Healthwatch England 24 October 2018
Meeting #25
Public Meeting Agenda

11.15-14.00 – Public Committee Meeting Agenda		
1.1 Presentation from Healthwatch Bristol	Morgan Daly	(30 min)
1.2 Welcome and apologies	SRF	To open the meeting
1.3 Declarations of interests	SRF	Committee Members
1.4 Minutes of the last meeting, action log, review of agenda and matters arising Appendix 1 – Action 38	SRF	To confirm the minutes and discuss the matters arising
1.5 Chair's Report	SRF	Verbal - for discussion
1.6 National Director's Report	IR	For discussion
1.7 Q2 Delivery and Performance Report including half year finance	IR	For discussion
1.8 Committee Members Update	Committee	Verbal - For discussion
1.9 Audit, Finance and Risk Sub Committee Meeting Minutes	DO	For discussion
2.0 Intelligence and Policy Report Q2	AMR	For discussion
2.1 Integrated communications and public affairs strategy	NT/IR	For APPROVAL
2.2 Standing Orders	SRF	For APPROVAL
2.3 Equality, Diversity and Human Rights (EDHR) Policy Update	IR	For APPROVAL
2.4 Forward Plan	SRF	For discussion
Questions from the public		

MEETING REFERENCE: CM181024
AGENDA ITEM: 1.4

AGENDA ITEM: Minutes and Actions from Previous Committee Meeting

PRESENTING: Sir Robert Francis

PREVIOUS DECISION: N/A

EXECUTIVE SUMMARY: This report updates the Committee on the minutes and actions from the previous Committee meeting – 01/08/2018

RECOMMENDATIONS: Committee Members are asked to **APPROVE** the minutes

Minutes of meeting No. 24
Location: 151 Buckingham Palace Road, London

Date: Wednesday 1 August 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
- Helen Horne - Committee Member and Chair of Healthwatch Cumbria
- Helen Parker – Committee Member
- Lee Adams – Committee Member
- Liz Sayce – Committee Member
- Ruchir Rodrigues – Committee Member

Apologies

- Phil Huggon – Committee Member

In attendance

- Imelda Redmond –National Director
- Neil Tester – Deputy Director
- Joanne Crossley - Head of Operations
- Jacob Lant – Head of Policy & Partnerships
- Amie McWilliam-Reynolds – Head of Intelligence and Analytics
- Leanne Crabb – Committee Secretary (minute taker)

	Introduction	Action
1.1	**Agenda Item 1.1 – Presentation from Healthwatch Camden** Frances Hasler, the Director of Healthwatch Camden talked about how Healthwatch Camden coordinated work with five local Healthwatch organisations: Barnet; Camden; Enfield; Haringey and Islington to help residents have a say in plans for urgent and emergency care in North London. More information about the project can be found HERE The presentation was very well received by the Committee. Liz Sayce commented that she was pleased to see the presentation reiterate that Healthwatch is not the citizen's voice, but a channel to it. Others commented that the presentation was brilliant, especially highlighting barriers. Imelda Redmond voiced that it really shows how important shared values are to achieving success.	
1.2	**Agenda Item 1.2 – Welcome and Apologies** Jane Mordue welcomed everyone to the meeting and thanked Frances Hasler for giving her excellent presentation. Apologies received from Phil Huggon.	
1.3	**Agenda Item 1.3** – Declaration of Interests Liz Sayce is the Chair of the Commission of Mental Health Equality – Mental health is discussed in agenda item 1.4 under Matters Arising.	
1.4 Action 3 Action 7.1	**Agenda Item 1.4** – Minutes from April 2018 Committee Meeting The Committee **APPROVED** the minutes. **Matters Arising:** Equality, Diversity and Human Rights (EDHR) statement: Imelda Redmond said that the EDHR statement will come to the next meeting and that implementation is integrated in to all our work plans. Liz Sayce requested it be noted that new members have joined the Mental Health Research Project and that prevention be part of the ongoing discussion - Action 7.1 has been amended to reflect this. **Actions** 1.41 - IR to bring EDHR statement to the next meeting	IR LC
1.5	**Agenda Item 1.5** – Chair's Report Jane Mordue introduced the Chair's Report. She highlighted: issues facing the network; mental health; and the June Committee workshop which looked at strengths and skills. The Committee **NOTED** the report.	

1.6	**Agenda Item 1.6** – National Director's Report Imelda Redmond introduced the paper. She highlighted the conference update noting that it is on track. She attended the East of England Healthwatch conference with a format of 50% of the day spent working with each other and sharing information. She also visited Brighton and Hove local Healthwatch. She commented that they work very hard on building strategic relationships which enables them to do hard challenges. Imelda Redmond announced that the new Healthwatch England website is now live and has much better capabilities and we are building content. Imelda Redmond advised that the Healthwatch #itstartswithyou campaign reached two million people. She highlighted the work done on the NHS Mandate and how we hold the NHS to account. She also advised that the timescales have changed for the Green Paper on social care and it is likely to come out in October. Helen Horne asked of there would be an advisory group formed regarding social care. Imelda Redmond responded that yes, we go out to the network to find people interested in the topic and they then advise her in advance of meetings. Liz Sayce asked about the metric for engagement in the NHS mandate and questioned how useful it was. Imelda Redmond responded that a lot of work went in to achieving this and we want it to go further. A general discussion took place regarding funding of the network exploring if more could be done and are we prioritizing the biggest risks. Gavin McGregor responded that there is comprehensive analysis of the biggest risk factors and we are in communications with local Healthwatch and local authorities on a regular basis and we have dedicated resources to help local Healthwatch wit commissioning. Helen Parker asked whether, as part of its work on the engagement literature review, Plymouth University would be able to help provide a detailed picture, through individual contact with Healthwatch, of the impact they were having through engagement work. Neil Tester responded that we would be helping to steer the reviewers in the direction of examples to explore further and that he would discuss where and how contact with some individual Healthwatch might fit into their methodology. Helen Parker then questioned whether we need to reprioritise this year's work. Imelda Redmond responded that she has asked the Leadership Team to reevaluate the workload. She also stated that the Committee needed to prioritise what they are asking Healthwatch England to do. Ruchir Rodrigues asked for assurance that we are compliant with data protection. Imelda Redmond confirmed that we are compliant. Jane Mordue asked for an update on the NHS 70 conversation. Neil Tester responded that for the NHS 70 conversation there are 30 core partners helping us plus many more are interested. He added that the focus for long term health and social care was: • Opportunities and challenges for data and technology • Roles, relationships and responsibilities • Will the needs be the same He also stated that in September and October we will be working on these strands and will be promoting them. The Committee **NOTED** the report.	

1.7	**Agenda Item 1.7 –** Committee Members Update Lee Adams advised that she attended a meeting with Care Opinion alongside Neil Tester and Jacob Lant. She added Care Opinion take consumer opinions and have a lot in common with Healthwatch and it would be good to work with them in the future. Lee Adams also advised the Committee that she chaired a roundtable meeting for national players on readmissions to hospitals. She noted the meeting was lively and interesting and ranged beyond readmissions and went in to how our data, which shows readmissions is escalating, disagrees with the NHS data. She added that the discussion ended up in a whole system approach and included leadership and governance. Helen Horne also attended. Helen Horne stated that she has been to a board meeting of Lancaster University's Health Innovation Campus and that they are using a population based approach.	
1.8	**Agenda Item 1.8 –** Delivery and Performance Report Imelda Redmond introduced the paper. She explained that the Programme Management Framework contains six programmes and each of them contains lots of work. She explained that we are all on track for delivery at the end of Q1. Liz Sayce commented that she liked the paper and especially the dials. She also asked why the KPIs that have not been started yet are green and asked that they be changed to white. Danielle Oum stated that she liked the paper and the ratings fitted well. Ruchir Rodrigues added that he liked the granularity. The Committee **NOTED** the report **<u>Actions</u>** 1.81 - JC to change unknowns on KPI report to white instead of green 1.82 – JC to add a simple appendix to show what outcomes we are trying to achieve by achieving our KPIs	JC JC
1.9	**Agenda Item 1.9** – Audit, Finance and Risk Sub Committee (AFRSC) Helen Parker introduced the paper. She noted that it was presenting figures from Q1 and we are on track. She added that recruitment is a little behind but ways are being looked at to fill the gaps temporarily. She also stated that there has been procurement of training for local Healthwatch and Healthwatch England and the Performance Framework is being looked at to ensure procurement requests are put in early. Helen Parker advised the Committee that the Programme Management report would go to each AFRSC meeting to help keep focus on it but will still come to the full Committee to keep them updated. The Committee **NOTED** the report.	
2.0	**Agenda Item 2.0 –** Intelligence Report Q1 Amie McWilliam-Reynolds introduced the paper. She highlighted that nearly half the feedback from the public are regarding primary care, especially GP appointments, and they are looking at regional information and especially at positive sentiment. She added that they are also linking this information to people who are homeless. Lee Adams commented that the report was very adult focused. Amie McWilliam-Reynolds responded that we get the largest amount of feedback from people over the age of fifty and not much for children. Imelda Redmond added that there is lots of network work taking place with young people and we would not expect individual feedback from this age bracket. Helen Horne raised the issue that we are getting a lot of reports about issues with GPs and appointments and asked where do we take it and how do we use it. Jacob Lant	AMR

	responded that it is a well-known issue and this is an opportunity to influence thinking if GP contracts are reviewed. He added that we can add to the conversation around what access people want and how can we get things redesigned so people can easily access advice for social care without feeling the need to ask their GP. Liz Sayce commented that the structure of the report was good. She added that she didn't like the term 'case study' as we are about the voice. It was agreed that should be changed. Danielle Oum raised the point that it was unclear how much work was being done across the network regarding personal budgets. She suggested contacting Andy Cave, CEO of Healthwatch Birmingham as his team are looking at this. Jane Mordue asked how the Research Helpdesk is going. Amie McWilliam-Reynolds responded that there has been a slight increase in use but the turnover of the network staff is high so they are continually promote the helpdesk to remind network staff of its existence. The Committee **NOTED** the report. **Actions** 2.01 – AMR to change the words 'case study' 2.02 – JL to liaise with Andy Cave to go out to the network asking what work is being done regarding personal budgets	JL
2.1	**Agenda Item 2.1 –** Standing Orders Jane Mordue introduced the paper on Standing Orders. It was agreed that all suggested amendments were acceptable. A few new amendments were requested as follows: • Helen Horne suggested that in 6.1.3 of the Standing Orders a three-day timescale for agenda and papers was too short and should be seven days or five working days. • Andrew Barnett recalled that in the original Standing Orders there was a section on behaviours and requested it be reinserted in to the document. • Helen Parker requested a list of reserve matters be included in the Standing Orders document. • Imelda Redmond requested a review date be inserted into the document for two years' time. **Decision** – The Committee requested the paper be brought back to the next Committee meeting including amendments for approval. **Actions** 2.11 - LC to make amendments to document and re-present it at the next Committee meeting	**LC**
2.2	**Agenda Item 2.2 –** Dates for 2019 Jane Mordue introduced the suggested dates for 2019 meetings. The Committee **APPROVED** the dates for 2019.	
	There were no questions from the public.	
	Jane Mordue closed the meeting.	

ACTION LOG

NUM	REF	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 policy presented for Committee approval as item 2.3	October 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.	Communications and public affairs strategy being considered by Committee under item 2.1	October 2018	

9.	CM180425	Imelda Redmond	2.5 CRM reporting to be looked at in a future Committee workshop.	Endeca presentation given at September workshop followed by discussion on how it works with CRM	October 2018	Completed
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.	Partner relationships are developing across the public and voluntary sectors. We will develop plans for formal partnerships for 2019-20 in the light of the Committees decision on the communications and public affairs strategy	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.	Done at September workshop	October 2018	Completed

18.	CM180425	Imelda Redmond	6.3 To consider how to work with RSA's health and wellbeing network		June 2018	completed
19.	CM180425	Gavin McGregor	6.4 Maximise impact from regional meetings		July 2018	Completed
20.	CM180425	Neil Tester	7.1 Give Committee regular briefings regarding the mental health research programme	Committee being updated regularly – Prevention is to be an ongoing part of the discussion. Members of the group are: Liz Sayce – Chair, Imelda Redmond – Project Owner, Jacob Lant – Joint Project Lead, Amie McWilliam-Reynolds – Joint Project Lead, Benedict Knox – Communications Lead, Andrew McCulloch – Committee Member, Helen Parker – Committee Member, Andrew Barnett – Committee Member, Lee Adams – Committee Member, Amy Kroviak – Committee Member	Ongoing	Completed
21.	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	Completed
22.	CM180425	Neil Tester	9.2 Share with HWE Committee media coverage information for local Healthwatch.		June 2018	Completed
23.	CM180425	Neil Tester	9.3 Future Delivery & Performance Report with percentages also include actual figure to help give context.		August 2018	Completed
24.	CM180425	Amie McWilliams-Reynold	9.7 Build a FAQ list from the questions coming into the research helpdesk.		October 2018	Completed
25.	CM180425	Imelda Redmond	9.8 To look at the CRM system and the consistency in its use across the network.	Discussed in September workshop	Sept 2018	Completed
26.	CM180425	Imelda Redmond	10.1		June 2018	Completed

			Timings of future AFRSC and Committee meetings to be looked at to ensure papers can be prepared and sent out in good time.			
27.	CM180425	Imelda Redmond	10.2 To consider giving a member of the AFRSC responsibility for staff personal development.	Helen Parker accepted this responsibility as part of her duties on the AFRSC	December 2018	Completed
28.	CM180425	Imelda Redmond	11.7 To share the HWE intelligence report with the network and Boards of local Healthwatch.	The HWE intelligence report is diarised to be released on Yammer and in the HWE newsletter in July and this will happen on an ongoing basis.	June 2018	Completed
29.	CM180425	Imelda Redmond	12.2 To draft a forward plan for future workshops.		Sept 2018	Completed
30.	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
31.	CM180425	Imelda Redmond	13.1 To speak to AK regarding how media coverage is tracked.		June 2018	Completed
32.	CM180425	Jane Mordue	14.1 Standing Orders Update to be carried over to 1 August Committee meeting.	Added to agenda	August 2018	Completed
33.	CM180425	Imelda Redmond	16.1 To set up a forward plan for future Committee meetings.	Completed – will be brought to all future Committee meetings.	August 2018	Completed
34.	CM180801	Imelda Redmond	1.41 To bring our Equality, Diversity and Human Rights (EDHR) statement to the next meeting	Equality, Diversity and Human Rights (EDHR) statement: Imelda Redmond said that the EDHR statement will come to the next meeting and that implementation is integrated in to all our work plans.	October 2018	Completed
35.	CM180801	Joanne Crossley	1.81 To change unknowns on Programmes report to white instead of green		October 2018	Completed

36.	CM180801	Joanne Crossley	1.82 add a simple appendix to show what outcomes we are trying to achieve by achieving our KPIs		October 2018	**Completed**
37.	CM180801	Amie McWilliam Reynolds	2.01 AMR to change the words 'case study'		October 2018	**Completed**
38.	CM180801	Jacob Lant	2.02 To liaise with Andy Cave to go out to network asking what work is being done regarding personal budgets	A briefing regarding personal budgets has been placed on Yammer so all local Healthwatch can access it as a response to this action after liaising with Andy Cave.	November 2018	**Completed**
39.	CM180801	Leanne Crabb	2.11 To make amendments to Standing Order document and re-present it at the next Committee meeting		October 2018	**Completed**

Appendix 1

Action 38:

38.	CM180801	Jacob Lant	2.02 To liaise with Andy Cave to go out to network asking what work is being done regarding personal budgets	A briefing regarding personal budgets has been placed on Yammer so all local Healthwatch can access it as a response to this action after liaising with Andy Cave.	November 2018

Personal budgets; a briefing for local Healthwatch

What they mean for people and providers

Personal budgets have been used in social care since the mid-1990s. Their use has increased steadily and consistently since then.

They are a key part of the government's aspiration to make care person-centered, and in 2014 the Care Act placed personal budgets into law for the first time, making them the default way in which social care should be funded and planned.[1]

What is a personal budget and how do they work?

A personal budget is the amount of money a council allocates to an individual to meet their identified care needs. A person-centered care plan should then be designed, using the budget to meet a person's care and support needs.

Once the plan is agreed the individual can choose to spend their budget in three distinct ways:

1. **As a direct payment**, this is where the council gives the personal budget directly to the individual. They are then permitted to spend the money themselves to meet their support needs. The councils will review how the direct payment is being spent after six months, and annually thereafter.
2. **As an Individual Service Fund**, this is where the council gives the money to an agreed care provider, they then use the budget to provide tailored services to the person using the service.
3. **As a council managed personal budget**, this is where the council hold on to the personal budget, and manages the individual's care and support on their behalf.

Alternatively, a person could decide to take their personal budget via a mix of these options, for example taking some of their personal budget as a direct payment, but leaving some for the council to manage.

What support is there to help people manage a direct payment?

[1] Department of Health and Social Care, *Care and Support Statutory Guidance*. https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#Chapter12

Following extensive public consultation, the Department of Health and Social Care found that direct payments were the most effective way to support people to achieve the outcomes they want. This recommendation is included in the guidance that accompanies the Care Act.

The Act says that councils should provide people who take a direct payment to manage it and use it effectively. They must provide a universal information and advice service to help people understand the range of care options available in the local area.

Some councils provide brokerage services, often referred to as care navigators. These services provide 'brokers' or 'navigators' whose job it is to help people plan and choose their care.

People who would have *'substantial difficulty'* being involved in their care plan and/or review are entitled to an independent advocate.

Local Healthwatch in action – are people being properly supported to use their personal budget?

Healthwatch Birmingham have recently been doing targeted research in their local area, looking at how effectively personal budgets are being used, and if people using personal budgets are being supported to take control over their care and support, to lead the lives they want to lead.

They decided to start this project following feedback from a local therapeutic gardening centre, who reported that social workers were not allowing personal budget users to access their service, regardless of their assessed need.

In response to these concerns, Healthwatch Birmingham, with the assistance of the Council, are investigating if social workers are properly supporting people to use their personal budgets effectively, and to make their own choices about the care and support they wanted.

They are looking to answer one key question, "Are Birmingham personal budget users being supported to take control over the services they access?"

Feedback that Healthwatch Birmingham has had from personal budget users so far suggests that there is a real lack of informed or supported decision making. They are keen to hear from many more people, and are working with the council to do this, so they can find out more about how well personal budgets are working for local people.

Healthwatch Birmingham will soon publish their report, and present their findings and recommendations for change to their local Health Overview and Scrutiny Committee.

How many people have a personal budget and how to they use them?

Overall the number of people receiving community care services has decreased over recent years.[2] However, the number of people receiving direct payments and/or personal budgets has steadily increased.

During the same timeframe, the number of people using services commissioned directly by the council, and not via a personal budget has dropped considerably. This is line with the intentions of

[2] NHS Digital, *Adult Social Care Activity and Finance Report*. https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/adult-social-care-activity-and-finance-report-england-2016-17

the Care Act which says that personal budgets should be the default option. The table below shows these recent trends in greater detail.

Figures on the number of people using an Individual Service Fund are not recorded, though anecdotally we know that uptake is limited.

The impact on people

	2014/15	2015/16	2016/17	% change
Direct payment only	103,145	109,835	110,880	**7.5%**
Part direct payment	40,920	43,510	43,585	**6.5%**
Council managed personal budget	350,410	353,795	369,615	**5.5%**
Council commissioned service only	114,640	89,640	72,855	**-36.4%**
Total	609,115	596,780	596,935	**-2.0%**

The primary purpose of personal budgets is to improve people's outcomes and experience of using social care. However, the evidence behind personal budgets is mixed.

Available data and reported experiences suggest that many personal budget holders get positive outcomes. However, there is also some considerable variability between local areas.[3]

Data shows that the uptake of personal budgets has been quicker amongst younger adults. Other evidence shows that working age adults get comparatively better outcomes from using personal budgets and direct payments, in contrast to older people.[4]

The data also shows no correlation between uptake of personal budgets and user satisfaction. Rolling out personal budgets does not necessarily mean improved outcomes; this is dependent

upon how effectively they are delivered, the quality of the care planning process and the availability of support in the local area.

When personal budgets are put in place without adequate support and information the user may struggle to get any benefit, indeed it is possible that a personal budget in this situation may have an actively negative experience of social care. This is particularly true for direct payment users who take on total control of, and responsibility for, their personal budget.[5] [6]

The impact on the care market

It is very difficult to measure the impact of the personalisation agenda and the roll out of personal budgets on the care market, as there a wide number of variables and other forces at play.

There are several key areas of personalisation policy that we would consider likely to have an impact on the size and structure of the market:

1. **Increase in micro-commissioning;** this is where the individual commissions a service via a direct payment rather than the council. It means that providers will have to enter multiple contracts rather than a standard framework or service level agreement. This would mean

[3] In Control, *Third National Personal Budget Survey*. http://www.in-control.org.uk/what-we-do/poet-%C2%A9-personal-outcomes-evaluation-tool/poet-for-adult-social-care.aspx
[4] In Control.
[5] NHS Digital, *Adult Social Care Outcomes Framework (ASCOF)*. https://digital.nhs.uk/data-and-information/publications/clinical-indicators/adult-social-care-outcomes-framework-ascof/current
[6] The National Audit Office, *Personalised Commissioning in Adult Social Care*. https://www.nao.org.uk/wp-content/uploads/2016/03/Personalised-commissioning-in-adult-social-care-update.pdf

that providers would lack certainty about the level of work they may have, and the income they could expect. This makes future planning and staff rostering more challenging.

2. **Decrease in block contracting;** block contracts (where a council would commission, for example, a set number of hours of home care and allocate them to users) should be phased out according to the Care Act.

   This is positive for users as they will have greater choice and control over how their care is planned and delivered, but removes certainty and stability for providers, as previously at the start of a contract cycle they would know their income and activity levels for the duration.

3. **Pressure to innovate and offer new models of care;** greater choice for the individual in how they spend their personal budget should mean that providers have to diversify and innovate to attract 'customers'.

4. **Preferred provider lists;** some councils operate this system, where they hold a list of approved care providers for people to spend their personal budget with. Some argue that this unfairly limits choice, and for those providers not on the list it will limit their ability to attract people to their service.

Another ambition of the Care Act and the personalisation agenda is to move care towards community settings, in preference to residential and nursing care homes. The table below shows how numbers of people accessing residential and nursing care has dropped significantly over recent years.

	2014/15	2015/16	2016/17	% change
Nursing	86,040	85,590	84,465	**-1.83%**
Residential	194,365	190,045	186,885	**-3.85%**
Total	280,405	275,635	271,350	**-3.23%**

This is not a direct result of the roll out of personal budgets, rather an impact of the broader personalisation agenda and a drive to move care towards community settings.

Next steps; integration and personal health budgets

Personal budgets for social care and personal health budgets work differently, the rules and guidelines are separate and people who use both will have to manage them as such. This can create confusion and act as a barrier to the integration of services.

To address this and to make long-term care more seamless for people with health and care needs, the Department of Health and Social Care (DHSC) are looking at rolling out Integrated Personal Budgets to a wider group.

In principle, an Integrated Personal Budget would allow an eligible person (someone with long-term health and care needs, who requires ongoing NHS funded healthcare as well as council funded social care) to pool both funding streams into one budget.

The DHSC consulted on this proposal in the summer of 2018, Healthwatch England submitted a response informed by the insight and intelligence gathered by the local Healthwatch Network.

The focus of our response was that the proposals were broadly positive and that our experience shows that people can often get the positive outcomes they want from health and social care by using a personal budget effectively. However, we also raised concerns that for personal budgets

to be effective people would need good quality information and advice, as well as support to manage the budget correctly.

Conclusion

Personal budgets and personalisation are a cornerstone of current social care policy. When implemented well, with adequate support, information and advice, they can have a positive impact on people's experience of social care.

However, the data available makes it difficult to draw an accurate picture of the impact of personal budgets at national level.

It is also difficult to measure or quantify the impact of the policy on the care market. Personalisation does present some challenges to care providers, namely that it removes much of the certainty associated with block contracts, and means that providers have to attract individuals to their service, rather than focus on winning large scale contracts from the statutory sector.

Another impact of personalisation policy is that councils are more likely to show a preference for community based models of care, in favour of residential or nursing homes.

healthwatch

About us

We are the independent consumer champion for health and care. Our job is to make sure that those who run local health and care services understand and act on what really matters to people.

A local Healthwatch exists in every area of England. We support them to find out what people want from health and care services and to advocate for services that work for local communities. Local Healthwatch also act as our eyes and ears on the ground, telling us what people think about local health and social care services. We use the information the network shares with us and our statutory powers to ensure the voice of the public is strengthened and heard by those who design, commission, deliver and regulate health and care services.

Contact us.

Healthwatch England
National Customer Service Centre
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

www.healthwatch.co.uk
t: 03000 683 000
e: mailto:enquiries@healthwatch.co.uk
@HealthwatchE
facebook.com/HealthwatchE

MEETING REFERENCE: CM181024

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

1.0 Update on activities

As September and the second quarter of 2018-19 ended, we said goodbye to our outgoing Chair, Jane Mordue, and welcomed our new Chair, Sir Robert Francis. I know Jane is delighted that she has a successor who will help the increasingly united network she was so keen to develop find its collective voice in the places where people need to be heard. I know I speak for the whole staff team in looking forward to working with Sir Robert and the Committee in the coming months and years.

Conference – Healthwatch2018

I thoroughly enjoyed seeing so many staff and volunteers from across the network at conference and it has been a pleasure to read the messages from Healthwatch people across the country, asking for their thanks to be passed on to all involved. The word that keeps coming up is "inspired", so we'll be working hard to keep up that momentum.

We delivered an impressive range of senior external speakers, engaging with the network and saying how valuable Healthwatch insight is. The line-up included NHS England National Medical Director Stephen Powis in relation to the NHS Long term Plan, CQC Chief Inspector of Social Care Andrea Sutcliffe and Izzy Seccombe on social care, and Jenny George, National Audit Office Health Value for Money Director, who described how the NAO is increasingly using our insight to inform its work programme as well as its individual reviews and reports.

We've built follow-up activity and sharing learning and resources with the network much more strongly into conference this year. Presentation slides can be downloaded from our website.

We also congratulated the many Healthwatch nominated for our awards and it was great to have Simon Stevens and Sarah Wollaston's contributions at the ceremony, recognising the important contribution of Healthwatch. Since conference we've been promoting network impact using our new publication showcasing the finalists - Making Your Voice Count 2018.

This year we have gathered more feedback from conference attendees than ever before. The overall conference evaluations are continuing to come in and we will update the Committee once we have analysed them fully. However, the early trends we're seeing so far have been excellent:

- 84% of people saying that the breakout sessions were engaging, interactive and interesting

- 78% of people saying that the breakout sessions will help their Healthwatch improve its activity over the longer term
- 82% of attendees saying they found the conference interesting challenging and fun
- 73% of attendees saying the things they learned at the conference will help them better carry out their role with Healthwatch
- 92% of attendees saying they would recommend the Healthwatch annual conference to a colleague.

NHS Long Term Plan

Our work in relation to the development and implementation of the Long Term Plan is covered in more detail in section 2 below but I want to highlight three things to the Committee:

1. It has been good to see NHS England and NHS Improvement responding to our message that making use of existing insight is vital given the short timescale they have been set for development of the plan, and that engagement needs to continue throughout implementation.
2. The planning workstreams have been very receptive to our insight (this is covered in the Intelligence and Policy report) and we are pleased by how it is shaping their thinking.
3. The forthcoming NHS England funding to enable our network to play a key role as local plans are developed into 2019 provides an important chance for Healthwatch to ensure people shape these plans but also to lay the foundations for further and wider opportunities for us all to work together in this way.

We are pleased with the level of interest shown by the network in this opportunity and are firming up arrangements for how this work.

Network development

We have been receiving very positive and constructive responses to our developing Quality Framework from commissioners of Healthwatch at our recent and well-attended events for them. We are continuing to work intensively with a number of individual Healthwatch and their commissioners to support the delivery of effective Healthwatch services and have been developing our annual analysis of the network's resourcing and its implications alongside our plans to tell the network's impact story during a period when key commissioning decisions will be made.

I was pleased to be able to feed back to conference delegates how we have heard and acted upon what the network told us they needed during the development of our strategy. A good example of this is our searchable Healthwatch Reports Library, which is moving into live testing and will be fully operational in Q3. This will enable the network to share and learn more easily, give better access to our insight for policymakers, commissioners and providers, and help demonstrate the value and impact of the network.

Carers

Our briefing on the needs and experiences of carers was technically published on the first day of Q3 and we will report more fully next at the next meeting, but I wanted to let the Committee know how well received it has been and well it has demonstrated the value of combining what the network hears from people with our analysis and policy insight in this way. We will continue to tell this story in a number of ways in the months ahead.

2.0 Influence and Policy and Public Affairs

2.1 Key Government Activity

New Secretary of State for Health and Social Care, Matt Hancock MP, set out his three early priorities. You can read more here.

1. **Workforce:**
   He has spent significant time engaging with staff and used early speeches and media interviews to recognise how hard they are working under current pressures. He also recognised the commitment shown by unpaid carers. He has stressed on a number of occasions how 'heart-breaking' it is to see staff feel so undervalued. He outlined his determination to make the NHS the best employer in the world.

   This has manifested itself in announcements about more mental health support for the workforce. He has also confirmed the Government's commitment to recruit 5,000 more GPs.

2. **Technology:**
   Following on from his time at the Department for Digital, Culture, Media and Sport, he has continued to show a strong interest in the use of technology to improve the health and care sector.

   In July he announced almost half a billion pounds to transform technology in the NHS in an attempt to reduce staff workloads and improve patient care.

   His support for technology, in particular the controversial GP at Hand service, have come in for criticism, but broadly speaking the focus on technology seems to be going down well with the sector.

3. **Prevention:**
   He has made it clear that taking pressure off staff and improving patient outcomes is not just about enhancing the way healthcare is delivered in hospitals. There also has to be significant focus on keeping people out of hospital in the first place.

   He has placed emphasis on improving screening and early intervention, and not just for cancer. As part of the prevention agenda he has also covered better signposting to services, e.g. how do we reduce the numbers of people who turn up in A&E who could be better served elsewhere. Much of this is about empowering people, giving them the tools they need to manage their own health and find the right services for them when they need assistance.

Since these early priorities, the Secretary of State has also reconfirmed his commitment to the importance of patient safety. This was an issue that had been put at the heart of the NHS by former Secretary of State Jeremy Hunt. To support this he has announced the development of a 10 year strategy to improve patient safety which will sit alongside the NHS Long Term Plan. We will be exploring with the DHSC how we can support the development of this.

At Conservative Party Conference, the Secretary of State also announced £240 million extra for social care in England to help people get home so the NHS can better cope with winter pressures. He said the money would help more people "who don't need to be in hospital, but do need care". Whilst this money has been welcomed by the NHS and Social Care, there have been concerns raised that it is still too focused on easing pressure on the NHS rather than a long-term solution for social care.

In other Government news the date for the Budget has been announced and will take place on 29 October.

2.2 NHS Long Term Plan Update

In August we engaged early with NHS England on initial thinking around the Long Term Plan, and by providing support to help shape the development of the discussion guide. In particular we were able to emphasise the importance of engagement and it was encouraging to see this reflected in the final questions.

NHSE discussion guide questions on engagement:

"- How can the NHS encourage more people to share their experiences in order to provide an evidence base for checks on whether changes introduced under the long term plan are driving the changes people want and need?"

"- How can the NHS improve the way it feeds back to people about how their input is shaping decisions and demonstrate that the NHS is the world's largest learning organisation?"

Given the tight timescales for development of the plans, we also took the opportunity to write to Simon Stevens in August and outline the importance of NHS England making the most of existing feedback shared by people to inform the plan's development.

During September we supported this approach by concentrating on packaging up our existing insight into a series of summary briefings to support a number of the Long Term Plan workstreams.

- **34,000 people's views on mental health.**
  Key point - Highlighted recent improvements in people's experiences of accessing mental health support through primary care, but stressing their desire for more peer support.
- **45,000 people's views on primary care.**
  Key point – People are very willing to see a variety of different types of health professional, but also pointing at how at times other popular policy initiatives, such as booking appointments online, are making it harder to see anyone other than the GP.
- **6,500 people's views on A&E.**
  Key point – The current 4- hour A&E target tells us little about current patient experience. Other factors including how quickly a person is triaged, and whether or not they are kept informed of how long they may wait should also be considered as a way of departments giving a more nuanced view of how they are managing demand.
- **750 homeless people's views of NHS services**
  Key point – how administrative barriers, such as the need for proof of address, are still creating serious barriers to access for groups in vulnerable situations.
- **5,500 carers' experiences**
  Key point – whilst our carers briefing focused primarily on what councils and the government need to do to improve support, we also highlighted the key role the NHS has in identifying carers earlier and signposting them to support to ensure people seek help before they hit crisis point.

The submissions have been welcomed by NHS England workstream leads and we have been asked to produce further insight briefings in other areas.

The value of our contribution so far, and the broader value of the network's connections with local communities, is reflected in the work NHS England is now commissioning us to do in terms of engagement around phase two of the Long Term Plan. This will focus on helping local areas translate the high level national plan in to something that is meaningful for local areas and give local people a chance to shape how it is delivered.

2.3 NHS Mandate

We reported last time that we had been invited to submit evidence to the DHSC about NHS England's performance against the Mandate. The evidence we submitted was welcomed by the Department but publication of the annual review has been put on hold whilst the new Secretary of State settles in. We are still awaiting an update on publication but will keep the Committee posted.

Elsewhere on the Mandate the team have begun discussions with officials on this year's process. A meeting was held on 24 July:

- We agreed with DHSC that it makes sense to align the Mandate with the Long Term Plan. This makes perfect sense from a priority setting point of view and would be actively unhelpful to design the Mandate outside of the long-term plan process.
- We agreed with the DHSC about the need to align thinking between Mandate for NHSE and the similar objective setting process for NHSI. This makes senses given the closer alignment between the two organisations.
- We asked about any possible consultation plans given the likelihood of significant changes to the Mandate this year. DHSC confirmed they would involve us early in discussions about any consultation.
- Our main asks this year are likely to focus on:
    - **The need to invest in public engagement** - In previous years we have asked for strong messages to be sent around the need for good engagement. We are now at a point where this needs to be followed up with new investment in this area. This is in part because if more tax payers' money is to be spent on the NHS then public expectations will change and they will want to see the money spent on the sort of changes they want to see. Knowing what these are requires good and consistent engagement.
    - **How to make NHS targets more meaningful for patients** – This will be a follow on from last year and will look to feed in to the clinical review of the targets announced by the Prime Minister. We want to ensure that patient experience and outcomes are put on an equal footing in judging NHS performance against core financial and output targets.

2.4 Hospital Discharge

At the last Committee meeting we reported that delayed transfers of care were continuing to fall. This trend has continued over the summer which is positive.

However, we have been re-running the analysis of emergency readmission figures we conducted last October and identified what appears to show a significant percentage increase in people returning to hospital for unplanned treatment within 30 days of being discharged in 2017/18.

This continues to raise important questions about patient flow and how tracking patient experience more consistently could help to surface what is happening.

We held a round table, chaired by Lee Adams, in August with Keith Willett, Director for Acute Care at NHS England and attended by representatives from NHS Digital, Nuffield Trust, the NAO, the Red Cross and the LGA. We discussed our early analysis and the progress on restarting the publication of the official national data set around emergency readmissions.

We will be publishing the findings of this work and a summary of the roundtable later in Q3.

The next steps on this will be about exploring how our insight can be used at a local level to unpick the challenges front line services are facing. This will involve engagement with a selection of local stakeholders to understand in more detail.

2.5 Social Care

I have continued to act as an advisor on the Government's forthcoming Social Care Green Paper, supported by our local Healthwatch advisory group.

We understand the Green Paper is due to be published in line with the NHS Long Term Plan, which is scheduled for November/early December. Whilst this means it has been delayed somewhat from the original timetable, we agree that it is important it is not developed in isolation of what has happening with the NHS.

We have used the extended timeframe to start publicly setting out our view of what the Green Paper will need to include, publishing the insights we have been sharing behind the scenes during Q1.

For example, the research we reported on last time on 'What people want from the future of social care' has now been released to the media, with continued positive responses from stakeholders regarding our key message of the need for better information and signposting in social care.

We also spent part of Q2 finalising the publication of our report on what it is like to be a carer. Developed from the 5,000-plus experiences shared with local Healthwatch, the briefing highlighted the following key messages:

- The number of carers is increasing and they are doing more than ever.
- Indeed the contribution made by family carers is to a certain extent propping up the rest of the social care system.
- Under the Care Act carers have a right to an assessment for support, as well as a right to information and advice about how to access help.
- However, our research suggests carers are not always aware of this.
- This is made worse by the fact carers often only start looking for help when they reach crisis point.
- Any delay at this point is therefore having a detrimental impact on the health and wellbeing of those they are caring for and the carers themselves.
- The unique research we undertook revealed previously unknown insight on waiting times for assessments – with average waits from referral for assessment to actually getting help currently at 57 days. This in itself is not an overly long wait but for those in crisis already it can have a very negative impact on them.
- However, this data only represents a sample of councils as of the 152 we asked 48% could not tell us how many carers in there are in their area. And only 23% were able to provide data on waiting times.
- This is worrying as it means councils lack the necessary data to make the necessary case for extra investment to support carers.
- We recommend the Government puts in place steps to resolve this issue in the Green Paper, in particular addressing the problems around council level data, strategic commissioning and Care Act implementation.

You can read the full report here.

Using the research mentioned above, and broader analysis of insight gathered from over 9,000 people about care services, we have developed **five tests** that the social care green paper must pass if it is to deliver the urgent changes people have told us they want to see.

1. **Is it understandable by the public and people who work in social care?**
2. **Will it support people to plan and make decisions about their care, will the public have access to high quality advice and information to help them make good decisions?**
3. **Does it facilitate quality and a wide range of choice in social care, do we have plans for a stable and varied social care provider market including care homes and support in the community, and will we have enough people with the right skills working in the sector?**
4. **Are the funding, charging and access thresholds fair, affordable and transparent?**
5. **Will it support families and carers?**

As mentioned above we expect to see the green paper published by the close of the year. We will of course be pulling together a response based on the above tests and will be looking to undertake further engagement with people on any proposals put forward by the Government.

Finally, on social care, during the summer I met with Ed Moses at the Department of Health and Social Care to discuss our contribution to Year 2 of Quality Matters, the cross-sector initiative which is working to improve quality in social care. It was noted that the workstream around feedback and complaints which Healthwatch jointly led on with the Local Government and Social Care Ombudsman had made significant progress in year 1 and that this would continue to be one of the core workstreams over the next 12 months. The detail of this is still being developed and we will update the Committee in due course.

2.6 Mental Health

The Committee will have noticed a significant flurry of news stories, external reports and announcements in recent days relating to mental health. These have included:

- Government plans to do more to support the mental health of staff working in health and social care.
- A series of reports about the growing problems in mental health for children and young people – including a report by the NAO. (Worth noting that the NAO decided to focus on CAMHS in part because of the significant volume of insight being generated by local Healthwatch on this issue.)
- The announcement of Jackie Doyle-Price MP as the new Minister for Suicide Prevention. (Note: Ms Doyle-Price already had Ministerial responsibility within the DHSC for Mental Health but this signifies increasing Government focus on the issue of suicide prevention.)

On World Mental Health Day the Government reiterated its commitment to improving Children and Young People's mental health. This includes the introduction of 8,000 staff to support mental health of young people in schools. There was also a commitment to make 70,000 additional places to specialist support available annually. Perhaps the most important thing to note is that this announcement covered both primary and secondary education which was a big step forward and follows our submission on the Government Green Paper on CAMHS earlier in the year which stressed the need to extend plans to primary schools.

Elsewhere on mental health we provided insight from local Healthwatch to support the Healthcare Safety Investigation Branch's review of mental health support in A&E departments. This is due for publication later in Q3.

In terms of our own mental health programme, at the beginning of August we launched the programme overview document**.** This was shared with key stakeholders and the network setting out the scope of the programme and rough timelines. (Downloaded 229 times in the first month). We also saw press coverage in key mental health trade press.

Also at the beginning of August we also kicked-off the first phase of primary research in to maternity and mental health with the launch of three surveys (public / professional / network). These have been widely shared online as a result of our social media outreach and promotion by the communications team.

- Had just over 800 respondents from the first push (this is more than we have ever had respond before to a survey exercise). Second push happening in October.
- Our content – in particular the surveys – has been shared by 106 stakeholder organisations and key individuals driven through our targeted communications.
- We have also undertaken online activity to target groups who are less likely to respond and had really positive engagement of former service users and individual professionals. For example, we supported Dr Andy Mayers who is a Perinatal Mental Health Expert in Devon to produce and a video appeal for more men to come forward and share their experiences.
- The involvement of local Healthwatch and stakeholders was supported through the development of a communications toolkit. In addition to stakeholders, over 60 local Healthwatch have pushed content significantly on social media.
- For the next phase of research we have had submissions of interest from 35 local Healthwatch which we are now reviewing.

At the beginning of September we launched the evidence summary report which brought together 34,000 people's views and experiences of mental health. Initial analysis after first month showed report had been downloaded 352 times. The accompanying literature review has been downloaded 125 times.

We have also started to produce content on mental health issues drawn from the evidence summary to encourage more people to talk to their local Healthwatch – see this, published on world suicide prevention day.

Looking more broadly at the programme, the team met with NHS Digital during Q2 to explore partnership opportunities that would enable better linking of our qualitative insight with their quantitative data on mental health.

2.7 Public Engagement in Service Change

Whilst the earlier section on the NHS Long Term Plan covers the majority of our work on major service change for Q2, there are two key pieces of information which I would like to bring to the Committee's attention.

In August the Government responded to the Health and Social Care Select Committee's report into Integrated Care Organisations, Partnerships and Systems. It was positive to see the Government's response emphasise the need for better public engagement in major service change programmes

and highlight the example of the work done by Healthwatch across South West London which gathered views from over 5,000 people from across a range of seldom heard groups. This follows significant work earlier in the year to inform the Committee's inquiry through providing written and oral evidence about the experience of Healthwatch in engaging with the service change agenda.

Following conclusions of the two judicial reviews into Accountable Care Organisations which we reported on last time, in Q2 NHS England moved to consult on the new contracts. We issued guidance to local Healthwatch on how best to respond to the proposals, in particular to stress the importance of existing requirements under the standard contract for the NHS to promote Healthwatch not being lost.

2.8 Key Appointments / Resignations

As mentioned at the start of this report, the biggest announcement of Q2 from a Healthwatch perspective was of course the announcement of Sir Robert Francis as our new Chair. This was announced at the end of September with Sir Robert taking over from outgoing Chair, Jane Mordue, from the beginning of Q3.

There are two big announcements at the CQC with Andrea Sutcliffe, Chief Inspector of Social Care, and Prof Steve Field, Chief Inspector of Primary Care, both announcing they will be stepping down. Andrea has been appointed as the new Chief Executive of the Nursing and Midwifery Council.

Former Government Minister and former Chair of the CQC, Lord Prior, returns to health as the new Chair of NHS England taking over from Malcolm Grant.
Jeremy Taylor, Chief Executive of National Voices, also announced he would be stepping down in the New Year. A successor hasn't been appointed yet.

Richard Murray, currently Director of Policy at the King's Fund, has been announced at its new Chief Exec. He will succeed Sir Chris Ham, who steps down at the end of 2018.

3.0 Key meetings I attended during Q2:

July	Quality Matters Board Meeting	Department of Health and Social Care
	East of England Regional Conference – How can the national strategy be interpreted locally?	Local Healthwatch - Guest speaker
	Local Government Association Conference	Birmingham – attended representing Healthwatch England
	Personalised Care Programme	Met with NHS England to discuss the programme
	Patients Association Meeting	Attended with Jane Mordue from Healthwatch met with Rachel Power and Liz McAnulty
	King's Fund	Attended a meeting with staff from the King's Fund at Cavendish Square, W1
	General Pharmaceutical Council	Met with Duncan Rudkin, Chief Executive of the General Pharmaceutical Council
	Healthwatch Brighton and Hove	Attended the launch of their annual report

	Nutricia	Met up with Kate Hall and Jo Solomon from Nutricia
	Department of Health and Social Care	Attended the quarterly DHSC and Healthwatch England meeting
	Care Opinion	Attended meeting along with the Healthwatch England Leadership Team and Lee Adams, a Committee member and were given a presentation by James Munroe, CEO of Care Opinion CIC
	Sustainability and Transformation Partnership Advisory Group	Meeting held at Skipton House with NHSE
	Integration Partnership Board	Organised by Department of health and Social Care
	NHS Funding – the next phase	Led by NHS Confed
August	National Children's Bureau	Met with Anna Feuchtwang, Chief Executive of the National Children's Bureau
	London Association of Directors of Adult Social Services (ADASS)	Met with Cathie Williams, Chief Officer of ADASS
	Social Care Green Paper Expert Advisory Group	Held at the Social Care Institute for Excellence – invited by Matt Hancock, Secretary of State for Health and Social Care
	NHS Long Term Plan Engagement Workstream	Attended meeting with NHSE
	Annual Leave	
September	Health and Care Innovation Expo	Attended the Expo in Manchester
	Healthwatch Lincolnshire AGM	Attended as a speaker
	Social Care Green Paper Expert Advisory Group	Held at the Department of Health and Social Care – invited by Matt Hancock, Secretary of State for Health and Social Care
	Centre for Public Scrutiny Health and Scrutiny Assurance Conference	Attended as a speaker
	Healthwatch Northamptonshire	Met with the Chair and CEO
	Care Quality Commission Board Meeting	Attended and gave Healthwatch England update
	Local Government Association Green Paper Sounding Board	Attended meeting to discuss emerging messages from public consultation
	NHS Long Term Plan Engagement Workstream	Attended meeting with NHSE
	Integration Partnership Board	Organised by Department of health and Social Care
	Sustainability and Transformation Partnership Advisory Group	Meeting held at Skipton House with NHSE
	Good Governance Institute – Annual Lecture	Held by the Royal Institute of Chartered Surveyors

AGENDA ITEM No.1.7

AGENDA ITEM: Q2 Delivery and Performance Report including half year finance

PRESENTING: Imelda Redmond

PREVIOUS DECISION: The Committee NOTED the performance report for Q1

EXECUTIVE SUMMARY: This paper summarises delivery and performance against KPIs during Q2 and provides an update on the financial position as at end September 2018. It reviews progress against the programme management framework.

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

The paper covers:

1. Programme management framework
2. Q2 delivery highlights and Q3 look-ahead
3. Budget summary
4. Performance against KPIs

1. Programme management framework

At the end of Q2 we applied a RAG rating to each activity within each programme stated below and to the programmes overall, to enable close performance management.

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

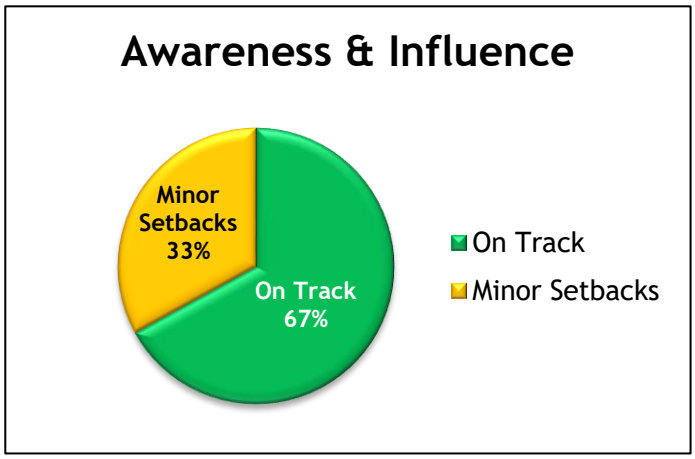
The Committee is asked to note that a Red rating within this framework denotes that substantial action is required to return a programme to its planned trajectory but does not imply that the programme activity will not be delivered. Table 1 below summarises the overall status for each programme.

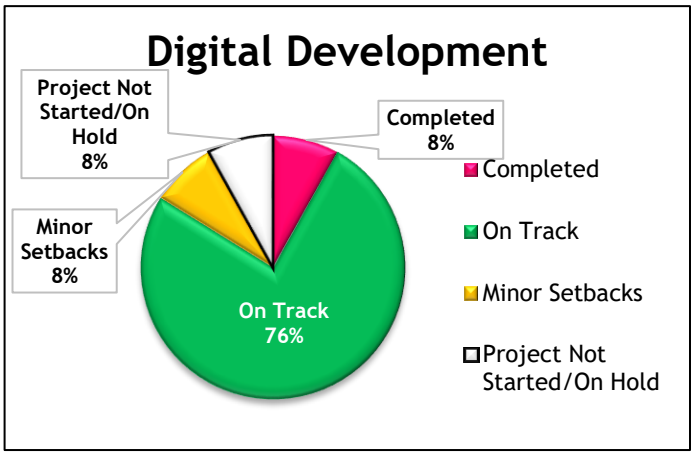
Table 1 – overall programme status

Programme	Summary	Overall Q2 delivery status	Commentary
Awareness and Influence	During the transition year of the strategy Healthwatch England will run a number of projects that will improve our marketing and communication with the external world, improve our influencing and develop in-depth work around a number of social issues.	**Amber**	Programme is still expected to achieve Green status as plans are now in place to increase staffing levels. We are adjusting activities to accommodate unplanned but strategically important work in relation to NHS Long Term Plan.
Digital Development	The first year of the digital programme sets the foundation for system integration and development of the estate in support of the Healthwatch strategy. It focuses on improving existing products, understanding what our digital users need and developing new tools to better understand our data.	**Amber**	Major elements of programme successfully delivered in Q1 but some schedules affected by a staff vacancy and a delay in procurement approval. Procurement resolved in Q2 and key appointment made, to start in Q3. There remains sufficient time within the overall programme to return to schedule and for the programme to achieve Green status.
Engagement	Healthwatch England will put in place the building blocks to ensure that Healthwatch England and local Healthwatch are seen to have real expertise in engaging with the public. This programme will be developed over the course of the year into a programme running to 2023.	**Amber**	New programme being developed to cover the life of the strategy. Initial activity underway, and draft literature review will be received just before Committee meeting. This will inform autumn roundtable to help shape remainder of programme.
Network Development	Healthwatch England will develop a new model of support to the network which will include a quality framework and learning and development support to the network and commissioners.	**Amber**	Although this project is on track we are currently experiencing a capacity issue and are monitoring closely. Plans are in place to resolve the capacity issue in November.

Organisational Development	Healthwatch England will be improving our approach to staff development, training, support and recruitment. We will support our committee to be high functioning. We will ensure that the PMF is fit for purpose and delivers good management information. We will do this through the lens of EDHR.	**Amber**	This programme is expected to achieve Green status. Grant funding to the network is expected to be completed by the end of financial year. The development of our new impact measurement is underway and due to be finalised.
Research, Evidence and Impact	Healthwatch England will run a number of projects that will improve our collection of insight from LHW, share that information with LHW and other partners to demonstrate evidence on 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.





List of Projects on track 67%
Run national #ItStartsWithYou campaign timed with NHS70
Support communication of Healthwatch insight (allowance of up x5 reports)
Develop Healthwatch marketing and communications materials
Social Care Programme
Additional Insight Sharing Activity
Expanding our professional support base
Stakeholder perceptions survey
Political Engagement

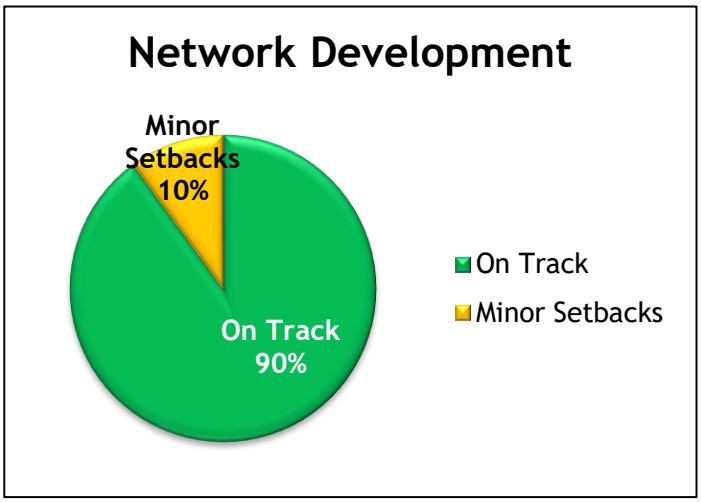
Projects with minor setbacks 33%
Develop, design and publish Healthwatch annual reports and plans
Marketing the role and impact of Healthwatch
Mental Health Programme:
Developing Healthwatch

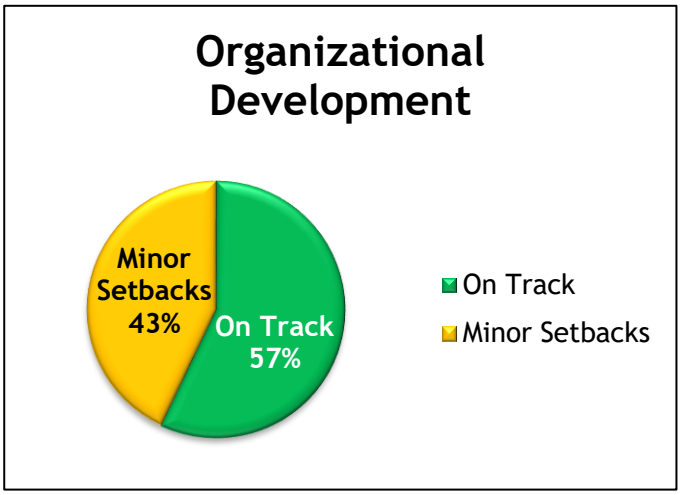
Completed Projects 8%
Intelligence System (CRM Development): Integrate APEx:

Projects with minor setbacks 8%
Develop local Healthwatch website design and navigation

Project Not Started 8%
Develop Healthwatch use of email and social media marketing

Projects on track 76%
Develop Healthwatch England website design and navigation
Healthwatch Feedback Centre
Systems Information and Signposting
Intelligence System Procurement (including web)
Intelligence System (CRM Development): Improve user functionality
Intelligence System (CRM Development: Data Import Function)
Support, Maintenance and Hosting (CRM and Web)
Data Warehouse (Store): SQL development
Data Interface (Architecture): Endeca development



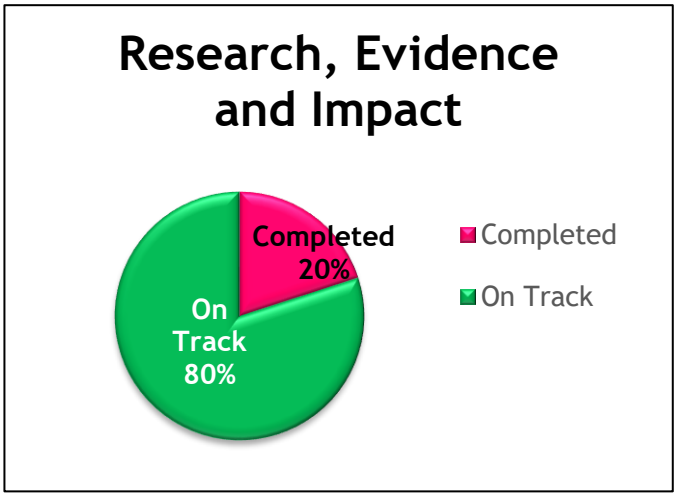


Projects on track 0%
Regional Stakeholder Engagement
Horizon Scanning
Review of Regional Networks and Collaboration
Sustainability (HW Network)
Sustainability (Commissioner Engagement)
Learning and Development
Provide communications training and support for local Healthwatch
Network Research and Intelligence Support
MAJOR) - Network Digital Support
Network Information Governance

Projects with minor setbacks 10%
Develop Network Model

Projects on track 57%
National Directors Meeting
Internal Staff Training
Collaborative operational working with CQC
Programme Management Framework (including EDHR)

Projects with minor setbacks 43%
Developing Key Performance Indicators and Impact Measurements
Procurement Support: need to clarify what this means
Healthwatch England Committee



Project Completed 20%
Healthwatch Knowledge Provision and Signposting

Projects on track 80%
Business Intelligence Collection:
Primary Research
Information Sharing
Intelligence Reporting

2. Q2 delivery highights and Q3 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 Q2 in support of each aim. They also indicate the areas on which we will be focusing in Q3.

Aim1: Support you to have your say	**Q2 delivery highlights**	**During Q3 we will focus on:**
	• Successfully launched our new website, updating the look, improving access to and engagement with content and increasing actions taken by visitors. The site is much easier to use for the majority of visitors using mobile devices. • We began working with the first 3 pilot Healthwatch to develop a process for local Healthwatch taking up our digital support offer for their own sites. This will improve consistency for people whichever site they are viewing, make it easier for local sites to use national content, and mean local teams can benefot from centrally negotisted hosting and technical support. • Continued leadership and support for activity across the network to promote #ItStartsWithYou, linked this year to the NHS70 celebrations. We launched our #NHS100 National Conversation on the very long-term future of health and care, adjusting our plans to take account of the announcement of the NHS Long Term Plan. We began the conversation using our initial national polling and with a joint event with the RSA Health, Care and Wellbeing Network.	• Using collateral and content developed in Q2 to enable the network to make the most of the annual showcase of conference and the awards. This includes developing awards entries that were not shortlisted into impact stories to use for network promotion. • Finalising the Annual Report for presentation to Pariament in November. Planning for our January event connecting Healthwatch with parliamentarians. • Continuing to pliot and planning for wider roll-out of our network digital support offer. The first sites will go live in Q3. We will also offer the whole network access to additional online advice and information content through an RSS feed, offering them new content for their sites each time we develop it for the national site. • Further media and digital activity, involoving partner organisations, to promote #NHS100 (in addition to our other autumn news stories) and development of our initial analysis of what people are saying about the future for publication. This will provide the basis for further work with stakeholders on the issues people raise.

	• Promoted the value and impact of Healthwatch using award entries ahead of conference and delivered record levels of online engagement with conference. • Delivered 2 waves of media and influencing training to support the network in raising the profile and increasing the influence of Healthwatch.	
Aim 2: Provide a high quality service to you	**Q2 delivery highlights**	**During Q3 we will focus on:**
	• Planning, implementation and promotion to ensure a successsful network conference, deivered in the first week of Q3. • Successful and well-attended regional sessions for commissioners of local Healthwatch, securing constructive feedback on the developing Quality Framework and network agreement. • Undertaking our analysis of network funding to deliver the annual State of Support review in Q3. • Completing our analysis of network risk, identifying where intervention and support is most needed and developing plans to use a range of approaches to deliver this, accelerating delivery of our network funing action plan. • Reviewed how people use the Healthwatch CRM enabling us to simplify what they see when they log on and make it easier to use. • Began development of our system to understand levels of connectedness between each Healthwatch, Healthwatch	• Sharing materials from conference to spread learning and community across the network. Completing conference evaluation to inform future planning. • Publishing our annual State of Support analysis and delivering messages about the risks arising from network resource pressures, togther with Healthwatch impact and value. • Piloting network leadership training. • Further developing a Healthwqtch induction pack for delivery in Q4. • Surveying Healthwatch to understand and develop network collaboration. • Further developing the Quality Framework and network agreement and our relationhip with commissioners in relation to this approach. • Implementing the CRM usability improvements as well as enabling all Healthwatch, whether or not they use the CRM, to share data with us easily and efficiently.

	England and other Healthwatch and develop One Healthwatch.	• Consulting on a framework for good quality Healthwatch research and working with local Healthwatch experts to develop a modular research training package. • Completing our analysis of Healthwatch annual reports to identify impact and combining this with analysis of annual data returns.
Aim 3: Ensure your views help improve health and care	**Q2 delivery highlights**	**During Q3 we will focus on:**
	• Developed and tested a way for all local Healthwatch who do not use the Healtwatch CRM to share their data with us to inform the national overview of what people are saying about health and care, including automatic importing from feedback centres. • Developed and undertook internal testing of the Healthwatch Reports Library, our national searchable database containing all Healthwatch publications. • Developed and rolled out changes to the Healthwatch England CRM which enable more efficient analysis of Healthwatch insight by the Intelligence team. • Made our social care findings more widely available to inform debate in the run-up to the Green Paper. • Published our well-received briefing on the needs and experiences of carers. • Built on the case we made in Q2 for effective engagement and the use of existing insight in the development of the NHS	• Undertaking initial external testing followed by wider public release of the Healthwatch Reports Library on our website to gain a better understanding of user needs for further development. • Using software to improve our analysis of local Healtwatch data and improve our reporting techniques. • Analysing the data contained in the Healthwatch CRM (30,000 records) to present top level findings indicating how people's experiences have changed over time. • Continuing our work to influence the NHS Long Term Plan and its implementation, including supporting the network to deliver community involvement activity. • Continuing our work in relation to social care Green Paper and ensuring our 5 tests for its success are understood and infuential. • Publishing our updated work on emergency readmissions and planning for further stakeholder work in Q4.

	Long Term Plan. We argued that transformation funding must include resource for effective engagement. Delivered this through intensive involvement in the engagement and clinica priorities workstreams while sharing our insight with other workstreams. Secured agreement from NHS England to resource the network to secure involvement of communities across England as local plans are developed following publication of the national plan. • Worked with key stakeholders to explore how they could best make use of our updated emergency readmissions findings in Q3. • Generated unprecedented response to our surveys on perinatal mental health, to inform our mental health programme.	• Publishing our findings on the experiences of homeless people. • Moving our work on perinatal mental health wider into the network and developing the second stage of the mental health programme – looking at transitions for young people. • Using the findings from our review of literature concerning public engagement to shape our longer-term programme.

3. Budget 2018-19 Summary

	2018-19 Annual Budget Total	Q2 2018-19 Spent to date	Q2 % of Annual Budget spent
PAY	£1,976,578	£937,689	47%
NON-PAY	£809,464	£237,511	29%
TOTAL	**£2,786,042**	**£1,175,200**	**42%**

We have now reviewed our headcount for 2018-19 and have identified new roles, which we are currently recruiting to along with the existing vacancies. We anticipate filling these roles by the start of Q4.

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

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	Position at Q1	Position at Q2	Notes
1	We will see a 5% increase in public recognition of Healthwatch	Annual Tracker	33%	Annual	38%	White			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%	White			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 (Baseline Total: **3,374,618**)	Quarterly	Overall Total: **4,555,735**	Green	Overall total: **989,426**	Overall total: **2,384,020**	On target – 52% of annual target achieved at end Q2.
	A. Social following		18,230		24,611		19,037	**21,816**	Above target
	B. Social reach		3,126,153		4,220,307		899,100	**2,217,181**	Above target (Using impressions)
	C. Website visitors		167,264		225,806		42,708	**82,976**	Below target
	D. Actions taken		18,258		24,648		20,010	**38,371**	Target achieved
	E. Number of engagements on social media		44,713		60,363		8,571	**23,676**	Below target – 39% of annual target achieved at

									end Q2, but substantially ahead of previous year's performance.
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	Green	4	20.61	Above target – 72% of annual target delivered at end Q2. Q1 figures are generally the lowest each year due to council election purdah restrictions and figures at end Q2 suggest we may exceed the target by end Q3.
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		**406,567**	Target not achieved. Below target by 2,633 – 19% increase against target of 20%. While this target was not achieved the AFRSC consider that the associated level of risk is amber not red.
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	Green		**707,816**	Assessment against target not possible. Year on year figures not comparable as this year's figures are broken down (**598,233** people visited signposting and information pages and **60,743** people contacted their Healthwatch for information directly) and this may mean inclusion of figures not included in

									previous years. Rated green due to substantial increase in overall figure.

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	Position at Q1	Position at Q2	Notes
7	We will see a new agreement in place with 80% of the Network	CRM	0	Quarterly	80%	Amber	0%	0%	Agreement in development stage. Workshop held at Conference.
8	80% of Local Healthwatch, their staff and volunteers will report with good or outstanding satisfaction with the service from Healthwatch England	Composite KPI Events, Training Annual Return	0	Annually	80%	White			Assessment due in Q4.
9	20 Local Healthwatch will take up the new digital offer	Regular tracking	0	Quarterly	20	Amber	3	3	3 active in pilot group, a further 35 signed up to find out more.
10	We will develop an involvement/contact index to track how engaged Healthwatch England is with Local Healthwatch and Local Healthwatch with each other.	To be developed. (Show variances as well as averages)	0	Quarterly	Yes/No	Green	0%	0%	Approach to index development agreed. Collaboration Survey tested and going out in Q3.
11	In order to let people know the difference their views have made, in year 1, we will analyse all local Healthwatch	Local Healthwatch annual reports	0	Quarterly	100%	Green		17%	Analysis on track for completion in Q3.

	annual reports and extract the outputs and outcomes to provide a baseline								

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.									
No.	**KPI Description**	Data Collection Method	Baseline	Reporting Frequency	Target	Status	Position at Q1	Position at Q2	Notes
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 local level; and report on the volume, nature and source of the impact captured.	Annual Tracker to be established	0	Annual	Yes/No	Green			On track for delivery in Q4.
14	We will see at least three strategic partnerships formed	Regular tracking via CRM	0	Quarterly	3	Amber	0	0	Discussions in progress with a range of organisations. Not yet clear if these will become formal partnerships.
15	We will develop the methodology for tracking the use of Healthwatch England	Regular Tracking	0	Annual	Yes/No	Green			Work planned but not due for delivery until Q4.

	and Local Healthwatch findings by national organisations								

Year 1 Organisational KPIs									
We are a well-run organisation that develops its resources well.									
No.	**KPI Description**	Data Collection Method	Baseline	Reporting Frequency	Target	Status	Position at Q1	Position at Q2	Notes
16	We will see 100% of the staff completing the staff survey	Staff Survey	98%	Annual	100%	White			Survey due in Q4.
17	The survey to show a 90% positive response	Staff Survey	90%	Annually	90%	White			Survey due in Q4.
18	We will see 100% of the budget spent on agreed priorities	Finance Reports	90%	Quarterly	100%	Amber	22%	42%	42% of annual budget spent in Q2 and procurement in hand. Action underway to ensure no underspend and that we manage NHS England funding for network effectively in-year.
19	90% of programmes on track	Leadership Papers. (Show variance as well as average)	80%	Quarterly	90%	Amber	47%	74%	Most programmes now rated amber in Q2, 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	0	Quarterly to Audit, Finance and Risk Sub-	Yes/No	Green	Reporting to begin from Q2.	Yes	On target. Report provided to AFRSC. Annual Report to Parliament on track for delivery in Q3.

		AFRSC on discharge of statutory duties		Committee from Q2; Annually to Committee					

MEETING REFERENCE: CM181024
AGENDA ITEM: 1.9

AGENDA ITEM: Audit, Finance and Risk Sub Committee Minutes

PRESENTING: Danielle Oum

PREVIOUS DECISION: N/A

EXECUTIVE SUMMARY: This report updates the Committee on the minutes and actions of the last AFRSC meeting held on 16102018

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. 5

Meeting Reference: AFRSC181016

Minutes of the Audit, Finance and Risk Sub Committee (AFRSC) 16 October 2018, 10:30am – 12:30pm

Attendees:

Danielle Oum (DO) – Chair

Andrew McCulloch (AM) – Sub Committee Member

Helen Parker (HP - Sub Committee Member

Phil Huggon (PH) – Sub Committee Member – attended via phone

In Attendances:

Neil Tester – Deputy Director (from 10:50)

Joanne Crossley (JC) – Head of Operations

Sandra Abraham (SA) – Strategy, Planning and Performance Manager – Attended via phone
Leanne Crabb (LC) - Committee Secretary (minute taker)

No.	Agenda Item	Action and Deadline
1.1	**Welcome & Apologies:** Danielle Oum (DO) welcomed everyone to the Audit, Finance and Risk Sub Committee meeting (AFRSC) Apology received from Imelda Redmond, National Director	
1.2	**Draft Minutes of Meeting of 18 July 2018:** Minutes of the last meeting were agreed	
1.3	**Matters Arising** JC advised that internal audit which had been discussed at a previous meeting would be brought up under the AOB section DO advised that the meeting with SEG was being postponed	
1.4	**Staff Development** DO asked if any sub-committee Member wanted to be the interface between the AFRSC and staff to strengthen assurance around staff access to appropriate and relevant development. HP accepted.	
2. 1	**Finance and Procurement** Joanne Crossley (JC) gave a report on finance. JC highlighted that we have spent 42% of budget as at end Q2. She advised although there are no major concerns at this point we would have been more comfortable nearer 50% at this point. We are awaiting some procurements to be approved and anticipate that these will be completed by end October. JC added that we have a budget allocation of £65k for local Healthwatch to fund specific work but we may consider increasing the amount once we have reviewed our procurement pipeline to determine which activities with a budget allocation will be paused. HP asked if we need further permissions from CQC to add to the grant pot. JC stated that that we don't need further permission if each individual grant is under a set amount but will clarify.	

	DO requested that the AFRSC undertake a deep dive regarding local Healthwatch grants at the next AFRSC meeting in January as there are risks involved with the grant giving process, particularly with regard the NHSE funds to be allocated by financial year end.	**LC**
	AM added that there was a risk to our reputation with local Healthwatch regarding perceived unfairness and that we had to provide assurance that we are being equitable with our grant allocations.	
	DO asked that the AFRSC is given oversight of the decision-making framework for how grants are being allocated.	**NT**
	A general discussion followed regarding the grant giving process and we agreed it would be useful to obtain simple expressions of interest from local Healthwatch so we are in position to allocate funds easily if there is an underspend. The Sub-Committee also requested that JC give them an update once the grants process formulated by the Leadership Team, and that the Sub Committee should receive monthly email updates so that they have oversight and are able to support sharing the risk.	**JC**
	JC gave an overview of recruitment. There are currently seven roles which are either vacant or will vacant imminently. We aim to have the roles filled by the start of Q4.	
	PH highlighted that there was a potential risk that not all positions will be filled in time and asked if we are considering offering secondment opportunities from local Healthwatch.	
	NT confirmed that one secondment role was already being advertised throughout the network and another would be shortly and that there is a good level of interest.	
	DO requested a monthly update is emailed to the Sub-Committee regarding recruitment.	**JC**
	<u>ACTION</u> • **LC add deep dive regarding grant giving process to the forward plan for January 2019** • **NT share the grant decision-making framework with the AFRSC members once agreed by the Leadership Team** • **NT arrange for monthly updates to go to the AFRSC members giving updates on the grant giving process** • **JC to send monthly emails to the AFRSC members giving an update on recruitment**	

3.1	**<u>Risk Registers</u>** **Sandra Abraham (SA) introduced the Strategic Risk Register and advised that as per the request at the last AFRSC meeting the Leadership Team have reviewed the risks and have provided the top three for your review. There is also a new column of planned mitigations.** **DO requested that risk SR02 regarding the distribution of grants to local Healthwatch and local Healthwatch staff being seconded to Healthwatch England to be added to the planned mitigations as these actions should help reduce the risk.** **AM advised that Healthwatch England needs to be doing enough to help and to be seen to be active in doing so.** **DO reflected that on risk SR04 it states 'inappropriate behaviour' which is misleading as it implies that it is an individual rather than the whole local Healthwatch and the wording needs to be amended.** **SA advised that regarding risk SR05 part of the mitigation was a visit to the CQC call centre who handle our calls in Newcastle (NCSC) which has now taken place and will be in agenda item 4.1. It also reflects concerns of whistleblowing and Healthwatch (England and the network) not responding and reporting appropriately. SA confirmed that mitigating actions being taken will reduce this risk.** **HP stated that we need to keep risks high until the mitigation is completed.** **HP asked that the mitigations for SR03 be reviewed to reflect the macro rather than the micro.** **SA advised she will take them back to the Risk Owners to review.** **<u>ACTIONS</u>** • **SA to arrange for Risk Owners to review the risks to reflect the AFRSC's concerns**	**SA**
3.2	**SA introduced a paper on KPIs.** **HP requested that the success indicators agreed as part of the strategy be included in future performance updates to the AFRSC.** **NT reflected that we will need to develop success indicators for each year as well as KPIs.**	**SA**

	DO queried Network Development programme management performance as it shows 90% of the activities as green which is at odds with our concerns regarding funding and requested that this be reviewed. NT explained that this was a result of the RAG rating referring to completion of activities and that we would need in developing future programmes to identify the relative importance of the projects within the programmes. **AM raised Aim 1 No 5 (We will see increase 20% in the number of people who share their views with the network) and commented that the risk should decreased to be amber. All present agreed with the motion.** **<u>ACTIONS</u>** • **SA to incorporate success indicators in the performance report** • **SA to amend Aim 1 No 5 to Amber with footnote stating agreed by AFRSC** • **SA to review Network Development's green status**	**SA** **SA**
4.1	**<u>Newcastle Call Centre (NCSC)</u>** **SA gave an overview on the visit made by SA and Imelda Redmond (IR) to the CQC call centre responsible for taking our enquiries.** **She advised there are 16 staff trained to respond to our calls and they receive over 200 calls per month. The visit highlighted that the templates being used to reply to queries do not align with our strategy and need to be amended. In future bespoke enquiries will be sent to SA for her to direct them to the appropriate staff member for a response.** **IR and SA will meet Sir Robert Francis to review how his enquiries are handled. SA will also receive monthly reports form NCSC and these will be shared with the AFRSC at future meetings.** **AM raised questions about safeguarding training for NCSC staff and how calls are quality assured. SA responded that this will be included with the reports at the next AFRSC** **<u>ACTIONS</u>**	**SA** **SA**

	• **SA to bring paper to the next AFRSC meeting providing an overview of the NCSC arrangements including how is the service funded, safeguarding training and their governance and quality assurance**	
5.1	**<u>Discharge of the Committee's Statutory Duties</u>** **NT introduced a paper updating the Committee on discharge of statutory duties.** **The AFRSC members agreed it was a useful document.** **AM questioned whether it should include asking DHSC and the CQC whether they agree we have discharged our duties.** **NT agreed for HWE to ask for feedback annually at the CQC Board Meeting we attend.** **<u>ACTIONS</u>** • **NT to arrange for HWE to ask CQC for feedback regarding discharging the Committee's statutory duties annually** • **NT to add strategic aims to column two**	**NT**
6.1	**<u>Forward Agenda</u>** • **LC to add deep dive additional funding to local Healthwatch and non pay expenditure to January 2019 on forward plan** • **LC to add HR review every six months to forward plan** • **LC to add Conference review to January 2019 on forward plan** • **LC to add ASFRC ToR review to January 2019 on forward plan**	
7.0 **7.1**	**<u>Any other issues</u>** **SA raised internal audits stating that we have an opportunity to suggest what we would like to see being audited next year. Our proposals would then be passed to the CQC.** **<u>ACTIONS</u>** • **SA to email AFRSC members for internal audit suggestions**	**SA**
	Date of next meeting – 24 January 2019	

Summary of actions (LAST UPDATED Oct 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	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.**	**Due diligence is going to be carried out starting end of 2018 – Gavin McGregor is taking the lead and it is logged on the Risk Register**	**July 2018**	**Completed**
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 the next workshop agenda: How Healthwatch England is supporting public bodies, such as Health and Wellbeing Boards, to engage with the public, and the impact we are having.**	**Added to workshop forward plan**	**September 2018**	**Completed**
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**	**Completed**
20.	**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.[Amendment – CQC have added us to their forward plan for January 2019 – date tbc by CQC]**	**October 2018**	**Completed**
21.	**18/07/18**	**Imelda Redmond Sandra Abraham**	**IR and SA to prepare a simpler Strategic Risk paper for the next AFRSC.**		**October 2018**	**Completed**
22.	**18/07/18**	**Sandra Abraham**	**SA to change Impact from very high to high on Information Risk Register**		**August 2018**	
23.	**18/07/18**	**Leanne Crabb**	**LC to add Internal Audit to the AFRSC Forward Plan to discuss in October.**		**October 2018**	**Completed**
24.	**18/07/18**	**Leanne Crabb**	**LC to add visit to Newcastle to the AFRSC Forward Plan for October.**		**October 2018**	**Completed**

25.	**18/07/18**	**Leanne Crabb**	**LC to email suggested 2019 meeting dates to the full Committee**		**August 2018**	**Completed**
26.	**16/10/18**	**Leanne Crabb**	**Add deep dive regarding grant giving process to the forward plan for January 2019**		**January 2019**	
27.	**16/10/18**	**Neil Tester**	**Share the grant decision-making framework with the AFRSC members once agreed by the Leadership Team**		**Nov 2018**	
28.	**16/10/18**	**Joanne Crossley**	**Send monthly emails to the AFRSC members giving an update on recruitment**		**Nov 2018**	
29.	**16/10/18**	**Neil Tester**	**Arrange for monthly updates to go to the AFRSC members giving updates on the grant giving process**		**Dec 2018**	
30.	**16/10/18**	**Sandra Abraham**	**Arrange for Risk Owners to review the risks to reflect the AFRSC's concerns**		**January 2019**	
31.	**16/10/18**	**Sandra Abraham**	**To incorporate success indicators in the performance report**		**January 2019**	

32.	**16/10/18**	**Sandra Abraham**	**To amend Aim 1 No 5 to Amber with footnote stating agreed by AFRSC**		**October 2018**	**Completed**
33.	**16/10/18**	**Sandra Abraham**	**To bring paper to the next AFRSC meeting providing an overview of the NCSC arrangements including how is the service funded, safeguarding training and their governance and quality assurance**		**January 2019**	
34.	**16/10/18**	**Neil Tester**	**To arrange for HWE to ask CQC for feedback regarding discharging the Committee's statutory duties annually**		**June 2019**	
35.	**16/10/18**	**Neil Tester**	**To add strategic aims to column two**		**January 2018**	
36.	**16/10/18**	**Sandra Abraham**	**To review Network Development's green status**		**January 2018**	

AGENDA ITEM 2.0

AGENDA ITEM: 2.0

PRESENTING: For information and discussion

PREVIOUS DECISION: None

EXECUTIVE SUMMARY: Quarterly intelligence and policy assessment of the views of 17,172 people who have spoken to local Healthwatch about their experiences of local health and care services. This report covers quarter two 2018/19

RECOMMENDATION: For information and discussion

The Healthwatch England Quarterly Intelligence and Policy Report provides an overview of the key themes we have identified from the insight obtained from local Healthwatch over the last quarter.

The report draws links between the intelligence and our policy activity together with the external opportunities to share our insight.

This quarter we have added in a summary of what we are hearing from the LGBT+ community and prisoners. This forms part of a more focused review of what people who often find it difficult to be heard have told us about their experiences of health and care services.

If you are interested in reading the more detailed version of this report it can be found on our website:

https://www.healthwatch.co.uk/report/2018-10-15/what-people-have-told-us-review-our-evidence-july-september-2018

Quarterly Intelligence and Policy Report - Q2 18/19

Executive Summary

The Healthwatch England Quarterly Intelligence and Policy Report provides an overview of the key themes we have identified from the insight obtained from local Healthwatch over the last quarter. The report also outlines some of the external opportunities that we have identified and the action we have taken.

The report includes an analysis of the insight that we have received from local Healthwatch drawn from their most recent publications and individual feedback captured through the Healthwatch CRM between 01 Jul 2018 and 31 Sep 2018.

This quarter we have added in a summary of what we are hearing from the LGBT+ community and prisoners. This forms part of a more focused review of what people who often find it difficult to be heard have told us about their experiences of health and care services. Last quarter we considered homeless people and older people who have dementia.

If you are interested in reading the more detailed version of this report it can be found on our website:

https://www.healthwatch.co.uk/report/2018-10-15/what-people-have-told-us-review-our-evidence-july-september-2018

What we have heard in Quarter Two 2018/19

17,172 people's views have been received by Healthwatch England and reviewed in Q2 18/19. This includes data collected from 109 publications which involved the views of 12,662 people and an additional 4,510 individual pieces of feedback received through the Healthwatch CRM.

Primary care	
Emerging themes	In Q2 we received increased levels of feedback on the following areas: People having trouble communicating with health professionals particularly around delays in their referrals to see a specialist. People wanting a more empathetic approach from clinicians and staff when discussing issues such as medication. Administrative issues in pharmacies resulting in wrong medication being dispensed or repeat prescriptions being stopped in error.

Primary care	
Ongoing themes	In Q2 we continued to hear that people: Have issues with GP appointments; this includes problems using telephone appointment systems and waiting too long for appointments. Would like to know how to register with a GP when they move area or their GP closes or merges. Struggle to find and access dental services as well as concerns over the cost of dental treatment services.
What are we doing?	We currently sit on the GP Patient Survey Steering Group. We are working with IPSOS MORI and NHS England to help review and develop the survey in time for next year and understanding how the new questions can be used to assist us with our work on underrepresented groups. The scale of evidence we hold on this area, combined with the analysis we have done to date, has secured interest from CQC for a piece of work next year on how people are experiencing variation in care. We have used our intelligence process to date to process 45,000 people's experiences of primary care. This has been put through the policy filter of the Long-Term Plan in order to inform our operational planning and we have also shared this insight with those working on the Long Term Plan. We have asked the teams developing the Long Term Plan to consider what our insight means for: - How the NHS designs technical solutions that work with people - Patient experience of extended opening hours - What people mean by continuity of care - The growing issue of GP closures and mergers - Better use of pharmacy
External opportunities	There is an opportunity for us to raise the profile of challenges faced by those not registered with a GP, e.g. homeless people. We have raised this as part of our evidence submission for the NHS Long Term Plan and we are planning to release a publication on the challenges that homeless people in particular experience before the end of the year.
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.

Primary care	
	We will review feedback on NHS111 to identify any geographical variation and correlation between providers of this service and incorporate it into our work on the NHS long term plan.

Secondary care	
Emerging themes	In Q2 we received increased levels of feedback on the following area: Staff in A&E, GPs and on hospital wards have not given timely diagnoses of conditions such as cancer or broken bones. This has meant that people have had to attend more appointments than necessary to get the treatment they need. People in crisis who are attending A&E are not receiving adequate mental health support and are just being treated for any physical symptoms. We have heard of two cases where patients in crisis overdosed on medication whilst in A&E. People struggle to access interpreters for hospital appointments which is compounded by responsibility for this being pushed back and forth.
Ongoing themes	In Q2 we continued to hear that people: Wait too long in A&E and for urgent care - however we are starting to receive more positive experiences of people receiving treatment within the four hour target waiting time with A&E departments. Have positive feedback about their interaction with staff in urgent care and A&E departments and are feeling listened to and being given detailed explanations about their treatment. However, this is not the case in non-emergency hospital departments where we heard problems about communication between staff and patients. Are continuing to wait long times for appointments with consultants or to have operations. We have heard some cases of patients facing multiple cancellations.
What are we doing?	• We have shared 6,500 people's experiences of A&E with NHS England to inform the long-term plan. This focused on the need for meaningful targets and systems for people to help set expectations around waiting times and support patient choice. These targets would also tell a more sensitive story about demand management in the NHS. A roundtable has been held at which we shared our early findings on this year's data on emergency readmissions work. Our findings will be published in October. We continue to work with the Department of Health and Social Care to ensure that they deliver on their commitment to publishing this data on an ongoing basis.

Secondary care	
External opportunities	Develop insight on people's views on waiting times, potentially through national research. This would enable us to build on our suggestion in relation to the NHS Mandate that current waiting time targets don't tell the full story of what it is like to be a patient. CQC has announced that they will undertake 3 new Local System Reviews and 3 repeat visits. We will continue to support them with this. We have suggested that there are ways in which our network could enable future activity to be undertaken more cost-effectively. This does not form part of CQC's immediate future plans but we will continue to explore this over the next few months.
Internal next steps	We will be looking at how the feedback about empathy towards patients across services has changed over time, as this is integral to good quality health and care service delivery. We will also begin an annual tracker to chart any changes in feedback received on people's experiences of A&E waiting times.

Social care	
Emerging themes	**We have not identified any new social care themes in the quarter.**
Ongoing themes	In Q2 we continued to hear that people: Have trouble finding consistent and accessible information about care at home services Ask for information about equipment services and care assessments. Find significant variation in the quality of care delivered across care homes, including hygiene and activities for residents
What are we doing?	The Healthwatch England National Director is acting as an independent advisor on the Social Care Green Paper. As we move closer to publication we will be initiating a working group to manage our overall contribution. We published 'What people want from social care' in September. In addition we have completed our analysis of the experiences of 5000 carers, which we published on the first day of Q3.

External Opportunities	The development and publication of the Social Care Green Paper presents multiple opportunities for Healthwatch to potentially make a difference. However in order to be most effective the Green Paper must answer these questions: Is it understandable by the public and people who work in social care? Will it support people to plan and make decisions about their care, will the public have access to high quality advice and information to help them make good decisions? Does it facilitate quality and a wide range of choice in social care, do we have plans for a stable and varied social care provider market including care homes and support in the community, and will we have enough people with the right skills working in the sector? Are the funding, charging and access thresholds fair, affordable and transparent? Will it support families and carers? We will use these tests to frame our next stages of policy work on social care.

Mental Health	
Emerging themes	In Q2 we received increased levels of feedback on the following area: People in crisis who are attending A&E are not receiving adequate mental health support and are just being treated for physical symptoms. As recorded in the secondary care section above, we have heard of two cases where patients in crisis overdosed on medication whilst in A&E.
Ongoing themes	In Q2 we continued to hear that: There is no straightforward pathway to access services for young people and that there is a lot of variation between areas. Adults as well as children and young people are waiting for a long time between asking for help and getting it; meaning that some people are reaching a point of crisis with no support.

Mental Health	
What are we doing?	We have started working on two specific areas of mental health support, maternity, and mental health services for people transitioning from childhood to adulthood. We have designed and released three surveys to gather the experiences of people, practitioners and stakeholders to formulate key questions for our network to ask their local communities, with unprecedented take up. The next phase is to mobilise local Healthwatch to collect evidence on our behalf. We have held a workshop to develop options for the Mental Health Programme Steering Group to consider our approach to researching some of the areas highlighted in our literature review. This will inform the next phases of work for the programme. We have used 34,000 personal experiences to inform the development of the NHS long term plan. This is helping the NHS understand services that need to be put in place – e.g. additional peer support – but also the targets used to measure performance.
External opportunities	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. Having reviewed the evidence gathered by local Healthwatch since January 2016 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.
Internal next steps	We are using criteria developed with the Healthwatch England Mental Health Programme Steering Group to prioritise further areas for work. In particular this quarter we have done some work on suicide and have planned activity around prisons and homeless people.

People who find it hardest to be heard	
LGBT+ Community	The following key themes have been identified this quarter on the challenges that people within the LGBT+ community face, particularly in relation to mental health: People fear the stigma that often accompanies conversations around mental health and sexual orientation. Health care professionals can sometimes lack awareness of the different types of support available for the LGBT+ community, At times, GPs make assumptions about people's sexual orientation and gender identity alongside making homophobic remarks. People experience long waiting times to access gender identity services
Prison Population	In Q2 we have heard from 113 people about health and social care for people currently in prison or who have recently left prison. The following key themes have been identified in this feedback: There are pockets of good practice in most of the prisons visited by local Healthwatch, however these are balanced by poor access to appointments and treatment. The biggest barriers to receiving treatment were lack of staff to enable prisoners to attend appointments, poor administration, and long waiting times.
External opportunities	NHS England has made significant commitments to dealing with health inequalities and we know that our insight will be useful in the Long Term Plan process. This can include general commentary on all health inequalities as well as specific evidence such as the work we are conducting on the experiences of homeless people or our planned work on prisons.
Internal next Steps	• We have already published some of our findings on the feedback we receive on LGBT+ issues on our website and will be looking at this community more closely in relation to mental health support as part of our mental health programme. • We will be undertaking development work to understand experiences of prisoners and the impact that Healthwatch can have with this vulnerable population.

MEETING REFERENCE: CM181024

AGENDA ITEM: 2.1

AGENDA ITEM: Integrated communications and public affairs strategy
PRESENTING: Neil Tester
PREVIOUS DECISION: The Committee agreed the Healthwatch England Strategy in January 2018 and received an evaluation of communications and influencing activity as part of year-end reporting in April 2018.
EXECUTIVE SUMMARY: This paper sets out:

1. Vision and purpose for communications and public affairs.
2. Our current situation and SWOT analysis.
3. Proposed approach.
4. Long-term goals.
5. Annual objectives.
6. Action plan.

RECOMMENDATIONS: Committee Members are asked to **APPROVE** this strategy.

1. Vision, purpose and approach for Healthwatch communications and public affairs

The overall Healthwatch strategy commits us to:

- Helping more people access the information they need to take control of their health and care, make informed decisions and shape the services that support them.
- Doubling the number of people sharing views with and seeking information from Healthwatch each year to a million by 2023.
- Ensuring health and care professionals use what people tell them to shape health and care services and support.

The proposed **vision** for our integrated communications and public affairs is:

The relationships and understanding that Healthwatch develops ensure people's voices shape health and care.

The **purpose** of this strategy is:

- To let people know why and how to share experiences with Healthwatch, understand the difference this makes, and take action.
- To let decision-makers know what people are experiencing and how to use Healthwatch insight to improve policy and outcomes.
- To develop a clear, shared identify for "One Healthwatch" across England that is widely seen and understood as an effective, relevant and essential link between people, services and policymakers.

2. Our current situation and SWOT analysis

Our existing focus is on:

- Ensuring people understand how and why to share their experiences with us.
- Delivering strong and usable evidence to those who can make change.

- Demonstrating how people's voices can make a positive difference.
- Demonstrating how this helps services improve and meet strategic challenges.
- Maintaining and developing awareness and understanding of the value and impact of Healthwatch, including the case for resourcing local Healthwatch organisations.
- Increasing communications collaboration across our network, operating more often as "One Healthwatch".
- Establishing an understanding of public and professional awareness and attitudes to provide baselines against which we can assess our future effectiveness.

We have now developed the most comprehensive picture we have ever had of what works in our communications activity, especially online. We know that:

- Public awareness of Healthwatch stood at 33% and understanding of our purpose at 11% in 2017-18. This year's plan aims to see 5-point increases in each of those scores.
- The improved communications support materials we provide for the network are used more often, more consistently by more Healthwatch.
- The more long-term we can be in our planning of Healthwatch-wide promotional campaigns and the earlier the network is engaged in setting their direction, the greater the involvement, activity and impact.
- Our updated website is enabling people to spend longer on the site, looking at more content and taking more action. We now offer a wider range of content relating to people's overall information needs, not simply content relating to Healthwatch activity and reports. But we face a challenge in continuing to grow the site's reach as a number of major websites that linked to ours and sent us substantial numbers of visitors sites have changed how they work, restricting these routes to us. This means that further growth in traffic to our site will increasingly rely on our own social media efforts and encouraging partner organisations and online media to link to us.
- We continue to reach increasing numbers of people through social media and are successfully increasing engagement (people sharing, replying to or commenting on our content and seeking more of it).
- The current growth in our media reach is coming mainly from driving regional, local and trades coverage. This was our planned response to begin to build our media profile back up after disinvestment. We are now once again making inroads with national media.
- Out tactic of returning to our back catalogue, linking previous work to new developments, continues to be an effective way of making our insight and resources go further.
- Our policy and public affairs contact with key national stakeholder organisations is wider, deeper and at a more strategic level than at any time in Healthwatch history. We have successfully established ourselves in a little over a year as a central player in the debate on the future of social care. We are making more consistent contact with local government audiences than ever before. We have maintained our key parliamentary relationship with the Health and Social Care Select Committee and continue to interact with other committees. Our interaction with individual parliamentarians is less frequent than it was before 2016. We have established positive relationships and undertaken joint activity with a range of voluntary sector organisations and plan to develop a number of these relationships into partnerships.
- The profile of our public affairs, policy and media activity relative to our wider communications work has been a direct consequence of previous decisions about priorities, which meant disinvestment in these areas of work. Over the past 18 months we have begun to build this team up. We are now recruiting to ensure that we have effective public affairs and policy leadership and support and that we take a campaigns-led approach to our overall activity. This should begin to have a practical impact in Q4 and accelerate as we start 2019-20.

- We have very limited financial resources to devote to these activities and the network rarely have communications and influencing expertise and dedicated posts. We now have an opportunity to bring in external short-term strategic and tactical support, to be more flexible and drive innovative, creative approaches from which the whole network can benefit and learn. Our recent series of externally-produced animated promotional videos is a good example of this.

Table 1 below represents our communications and public affairs **strengths, weaknesses, opportunities and threats**.

Table 1

Strengths	**Weaknesses**
Nationally owned brand whose personality distinguishes us from other public bodies Support we provide for the network to use the brand is increasingly effective and widely used Where our messages get through at national level, our voice is respected Increasingly asked for insight by civil servants and arms' length body staff, including invitations to join programme boards and advisory/steering groups Reputations and backgrounds of Chair, Committee and National Director Growing visibility and assertiveness without disrupting positioning as a constructive force for improvement Wealth of stories to tell from the network and growing perceived value of how we pull together national insight Unique statutory position provides key hooks for national public affairs activity	Limited financial resources for this activity at national and local levels Low levels of understanding what Healthwatch does amongst public, professionals and policymakers Infrequent/one-off contact with some stakeholders including parliamentarians Limited awareness of strategic value in local government Limited range of advocates to champion our impact Using relatively narrow range of traditional techniques Limited relationships with national media Limited involvement of volunteers including local board members in public campaigns and influencing work We lack a coherent narrative about public involvement and engagement and the role of Healthwatch
Opportunities	**Threats**
Exploit the development of the Healthwatch Reports Library to engage new audiences differently and promote impact Build upon the common purpose in the network demonstrated at conference, including harnessing funding concerns to tell consistent stories of impact	Political and parliamentary (and therefore media) attention is focused elsewhere Funding pressures on councils further reduce network resources and/or reduce the ability of other local organisations to act as partners or advocates

Develop relationships with parliamentarians by providing relevant, tailored information and through range of face-to-face activities Maintain momentum of involvement in development of Long Term NHS Plan and local plans through implementation period Use our five-year corporate strategy to build focused, long-term campaigning approach Ensure network leadership and influencing training and volunteer development enable effective participation in these activities Develop partnerships that enable us to share channels with others, reaching more people and connecting with target audiences at reduced cost Use our developing programme on public engagement to carve out a clear identity as an authoritative voice and source of information on these issues Build networks, communities and partnerships that reduce reliance on media channels and political attention	Constraints on public bodies' digital activities could mean we struggle to move with our audiences Reductions in national funding further limit ability to support these activities

3. Approach

The proposed approach to delivering this through integrated communications and public affairs activity is as follows.

- We will achieve integration of our communications and public affairs approaches by taking a **campaign planning approach**. We will plan new projects on this basis from the start, ensuring everyone involved in delivering elements of every campaign understands the links between activities and how they contribute to overall objectives and this strategy. This clarity will also make it easier for us to identify and build partnerships with other organisations who can help.

- We will plan by **starting from what we want to achieve**, identifying the audiences who can help us achieve our aims and then identifying the right channels, messages and content for them. Our programme management framework builds **equality and diversity** issues and objectives into all planning and this will ensure we always consider how we can visibly connect with all sections of the community.

- We will adopt an **experimental and creative approach to planning and delivery**, always asking who can help make our messages and content go further and reach new people, as well as what new techniques we could borrow or invent. The experimental approach we

are taking to the #NHS100 national conversation is a good example of how this will drive us into fertile new territory.

- We will increasingly move away from reliance on launching set-piece reports, instead focusing on generating a **range of formats** that will work for each of our audiences to improve how often our materials are used, shared and responded to. This will include accelerating our use of **video, audio and storytelling**.

- We will maximise the power of our brand by delivering as **"One Healthwatch"**, ramping up how we involve the network in planning and delivery and building on our existing support with information that enables local tailoring, contextualising data from Healthwatch and other organisations, and focused policy and public affairs briefings to enable more effective local influencing work.

- We will continue to develop our **audience and content strategy** to ensure a regular stream of fresh, relevant, reliable content that means people will get the information they need; policy and professional audiences will perceive clear links between our insight and the issues they are interested in; and all audiences will gain a clear picture of the impact and value of Healthwatch in improving health and care. This will include exploiting the potential of our new Healthwatch Reports Library. We will also need to build further on our existing commitment to making our communications and content accessible to people with specific communication needs.

- We will place **regional and sub-regional lenses** on this work and build these angles into all of our plans. The 7 new NHS England / NHS Improvement regions will create specific stakeholder and public affairs environments in which we will lead and support Healthwatch to influence effectively, while retaining a clear voice at the level of Integrated Care Systems and maintaining the visible relevance of each Healthwatch to the communities within its local authority area. We will specifically adopt a **pan-London approach** to working with Healthwatch across the capital, who support this as a route to raising awareness in a difficult media market, developing local authority relationships in a complex council environment and building on our emerging links at the level of London-wide government.

- As the Committee has previously discussed, to engage meaningfully with policy and public affairs audiences as well as generating the professional culture change our strategy aims to deliver we will need to develop a more **confident public voice on a wider range of issues**. We have successfully established ourselves as constructive but assertive on people's behalf in relation to public involvement in major change and long-term planning. We will now take the learning from how we have achieved this and use it – **always basing our position on our own and other strong evidence** – to engage in wider conversations and debates. This approach is intended to generate more opportunities for us to demonstrate how we operate and what we are about, leading to more decision-makers and those who help inform their decisions coming to us and inviting us into new networks and environments. For example, if we are to achieve our strategic aims about professional culture change, we will need to engage in debates about professional education and regulation. This means we will need to expect, welcome and embrace others challenging us. It will show they are listening.

- We will allocate staff time to building **online and physical networks and communities** that connect those who are committed to or interested in our culture change. This is

intended to generate a cascade of our messages and content through the wider networks in which those community members also exist. We hope that Committee members will want to play an active part in these communities, drawing others into them but also gaining additional insights to bring to Committee discussions. The same is true for the wide range of volunteers and local board members we have across the network.

- However much information we provide through the media, online and through our own and others' channels, the key to effective public affairs is establishing **authority and trust**. This will continue to require face-to-face contact with those who make and influence decisions, including parliamentarians and we will achieve this through a planned programme of senior meetings to build new relationships and unlock the value of existing ones; through seeking significant speaking opportunities to drive and shape debates that set the context for those meetings; and through effective management of the increasing number of inbound invitations to meetings, events and strategic forums. We will unleash the **power of our 6,000 potential ambassadors** by ensuring that everyone who volunteers or works for Healthwatch knows what we are trying to achieve across the board and is also updated regularly on our latest insights and messages – as well as the influencing opportunities presented by the work of others. We will do this by building on the development of the Intelligence and Policy Report and our network intelligence briefing. This work will also help to ensure the Committee is sighted on developing opportunities and positions.

- We will take a **phased and developmental approach** to implementation and refinement of this strategy, to ensure that each of the planned steps forward and new approaches is given the necessary focus to maximise effectiveness.

4. Long-term goals

By 2023, when we reach the end of the overall strategy period, we aim to have attained 5 long-term goals:

- To have achieved year-on-year improvements in awareness, understanding and attitudes amongst all of our key audiences.
- For those setting health and care policy, commissioning and delivering services to be making increasing use of our insight and feeding back to people about this.
- For others to see us and interact with us as "One Healthwatch".
- For others to promote the value and impact of Healthwatch as part of their broader support for public involvement in health and social care.
- To have evaluated and be able to specify the contribution our communications and public affairs work has made to successful delivery of our overall strategy.

Appendix 1 contains the relevant indicators of success agreed as part of the 2018-23 strategy.

5. Annual objectives

Detailed workplans and targets (including specific reach and awareness targets) will be set and reviewed annually as part of the business planning process.

Year	Objectives
Q3-4, 2018-19	We have measured public awareness and attitudes, established baselines and identified the information people need from us.

	More people are aware of and understand the role of Healthwatch.
	Our staff and volunteers understand our vision, purpose and approach and their role in delivering our strategy.
	We have systems in place to provide volunteers with the information to be effective ambassadors.
	Our commitment to equality, diversity and human rights is embedded in all of our communications and public affairs activity.
	We have measured stakeholder awareness of, understanding of and attitudes to Healthwatch and set baselines.
	We have measured professional awareness of Healthwatch and attitudes to/experience of involving people in care; and set baselines.
	We have effectively communicated the messages from our engagement literature review so services understand the economic and quality benefits of involving people.
	We understand the informal network of health and social care professionals and policymakers willing to champion the value of public involvement; we are making contact with them; and we have plans in to launch new networks and communities.
	We have tested the use external stakeholders are able to make of the Healthwatch Reports Library and have built use of this resource into communications and public affairs plans.
	We have used our Annual Report to Parliament to support our initial programme of meetings with stakeholders and parliamentarians, including our January event to connect parliamentarians with local Healthwatch.
	We have effective plans and the right resources in place to deliver 2019-20 activity and develop longer-term plans.
2019-20	We have achieved significant roll-out of our network digital support offer to improve consistency.
	Volunteers report they are using our briefing materials and this is improving their ability to represent Healthwatch.
	We have reached more people with more information; we have reached more stakeholders with more insight; more organisations and individuals, including local and national politicians, are referencing Healthwatch work and impact.
	We have delivered improved levels of public awareness and understanding of Healthwatch.
	We have delivered improved levels of awareness, understanding and positive sentiment amongst local and national stakeholders.

	We are informing and interacting effectively with existing networks of health and social care professionals and policymakers willing to champion the value of public involvement; and we have established new networks and communities.
	We have delivered and measured the impact of activity in each NHS region, in each STP/ICS area, and across London.
2020-2021	We have reviewed and if necessary updated this strategy.
	We have continued to reach more people with more information, and more stakeholders with more insight; and we have delivered a further increase in the number of organisations, including local and national politicians, referencing Healthwatch work and impact.
	We have continued to deliver increased levels of public awareness and understanding of Healthwatch; and we can make links between communications activity and numbers of people sharing information with and seeking information from us.
	We have delivered further improved levels of awareness, understanding and positive sentiment amongst local and national stakeholders.
2021-2022	We have continued to reach more people with more information, and more stakeholders with more insight; and we have delivered a further increase in the number of organisations, including local and national politicians, referencing Healthwatch work and impact.
	We have continued to deliver increased levels of public awareness and understanding of Healthwatch; and we can make links between communications activity and numbers of people sharing information with and seeking information from us.
	We have delivered further improved levels of awareness, understanding and positive sentiment amongst local and national stakeholders.
2022-2023	We have achieved further year-on-year improvements in awareness, understanding and attitudes amongst all of our key audiences.
	Our public, policy and professional audiences see us and interact with us as “One Healthwatch”.
	Other national and local organisations, policy and political stakeholders and clinicians promote the value and impact of Healthwatch as part of their broader support for public involvement in health and social care.
	We have evaluated and can specify the contribution our communications and public affairs work has made to successful delivery of our overall strategy.

6. Action plan

Year	Action
Q3-4, 2018-19	Deliver public awareness and attitudes survey and set baselines to inform 2019-1920 plans.
	Implement integrated campaign planning approach to activity surrounding: • Emergency readmissions • NHS Long Term Plan • Social Care Green Paper • Mental health programme • Annual Report insight • Network funding • Communication of impact • Messages from our engagement literature review
	Reinforce communication to staff and volunteers so they understand our vision, purpose and approach and their role in delivering our overall strategy, as well as their role in relation to our communications and public affairs plans.
	Implement briefing systems to provide the Committee and network volunteers with the information to be effective ambassadors.
	Ensure our commitment to equality, diversity and human rights is embedded in all of our communications and public affairs plans and activity.
	Measure stakeholder awareness of, understanding of and attitudes to Healthwatch and set baselines for 2019-20 work.
	Measure professional awareness of Healthwatch and attitudes to/experience of involving people in care; and set baselines for 2019-20.
	Identify key health and social care professionals and policymakers willing to champion the value of public involvement, contact them and plan to launch new networks and communities in 2019-20.
	Test the use external stakeholders are able to make of the Healthwatch Reports Library and build use of this resource into communications and public affairs plans for 2019-20.
	Use Annual Report to Parliament to support an initial programme of meetings with stakeholders and parliamentarians, including delivering our January event to connect parliamentarians with local Healthwatch.
	Develop effective plans and put the right resources in place to deliver 2019-20 activity and develop longer-term plans.
2019-20	Deliver significant roll-out of our network digital support offer to improve consistency.
	Measure how volunteers are using our briefing materials and how this is improving their ability to represent Healthwatch.

	Implement campaign planning approach across all activity and make public affairs use of all insight shared.
	Deliver and measure the impact of activity in each NHS region, in each STP/ICS area, and across London.
2020-2021	Use evaluation to review and update strategy.
	Deliver integrated activity to achieve annual objectives.
2021-2022	Deliver integrated activity to achieve annual objectives.
2022-2023	In addition to delivering planned activity, measure achievement of the long-term goals for the communications and public affairs strategy.
	Support public and stakeholder involvement in development of post-2023 strategy and update communications and public affairs strategy as part of this process.

Appendix 1: Relevant indicators of success from the Healthwatch 2018-23 strategy		
2018-19	**2020-21**	**2022-23**
We understand and can track public awareness, attitudes and experience of being involved in care.	We provide common ways for people to get or find the information they need to have their say.	More people know their rights and can access the information they need to make decisions about care and the services that support them.
We have identified the information people want to know to take control of their health and care.	We run campaigns across England to target those who find it hardest to be heard.	More people are confident about how to be an equal partner in their care.
We have increased public awareness and understanding of Healthwatch.	We work with a range of organisations to empower more sections of the community to have their say.	
Our staff and volunteers understand our vision, purpose and approach and their role in delivering our strategy.	We make the most of our volunteers' talent by supporting more of them to champion and represent the views of their community.	We can demonstrate the added value our work has for society.
Our commitment to equality, diversity and human rights is embedded in our day-to-day work with communities, colleagues and partners.		
We understand and can track professional awareness, attitudes and experience of involving people in care.	More professionals understand our role and report a positive change in attitude towards involving people in care.	The NHS and social care services use people's experiences of care to measure their performance.
Services understand the economic and quality benefits of involving people.	Evidence about people's views of health and care can be easily accessed and reflects the diverse communities we serve.	The involvement of people in shaping care is a core subject in the education of health and social care professionals.
A network of health and social care professionals and policymakers to promote and champion the value of public involvement exists.	We have helped services and policymakers understand and adopt better ways of mobilising their communities to solve problems.	Every section of the community plays a greater role in setting health and care priorities.

AGENDA ITEM No: 2.2

AGENDA ITEM: Updated Standing Orders and Accountability Framework

PRESENTING: Sir Robert Francis

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

RECOMMENDATIONS: The Committee is asked to **APPROVE** the suggested amendments.

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. This was brought to the Committee at the 1 August Committee Meeting and the Committee requested the following amendments:

- in 6.1.4 of the Standing Orders a three-day timescale for agenda and papers was too short and should be seven days or five working days.
- that behaviours be inserted in to the document.
- a review date be inserted into the document for two years' time.

These have been added into the document and highlighted in pink.

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.

1.3 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.

3.2.4 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.

3.2.5 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.

3.2.6 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[7]

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 the access

[7] The Members' Code of Conduct

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.

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

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

5.4 Chairing Meetings

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

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

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

5.5 Quorum for Meetings

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

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

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

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

5.6 Voting

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

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

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

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

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

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

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

5.7 Notices of Motion

5.7.1 Any motion proposed must be seconded before it is considered.

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

.

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

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

5.7 .5 The mover of a motion has a right of reply at the close of any discussion on the motion or any amendment thereto.

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

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

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

6. AGENDAS, MINUTES AND PAPERS

6.1 Setting the Agenda

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

6.1.2 Committee members wishing to put forward agenda items should notify the Chair at least 15 clear working days before the meeting. The request must state whether the item of

business is proposed to be transacted in the presence of the public and must include appropriate supporting information. Requests made less than 10 clear working days before a meeting may be included on the agenda at the discretion of the Chair.

6.1.3 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).

6.1.4 The agenda will be sent to Committee members at least 7 days (5 clear working days) before the meeting and supporting papers will accompany the agenda, save in emergency.

6.1.5 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.

7.1.3 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.

7.1.4 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.

7.1.5 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[8]

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.

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

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

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

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

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

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

10.1 Suspension of Committee Standing Orders

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

10.1.2 A decision to suspend Committee Standing Orders will be recorded in the minutes of the meeting.

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

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

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

10.2 Approval, Variation and Amendment of Committee Standing Orders

10.2.1 Any amendment to these Committee Standing Orders can only be approved if:

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

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

August 2012
Updated: April 2018 **(if agreed at April Committee)**
To be reviewed July2020

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.[9] 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

[9] 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

way that delivers value for money and has appropriate governance, risk management and internal controls in place.

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

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

2.4 The CQC Chief Executive's responsibilities as Accounting Officer for HWE

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

2.4.2 The CQC AO's responsibilities extend to HWE for:

- safeguarding the HWE public funds for which he has charge and ensuring propriety and regularity in the handling of those public finds;
- ensuring that HWE's resources are used economically, efficiently and effectively for the purposes intended;
- 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[10]

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

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

systems, including by using CQC's Audit and Risk Assurance Committee to help HWE to address key financial and other risks.

3.2.3 Individual Committee Members should:

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

3.3 Terms of HWE Committee Appointments

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

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

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

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

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

3.3.5 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[11]

4.1 Annual Report and accounts

4.1.1 HWE's audited accounts will be published within CQC's audited accounts after the end of each financial year. The rules governing the external audit of CQC, as set out in the DHSC/CQC Framework Document, will apply to HWE and CQC's Governance Statements will also make reference to HWE.

4.1.2 HWE is required to publish its own annual report which outlines its main activities and performance during the previous financial year and sets out in summary form forward its plans. A draft of the report should be submitted to the Department and to the CQC Board at least 10 working days before the proposed publication date.

4.1.3 The report and accounts will be laid in Parliament and made available on HWE's website.

4.2 Corporate Governance

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

4.3 Strategic and Business Planning

4.3.1 HWE will prepare and publish a strategic plan and an annual business plan which reflects HWE's statutory duties, has regard to DHSC policy and includes a budgeted work programme for that year. The HWE plan will be produced in accordance with the Department's business planning guidance and Managing Public Money and will demonstrate how HWE is contributing to the achievement of the Department's objectives.

4.3.2 The Accounting Officer will confirm that the proposed plan and budget are within approved funding provision for HWE, meet HWE's statutory role and contribute to the achievement of DHSC's objectives. The AO may veto anything in HWE's business plan which he believes is not a proper use of HWE's funds.

4.4 Budgeting Procedures

4.4.1 Unless agreed by the Department of Health and Social Care and, as necessary, HM Treasury, HWE shall follow the principles, rules, guidance and advice in *Managing Public Money*. The HWE Director will refer any difficulties or potential bids for exceptions in the first instance to the CQC Accounting Officer and then to the Sponsorship Team for CQC in the Department of Health and Social Care.

4.4.2 Each year the Department will send the Care Quality Commission a formal statement of the annual budgetary provision allocated by the Department for HWE in the light of competing priorities across the Department and any forecast income approved by the Department. Any grant-in-aid provided by the Department of 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

[11] 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

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)
To be reviewed July2020

AGENDA ITEM No.2.3

AGENDA ITEM: Equalities, Diversity and Human Rights Policy Update

PRESENTING: Imelda Redmond

PREVIOUS DECISION: The Committee agreed at the August meeting to consider the Equality, Diversity and Human Rights Policy in October

EXECUTIVE SUMMARY: This paper proposes an updated Equality, Diversity and Human Rights Policy

RECOMMENDATION: Committee Members are asked to **APPROVE** the EDHR Policy.

Healthwatch England Equality, Diversity and Human Rights Policy

Narrative

The scope of the policy covers Healthwatch England as an organisation and does not extend to local Healthwatch.

We are grateful for the advice of CQC EDHR Coordination Group Chair who will provide support to our policy to ensure that we are aware of legal changes as and when they occur. See draft version of the Policy below.

We will have an external facing Public Sector Equality Duty Statement which is embedded in the Policy. The statement will be featured on our website.

An EDHR Duties Impact Assessment form (EHRDIA) will be embedded into our Programme Management Framework. The assessment will cover all six programmes and be overseen by Imelda.

We have joined the EDHR network at CQC, which informs us on developments around legislative changes, staff equality and inclusion. The Network provides a forum for engagement and advice to our equality objectives.

Healthwatch England
Equality, Diversity & Human Rights Policy

Policy Statement for Staff

Healthwatch England (HWE) is committed to creating a culture where staff are valued, involved, supported and feel safe from discrimination. HWE recognises the real benefits of having a diverse community of staff and is working towards building and maintaining an environment which values diversity, in which human rights, diversity and equality of opportunity are promoted actively, and in which unlawful discrimination is not tolerated.

HWE believes everyone should be treated with dignity and respect and acknowledges that discrimination affects people in complex ways and is committed to challenging all forms of inequality. To this end, HWE will aim to ensure that:

- In line with the Equality Act 2010, individuals are treated fairly, and protected from discrimination, regardless of
    - Age
    - Disability
    - Gender reassignment
    - Pregnancy and maternity
    - Race (including ethnic or national origins, colour and nationality)
    - Religion or belief
    - Sex (gender)
    - Sexual orientation
    - Marriage and civil partnership

- it affords all individuals the opportunity to fulfil their potential

- it promotes an inclusive and supportive environment

- it recognises the varied contributions to the achievement of HWE's strategic priorities made by individuals from diverse backgrounds and with a wide range of experiences

Scope
This policy applies to all HWE staff

Key Principles
The key principles that underpin this policy are:

- Everyone is entitled to a working environment which promotes dignity and respect for all.

- No form of intimidation, bullying or harassment will be tolerated, and any such case will be fully investigated. Support is also in place via an employee

assistance programme (link), for any employee who feels they have been discriminated against or needs support.

- HWE will avoid unlawful discrimination in all aspects of employment including recruitment, promotion, opportunities for training, pay and benefits, discipline, performance management and selection for redundancy.

- All individuals working for HWE are required to assist the organisation in meeting its commitment to provide equal opportunities in employment and avoid unlawful discrimination.

Person and role specifications will only require what is necessary for the effective performance of the job. Candidates for employment or promotion will be assessed objectively against the requirements for the job, taking account of any reasonable adjustments that may be required for disabled candidates.

HWE will continuously review its employment practices and procedures to ensure fairness.

HWE will monitor the

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Race (including ethnic or national origins, colour and nationality)
- Religion or belief
- Sex (gender)
- Sexual orientation
- Marriage and civil partnership

composition of the existing workforce and of applicants for jobs where this information is given, and will consider what action is appropriate to address any issues which are identified as a result.

The commitment to human rights, diversity and equality in the workplace is good management practice and makes sound business sense.

HWE will provide mandatory training in equality, diversity and human rights for all employees and ensure that equality and human rights issues are covered in other training where relevant.

Breaches of HWE's Equality, Diversity & Human Rights Policy will be regarded as misconduct and could lead to disciplinary proceedings.

Equality Statement

HWE is committed to ensuring that all people management policies, and their application, are free from any form of discrimination on the grounds of:

- Age

- Disability
- Gender reassignment
- Pregnancy and maternity
- Race (including ethnic or national origins, colour and nationality)
- Religion or belief
- Sex (gender)
- Sexual orientation
- Marriage and civil partnership

HWE will monitor use of this Equality, Diversity & Human Rights Policy in order to identify any adverse impact on any particular group of individuals, and take action accordingly.

Effective Date
This policy is effective from 1st November 2018

Review
This policy will be kept under review in terms of changes to legislation and information arising from equalities monitoring. We will also undertake formal review of this policy and its associated procedure and guidance documents on a rolling two-year basis.

* A "worker" is an individual who has a contract personally to do work' for HWE (this includes contractors and temporary staff). When applying the terms of this policy to a "worker" managers should first seek advice from the CQC HR Advice and Guidance team.

All employees should confirm that they have read this policy as part of the induction process.

Supported by CQC HR Policy – Equality, Diversity and Human Rights – final version – effective 1st February 2011 Joint Negotiating and Consultation Committee – ratified 15th June 2011

Our Equality Duties and Ambitions

Public Sector Equality Duty Statement

As a public sector organisation, Healthwatch England has legal duties under the Equality Act 2010. We want to make a significant difference through our work on tackling inequality for people who use our services and for our own staff.

The general equality duty requires us to consider equality when we are designing and delivering public services and in how we carry out our internal functions such as in human resources.

At Healthwatch England, we use **Equality Impact Analyses** to ensure that changes to our policies and to the way we do our work continue to advance equality, eliminate discrimination and foster good relations between people who share protected characteristic under the Equality Act 2010:

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Race (including ethnic or national origins, colour and nationality)
- Religion or belief
- Sex (gender)
- Sexual orientation
- Marriage and civil partnership

The specific equality duty requires us to provide information about what steps we are taking on equality. This will be published in our Annual Report. We have set specific and measureable equality objectives for our organisation as part of our strategic aims.

AGENDA ITEM No: 2.4

AGENDA ITEM: Committee forward plan

PRESENTING: Sir Robert Francis

EXECUTIVE SUMMARY: This report shows the forward plan for Committee Meetings and Committee workshops

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

Healthwatch England Public Committee Meeting Forward Agenda 2018/19

Oct 2018 Public Meeting	• LHW Presentation • Welcome and Apologies • Declarations of Interests • Previous Minutes, Actions and Matters Arising • Chair's Report • National Director's Report • Committee Member Update – verbal • Delivery and half year financial and performance results • AFRSC Minutes • Intelligence Report • Integrated Comms and Public Affairs • Update Standing Orderss • Questions from the Public
Feb 2019 Public Meeting	• LHW Presentation • Welcome and Apologies • Declarations of Interests • Previous Minutes, Actions and Matters Arising • Chair's Report • National Director's Report • Committee Member Update – verbal • Delivery and Performance Update Draft budget Draft work plan 2018/19 • AFRSC Minutes • Intelligence Report • Summary of Audit (if completed) • Conference Evaluation Paper • Review June Workshop Actions • Questions from the Public
May 2019 Public Meeting	• LHW Presentation • Welcome and Apologies • Declarations of Interests • Previous Minutes, Actions and Matters Arising • Chair's Report • National Director's Report • Committee Member Update – verbal • Annual Delivery and Performance Update • AFRSC Minutes – including 2019/20 Budget • Annual Intelligence Report • Questions from the Public
Aug 2019 Public Meeting	• LHW Presentation • Welcome and Apologies • Declarations of Interests • Previous Minutes, Actions and Matters Arising • Chair's Report

	• National Director's Report • Committee Member Update – verbal • Delivery and Performance Update • AFRSC Minutes • Intelligence Report • Questions from the Public
Nov 2019 Public Meeting	• LHW Presentation • Welcome and Apologies • Declarations of Interests • Previous Minutes, Actions and Matters Arising • Chair's Report • National Director's Report • Committee Member Update – verbal • Delivery and Performance Update • AFRSC Minutes • Intelligence Report • Annual Report • Annual Data Return • Questions from the Public
	Dates for meetings after 2019: Review Standing Orders – July 2020

Healthwatch England Workshop Forward Plan 2018/19

Dec 2018	• Data return • Key messages • How Healthwatch England is supporting public bodies, such as Health and Wellbeing Boards, to engage with the public, and the impact we are having.
Apr 2019	• Review 'Working together to deliver our objectives' from June 2018 workshop • Stakeholder map
July 2019	• Conference
Oct 2019	• Annual Report
Nov 2019	• Data return

End of public session papers