2018	

21.	18/07/18	Leanne Crabb	LC to confirm we are on the agenda for the CQC's next ACGC meeting and to ensure we prepare a paper for it.	Have confirmed with CQC we are on 6 October ACGC agenda and have added an item to September Leadership Team meeting to discuss paper.	October 2018	Completed
22.	18/07/18	Imelda Redmond Sandra Abraham	IR and SA to prepare a simpler Strategic Risk paper for the next AFRSC, which would also serve as a high-level summary for the full Committee.		October 2018	
23.	18/07/18	Sandra Abraham	SA to change Impact of a data breach within the network from very high to high on Information Risk Register		August 2018	
24.	18/07/18	Leanne Crabb	LC to add Internal Audit to the AFRSC Forward Plan to discuss in October.		October 2018	Completed
25.	18/07/18	Leanne Crabb	IR to feed back on findings and actions from her visit to Newcastle to discuss the HWE enquiries service at the October AFRSC.		October 2018	
26.	18/07/18	Leanne Crabb	LC to email suggested 2019 meeting dates to the full Committee		August 2018	

MEETING REFERENCE: CM180801
AGENDA ITEM: 2.0

AGENDA ITEM: Q1 Intelligence Report

PRESENTING: Amie McWilliam-Reynolds

PREVIOUS DECISION: N/A

EXECUTIVE SUMMARY: This report provides a summary of intelligence gathered from the local Healthwatch network over the last quarter

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

Quarterly Intelligence and Policy Report Q1 18/19

Healthwatch England Committee Meeting 19 Jul 2018

Overview of what we have heard in the last quarter

26,814 peoples view have been received by Healthwatch England and reviewed in Q1 18/19. This includes 168 publications involving the views of 23,167 people and an additional 3,647 individual pieces of feedback.

Primary Care	
Emerging Themes	In Q1 we received increased levels of feedback on the following areas: • People who have long-term conditions who need to take regular medication are having issues with their medication not being ready on time, or have issues booking a regular appointment for medication review due to the limitations of the appointment system. • Significant variation in the level of service provided by NHS 111. In some regions we are hearing people attending A&E services after failing to receive any practical advice from NHS111.
Ongoing Themes	In Q1 we continued to hear that people: • Have issues with GP appointments; this includes problems using telephone appointment systems and waiting too long for appointments. • Have difficulties registering to a GP. • Struggle to find and access dental services as well as concerns over the cost of dental treatment services.

Primary Care	
What are we doing?	• We currently sit on the GP Patient Survey Steering Group. We will be working with IPSO Mori to promote the findings and use of the survey due for publication in early Aug 2018. • Due to the volume of feedback we receive on this area, we undertaking more in-depth analysis at a local and regional level.
External Opportunities	• One of the main aims of the GP Forward View is to increase the number of appointments made available to patients at evening and weekends as part of general drive towards 7 day services. It also sets a clear ambition to increase the use of online booking systems to make things more convenient. • However, our evidence suggests that two years in to the GP Forward view these initiatives are not yet substantially changing the feedback we receive from people about their experiences of accessing the GP. • There is therefore an opportunity to map the evidence we gather against the national statistics on access to help provide a more detailed view on progress from the patient perspective.
	• There is an opportunity to raise this analysis directly with NHS England and also the Regulation of General Practice Programme Board which has prioritised 'access' as a key issue for 2018/19. • There is also an opportunity for us to raise the profile of challenges faced by those not registered with a GP – e.g. homeless people, migrants, students. The experience of these groups is not picked up by the GP patient survey as this only covers those registered. Therefore this is a gap in current system insight.
Internal next steps	• We will be using the large volume of feedback we receive to identify regional variation in people's experiences of GP services comparing against our previous findings on Primary Care. We will also be looking at what works highlighting initiatives that have generated positive experiences for patients. • We will review feedback on NHS111 to identify any geographical variation and correlation between providers of the NHS111 service.

Secondary Care

Secondary Care	
Emerging Themes	In Q1 we received increased levels of feedback on the following area: • Access to British Sign Language (BSL) interpreters. People told us that services put the responsibility on the patient to get an interpreter. This information is sometimes only given to patients when they arrive for appointments.
Ongoing Themes	In Q1 we continued to hear that people: • Wait over 4 hours in A&E before receiving any urgent care or treatment and wait up to 11 months to receive non-urgent hospital appointments. • Generally recognise that hospital staff are very busy but could show more empathy towards patients.
What are we doing?	• Insight on A&E shared with DHSC cross system insight group – multiple references to our findings made in final report in understanding pressures on system. • Emergency readmissions work resulted in DHSC/NHSE agreeing to publish this data again. Since this agreement the National Audit Office, the Public Accounts Committee and Quality Watch (joint initiative by the Health Foundation and Nuffield Trust) have all referenced our work and the need to address the data issue as a priority. A roundtable has now been called with key players for July.
External Opportunities	• Develop insight on people's views on waiting times. This would enable us to build on our suggestion in the NHS Mandate that current waiting time targets don't tell the full story of what it is like to be a patient. This insight should be developed ahead of the winter period to enable the organisation to engage effectively in the winter pressures debate and focus attention on what matters most to people. • The CQC's Local System Review has been supported and promoted by Healthwatch over the last 12 months to encourage a move away from focus on DTOC and for whole systems to look more at patient flow to review performance. The final report was published in July but the CQC is looking to extend. We will continue to work with local Healthwatch to support the development of this approach.
Internal Next Steps	• We will be looking at how the feedback about empathy towards patients in hospitals has changed over time.

Social Care

Social Care	
Emerging Themes	In Q1 we received increased levels of feedback on the following area: • Requests for information about social care services, particularly questions about assessments, access to care at home, care home entry and equipment services.[1]
Ongoing Themes	In Q1 we continued to hear that people: • Have issues accessing appropriate home care services that are reliable and where adequate time is allowed. • Find significant variation in the quality of care delivered across care home.
What are we doing?	• Healthwatch England National Director is acting as an independent advisor on the Social Care Green Paper. • Meeting with Minister of State for Care, Caroline Dinenage MP highlighting the poor level of information available when seeking care. • Conducted primary research to explore people's needs and wants around social care and shared with DHSC and other key stakeholders. • We have provided feedback to the CMA on their guidance around care homes. We were broadly supportive of the guidance and our comments focused on implementation and consistency of application. • On schedule to publish the 'single complaints statement' for social care developed in partnership with the LGO. This is part of the Quality Matters Initiative.
External Opportunities	• The Green Paper has been moved back from July to align with the publication of the NHS long term plan, likely to be November. This means we may well need to factor in additional research activity on the proposals for Q3 and Q4. • Continue to work with DHSC to discuss their upcoming feedback strategy for health and social care. Our contribution to include review of current provision of complaints advocacy in social care and the extent to which the social care system is learning from complaints.
Internal Next Steps	• As part of the wider strategy we are continuing to look at what types of information people are requesting to help improve our signposting services.

Mental Health

[1] 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.

Mental Health	
Emerging Themes	In Q1 we received increased levels of feedback on the following area: • IAPT service and predominantly about the limited number of sessions offered. People felt this was not enough and had to start the whole referral process again to get further support.
Ongoing Themes	In Q1 we continued to hear that: • Children and young persons are still facing problems gaining access to timely support from Child and Adolescent Mental Health Services (CAMHS). • Adults also face long waiting times to access help and are seeking alternative support mechanisms whilst they wait.
Policy Context	• On 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.
What are we doing?	• We have conducted a scoping of the patient experience we have received, literature review and focus groups to determine the areas we want to work on as part of the Mental Health Work Programme. • We plan to publish content on this initial phase of work in the forthcoming months. • We have started working on two specific areas of mental health support, maternity and mental health and support for people transitioning from childhood to adulthood.
External Opportunities	• Stakeholders are increasingly interested in using user feedback to inform service change in this area, in particular to test out whether or not the Mental Health Forward View is achieving the outcomes intended. • On maternity and mental health we understand there is significant new investment in this area which aims to see new services implemented by March 2019. This provides a useful context for our findings to help highlight how effective these services are meeting people's needs. • On CAMHS specifically the CQC is launching a campaign in October to push for young people to share their experiences with services to help them improve. This could provide an opportunity for us to join forces and support the wider work around transition. • Having reviewed the evidence gathered by local Healthwatch since January 2016 (engagement with over 35,000 people) there are also opportunities to share content on a broader range of mental health topics. The focus here will be on sharing insights which add something new to the mental health policy debate.

Mental Health	
Internal Next Steps	• We are using criteria developed with the Healthwatch England Mental Health Programme Steering Group to prioritise further areas for work as part of this work programme.

Protected Characteristics - Dementia in Older People	
Key Themes	4% of our feedback over the last two years has related to support for those with dementia. The following key themes have been identified in this feedback: • Access to information remains a key concern for carers looking after those with dementia with carers frequently enquiring about the support available. • Care pathways for those with dementia can sometimes feel unclear, confusing and unrealistic. • Greater awareness is need of how to keep those with dementia active in the community for as long as possible.
Internal Next Steps	• We will review the feedback we have received to update on the state of dementia care and awareness following on from the report released in Jan 2017.

Under Represented Groups - Homelessness	
Homelessness	In the last quarter we have heard from 543 persons about health and social care support for the homeless community. The following key themes have been identified in this feedback: • Access to health services is impeded by factors around homelessness such as lack of address, lack of identification and chaotic lifestyle • The homeless population face particular challenges registering with a GP. • Services do not understand challenges of being homeless and were unable to give holistic support.
Internal Next Steps	• We will be work to understand experiences of vulnerably-housed and homeless people using health and care services with an initial focus on primary care.

Where does our data come from?

Healthwatch England is able to provide 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 Q1, we received 168 publications from 68 local Healthwatch involving 23,167 people. A third of these reports (34%) relate to social care, all were about 'Enter and View' visits to Care Homes.

FIGURE 1. VOLUME OF HEALTHWATCH INSIGHT COLLECTED IN Q1 2018/19 (compared to 2017/18 averages)

	Number of LHW Reports	% of LHW Reports	% LHW Reports (Q1 17/18)	Number of Individual Feedback	% of Individual Feedback	% of Individual Feedback (Q1 17/18)
Primary Care	41	25%	12%	1537	42%	37%
Secondary Care	23	14%	13%	1131	31%	27%
Social Care	55	34%	40%	388	11%	10%
Mental Health	13	8%	8%	166	5%	3%
Other Care	26	16%	26%	425	12%	5%

Please note: Some reports/individual pieces of feedback cross multiple service areas.

We received 3,647 individual pieces of feedback from 48 local Healthwatch. The same quarter last year we received 1,092 individual pieces of feedback. This is the most feedback we have received through the CRM for any quarter. This increase appears to be a result of the 48 Healthwatch using the CRM more regularly to capture feedback.

Overall, almost half (42%) of our feedback 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.

What are people asking us about?

In Q1, Healthwatch received 532 requests for information as identified through the individual feedback collected by 36 Local Healthwatch and passed to Healthwatch England. However, this data is skewed with almost two thirds (57.7%) of this information originating from Healthwatch Essex. For this reason, the Intelligence and Digital Team are working with the network to understand how they are using the CRM to capture signposting and requests for information as part of the Healthwatch strategy.

Over a quarter (26.5%) of the requests relate to social care, in particular:

A third of these requests were made on behalf of a relative, friend or person cared for and over a quarter (26.5%) of the requests relates 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

Many queries (13.5%) related to care at home specifically:

4. How to get care/help at home
5. How to get needs assessments and equipment
6. What services are available once discharged from hospital

A further quarter (24%) of requests was 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 (see GP section for further information).

What are people telling us about Primary Care?[2]

During the last quarter, 41 local Healthwatch reports were published covering primary care involving the views of 10,070 people. In addition, we received 1,537 individual pieces of feedback from members of the public about primary care through the Healthwatch network. This accounts for 42% of the all individual feedback received.

Over the last year we have seen an increase in the proportion of our feedback relating to primary care. During the same quarter last year (Q1 17/18), primary care accounted for 32% of all individual feedback received.

General Practice

We have received 38 reports from local Healthwatch including feedback from 7,138 people about GP services. In addition, we received 1,250 individual pieces of feedback about GP services which accounts for around a third (34.3%) of our individual feedback received by Healthwatch England.

The following emerging theme has been identified across this feedback:

Emerging Theme - Medication issues

This quarter we have started to hear more about people who are having issues with prescriptions of medication from their GP. Particularly people who have long-term conditions

[2] The following services are included in the primary care category; General Practice, Dentistry, Pharmacy, NHS 111 and Opticians. The majority (81%) of our primary care feedback relates to GP services.

and need to take regular medication are having issues with their repeat prescriptions not being on time. Others have raised issues with doctors changing the medication they are prescribed or refusing to prescribe them a particular medication.

The following ongoing themes have been identified across this feedback:

People struggle to make appointments with a GP

In Q1, we have continued to hear about the difficulties in being able to get a GP appointment. Over a half of the negative feedback we receive relating to GPs is around issues with booking appointments, particularly via the telephone appointment system.

People want to know how to register to a GP

Almost a quarter of feedback we receive relating to GPs are concerns about how to register with a GP for those who have recently moved to a new area. Other people have told us they have difficulties due to not meeting catchment area regulations, or in some cases due to practices merging which requires people to re-register.

People want to see the same GP

We have continued to hear that people see a different doctor every time they visit their GP surgery. People feel it's important to see the same GP to build up patient/doctor relationship.

Case Study

Healthwatch Cornwall: "Rang the surgery recently, line was engaged. Can't even get through to the waiting queue. Finally got through and was told would get a call back. Two hours later called back but have had to wait 5 hours once for an urgent appointment. Did get an appointment for same day but never get to see same doctor - always have to explain situation and sometimes see the nurse who then has to see doctor. Need more doctors and staff to manage ever-growing population."

Other Primary Care

In the quarter, we received 8 reports from local Healthwatch about other primary care services notably dentistry and pharmacy, which involved feedback from around 3,718 people.

In addition, we received 287 individual pieces of feedback from members of the public through the Healthwatch network, the majority of which related to dental services. The feedback was largely (43%) positive, relating to the excellent service received, especially at opticians. We identified the following themes from this feedback:

The following emerging theme has been identified across this feedback:

Emerging Theme - People turn back to A&E after an unhelpful NHS 111 experience

Whilst some people reported good experiences of the NHS 111 service, many people have told us that NHS 111 can be an unhelpful and sometimes unnecessary process, with long waits for a

call back to speak to a doctor or to get an appointment somewhere. People want to avoid using urgent and emergency services or GP services when they recognise it may not be necessary however, NHS 111 is not consistently meeting people's needs so people end up using these services in the end.

Case Study

Healthwatch Wakefield: "NHS 111 - Not very impressed if I am being honest. I fell at home and hurt myself so I phoned 111. But to be honest they weren't very helpful at all. Ended up having to phone 999 and get paramedics out in the end. They, by the way were fantastic and very helpful and got me to A&E quickly, safely and they treated me very well indeed."

The following ongoing themes have been identified across this feedback:

Getting an appointment with a dentist

We continue to hear from people struggling to find and register with a dentist particularly those who take on NHS patients. People also told us they can't always find a dentist that can offer them immediate dental treatment in emergencies.

Disputes and confusion over the cost of dental treatment

Much of our negative feedback about dental services relates to the lack of clarity around payments for treatments and whether treatment is covered on the NHS or not. People feel that their dentist could be clearer when explaining dental costs, especially if they need further treatment.

What are we doing?

As of March 2018, we now have a seat on the GP Patient Survey Steering Group – attended by the Head of Intelligence. We will be working with IPSOS Mori to promote the findings and use of the survey due for publication in early Aug 2018.

There is also an opportunity for us to raise the profile of challenges faced by those not registered with a GP – e.g. homeless people, migrants, students. The experience of these groups is not picked up by the GP patient survey as this only covers those registered. Therefore this is a gap in current system insight.

There is also an opportunity for us to draw together two recent bits of work by the General Medical Council and the CQC that could help promote the value of GPs gathering feedback from their patients. As part of their review of revalidation the GMC stressed the importance of GPs using feedback to support professional development and CQC in their review of Primary Care found that the practices that prioritised patient feedback were more likely to found 'outstanding'. We could look to push this general message through partnership with the Royal College of GPs and encourage GPs to work with local Healthwatch to find ways of making the most out of patient feedback.

Due to the volume of feedback we receive on this area, we will be using the large volume of feedback we receive to identify regional variation in people's experiences of GP services

comparing against our previous findings on Primary Care. We will also be looking at what works highlighting initiatives that have generated positive experiences for patients.

We will also be reviewing feedback on NHS111 to identify any geographical variation and correlation between providers of the NHS111 service.

What are people telling us about Secondary Care?[3]

A&E and Urgent Care

Local Healthwatch have produced 8 reports about A&E departments during the last quarter involving the views of 1191 people. We also received 134 pieces of individual feedback from members of the public relating to A&E departments. This represents 3.7% of all individual feedback received. We identified the following themes from this feedback.

The following ongoing themes have been identified across this feedback:

Organisation and staffing is hit or miss

Feedback about staff remains one of the key themes of this information. In general, people recognise the pressures of hospitals in A&E and urgent care however people felt that staff didn't work well together and did not necessarily show enough empathy towards the patient.

Still waiting to be seen in A&E

In this quarter, we continued to hear about people waiting between 5 to 12 hours in A&E (~32%) before receiving treatment. We also heard a few cases of people waiting for hours for an ambulance.

Case Study - When it goes well

Healthwatch Wakefield: "My wife had breathing difficulties at night which had gotten worse so we too her to the A&E department at Pontefract. What can I say other than they were fantastic. They saw to her almost immediately without delay and had her triaged and with a doctor in no time. That doctor was superb, checked her thoroughly and spent time assessing and treating her. Everyone made her feel better and calmer thus helping her breathing. The care and attention she received by the staff was great. Brilliant example of an excellent NHS."

What are we doing?

We recommend 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

[3] The following services are included in the primary care category; General Practice, Dentistry, Pharmacy, NHS 111 and Opticians. The majority (81%) of our primary care feedback relates to GP services.

In Q1, we received 20 reports from the local Healthwatch network about hospitals involving the views of 2,714 persons. In addition, we received 998 individual pieces of feedback covering 50 hospital services which made up just under a quarter (27.3%) of the total feedback.

This quarter we've heard less about delays in discharge, though we continue to receive a lot of feedback about quality of care, appointments, and access to services. Generally feedback about hospitals is mixed with 39% negative feedback, 31% positive and the rest being mixed.

The following emerging theme has been identified across this feedback:

Emerging Theme – Lack of BSL interpreters and blue badge parking

In this quarter we heard of problems with blue badge parking which delayed patients' attendance at their appointment. We also heard about problems with accessing British Sign Language (Interpreters) during appointments making it impossible for some deaf people to communicate effectively. On some occasions we heard that patients were to organise their own BSL interpreter.

The following ongoing themes have been identified across this feedback:

Patients have concerns about follow up care.

Whilst we heard positive experience about care in hospital people had more trouble receiving follow up care from GPs due to long waits and a perceived lack of empathy. We heard specifically about the level of care given to elderly parents and felt they weren't always as informed as they should have been.

Appointments running to time

We heard more positive comments about hospital appointments in this quarter than we have heard previously, with fewer people having to wait on arrival. Most people felt pleased with the level of care provided during appointments.

Long waiting times for consultant appointments

Waiting times to see consultants or have operations continue to be a negative barrier to services; we've heard people waiting up to 11 months for 'urgent' appointments and left without information on what to do in the waiting period.

Case Studies

Healthwatch Cornwall: "After my operation I was never seen by surgeon. I saw a registrar post-op for a couple of weeks before being signed off. I was expecting a few weeks of recovery or pain but it went into months. I am still experiencing increasing pain. I went to the GP, who managed to get one further appointment at the hospital. No follow up appointments offered. I then had a recent test for cancer, unfortunately positive. I saw a consultant whose attitude was difficult, lacking in people skills. I'm a carer, so I need to plan ahead. The consultant again had an abrupt and tactless manner, lack of empathy, as if I am expected to know what to do."

What are we doing?

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.

We will be looking at how the feedback about empathy towards patients in hospitals has changed over time.

What are people telling us about Social Care?[4]

During the last quarter, 55 local Healthwatch reports were published on services relating to social care capturing the views of 1,350 people. This included 48 Enter and View reports on Care Homes, which have been mostly positive.

We also received 388 pieces of individual feedback from members of the public through the Healthwatch network, representing 11% 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 equipment services.

We identified the following emerging theme from our feedback:

Emerging Theme: Increase in requests for information about equipment services

In this quarter, we had more request for information about equipment and related services including incontinence pads, wheelchairs and home adjustments being the main types of equipment needed. We also continue to receive questions about social care assessments and people wanting to set up carers to help with elderly family.

We identified the following ongoing themes from our feedback:

Lack of consistent and accessible information about care at home services

Continuing from the report we published on domiciliary care last year, we have had high levels of feedback about care at home. People still tell us they have trouble accessing the most appropriate home care services, with some people needing help to set this up for themselves or a family member.

Unreliable staff and care at home appointments rushed due to demand

Most people receiving care at home want to build relationships with their carers but due to care staff having many patients appointments are often rushed or carers do not turn up. This also impacts on those who have time sensitive needs such as medication.

[4] The following services are included in the primary care category; General Practice, Dentistry, Pharmacy, NHS 111 and Opticians. The majority (81%) of our primary care feedback relates to GP services.

Case Studies

Healthwatch Birmingham: "The individual attends a support group every eight weeks and normally a carer attends with him. However, today they told me last minute that my carer is not able to come with me as she is attending training. They only told me this about an hour before I had to travel and this made me feel very anxious, upset and stressed. I was devastated. I would have liked to know in advance so I could have prepared myself better to travel on my own. I don't want this to happen ever again. I am serious about this as it made me feel very stressed. I want you to tell them because if I do, they might not respect me. I am very happy living at this care home as I have been living here for many years. I definitely do not want to move as I want to stay local. I just want them to know how this incident affected me."

Poor staffing limiting the quality of care provided for resident

We have received more positive feedback about care homes in this quarter. However, we have also heard of people not receiving adequate care in care home – for example one elderly woman with dementia was severely dehydrated and went to hospital as a result. Another person said that their sister who has learning disabilities was not taken for her appointments and finds the staff to be rude.

What are we doing?

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.

As part of this work we had a positive meeting with the Minister of State for Care, 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.

Following this session we commissioned further research to help inform the development of the Green Paper.

We conducted two deliberative focus groups sessions and some national polling activity to explore people's needs/wants around social care. We have shared our insights from these events and from public polling we conducted with the DHSC, as well as a range of other stakeholders from across the sector.

The key finding from this work was that there is a lack of a trusted independent information and advice to support people to plan for their social care. We highlighted the fact that this lack of trusted information was often a barrier to effective planning, and we suggested that a consistent, independent and trustworthy information and advice service was developed to support people to understand and make the right decisions about their social care.

The green paper was initially due for publication in the summer; however the Department for Health and Social Care (DHSC) have since announced that publication will be delayed to align with the NHS long-term plan – likely to be November.

In addition to activity around the Green Paper we have also continued to push around Healthwatch England's long term policy ask for better support for those wanting to complain about social care services.

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.

The CMA have since developed draft guidance for care homes to comply with consumer law, we submitted a response to the consultation that was broadly positive, though made a range of suggestions about the guidance could be implemented and communicated more effectively.

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.

In the June the DHSC published the Carer's Action Plan, which sets out a series of practical policy initiatives to improve the lives of carers. We have conducted research into issues faced by carers, looking at feedback local Healthwatch have received from carers, we also gathered information from councils about waiting times for carer's assessments and analysed secondary data. We will be publishing these findings later this year.

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.

What are people telling us about Mental Health?

We received 13 reports involving the views of 1008 people on mental health services, on topics ranging from acupuncture efficacy to crisis services. In addition, we have received 166 pieces of feedback about mental health. We identified the following themes from this feedback:

From the feedback we have identified the following emerging theme.

Emerging Theme: Variations in waiting times and number of sessions

In this quarter, we've heard more about IAPT Services than previously with 35 people talking about these services. We hear about variation between services available. For example, we heard one person was promptly given six months of one-to-one support which they found really helpful and another person was told to wait three months for four counselling sessions. It is unclear as to why these variations occur. A number of people wanted to get more than their allotted sessions and had to wait three months after their sessions to self-refer again.

Case Studies

Healthwatch Kent "Another Carer was referred to Think Action (IAPT) by Carers' Support. She really benefited from the service, but was told that they could only offer 8 sessions at a time and so she waited the 3 months and then re-referred herself each time. She had not long been receiving support when she took an overdose with the intention of ending her life, but she did not take enough. She spoke about this to her Counsellor, but she was still told that they can only offer 8 sessions at a time. During one of the 3 month gaps she experienced extreme suicidal thoughts again and came to Carers Support and told staff that she wanted to jump in front of a train. We referred her to Single Point of Access who assessed her and she is now under the care of Coleman House. She has a history of self-harm and extreme anxiety with regular panic attacks. She also has a long term physical health condition."

Still no straightforward pathway for young people…

We continue to hear about problems with diagnosis and subsequent support from CAMHS. Young people and their parents/carers often tell us they have struggled to access services due to waiting times for diagnosis and unclear care pathways for young people.

…or adults waiting for support

We have heard that because of the long waiting times for appointments with mental health services, adults are seeking alternative routes of help and support mechanisms for their mental health between appointments.

What are we doing?

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 MH 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.

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.

We have conducted a scoping of the patient experience we have received which has identified a number of areas of focus. We are using criteria developed with the Healthwatch England Committee to prioritise these areas and provide the onward direction of the Mental Health work programme. Further areas of focus may be identified throughout the work programme.

A literature review and focus groups have been undertaken, the findings from which will be overlaid on the patient experience outlined above to identify any potential opportunities for

additional research work. We plan to publish content on this initial phase of work in the forthcoming months.

We have started working on two specific areas of mental health support, maternal mental health and transitioning from childhood to adulthood.

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.

What are people telling us about protected characteristics and seldom heard groups?

Protected Characteristics

In the quarter we have received 29 local Healthwatch reports involving the views of 8840 persons that specifically look at health and social care issues of specific protected characteristics. In addition, we received 303 pieces of individual feedback where protected characteristics were specified in full. This means that no protected characteristic detail was recorded for 1973 pieces of feedback.

Older persons – Dementia

We continue to hear significant levels of feedback about dementia. In the last two years we have heard from 2582 people who live with dementia or carers; feedback about dementia support accounted 4% of our data last year. The key themes across this feedback are as follows:

- **Information provision remains a key concern** for many people, especially carers. People have told us there is not enough information that can be easily accessed, especially after they have been diagnosed.
- **Consistently available support** remains a key theme especially with services in the community. We've heard that care pathways can feel unrealistic and unsupportive, with professionals not always communicating in a clear way. Services don't work together as well as they could.
- **Greater awareness of dementia** is needed and on how to keep people with the condition active in the community for as long as possible.
- **Family Carers are increasingly asking for support**. Up to 76% of our unsolicited feedback on dementia comes from carers, which indicates that carers continue to struggle to get the information they need to care effectively. A full briefing can be found here.

What are we doing?

We will be reviewing the feedback we have received to update on the state of dementia care and awareness following on from the Healthwatch England report published in Jan 2017. This will include what has changed and what still needs to be done.

Under-represented Groups

In the last quarter we have received 7 local Healthwatch reports involving the views of 526 persons from the homeless community. We have been able to identify 17 individual pieces of feedback that concern members of under-represented groups. This feedback highlighted two key areas of interest that have been

Under-represented Groups - Homelessness

One area we have started to hear more about is health and social care needs of homeless community. In the last two years we have heard from 886 people shared their views on health and social care for this community. The key themes across this feedback are as follows:

- **Access to health services** is impeded by factors around homelessness such as lack of address, lack of identification, lack of phone credit, and chaotic lifestyle which can make it hard to attend appointments or follow health advice.
- **Registration with GP services** in particular has been a challenge with at least 5 local Healthwatch reporting on this; there appears to be variation in whether someone can register without a fixed address.
- Services didn't truly understand challenges of being homeless and were **unable to give holistic support**. People need to feel understood by professionals and be able to get help with housing, their health, and work all together in one place.

What are we doing?

We will be undertaking development work to understand experiences of vulnerably-housed and homeless people using health and care services. This development work will focus initially on primary care subsequently extending to other service areas in line with stakeholder focus.

There is opportunity to build the local Healthwatch network into this development to help identify regional variation in services and potential solutions that could be applied on a wider national basis. Part of this work may involve identifying where Healthwatch could signpost and raise awareness of services that can help the homeless population.

AGENDA ITEM No: 2.1

AGENDA ITEM: Updated Standing Orders and Accountability Framework

PRESENTING: Jane Mordue

EXECUTIVE SUMMARY: This paper includes updated versions of our Standing Orders and Accountability Framework

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

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 sub-committee 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[5]

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

[5] 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.

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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[6]

9.1 Register of Interests

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

[6] The Policy on Registering Interests is available in full as a separate annex to this document.

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 ENGLANDACCOUNTABILITY 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.[7] 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

[7] 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

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;
- 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[8]

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 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;

[8] The HWE Members' Code of Conduct is included in the HWE Standing Orders

- 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.

3.3.5 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 RESPONSIBLITIES[9]

4.1 Annual Report and accounts

[9] 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

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 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 polices 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)

AGENDA ITEM No: 2.2

AGENDA ITEM: Dates for 2019

PRESENTING: Jane Mordue

EXECUTIVE SUMMARY: This paper includes suggested Committee dates for 2019

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

Dates for 2019

CQC Board	16-Jan	20-Feb	20-Mar	24-Apr	15-May	19-Jun
Committee Workshop	10-Apr	10-Jul	09-Oct			
Public Committee	5 & 6 Feb	13 & 14 May	30 & 31 Jul	5 & 6 Nov		
Leadership Meeting	16-Jan	19-Feb	19-Mar	17-Apr	21-May	18-Jun
AFRSC	24-Jan	30-Apr	19-Jul	18-Oct		

CQC Board	17-Jul	18-Sep	16-Oct	20-Nov	18-Dec	
Committee Workshop						
Public Committee						
Leadership Meeting	17-Jul	20-Aug	17-Sep	16-Oct	19-Nov	17-Dec
AFRSC						

End of public session papers