HEALTHWATCH ENGLAND
COMMITTEE MEETING PAPERS

Wednesday 4th February 2015
London

Venue: Holiday Inn, 137 King's Road, City Centre, Brighton BN1 2JF

TABLE OF CONTENTS

AGENDA ITEM: 2

SUBJECT OF REPORT: Previous Committee Minutes

PRESENTING: Anna Bradley

PURPOSE: This report will reflect the minutes and actions of the Committee Meeting of 22 October 2014

RECOMMENDATIONS: The Committee are asked to approve the minutes and action log of the Committee Meeting of Wednesday 22 October 2014

RESOURCE IMPLICATIONS: N/A

RISK AND MITIGATION: N/A

EQUALITY AND DIVERSITY: N/A

Previous Minutes of the Committee Meeting on Wednesday 22 October in Hammersmith, London

Present (Committee Members): Anna Bradley (Chair), John Carvel, Deborah Fowler, Christine Lenehan, Pam Bradbury, Michael Hughes, Jenny Baker, Patrick Vernon, Alun Davies, Jane Mordue, Liz Sayce, Andrew Barnett and Paul Cuskin.

In attendance: Dr. Katherine Rake, Dr. Marc Bush, Sarah Armstrong, Deborah Laycock, Sarah Vallelly, Kathy Peach, Susan Robinson and Esi Addae.

A full recording of this session is available at www.healthwatch.co.uk or https://www.youtube.com/watch?v=Aa-EutX3LaA&feature=youtu.be

AGENDA ITEM 1 - Welcome
The Chair opened the meeting and thanked local Healthwatch present for their contribution during the workshop earlier in the day.

AGENDA ITEM 2 – Previous Minutes
Deborah Fowler clarified that in relation to the Accessing Primary Care project it was agreed that the project should be forward looking. Rather than considering the current problems often experienced in accessing GP services, the project should consider what people might like primary care to look like in 5 to 10 years.

AGREED: The minutes if the meeting held on 22 October 2014, were reviewed and accepted as a true record of the meeting.

AGENDA ITEM 3 – Declarations of Interests

Alun Davies declared his active involvement in the Green Party. He will be an agent for a Green Party candidate in the local election to Bristol City Council. It was agreed that Alun Davies would take leave from the Committee for the duration of the election campaign. This will be from March to May 2015 and would be confirmed at the February 2015 Committee Meeting.

AGENDA ITEM 4 – Chair's Report
Anna Bradley presented her report to the Committee.

Members welcomed the Chair's report and the following comments were made:

- Congratulations were given to the staff team for their work in delivering the launch of the Annual Report. They also noted fantastic attendance and engagement between local Healthwatch and their MPs and encouraged local Healthwatch to build on this.
- It was highlighted that the Children and Young People's Mental Health and Wellbeing taskforce should also consider avenues where there are system failings in recognising mental health issues in children. Committee Members appreciated hearing that issues of mental health and wellbeing are being addressed as an area of joint working between the Department of Health and the Department of Education.

1. **ACTION – To capture the follow up activity between local Healthwatch and their MPs after the Annual Report launch event**

AGENDA ITEM 5 – Chief Executive's Report
Dr. Katherine Rake, Chief Executive, presented her report to the Committee.

Committee Members welcomed the Chief Executive's report and the following comments were made:

- The update on the evaluation and learning from the Annual Conference was appreciated and Members asked for more local Healthwatch involvement during workshop sessions at the next Conference.
- It was noted that the staff team continue to have conversations with the Department of Health on the budget pressures facing local Healthwatch. They were assured that a letter from the Department of Health will be sent out in advance of funding negotiations proceeding.
- The financial sustainability of local Healthwatch was recognised as an ongoing issue. It was suggested that the role of Healthwatch England will be to support local Healthwatch during conversations with respective local authorities on the funding of statutory functions.
- An update was requested on the development of the Memorandum of Understanding with NHS England.
- It was noted that many local Healthwatch are changing their form and would need support and training on the different models of governance.

2. **ACTION – Present the NHS England and Healthwatch England Memorandum of Understanding at the February Committee Meeting**

AGENDA ITEM 6 – Care.data and Accredited Safe Havens
Sarah Vallelly presented her report to the Committee.

Committee Members welcomed the report on Care.data and Accredited Safe Havens, the following comments were made:

- That Care.data was part of a broader issue around the protection of health and social care information. The paper highlighted the Healthwatch principles for information on health and social care, rather than Care.data alone.
- That the role of Healthwatch England is to be a critical friend to the Care.data programme, to hold it to account and to challenge it. Importantly for consumers, this should mean that they have enough information to make an informed choice.
- It was agreed that the role of the 4 local Healthwatch involved in the Clinical Commissioning Group (CCG) pathfinders phase will be to help access harder to reach communities and that different models of communication are explored appropriately.
- The Committee emphasised the importance of the process for the public to opt out.
- It was agreed that the principles would be referred to as the Healthwatch principles for information sharing and social care as this will also incorporate Care.data.
- Clarification was sought on who determines whether the process is 'unduly compromising of people's anonymity, safety or treatment and tasked the staff team to clarify this term.
- Discussions addressed the ownership of data and who in turn authorises access.
- That the next stage will be the assurance needed for the public on the protection of anonymity and how this assurance will be shared publicly.

AGENDA ITEM 7 – Local Intelligence Report
Deborah Laycock and Sarah Vallelly presented the Local Intelligence report to the Committee.

Committee Members welcomed the Local Intelligence report and the following comments were made:

- Concerns were expressed about the nature of social care service providers who are not registered by the CQC. The Committee were assured that there are ongoing conversations with CQC on the quality assurance of providers paid for by personal budgets who fall outside the standard areas of registration and regulation.
- Questions were raised about identifying the escalations service as a pressure point and the strategic decisions required from the Committee.

3. **ACTION: To present proposals of how the escalations process will develop at the February Committee Meeting.**

AGENDA ITEM 8 – The principles of the special project on Child and Adolescent Mental Health Services (CAMHS)
Dr. Marc Bush presented the outline of the special project on Child and Adolescent Mental Health Services to the Committee.

Committee Members welcomed the outline of the special project on Child and Adolescent Mental Health Services and the following comments were made:

- There was agreement that the role of Healthwatch England on the Children and Young People's Mental Health and Wellbeing task force was not to replicate work but to highlight the inclusion of under presented groups. These include but are not limited to lesbian, gay and transgender (LGBT) youth, young offenders and Black and Minority Ethnic (BME) groups.
- The Committee were clear that the overall purpose would be to make sure that work on CAMHS (within larger system changes) recognises the importance of the difference that can be made to the lives of children and young people.
- It was suggested that local Healthwatch working on CAMHS projects should be involved in the project.

AGREED: The Committee agreed the principles and the approach of the Child and Adolescent Mental Health Services activity.

It was agreed that the project on CAMHS becomes an important activity for Healthwatch England but it may not be specifically a special project. The Committee agreed that the next second project would be on hold. The next stage would be to review CAMHS as the next project after the publication of the Children and Young People's Mental Health and Wellbeing task force report.

4. **ACTION: Setup a reference group for local Healthwatch who are working on CAMHS projects to include their activity in the overall work and the Healthwatch England task and finish group – currently**

AGENDA ITEM 9 – Diversity and Inclusion Update
Sarah Armstrong presented Diversity and Inclusion update to the Committee.

Committee Members welcomed the Diversity and Inclusion update and the following comments were made:

- It was suggested that in the next data return from local Healthwatch, questions are asked on how diversity issues are being addressed in engagement work.
- Committee Members noted that the approach to diversity and inclusion should be two fold, the goal to make it part of everyday work and the other to consider it as a standalone issue.
- They encouraged the opportunity for local Healthwatch to share learning on diversity and inclusion issues.

AGREED: The Committee agreed the approach of the Diversity and Inclusion plan

5. **ACTION: Present the accessibility policy and good practice guidance to the Committee in February**

AGENDA ITEM 10 – Working relationship with the Care Quality Commission (CQC) on

inspections
Susan Robinson presented the update on the working relationship with CQC.

Committee Members welcomed the update on the working relationship with CQC on inspections and the following comments were made:

- The update on the on-going dialogue between CQC and Healthwatch England as well as local Healthwatch was appreciated.
- Assurance was given that material is being produced to share with inspectors at CQC highlighting the importance of the relationship they have with local Healthwatch.
- Clarity was sought on the communication that is shared with local Healthwatch post inspections.

AGENDA ITEM 11 – Service Change Project Plan
Susan Robinson presented the Service Change Project Plan.

Committee Members welcomed the Service Change Project Plan and the following comments were made:

- Committee Members appreciated the project plan and also highlighted that the next stage would be to move toward how local Healthwatch support each other and share learning from their experience of service change.
- The Committee were assured that the geographical areas were not the only areas of support and that the resource pack to be produced will be shared with the whole network.
- The Committee highlighted that as the project develops Healthwatch England's leadership role needs to be clearer, in particular; 1. Draw out learning from local Healthwatch for national conversations; and 2. Demonstrate value and difference that more strategic conversations with the public can make on service change. E.g. Work on Primary Care.

AGREED: The Committee agreed the Service Change project plan

6. **ACTION: A plan for Healthwatch England's role on Service Change to be presented at the May Committee Meeting**

AGENDA ITEM 12 – Public Participation session

AGENDA ITEM 13 – Enhanced Governance (a. Senior Independent Member; b. Terms of Reference for the Remuneration Committee and c. Conflicts Policy)
Sarah Armstrong presented the Enhanced Governance report.

Committee Members welcomed the Enhanced Governance reports and the following comments were made:

<u>Senior Independent Member:</u>

- As part of further governance processes, the Committee were assured that the next stage will clarify the governance arrangements for all roles and policies.

Conflict of Interest Policy

- In regards to the conflict of interest policy, Members wanted an inclusion of recent past conflicts as part of the policy.
- The team were tasked to clearly define the explanation and to note that the form should be a prompt tool for Committee Members.
- In relation to political conflict, it was clarified that Alun Davies would take leave from the Committee for the duration of the election campaign (March to May 2015).
- It was suggested that in continuing with discussions – the Committee would further discuss political interests.

Terms of Reference for the Remuneration Committee

- It was noted that the terms of reference should include a section detailing the equality and diversity aspects issues of pay and performance for the Senior Management Team.

AGREED: The Committee agreed the Senior Independent Member role; Conflict of Interest policy and the Terms of Reference for the Remuneration Committee

7. **ACTION: Present the Complaints Champion terms of reference and Whistleblowing policy as further development of governance arrangements at the February Committee Meeting**

8. **ACTION: Redraft the definition within the Conflict of Interest policy**

9. **ACTION: Bring back a paper on political conflicts in May**

AGENDA ITEM 14: Committee Forward Plan
Esi Addae, Committee Secretary presented the Committee Forward plan for approval.

The Committee welcomed the plan and the following comment was made:

- It was noted that the local intelligence report should be included as part of the standing items and that updates for major reports should be included within respective reports.

AGREED: The Committee agreed the Committee forward plan

8. ACTION: Present the Committee forward plan for approval in upcoming Committee papers

AGENDA ITEM 15 – Audit and Risk Sub Committee Chair's Report
Jane Mordue, Chair of the Audit and Risk Sub Committee, presented the report to the Committee.

The Committee welcomed the update and no comments were made.

AGENDA ITEM 16 – Committee Members update

- There were no comments regarding the Committee Members update.

AGENDA ITEM 17 – Operational Update

Sarah Armstrong, Head of Operations, presented her update to the Committee.

Committee Members welcomed the update and the following comment was made:

- They wanted an opportunity to reflect on the correlation between media activity and enquiries and the need to monitor this as large projects are launched in the future.

Conclusion

The Chair thanked everyone for their time and contribution.

AGENDA ITEM 2
ACTION LOG

DATE	LEAD	ITEM	ACTION	DEADLINE	STATUS
25/09/13	Katherine Rake	Progress NHS England Memorandum of Understanding to completion	The draft principles were presented to the Committee in July and the Memorandum of Understanding is presented for approval at this Committee Meeting	Ongoing Superseded	Completed In progress
21/11/13	Sarah Armstrong	When full staff team in place, they are to be introduced to the Committee formally through a number of staff/Committee engagements	Committee Members informally engaged with staff after the December Committee Workshop. An engagement plan has been developed for each Committee Member	Quarter 2	In progress
13/02/14	Marc Bush and Deborah Laycock	Contact local Healthwatch about their escalations and ask them to comment on their experience of Healthwatch England handling their escalated query or concern	The escalations handbook was updated in collaboration with local Healthwatch and a monthly update has been initiated. A webinar for local Healthwatch was held in August to further support local Healthwatch. The Senior Management Team will be finalising the oversight and decision making process for escalations in Quarter 3	Ongoing	Completed
13/02/14	Katherine Rake	Contact the Chief Executive of NHS England to discuss the next phase of Care.data	Healthwatch England are engaged in informing the phased roll-out and how the programme engages with local Healthwatch	Ongoing	Completed
14/05/14	Marc Bush	Schedule our policy and intelligence products for Healthwatch England. To	The timeline of our policy and intelligence products were approved at	Ongoing	Completed

DATE	LEAD	ITEM	ACTION	DEADLINE	STATUS
		integrate the escalation and intelligence report	the July Committee Meeting and the second integrated escalation and intelligence report was presented at October Committee Meeting		
22/10/14	Kathy Peach	To capture the follow up activity between local Healthwatch and their MPs after the Annual Report launch event	Local Healthwatch reported engagement with their local MPs as part of the data return and also commented informally using Yammer, the results are highlighted in the Chief Executive's report	Quarter 3	Completed
22/10/14	Katherine Rake	Present the NHS England and Healthwatch England Memorandum of Understanding at the February Committee Meeting	The Memorandum of Understanding with NHS England is presented for approval at this Committee Meeting	Quarter 3	Completed
22/10/14	Deborah Laycock	Present proposals of how the escalations process will develop at the February Committee Meeting	The proposals of the approach to the escalations process are part of the Local Intelligence Report, presented at this Committee Meeting	Quarter 4	Completed
22/10/14	Marc Bush Current oversight by: Zoe Mulliez	Set-up a reference group for the Committee task and finish group and local Healthwatch who are working on CAMHS projects to include their activity in the overall work	A group of local Healthwatch working on CAMHS projects have been identified and their evidence and comments are being incorporated into the national discussion	Ongoing	In progress
22/10/14	Sarah Armstrong	Present the accessibility policy and good practice guidance to the Committee in due course	An update on the accessibility policy and organisational approach is being developed by Alun Davies and the staff working group. The final report will be presented to the Committee for approval	Quarter 1 (2015/16)	In progress

DATE	LEAD	ITEM	ACTION	DEADLINE	STATUS
22/10/14	Sarah Armstrong	Present the Complaints Champion terms of reference and Whistleblowing policy at the February Committee Meeting	Both the Complaints Champion role and the Whistleblowing policy are presented as part of the Enhanced Governance at this Committee Meeting	Quarter 4	Completed
22/10/14	Esi Addae	Redraft the definition within the Conflict of Interest policy	The definition has been re-drafted and included in the Enhanced Governance overview	Quarter 4	Completed
22/10/14	Esi Addae	Bring back a paper on political conflicts	The organisational approach to political conflict will be presented at the May Committee meeting	Quarter 1 (2015/16)	In progress
22/10/14	Esi Addae	Present the Committee forward plan for approval in all Committee Papers	The Committee forward plan will be presented at all upcoming Committee Meetings	Ongoing	In progress

AGENDA ITEM: 4

SUBJECT OF REPORT: Chair's Report

PRESENTING: Anna Bradley

PURPOSE: This report aims to highlight the Chair's activity since the last Committee Meeting on 22 October in London.

RECOMMENDATIONS: This report is for information

RESOURCE IMPLICATIONS: N/A

RISK AND MITIGATION: N/A

EQUALITY AND DIVERSITY: N/A

Introduction
In this quarter, my work has included the development of our work on the Special Inquiry as well as further developing external engagement on our Complaints Programme and our work on Integration.

Complaints Programme
During the last quarter, I have met with a number of members from the Health Select Committee to brief them on the recommendations from *Suffering in Silence*. The purpose of this engagement was to support the Committee's own inquiry on complaints and raising concerns. I have had a number of positive meetings with Valerie Vaz MP, Virendra Sharma MP and Andrew Percy MP.

Moreover, I have also had a follow-up meeting with the Rt Hon Oliver Letwin, Minister at the Cabinet Office, to see how we can work to support the review he is currently leading on public sector complaints. In addition, I met with Bernard Jenkin MP, Chair of the Public Administration Committee, to discuss some of the key recommendations from Suffering in Silence. As a follow-up, I wrote to him in his capacity as Chair of the Public Administration Committee, setting out our recommendations for the provision of health and social care advocacy.

Integration
I led a session on integrated care at the Health Service Journal Summit, titled, *'What next after the Better Care Fund'* where I drew on the experience of local Healthwatch involved in the Better Care Fund development process and highlighted how challenging it can be to meaningfully engage the public in the integration process. I delivered a keynote speech at the Westminster Health Forum Seminar looking at the next steps for improving patient experience and safety in health and social care. It was a useful opportunity to highlight the work Healthwatch is doing both at a national and local level.

Healthwatch England Committee
Since our meeting in October, there have been opportunities for Committee Members to be involved in the work of Healthwatch England and the wider network. The development plan detailing involvement with local Healthwatch and external stakeholders continues and continues to be reviewed. For example, a quarterly teleconference has begun for the four Committee Members who are also chairs of local Healthwatch to share ideas and regional intelligence with the Development Team. There was discussion on issues on the longevity of local Healthwatch contracts, the impact of the co-commissioning and commissioning landscape and how to support local Healthwatch set their priorities and plan for the upcoming financial year. We will continue discussions at the next meeting including how the Regional Committee Member role develops.

Following our meeting in October, we continue to review the governance assurance for the Committee. During this meeting, we will explore the roles and polices surrounding:

- The Complaints Champion;
- The Caldicott Guardian;
- The Terms of Reference of the Finance and General Purpose Sub Committee;
- The Terms of Reference of the Executive Investment Committee; and
- The Whistleblowing policy.

The role of Senior Independent Member (SIM) was presented and approved at the October meeting and I am pleased to announce that John Carvel has been appointed as the SIM for the Committee. At the Committee Workshop in December, we discussed work and clarified that the role should be used when all other avenues have been exhausted. We also agreed that when Committee Members want to invoke the SIM role, this must be made clear. Any situation discussed with the SIM in this capacity will be regarded as confidential and will be used to try to find solutions through one to one conversations.

I wrote a blog for Healthwatch on issues of independence and conflicts. I highlighted the unique position of the network as the only body that is charged with single-mindedly speaking up for the interests of people. I aim to support on an ongoing conversations across Healthwatch on this topic, to help us arrive at a shared understanding about these issues.

Engagement with local Healthwatch
I joined Healthwatch in the Wessex area with Jenny Baker, to discuss their relationship with local authorities and their future in regards to funding and political plans. It was very helpful to hear about their local network and ongoing work.

I joined the regional meeting of Healthwatch in London. It was a great opportunity to hear about all the excellent work taking place across the London region as well as hear some of the key challenges facing them. I also met with the Chair of Healthwatch Wigan, Sir Ian McCartney. Sir Ian provided me with a useful update on service reconfiguration plans in Greater Manchester and the positive contribution local Healthwatch in the area are making.
Attending regional meetings, I have heard more from local Healthwatch about the issues they wanted to know more about. This included highlighting our current work on

complaints advocacy with local Healthwatch clarifying and what future might hold for the network. There was also discussion on how local Healthwatch engage with national system players, not only to know more about what they are doing, the purpose of key areas of work but importantly how local Healthwatch can engage with them.
Following from further discussions on conflicts, I established that whilst standard conflicts were manageable for most local Healthwatch, there was an expression to explore political conflicts and conflicts with local authorities and or commissioners. Anxieties were shared on what co-commissioning means for local Healthwatch; this is something that is explored further in the NHS England paper.

Strategic Partners

Department of Health
A key part of my activity this quarter has been to take forward our developing relationship with the Ministerial Team. In November, I had two very positive meetings with the Rt Hon Norman Lamb MP, Minister for Care and Support, and the Rt Hon Earl Howe, Parliamentary Under Secretary of State for Quality. As our sponsor minister, Rt Hon Norman Lamb MP, was keen to get an update on the performance network as well as Healthwatch England's work report on the complaints system, *Suffering in Silence*. In addition, I raised concerns from the network about uncertainties surrounding financing for local Healthwatch. Following the meeting, the Minister wrote to all councils to remind them of their responsibilities to ensure local Healthwatch is sufficiently resourced to carry out its statutory functions.
In addition, in my meeting with the Rt Hon Earl Howe, we discussed our complaints programme but I also used the meeting as an opportunity to highlight our concerns around the new commissioning landscape and the importance of ensuring the public are properly engaged in the future shape of services.

NHS England
In December, I met with Simon Stevens, Chief Executive of NHS England. During the meeting, we discussed how Healthwatch England and local Healthwatch could play an active role in taking forward NHS England's *Five Year Forward View*. I also raised some of our concerns around ensuring accountability and transparency in the new commissioning landscape and pointed out the need to ensure both public and local Healthwatch are involved in this process.

Monitor
I met the Chair of Monitor, Baroness Joan Hanham, to discuss our relationship with Monitor. We used the meeting to discuss the development of a shared Memorandum of Understanding and identify areas of shared interest. Katherine and the team are devloping this area of work.

External engagement
I continue to have a number of 1-2-1 meetings with key influencers in health and social care to build relationships with partners for both Healthwatch England and the network. The key focus of my external engagement over the last quarter has been to develop a

supportive base of advocates for Healthwatch England's work on complaints but also, to prepare the ground for the publication of our final report from the Special Inquiry.

Members are invited to DISCUSS.

AGENDA ITEM: 5

SUBJECT OF REPORT: Chief Executive's Report

PRESENTING: Dr Katherine Rake OBE

PURPOSE: This report aims to highlight the Chief Executive's activity since the last Committee Meeting in October

RECOMMENDATIONS: This report is for information

RESOURCE IMPLICATIONS: N/A

RISK AND MITIGATION: N/A

EQUALITY AND DIVERSITY: N/A

Delivery on key activities
My report for this quarter will provide an update on the following:

- Special Inquiry;
- Complaints Programme
- Staffing
- Strategy
- The Healthwatch network; and
- External engagement.

Special Inquiry
The focus of the Special Inquiry has been on the unsafe discharge of three groups; people with mental health conditions, homeless people and older people. We have started to produce briefings which have been shared with a small group in advance of the publication of the full report before the end of March. The mental health briefing was published in December 2014 and will be followed by briefings on homelessness and on older people in the shared at the end of January 2015.

Complaints Programme
We are continuing to build on our work to improve the experiences of health and social care complaints systems. We are continuing to work with the Health Service Ombudsman and Local Government Ombudsman to encourage a range of organisations to use the person-led vision for complaints handling, published in November 2014, in their work. We are planning how best to take forward the recommendations we made in our report *Suffering in Silence*, which was published in October 2014. We are developing a set of standards for complaints advocacy services, which we aim to publish in February 2015, and will be working with the Department of Health and the Local Government Association to discuss how these will be taken forward. By the time of this meeting, we will have held an online discussion with local Healthwatch on 27 January to discuss further our work on

complaints advocacy. We are also continuing to consider a broader role for Healthwatch in the provision of complaints advocacy standards.

We sent Freedom of Information requests to acute trusts in England in order to understand the policy on how third party (those who witness rather than personally experience poor care) complaints are recorded. Of the 164 trusts we approached, we received responses from 123. Our figures revealed that a third of NHS hospitals do not record complaints about patient care made by visitors to patients, contractors or other 'citizen whistleblowers'. It was fantastic to see presented in the media, we received media coverage in The Telegraph, The Times, ITV News as well as a comment piece from Anna Bradley on BBC News.

Update on Staffing
We have successfully recruited to our Senior Management Team and I can announce the appointment of Neil Tester as the new Director of Communications and External Affairs. Neil joins Healthwatch England from Relate where he was the Head of Federation Development. He has a background in marketing, public policy and strategic communications. I would like to take the opportunity to thank Kathy Peach our Interim Director for her support and diligence during her time with Healthwatch England. A further update on staff recruitment activity is detailed in the Operational update report.

Strategy Development
A strategy development plan has been initiated for how we will progress our next 3 year strategy. This was shared with Committee Members at the last Committee Workshop. This begins the process of how we will articulate our key priorities for the upcoming 3 years. We are unique in starting and ending with the consumer, always looking at health and social care systems together, and working with the power of the network. As such, we are beginning our internal reflections on what we have learnt from our current strategy and the lessons for the future.

Healthwatch Network Update
There is now a full complement of development officers working across all the regions as a result of welcoming our latest starter, Kuldip Kaur Kang, who covers the central region.

A summary of activity delivered since the last meeting:

	Support needed	Healthwatch England response
Sustainability	Local Healthwatch income	• Supporting Healthwatch in understanding their income position and providing assistance as they negotiate contracts and income (ongoing) • Published the 14-15 financial position • Collected intelligence on the 15-16 funding
	CRM system	• 17 local Healthwatch set up with the CRM system with a further 15 to receive the system by the end of March • Preparing for further roll out post April 15
Impact	Best practice	• Preparing for *Writing Case Studies* training to be delivered in February 15 • Sharing of good practice examples via the newsletter with a particular increase in Social Care stories
	Media/raising awareness	• Media support was given to the network including support to 12 local Healthwatch relating to recent NHS hospital Major Incidents
	Internal and Public Policies	• Care Act 2014 briefing provided to the network
Engagement	Regional meetings/support	• Seven network meetings and focussed sessions including a Research Skills workshop with Yorkshire and Humber network • London Policy and Insight Officer's meeting • Committee members engagement with the network • Presentations received from key stakeholders including Monitor, Care Quality Commission, General Medical Council & NICE
	Communication from/with Healthwatch England	• Online discussions including Finance, Enter & View, and Commissioning Cycle • Escalation bulletin produced and circulated • Yammer survey showed 88% of users find it easier to communicate with others compared to original version • Bi annual data return completed by 85% of the network • Supported the King's Fund Evaluation of the network
	Working with Statutory Bodies	• Brokered relationship with CQC on local Healthwatch contribution during inspection process • Preparing Service Change resource packs to support engagement and influence system players e.g. CCGs
Leadership	Standardised documents	• Refreshed guidance on Enter and View and new report & letter templates
	Healthwatch organisation development	• Seven 1-2-1 visits to assess needs of local Healthwatch in the four key areas • Conflict of Interest guidance provided to the network

As noted in my previous Committee report, on the 14 October 2014 we launched our second annual report, *Loud and Clear: making consumers' voices heard*, in Parliament alongside our report on the complaints system, *Suffering in Silence*. We had a turnout of over 70 parliamentarians attending along with over 40 other key stakeholders from across the health and social care community, including Sir Robert Francis QC. Moreover, we had a very strong representation from across the network with over 100 representatives from local Healthwatch joining us to mark the occasion. I am pleased to report that we got very positive feedback from the network on the event, with over 70% of local Healthwatch who attended reporting that it was very useful in terms of meeting with their local MP.

On 18th November I attended the Healthwatch Greenwich Annual General Meeting and presented an overview of our activities. Also in November, I attended the Local Government Association organised event, discussing the critical success factors for Health and Wellbeing Boards and their role in the integration agenda. It was beneficial to discuss how local Healthwatch can work effectively on the board to achieve local goals. Importantly, I also reflected on the important role local Healthwatch have in representing the consumer voice on the board.

We know that funding is one of the core ongoing concerns for local Healthwatch, particularly in light of the unprecedented financial pressures facing local councils. We gathered information from local Healthwatch about their current funding and their understanding of the 2015/16 budget. With this information, we provided tools to enable local Healthwatch to have conversations with their commissioners to not only show impact but to also conduct good budget negotiations. We shared our concerns with the Department of Health including with the Minister, The Rt Hon Norman Lamb MP who responded to us. In his response to Healthwatch England, the Minister recognised the concerns from some local Healthwatch about their position for the next financial year, committed to transparency and asked for examples where longer term contracts were leading to better outcomes.

The Minister subsequently wrote to councils reinforcing the point Healthwatch England has been making about statutory funding for councils being used to support local Healthwatch to deliver statutory activities. The letter to councils reminded them that they have a statutory duty to put local Healthwatch arrangements in place, and that it is up to councils to decide how best to fulfil this duty. The letter goes on to reflect the concerns we have raised about transparency, recognising councils will be taking steps to ensure their decisions about funding for local Healthwatch are transparent to their local community. The letter finishes by reflecting on councils' support in "ensuring your local Healthwatch will be sufficiently resourced to deliver on statutory responsibilities."
In addition to the letter to councils, the Government previously published the local government finance settlement just before Christmas followed by local authorities being sent a circular about the second element of funding for local Healthwatch (the Local Reform and Community Voices grant).

Additionally, I chaired a couple of online discussions on finances and sustainability with the Chief Executive network highlighting our work with the Department of Health, and our concerns about the transparency of local Healthwatch funding.

The King's Fund launched a survey as part of the evaluation of local Healthwatch commissioned by the Department of Health. The survey offered local Healthwatch the opportunity to showcase their work, highlight challenges and to make suggestions on how improvements can be made. A member of our staff has been interviewed as part of the survey and we will comment on the draft report which is scheduled for publication in late February.

Work with statutory partners

NHS England

The Memorandum of Understanding with NHS England is presented to the Committee for approval at this meeting. This is a significant step forward which is captured in a subsequent paper which includes further detail on our working relationship. This allows for further exploration of our work in regards to the changing commissioning environment.

CQC

I continue to meet David Behan, Chief Executive, on a quarterly basis as well as regularly meeting with Eileen Milner, Executive Director of Customer & Corporate Services to review services and working arrangements. We are currently reviewing the Service Level Agreements we have with CQC to ensure that they reflect both of our requirements.

External engagement

I continue to meet with our key stakeholders from across the health and social care community to build a clear picture of key issues for consumers, promote the work of the network and of Healthwatch England, and also to identify areas of joint working. During the last quarter, much of this has been themed around our work on the complaints system and taking forward our recommendations from Suffering in Silence and also the Special Inquiry on Unsafe Discharge.

In November, I attended the Richmond Group (a coalition of 10 of the leading health and social care organisations in the voluntary sector) Chief Executive's a group dinner where I presented an overview of the network and our complaints programme. I have continued to develop our relationship with key regulatory bodies, meeting with the General Medical Council in December as well as presenting and at the Healthcare Chief Executive Steering Group. This group brings together the key regulatory bodies from across the healthcare community and I used the opportunity to share our work on complaints and identify some key areas where we can work together.

I represented Healthwatch England at two conferences, participating in panel discussions – The conferences were the Managers in Partnership annual conference and an NHS England conference focusing on the future of Health, both of which took place in November. The engagements proved a useful opportunity to highlight our work at a national level but also, to illustrate how we work with and support the network.

Members are invited to DISCUSS.

AGENDA ITEM: 6

SUBJECT OF REPORT: Consumer Index update

PRESENTING: Sarah Vallelly

PURPOSE: To update the Committee on progress with the first version of the Consumer Index and to outline governance touch points for the Committee

RECOMMENDATIONS: That the Committee discuss and note the proposed milestones and approve the refined approach

RESOURCE IMPLICATIONS: N/A

RISK AND MITIGATION: N/A

EQUALITY AND DIVERSITY: We will address inequalities in how our consumer principles are experienced, through the use of case studies, policy narratives and consumer insight work to supplement the top-line quantitative data.

Introduction

The purpose of this paper is to update the Committee on the development of the consumer index since the last discussion at the September workshop having included Committee comments. It outlines the main steps we are taking to build the consumer index, our overall aims for the communication plan, key milestones and governance points. The purpose of the Consumer Index is to build a credible way of measuring consumer experience against the eight consumer principles that Healthwatch England established in 2013.

The Committee advised us to:

- adapt the central research question so that we sharpen the focus of the project
- be clear about our key audiences for the final product
- scale back the overall ambition of the project
- review the project as it progresses
- ensure that it has impact and delivers value for money

We have reflected on these suggestions and refined our overall approach so that our ambition for the Consumer Index is realistic and can be operationalised within our existing organisational capacity.

Overview

The Consumer Index is a long term project which will develop over 5 to 8 years. The overarching purpose for this first edition of the index is proof of concept (will it work, who will use it and how will they use it?). We seek to start a debate about the relationship

between internationally recognised consumer guidelines and English health and social care, with the index launching in October 2015. The Committee advised that we slightly adapt the central research question that the Consumer Index addresses so it now reads *"To measure the experience of the realisation of people's rights in health and social care over time."*

Overall approach

In our early thinking, we had planned to focus on a more limited number of principles and explore these in detail. Having reflected on the discussion with the Committee at the September workshop, we further tested the feasibility of this approach and concluded that a more manageable and realistic approach would be to include the breadth of the Healthwatch England consumer principles (please see appendix 2) from the start. Then, rather than building in additional principles over future versions, we can focus on increasing the depth and richness of the index over time. The advantages to this approach are summarised below.

Consistent trend tracking - To build detail and to track trends in terms of whether principles are met or unmet broadly from the start enables us to monitor change consistently over time across all our consumer principles.

Optimise effective engagement - It optimises our opportunities to engage and involve the maximum range of key stakeholders including Local Healthwatch. If we start with just one or two principles we may limit the overall reach and potential to influence broader debate when we publish the first edition in October.

Easy to understand - A more uniform application and understanding of the principles against a simple and clear framework

Early identification of evidence gaps – Identifying aspects of our consumer principles where evidence may be thin and patchy from the start helps to think about long term strategies for addressing these gaps and engaging the system to collect better consumer experience data.

External Communications planning

The Committee advised that we be clear on the key purpose and the audience for the Consumer Index. In the first year, our aim is to build appetite for the application of international consumer principles for measuring people's experiences of the English health and social care system. We are then well-positioned to use this tool to influence change in the health and social care system in future years, which is the ultimate ambition. For the prototype edition the core audience will be key system players.

Next phase of development

In the next phase of the project Q1 (2015/16) we will be setting up a small working group of local Healthwatch to introduce the thinking behind the consumer index and to work with them to establish ways of making the long term product useful and useable for them.

Additionally we will discuss and explore ways to involve the Healthwatch network in the project longer term.

Also in Q1 (2015/16) we will produce a long term plan for the development of the index which will include ideas for how we can involve the local Healthwatch network for example in data collection.

A data acquisition plan is in place which outlines the quality standards for the data that we select and use to measure the eight consumer principles. Whilst the credibility of the data and technical framework for the consumer index is fundamental, this will be supplemented with consumer insight highlighting one principle where the consumer experience is significantly below standard. This will be considered as part of the Senior Management oversight of the overall project. We will also produce a policy narrative piece that stands alongside this highlighting inequalities in experience across different consumer groups and a set of case studies (one for each consumer principle) using photography and film. All of these will be published on an interactive platform.

As per the Committee's suggestion, we recognise the necessity of good working relationships with key stakeholders, especially when we are seeking to gain information and data from other organisations in the system. To this end, we are developing a stakeholder engagement plan and have embarked on a series of individual meetings with the intention of gaining early buy in and engagement with the project. The project timeline (Appendix 1 below) outlines the main activities in each phase of the project for the first year.

Committee Governance touch points

In addition to the internal working group, the local Healthwatch group and regular updates to SMT we are forming a reference group comprised mainly of external stakeholders. We plan to come to the May 2015 Committee workshop to discuss the first draft of the overall framework for the index and to the August workshop to update on what the data from the framework is telling us, the consumer insight work and the emerging communications messages. In November we will review the prototype project and lessons learned to inform the next annual version of the Consumer Index.

Next steps

In the next phase of the project we will finalise the membership of the reference group and plan to seek suggestions from Committee Members.

Members are invited to APPROVE the refined approach and NOTE the proposed milestones.

Appendix A: Project timeline

Phase	Description (main objectives)	Steps / activities	Outputs
Dec 2014 – Mar 2015	Development and initial testing	Research to explore how the international guidelines can be translated to the English health and social care context Identifying and prioritising the topics that will be used to illustrate each principle Collection and review of existing evidence and data to see what is available and feasible for the framework Initial contact with stakeholders and experts to test our thinking	Fully developed definitions of the eight consumer principles First draft of the framework for the index *(**See Appendix 2**)*
April – June 2015		Further testing and refining the framework First cut of results from the index Primary data collection (Survey/ poll) In-depth investigation of one consumer principle where evidence shows poor consumer experience or inequalities Further engagement and debate Start technical build for the online resource	Draft messages for final index Publication of the extended definitions of the principles and associated media activity Technical papers / think pieces
July – October 2015	Interpret and publish findings	Continued refinement of the index and the measurement accorded to each consumer principle Build a narrative about what the index tells us about people's experience of the principles and variance across different groups Finalise report and continue stakeholder engagement prior to and following publication of resource	Final Consumer Index product Ongoing stakeholder engagement Review (MEL) and plan for next phase of development

APPENDIX B: Template for consumer principles framework

Principle – (overall assessment)

1) Essential services
2) Access
3) Safe, dignified and quality service
4) Information and education
5) Choice
6) Being listened to
7) Being involved
8) A healthy environment

Description

Our expanded definition of each principle to define parameters i.e. what we measure and how we measure it.

Illustration

One key scenario / example to further explain the description in practical terms.

Proxies

Shortlist of the key data sets that we have identified tested and validated as being most credible to assess performance against the overarching principle. For the index to be credible we will only include data sets that have the following characteristics:

a) Representative sample
b) National comparability
c) Regional break-down
d) Trusted (and quality assured) data source
e) Regularly updated *(at least once every two years)*
f) Not consumer satisfaction indicators – outcome measures are preferred where available. However, we will consider patient experience measures from credible sources e.g. NHS England

Narratives

Policy / consumer insight / polling evidence to provide some further context, highlight gaps in availability or quality of data, identify approach for future work. Areas of contestation where the overall assessment masks huge variance

Where there is a 'right' in the NHS constitution: descriptive paragraph to demonstrate how people are experiencing that particular domestic right under the NHS constitution based on evidence from the proxies.

AGENDA ITEM: 7

SUBJECT OF REPORT: Local Intelligence Report

PRESENTING: Sarah Vallelly and Deborah Laycock

PURPOSE: This report provides the Committee with an overview of escalated issues arising from the network and outlines plans to develop the local intelligence infrastructure. The report provides an overview of escalated issues arising from the network between October – December 2014 (Quarter 3) as well as an update on improvements made to the escalation process.

RECOMMENDATIONS: N/A

RESOURCE IMPLICATIONS: N/A

RISK AND MITIGATION: There are resource implications to ensure the methodical and robust assessment of information shared from local Healthwatch whilst the Customer Relationship Management (CRM) system develops. This is being mitigated and addressed in the full 'Local Intelligence plan' and business planning for 2015/16.

Background

The escalation process has now been in place for 10 months with time to test and now reflect on where improvements in the process are needed. In this time we have clarified the purpose of the process and what constitutes an escalation as well as sought feedback from local Healthwatch on what they need from the escalation process. We have designed and implemented a structure to the process, established a formal referral procedure with NHS England and CQC, improved regular communication with local Healthwatch, and we have strategically used escalation intelligence with external stakeholders.

However, as identified at the last Committee meeting, and as reinforced in feedback we have gathered from Healthwatch England staff involved in the escalation process, improvements are needed in respect to how escalation cases are triaged, prioritised, investigated and followed up.

Update on Escalation Process

Consequently, we have strengthened our triage system to ensure that all cases coming into the escalation process are assessed against the escalation criteria, referred back to local Healthwatch in a useful way if they do not meet the criteria, and have the most appropriate Healthwatch England staff member leading the investigation of the case.

An area we have found challenging is how we put in place a prioritisation process for escalations that is consistent and transparent to local Healthwatch. The difficulty is in developing criteria that can be applied to a small number of highly complex, diverse issues. Our proposal is to focus the prioritisation process on risk and impact. Risk in terms of the severity and immediacy an issue has on health and social care consumers. Impact in terms of the value added that Healthwatch can play in taking forward the issue, as well as

the impact it will have on seldom heard groups/the number of consumers impacted by the issue. We will continue to refine the prioritisation process and will present a draft to the Committee in May.

Following up and showing the impact of our work on escalations is an area where we have done less well to date. As a next step in reviewing what impact we have had and whether we used the right tactics with the right stakeholders in escalation cases, we have planned an SMT level session that will work through Q3 escalations. The session will look at the actions we took and the effectiveness of these actions, whether we achieved what we set out to do in each escalation case, and whether the cases were prioritised appropriately.

We are also trialling a more robust follow up process whereby progress on an escalated issue is reviewed three months after closing. This will involve speaking with local Healthwatch as well as stakeholders who committed to taking action on the issue. If there has been no improvement in the escalated issue, a decision will be made by SMT on whether to re-open the case (using the prioritisation process once it is agreed).

Report - Escalated issues in Q3 2014/15 (October – December)
During Q3 we have received 8 escalations, from 6 local Healthwatch. Three escalations focus on issues with accessing dentistry services. The other escalations relate to issues with Children and Adolescent Mental Health Services, lack of consultation with service users on current changes to specialised commissioning, GPs charging patients for letters, and 2 escalations related to CQC ways of working.

The number of escalations in Q3 is a notable reduction in the number received in Q2 (20 escalations) and Q1 (20 escalations). Further enquiry is needed to ascertain the reason for the reduction but anecdotal evidence suggests a combination of:

- the increasing capacity of local Healthwatch to resolve issues at a local level now that they are entering their second year in operation,
- better understanding of the purpose of the escalation process and what constitutes an escalation. T
- increased peer support and learning from the network through communication on Yammer.

In support of this, we have found that recent escalations have been of an increasingly complex nature.

As requested by the Committee, we have brought to the front of this section updates on the escalation cases presented at previous Committee meetings.

1. **Independent investigation of deaths in secure mental health settings**

As previously reported to the Committee, in June 2014 we had a concern escalated to us by Healthwatch Northamptonshire regarding a review undertaken into the deaths of four patients of a low secure unit in 2010/2011. It raised wider concerns about the quality of care at the facility and the policy governing investigation in these settings.

In October 2013 NHS England committed to undertaking a review into the facility – initially focused on the deaths themselves but a later terms of reference broadened to look at lessons learnt from the deaths. In August 2014, in response to our formal raising of the issue with NHS England we were informed that the review team was in place and would report in November 2014. When no report was launched we followed up with NHS England, to be told that the report would be due in February 2015.

In July 2014, due to the concerns we raised on the facility, the CQC carried out an unannounced inspection. CQC also carried out a comprehensive inspection of the facility in September 2014. Neither of these inspection reports have yet been released.

Therefore, the only recent report on the facility available in the public domain is the Enter and View report of NHS Northamptonshire.

Since the last Committee meeting we have escalated this issue to Simon Stevens, CEO of NHS England and await a response. We raised that we still remain seriously concerned about the facility, and believe that there has been a lack of action and urgency shown by NHS England on ensuring that lessons have been implemented from the deaths.

We also continue to look into the process for investigating deaths that occur in mental health settings and the apparent inconsistency with the investigation of deaths in other custodial settings. We will be meeting with the Independent Advisory Panel (IAP) on Deaths in Custody who have been a vocal advocate for more clarity and consistency in the investigation of deaths in mental health settings. We are also awaiting the delayed release of the updated NHS Serious Incident Framework which seeks to provide clearer guidelines on when a death should be investigated.

2. Flu vaccination programme in children

In August 2014, Healthwatch Kirklees escalated to us a concern around inequalities emerging in the current flu immunisation programme in children. The programme now provides vaccination to all 2, 3 and 4 year olds with further pilots also occurring in primary and secondary schools. The programme in children involves a nasal spray which contains porcine gelatine and is not accepted by many members of the Muslim community in England.

We are clear that we will not be able to influence the current vaccination programme that is in progress but are pushing for learning to be reflected in next year's flu programme. We have formally responded to Public Health England (PHE) outlining our concerns of the apparent inequality the programme causes as no alternative to the nasal spray is offered. We know that when this same situation arose in Scotland, after taking a legal opinion, the decision was made to allow an alternative to the nasal spray to be available. We have asked PHE why they have not taken similar steps in England. We also asked how community members will be consulted at an early stage in the planning process for the 2015/16 programme and the confidence that PHE has that community-level immunity can be reached in Muslim areas with low uptake of the vaccination.

We will be meeting with Paul Cosford, PHE Director for Health Protection and Medical Director, to seek assurances that our concerns are being addressed.

3. Accessibility of Gender Identity (GI) services

From July 2014 we had a number of concerns raised with us around access to gender identity services by eight local Healthwatch. Through raising the issue locally, it was clear to local Healthwatch that this was a national issue that needed to be raised with NHS England (as the national commissioner of this specialised service).

As reported in the last Committee Meeting, we formally escalated the issue to NHS England. Main concerns included considerable delays in accessing the service (in particular male to female surgery), insufficient support when waiting to access the service and surgery and a lack of communication with individuals using gender identity services or attempting to access them.

We have had formal correspondence back from the Director of Specialised Commissioning at NHS England Richard Jeavons. Richard also attended a meeting with Healthwatch England and senior NHS England staff to answer our concerns on gender identity services.

NHS England's response acknowledged that demand for services for transgender people is increasing each year with relatively few specialist services able to cope with demand. We now know from NHS England statistics that the waiting time for male to female surgery at Charing Cross Hospital is in excess of 21 months. NHS England confirmed that gender identity services come under the 18 week referral right so this is a very clear breach of the rights of patients as set out in the NHS Constitution.

Whilst NHS England had a Task and Finish Group already in place to look at aspects of gender identity services, we believe that our formal escalation has added a sense of urgency and has also ensured the work of the Group looks at the whole range of access and communication issues facing individuals.

In addition, we flagged our concerns with the specialised commissioning public and patient voice assurance group (PPVAG) who also had concerns regarding gender identity services and we are subsequently jointly raising our concerns to NHS England. Our evidence has been used by the group to push for improvements in the service.

This is an issue where we feel there is still a long way to go to achieve change and positive impact on transgender individuals trying to access services or surgery. We will raise again with NHS England our specific concerns on the lack of communication with service users, and will seek regular checks on the work of the Task and Finish Group. However, in regards to access to surgery, there remains the issue that, there are not enough specialist consultants to deliver this service. We will continue to push for a contingency plan that allows for immediate expertise to be brought in now to address the backlog, alongside a long-term strategy to train up consultants in this speciality.

4. Concerns with quality assurance of non-regulated services

At October's Committee meeting we highlighted two escalations about concerns with quality assurance mechanisms in non-CQC regulated services (Healthwatch Nottinghamshire and Healthwatch Richmond).

We are increasingly concerned that users of these non-regulated services (including self-funded and personal budget holders) have:

- no means to make an informed choice of service based on quality;

- no way of raising concerns about the quality of services they receive; and that safeguarding mechanisms do not always cover these services impacting on the safety of all service users – in particular vulnerable users.

Following the two escalations, we facilitated a teleconference between Department of Health policy leads for CQC and personalised care, the Chief Executive at Healthwatch Richmond and Chair of Healthwatch Nottinghamshire. The purpose was to clarify the current policy work in this area and to identify policy gaps where they exist. The response was that the understanding of the "grey area in regulation" is on the CQC's future work planning. We have since heard that the CQC are drafting internal regulation guidance that may in part address some of these areas but we do not have full clarity on this. We will therefore be formally writing to the Department of Health to ask that these "grey areas" of regulation are clarified to ensure that there are relevant safeguards in place for consumers to receive safe and quality care.

Resolved escalations

We received a number of escalations around accessing information on NHS Choices. Amongst the issues escalated were inaccuracies in:

- distance between practices recorded on the website (Healthwatch Sefton, July 2014)
- the information recorded on the website being out of date (Healthwatch Haringey, August 2014)
- GPs providing insufficient information on NHS Choices (Healthwatch Southend, June 2014)
- and similar inaccuracies found as part of the NHS Healthy Start website (Healthwatch Southend, July 2014).

As a result of this, we met with NHS Choices and explained the concerns which we had heard from the network. They welcomed the experience of local Healthwatch and indicated that they are doing a wider review of how to ensure the Choices site contains up to date, consistent information and would welcome local Healthwatch input into that.

Whilst the emphasis is not on local Healthwatch to identify and report inaccurate information on NHS Choices, some local Healthwatch wanted to know how they could report issues with Choices if necessary. The Choices Team therefore clarified the process for how local Healthwatch can note inaccuracies on the website, as well as providing a contact email for local Healthwatch to be able to get in touch directly to report issues. This has all been summarised in a briefing for the network, and forms part of ongoing work with NHS Choices.

In addition, two webinars were held for local Healthwatch by NHS Choices in September to understand how NHS Choices works. This included a guided walkthrough of the NHS Choices website and discussing questions posed by local Healthwatch.

We have also worked with NHS Choices to include the contact details of each local Healthwatch added to NHS Choices. In order to do this, we consulted the network to ensure we had up-to-date contact information and offered them the opportunity to tailor

a brief description about who they are and what they do. As of the week commencing 19th January, all local Healthwatch are listed on the NHS Choices website. Local Healthwatch are required to notify Healthwatch England of any changes in their contact details and these will be sent on monthly to NHS Choices to ensure the information is up to date.

Wider local Intelligence

Research and consumer insight investigations by local Healthwatch
In addition to information received through the escalations process and enquiries we have undertaken a rapid review of 20 reports received from local Healthwatch throughout quarter 3. The purpose of this is to build our understanding of issues that local Healthwatch are working on within their local capacity. We have also reviewed all the current work local Healthwatch are conducting on primary care.

Access to primary care
Access to GPs is a significant ongoing key theme for research and investigations conducted by local Healthwatch. The issue was referenced in October's Committee paper. A high proportion of reports sent this quarter also focussed on Access to GPs, including a particularly interesting report examining GP access from the stance of deaf people (Healthwatch Wokingham Borough). The most recent local intelligence data return (December 2014) told us that 63 of local Healthwatch respondents said that access to GPs was their biggest priority for 2015. We know from the data that nearly all of local Healthwatch have either completed work on primary care or plan to do so.

Because of the clear importance of the issue across the network, we are trialling a consumer insight briefing on what local Healthwatch are telling us about primary care. The purpose of this briefing is to give an overview of the work that is happening across the network and draw together analysis of investigations and research that have been carried out over the last year. The briefing is intended as an influencing tool for local Healthwatch to use locally in meetings with key stakeholders and to communicate with our Department of Health sponsorship team and key system players. The findings of this piece of work will also help to inform the research questions being put together for the commissioned element of our primary care project. The consumer insight briefing will be published in February.

Apart from access to GPs there were a number of other themes identified in the local Healthwatch reports received in quarter 3:

- **Access to mental health services** (covered in 6 reports), with three reports focussing on CAMHS or youth access to Mental Health services (Healthwatch Brighton and Hove, Hillingdon and Kent). This resonates with early findings from the local Intelligence return, which noted mental health was a top priority for local Healthwatch.
- **Care homes for older people** - there were reports from enter and view visits to care homes for older people from Healthwatch North East Lincolnshire, South Gloucestershire and Leicestershire.

In the short term, we will continue to monitor the reports coming in from local Healthwatch about their research and investigations and once a quarter we will conduct a trawl of all the websites to check if we have missed any publications. If we identify a trend of a significant number of local Healthwatch looking at a particular theme or if a particular report brings a unique perspective or has delivered impact locally we will include an overview in future versions of this Committee report. We also plan to deliver periodic consumer insight briefings similar to the one we are currently producing on primary care which give a snapshot of what the network are saying on a particular key topic concerning health and social care.

While local Healthwatch should in practice send through research reports that make recommendations, (part of s.221, Local Government and Public Involvement in Health Act, 2007, as amended by the Health and Social Care Act, 2012) this is not yet happening routinely. As such, the reports reviewed in this section are primarily illustrative of the research being carried out by the network, rather than offering proportionally representative insight.

Longer term, as the CRM system is embedded and take-up increased along with delivery of the full local Intelligence Plan, we would expect to see evidence captured and communicated more systematically by the network as we continue to upskill them and provide consistent tools and templates in conjunction with the Development team.

Issues arising from enquiries

A key source of information for building our understanding of local intelligence is the use of information which comes through enquiries to Healthwatch England. While enquiries are not a representative mechanism for measuring concerns faced by the whole population, they do provide us with insight into some of the issues being faced on the ground. As the local intelligence infrastructure, and critically the roll out of the CRM continues, there will be more opportunities to develop our understanding of health and social care concerns through analysis of enquiries received in the network.

The most prevalent issue was, as in the previous quarter, GPs which were 20% of all enquiries received. Concerns raised around GPs, including issues in asking GPs to sign forms for financial support (such as Employment and Support Allowance) reflected in an escalation by Healthwatch Cornwall, people looking for signposting to where they can make complaints about GPs, which was similar to an escalation raised by Healthwatch Camden. There was also a notable proportion (17%) of callers who were raising issues concerned around hospitals, either with their own or their relative's care. This provides more supporting evidence for the lack of clarity in the complaints and advocacy system, as reflected in the Healthwatch England report *'Suffering in Silence'*.

Next steps for local intelligence

As outlined in the previous local intelligence report the Committee have asked that we develop an approach for putting the information from escalations into the context of broader local intelligence and fully realise an evidence based approach. This will serve to

enrich the analysis and also to look at the full range of information flows into Healthwatch England and highlight emerging issues which may become more significant later on.
The Local Intelligence programme and structure is developing and we are currently finalising the blueprint for the programme, which will be shared with the Committee.
The local intelligence programme has two key aims, which are to:

- Harvest better information from local Healthwatch, and put this intelligence into context in order to influence the work of Healthwatch England.
- Increase the research and intelligence capacity of local Healthwatch to enable them to better interpret the needs of their local population.

Since the previous committee report on Local Intelligence we have made the following progress:

Purpose:	**What is it?:**	**What we've done up to December 2014 (Outputs & activities)**
To ensure local Healthwatch are skilled and equipped to carry out effective research within their locality.	Guidance, training materials and tools to support the work of local Healthwatch	• Developed an enter and view template to ensure consistency across reports and recommendations • Created ethical considerations pack as part of a broader research toolkit
To enable local Healthwatch to access the right information to help them to carry out their statutory responsibilities effectively.	Initially, data sharing agreements with Public Health England and NHS England and other system stakeholders	• Briefing for local Healthwatch on MyNHS data resource shared through Yammer. • Feedback from local Healthwatch on MyNHS presented to NHS website developers and presented at DH meeting on transparency and referenced with Secretary of State at a roundtable meeting (Healthwatch England Chair in attendance). • Meetings with PHE, NHSE and patient experience organisations to review potential tools for local Healthwatch to test and use.
To share and build upon knowledge gathered from local Healthwatch Reports and investigations	Reviews of local Healthwatch reports (desk research) with a specific focus on a particular theme	• Written draft Consumer Insight snapshot briefing on what the network are saying about Primary Care.
To provide a systemised analysis of all incoming information flows to Healthwatch England	To triage issues and develop an early warning system	• Monthly meetings of Policy, Development, Enquiries and Intelligence teams to discuss information emerging from the network, to correlate issues across information streams.

Planned Local Intelligence activities for Quarter 4 (2014/15)

The intended developments before the end of March 2015 are as follows:

Purpose:	What is it?	Planned developments:
To ensure local Healthwatch are skilled and equipped to carry out effective research within their locality.	An accessible guide to the most useful and relevant existing data source and how the data can be used most effectively	• Access and guidance for the Local Healthwatch network on the SHAPE tool from Public Health England. This provides an interactive map on the location of GPs, Hospitals and other health and care services within each local area
To share and build upon knowledge gathered from local Healthwatch Reports and investigations	Literature review of local Healthwatch reports with a specific focus on a particular theme	• First consumer insight briefing based on what local Healthwatch insight to be published in February
To promote better understanding of local population dynamics and trends for local Healthwatch so they are better able to interpret their findings	Sharing quality assured information with local Healthwatch on their local area, to support decision making work and put findings from consumers into context	• Sharing the PHE 'Local Health profiles' with local Healthwatch, which outline the characteristics of the Local population. • Exploring partnership work with online providers of patient experience data

Members are invited to DISCUSS.

Appendix C: All escalation cases received October-December 2014

Escalated issue	Local HW escalating issue	Healthwatch England Actions and next steps
Access to NHS Dentistry Many issues locally with accessing dentistry, including: 1. Patients are routinely given misleading information about the availability of NHS dentists in Kirklees, leaving them confused and frustrated. 2. Significant numbers of patients in Kirklees are struggling to find an NHS dentist for routine NHS treatment. 3. Unequal access to NHS dentistry across Kirklees may be contributing to the wider issue of health inequalities. 4. NHS dental contracts appear to be inflexible, based on historical demand and not an objective assessment of need, demand or accessibility. There is currently no NHS Dental Access Strategy for Kirklees. 5. There were examples of poor practice which need to be raised with NHS England, the commissioner for NHS dentists. 6. There is a developing issue specifically around dentures for older people, linked to the ageing population in Kirklees.	HW Kirklees (on behalf of 5 West Yorkshire Healthwatch)	We have received 6 other escalations in the past on dentistry – 9 now in total. We raised the concerns with NHS England who confirmed that they were taking a number of steps to address issues with access to dentistry. Local Healthwatch were also invited to sit on a number of strategic groups looking at access to dentistry. As we have had three more escalations in on dentistry in the last quarter we are identifying if any further actions should be taken to raise issues around dentistry.
Dental services for people with learning disabilities There is currently no national survey of the dental needs of people with learning disabilities, despite the fact that local studies and anecdotal evidence suggest people with learning disabilities have poorer dental health than the general population.	HW Sheffield	Please see above re: next steps on dentistry escalations

Access to NHS Dentistry Issues identified include: • Inaccurate and out of date public information available to the public; • The difficulty in registering with an NHS dentist within reasonable travelling distance and long waiting lists for those who are taking new NHS patients; • Difficulties for people with physical disabilities who use a wheelchair finding an accessible dental surgery; • The public unclear how to get unplanned dental care and issues relating to the re-commissioning of this service.	HW Bradford	Please see above re: next steps on dentistry escalations
GPs charging for letters Enfield have had examples of GPs charging patients for letters from their local Citizens Advice Bureau, including a mother of child asked for £350 for a letter to say her child was fit enough to take part in Christmas play.	HW Enfield	Action: This is a new case and we will be gathering further information from Enfield.
Children and Adolescent Mental Health Services (CAMHS) Delays in accessing CAMH services and lack of pastoral care in schools.	HW Cambridgeshire	Action: we have raised the issue in a letter to Jon Rouse (Department of Health). We are also sharing intelligence from the network on CAMHS with the Children and Young People's Mental Health and Wellbeing Taskforce of which HWE is a member. Next steps: we have provided feedback on the draft report of the Access and Prevention task and finish group, identifying the most relevant section to include the issues raised by HW Cambridgeshire. We are also going to make sure the Taskforce report addresses the issues raised by HW Cambridgeshire.

Changes in renal commissioning Document from the National Kidney Foundation (NKF) causing considerable anxiety among patients at the hospital and inadequate consultation/engagement with service users by NHS England and the hospital.	HW Southend	Action: we have written to DH and NHS England to know whether NHS E have consulted with patients on renal commissioning. Next steps: we are going to undertake further desk research and write to Jason Stamp, chair of PPV AG, in order to get more information and suggest to jointly raise the issue to NHS England.
CQC ways of working There is a question about the way that the CQC interacts with the local health economy, and the impact that this could be having on patient safety overall in our system.	HW Kirklees	This escalation case is being taken forward outside of the escalation process. It will be discussed with CQC in the regular touch point meetings between HWE and CQC.
CQC ways of working There is a loss of up to date information from CQC of local inspection results.	HW Enfield	Please see above re: next steps

Appendix D: All other currently open cases

Escalated issue	Local HW escalating issue	Healthwatch England Actions and next steps
NHS Continuing Healthcare (CHC) The issues around CHC include: - Previous Unassessed Periods of Care (PUPoCs) and the backlog that has not been cleared - *PUPoCs are arrangements allowing any person who thinks they should have had assistance with the cost of their care from the NHS - and had not been previously assessed for CHC - to apply for costs to be refunded* - Risk that the information needed to carry out retrospective assessments has been deleted by health professionals - Assessment process for CHC too complex - Discharge process causing time-related issues for CHC (patients have to wait until they are nearly recovered to be assessed) - Lack of information and explanation for the individuals interested in CHC, awaiting assessment or accessing CHC, as well as health professionals - Artificial distinction between social and health needs (split between CHC and social care) - Opinions of healthcare professionals with specialist 'condition specific' knowledge being downplayed in hospital by Multidisciplinary Teams (MDTs) - Lack of involvement of community healthcare professionals with specific knowledge of people's care needs in the assessment (leaving the individuals to represent their care needs all on their own) - Difficulty for patients to provide 'evidence' of care needs - Mechanistic decision-making during the CHC needs assessment without professional judgement - Lack of empathy demonstrated by assessors - Regular reviews process for CHC holders too difficult and stressful for patients with non-improving conditions - Process for appealing against the decision on CHC eligibility too complex	HW North East Lincolnshire (supporting information from HW Northamptonshire and HW Swindon) Other issues have been raised by charities, and at the Committee Workshop the Committee agreed to third party escalations by exception.	Actions: We attended a CHC network meeting in London. Karen Scarsbrook, who is working for NHS England and dealing with NHS CHC at the regional level, told us that the issues were familiar to her and that a training programme on CHC had been developed by staff working within this policy area from the NHS, Adult Social Care and patient representative groups. We have shared the information with the network so that they can access it. Next steps: CHC has also come up in the Special Inquiry. Therefore, we are making sure the concerns raised by LHW and related to NHS CHC and the discharge process are included in the older people briefing (to be released in January 2015) We will write to NHS England regarding broader CHC issues including short and long term requests. We will potentially create a media story around CHC.

Statutory Sick Pay Percentage Threshold Scheme abolition Following the abolition of the Statutory Sick Pay (SSP) Percentage Threshold Scheme (PTS) in April 2014, disabled people with their own care staff are no longer able to claim the SSP for their carer if absent due to illness. They are also no longer eligible for the new Employment Allowance. This affects people with personal care budgets.	HW Cheshire West and Chester	HWE has raised the issue with the Local Government Association and is awaiting a response.
Pharmacy-managed repeat prescription service Luton Clinical Commissioning Group (CCG) has decided to stop the pharmacy managed repeat prescription service. This service has been estimated by the CCG to affect 60,000 out of a population of just over 200,000 (30%).	HW Luton	We raised this issue to the Chief Pharmaceutical Officer of NHS England. HW Luton carried out great work locally to work with partners to propose a compromise solution to the service being scrapped. This solution has not been accepted by all locally. As progress on this case is needed locally, HW Luton will be supported by its local Development Team lead to continue championing the issue locally as well as engaging with local NHS England team.
Take up of flu vaccination Recommended vaccination for children is a nasal spray that contains porcine gelatine. For Muslim communities and other members of the community who do not want to have gelatine there is no alternative being provided.	HW Kirklees	Please see update in the previous section of this report.
Investigation of deaths in secure mental health setting. The escalation raises concerns about the review undertaken into the deaths of four patients of a medium secure setting in 2011. It has raised wider concerns about the quality of care at the facility	HW Northamptonshire	Please see update in the previous section of this report.

Accessibility of Gender Identity Services There is a lack of surgeons able to carry out this service and there are wider issues about the treatment of trans individuals by the system.	HW Telford and Wrekin, HW Torbay With supporting evidence from HW Nottingham, Devon, Hertfordshire, Central West London, Liverpool, Plymouth.	Please see update in the previous section of this report.
Social Care: Quality Assurance There is a potential gap in regulation of services purchased through personal budgets where services do not provide 'personal care' and therefore are not CQC registered, and where the service concerned has no contractual relationship with the Local Authority. This may leave vulnerable people with nowhere to go to raise serious concerns about such a service.	HW Nottinghamshire	Please see update in previous section of report
Electronic Prescription Service Patient safety concerns connected with the electronic prescription service now being rolled out across the country. There is no standardisation of the way in which the various pharmacy system suppliers display messages which are often important to patients.	HW Stockport	HWE has followed up with NHS England on activity they have committed to resolve this issue. We have followed up and are currently awaiting a response.
Maternity Services Liaison Committees (MSLCs) Inconsistent funding of MSLCs across Cambridgeshire causing concern locally about engagement of maternity services	HW Cambridgeshire	Actions: We contacted the National Childbirth Trust (NCT) who shared unpublished data about the discrepancy of funding of MSLCs. We might run a joint press release on the issue. We have also contacted NHS England who confirmed the imminent publication of Maternity services guidance for CCG (currently going through legal clearance). Next Steps: to revisit case once NHS England has published the new guidance.

Regulation of domiciliary care A number of previous care homes are now registered as private residences and not subject to CQC regulation raising concerns about the quality of care for vulnerable people.	HW Richmond	Please see update in previous section of report
Delays in social care assessments Include long waiting lists for adult social care assessments. HW Cambridgeshire is concerned about the existence of a further wait for a care package to be arranged (the 'pending list'). HW Isle of Wight believes these delays result in a 'quantity not quality' approach.	HW Cambridgeshire, HW Isle of Wight, HW Bristol	Actions: We have written to David Pearson, President of the ADASS, in order to invite him to write a joint letter with us to DH. The objective of this letter would be twofold: • to ensure the implementation of the Care Act in April 2015 will result in fewer delays in social care assessments and in setting up the appropriate package of care • to have assurance that, in the meantime, the Department of Health addresses the issue of late assessments and provide support to the people waiting for their assessment or care arrangements Next steps: David Pearson responded to us, showing his interest in taking action to raise the issues. We will meet with David on the 9th of February to discuss this further.

Ambulance Arrival to Clear Targets This is the time it takes an ambulance to hand over a patient when arriving at hospital. Targets are not being met in the East of England region. Data has shown that up to 1000 hours have been lost in one region to ambulances waiting to handover patients.	HW Luton	To ascertain if this is a regional or national issue we are sourcing data to build a national picture of arrival to clear times. Initial research shows that data made public by Ambulance Trusts is not consistent nationally. Most data released is in response to Freedom Of Information requests. A call out to the network has also been done to see if this is an issue raised with other local HW. We have asked NHS England to: • Clarify availability of data on to clear times by region and clarification as to if and how this could be made publicly available • Clarify whether NHS England is aware of an issue with delays in to clear timings nationally • Explain any plans NHS England have to help trusts to improve their ability to meet arrival to clear targets. NHS England have clarified the available data on the subject, and we are currently reviewing whether this may be suitable material for a media story.
Implementation of NICE guidelines Inconsistent and non-transparent decisions made by CCGs on implementation of NICE guidance - particularly relating to knee replacement surgery and IVF treatment.	HW Hillingdon, HW Central West London	We will be writing a joint resource for local HW with NICE and Regional Voices which sets out legal status of NICE guidelines and responsibilities on CCGs. Release date TBC.

AGENDA ITEM: 8

SUBJECT OF REPORT: Standards for local Healthwatch

PRESENTING: Mark Gamsu, Susi Miller and Gerard Crofton-Martin

PURPOSE: To present the approach to our work on standards

RECOMMENDATIONS: For approval

RESOURCE IMPLICATIONS: N/A

RISK AND MITIGATION: N/A

EQUALITY AND DIVERSITY: N/A

Members are invited to APPROVE.

AGENDA ITEM: 9

SUBJECT OF REPORT: December 2014 Intelligence Return feedback and the Healthwatch Offer 2015/16

PRESENTING: Gerard Crofton Martin and Susan Robinson

PURPOSE: To present the results of the December 2014 intelligence return and the supporting offer – the offer is a package of support, guidance and advice provision available to local Healthwatch

RECOMMENDATIONS: This report is for approval

RESOURCE IMPLICATIONS: N/A

RISK AND MITIGATION: The feedback is used to identify areas for improvement which are addressed by the Senior Management Team and delivered particularly through the Offer to local Healthwatch

EQUALITY AND DIVERSITY: There are no specific implications in relation to Equality and Diversity

Background

Nine months ago, Healthwatch England had limited intelligence about the network, and had yet to develop and implement a consistent approach to gathering and reviewing information that would help us to better plan our support to local Healthwatch. We have now implemented an approach that enables us to gather information from local Healthwatch at two points in the year, and undertake a monthly exercise to gather specific information that we may need to support our work from a smaller sample of local Healthwatch.

Our first intelligence return ran in May/June 2014 giving us insight into local Healthwatch priorities, finances, relationships and their impact. Following our analysis of local Healthwatch annual reports and their funding situation, Healthwatch England undertook a second exercise which went live in November. This was delayed until after the original deadline for local Healthwatch to respond to the Kings Fund survey had passed.

The survey was closed at the end of December, with 127 local Healthwatch having initiated a response; a response rate of more than 85%. The responses are inclusive of four local Healthwatch who submitted a partial response, included; this gives an overall completion rate of 83%.

While the completion rate for larger local Healthwatch (defined as five or more full time equivalents) was 91%, the completion rate for smaller local Healthwatch (defined as two or fewer full time equivalents) was 74%, suggesting that local Healthwatch with fewer staff may be less likely to be able to give their time to complete the questionnaire.

The return focused on areas where there is additional value in Healthwatch England and local Healthwatch working together, for example on our programme of work on complaints and unsafe discharge. The return also concentrated on gathering feedback about the support we had been providing local Healthwatch. This is the first occasion in which we can compare feedback with a previous benchmark to consider our performance. We will use the feedback to shape the support offer in 2015/16.

Our approach to analysis

In the three weeks we have had to start to analyse the information, we have focussed on a simple individual analysis of every question. In addition, where there is a historical point of comparison from the previous return, we have compared the current response with the previous response to look at any changes. We have also started to segment responses by size of local Healthwatch (fulltime equivalents).

The figures quoted in this paper relate to % response rates for specific questions. The response options often had two positive (good, very good options) as well as two negative (poor or very poor) options. In the initial response the positive options are combined, as are the negative options. However, we have also tracked responses to see if local Healthwatch have responded less positively than before.

Our overall relationship with the network

Overall, 92.5% of local Healthwatch respondents felt they have a good or very good relationship with Healthwatch England compared with 88% in June 2014. 29% rated the relationship as very good and 63% rated the relationship as quite good. Overall there were 27 local Healthwatch who answered more positively than previously while 21 answered more negatively than previously. This puts us in the enviable position of having developed a trusting relationship with the network and a relationship which is mature enough for the network to be willing to identify areas which we need to improve further.

The difference we are making for people using health and care services

21 respondents selected "not applicable" but of the remaining responses, 82.6% of these respondents felt Healthwatch England was making a positive difference for people using health and care services. 6.5% rating the difference as excellent and 76% rating the difference as good. This is similar to the previous figure of 82%. However closer inspection shows that overall just one respondent gave a more positive response than last time, with seven responses were more negative in their view of the difference we are making. This is an area we will need to address.

Current Support from Healthwatch England teams

The network were asked to rate the usefulness of the support from some of the teams in Healthwatch England. Overall, the responses received showed a positive rating of 92% across all teams. This masks some variation across the teams. For example, less than 3% of respondents had a negative view about the support available from the Development Team compared with 12% for media and 14% for policy. However, both these teams showed improvements compared with the previous return particularly the policy team with 9 local Healthwatch increasing their assessment of the support.

Table 1: Tracking of respondents' ratings for support received for the three teams for which we have previous data

Team	Increased	Decreased	Aggregate change
Development Team	21	17	+5
Media Team	11	9	+2
Policy Team	9	3	+8

Smaller local Healthwatch were more likely to suggest that the stated support was not applicable. For example, across the spectrum of support available from the development team, 32% of the smallest local Healthwatch suggested it was not applicable compared with 19% of the larger local Healthwatch.

The positive feedback about the support from the Regional Development officers improving from 90% to 97% (this excluded the 16 respondents suggesting it was not applicable) was pleasing and reflects the additional resource that has been invested in this area. Interestingly, a third of the 19 responses that rated the support from Development officer as either poor (two)/very poor (one) or not applicable (16) and 38% of respondents rating visits for development officers as "not applicable" were from just one of the four regions. This was the central region and reflects the fact there was no designated development officer until November 2014.

Support Products

Table 2 (below) summarises the usefulness of the support resources to all respondents as well as the usefulness to those respondents who used the support. The support areas have been grouped into the following broader headings:

- Development Team support
- Templates
- Guidance and support
- Resource packs and toolkits
- Briefings
- Training

The support from the Development Team and the branded templates appear to be particularly well received. One of the main themes is that those local Healthwatch which used the support have found it useful but too often resources were not read or used. We have not undertaken further work to identify the reasons why resources have not been used or read.

Once again differences can be seen according to size of local Healthwatch. For example, on average the largest local Healthwatch read 54% of policy briefings compared with 46% of the smallest local Healthwatch. This could indicate that the larger local Healthwatch are more likely to have time to read the policy briefings. There could also be an indication that the larger local Healthwatch have more staff resources available to attend network meetings to find out about the briefings; 15% of smaller local Healthwatch rated regional meetings as not applicable compared with 3% of larger local Healthwatch.)
Similarly the media training was attended by 32% of the smallest local Healthwatch and

59% of the larger local Healthwatch. Again, this would seem to start to indicate the smaller Healthwatch are not able to allocate staff time away from the office or local Healthwatch work.

Table 2: Respondents ratings for usefulness of support provided by Healthwatch England

Area of support	Product or Service	% of all respondents who found the resource useful	% of all respondent who did not find the resource useful	Not applicable	Have not used/read
Development Team support	Usefulness of responses from development team	85.6%	8.5%	5.9%	
	Regional network meetings	77.1%	12.7%	10.2%	
	Individual visits from regional development officer	63.6%	2.5%		33.9%
Templates	Templates and Branded Materials	90.1%	5.8%		4.1%
	Annual report template and guidance	83.3%	15%	1.7%	
	Enter and View report template	71.4%	9%	19.6%	
Guidance and support	Support on CQC inspections	47.3%	20.2%	32.5%	
	Negotiation of a named contact with CQC	44.8%	19.9%	35.3%	
	Local Healthwatch finance guidance	43.8%	25.9%	30.4%	
Resource packs and toolkits	Complaints Resource Pack	49.6%	2.5%		47.9%
	Volunteer Toolkit	40.9%	8.7%	50.4%	
	Freedom of information resource pack	38.3%	7.8%	53.9%	
Briefings	Care Act Briefing	62.8%	6.3%		30.9%
	Better Care Fund Briefing	54.2%	6.2%		39.6%
	Duty of Candour Briefing	44.7%	10.6%		44.7%
	List of Current Legislation	37.9%	4.2%		57.9%
	Trust Special Administrator Briefing	29.5%	11.5%		59.0%
	Immigration Act Briefing	25%	11.5%		63.5%
	Legislative Reform Order Briefing	24.5%	10.6%		64.9%
Training	Training given on the second day of annual conference	55.1%	9.3%	35.6%	
	Media Training	45.3%	5.8%		49.6%
	Key Message Training	25.2%	8.4%		66.4%
	Bite size e-learning complaints module	18.3%	3.4%		78.3%
	Complaints Tutorial	16.1%	4.2%		79.7%

Highest rated areas of support

In addition to rating support, local Healthwatch were asked to identify their top three areas of support that were most useful. While there was not a list of options to choose from, previous questions may have acted as a prompt. There were 309 responses clearly identifying the value placed on the support from Development Officers.

Some areas that had been rated less positively by the majority of the local Healthwatch have been rated as most useful by some individual local Healthwatch. This highlights how some pieces of work are timelier depending on the situation of an individual local Healthwatch. For example, the work on finances was the 14th most positively received piece of support for all local Healthwatch but came in 8th on the list of areas of support that were of most use to individual local Healthwatch. This may have been because of the status of the contract and commissioning cycles of these local Healthwatch.

Table 3: Most valued areas of support to local Healthwatch

Local Healthwatch suggestions for their top three areas of support	Number of responses
Development Officer	50
Annual report Templates	37
Regional Meetings	36
Enter and View support	30
Annual Report Guidance	25
Annual Conference	18
Policy Work	18
Local Healthwatch Finance Guidance	16
IT Systems	15
Communications and Media support	12
Support to work with CQC	11

Areas of future support

Healthwatch England uses the return to investigate both areas that local Healthwatch are suggesting support is needed as well as areas where we predict support might be needed. This enables us to plan our support based on local Healthwatch needs. For example, some local Healthwatch had suggested to Healthwatch England that they were having problems retaining volunteers. We therefore asked local Healthwatch about this in the return. 68% of respondents said their volunteer numbers were increasing while volunteer numbers stayed the same for 28% of the 121 responses to this question.

Support needs may also change over time. In the previous data return Healthwatch England asked local Healthwatch if they were thinking of changing their legal status with a view to potentially needing to provide support. At this time 6% of local Healthwatch were planning on changing their status and had not decided what they were changing their status to. In the most recent return over 20% of the 121 respondents were planning on changing their legal status by April 2016. In addition to this, it is worth recognising that there are also 30 local Healthwatch whose initial contract ends in 2015, and a further 43 local Healthwatch with either a break or extension clause scheduled for 2015.

In addition to asking about possible areas of support, local Healthwatch were given the opportunity to suggest changes to the existing support. There were 37 suggestions which tended to focus on improving current support. The top five requests being:

1. Communication on what support is available
2. Working across boundaries
3. Visiting local Healthwatch
4. Support with best practice
5. Regional specific work and training

Communications with local Healthwatch

Local Healthwatch continue to find the newsletter useful (97%) which is just up on last year (96%). Yammer is well received by 86% of respondents while the communications centre has dropped from 91% to 69%. This may be due in part to local Healthwatch requiring separate log-in details to the Communications Centre as well as 10% of respondents being aware of it. The Hub has improved since the re-launch with 61% of respondents finding it useful.

Our key areas of work

Although 11% of local Healthwatch respondents stated they had chosen not to engage with our work on unsafe discharge, overall local Healthwatch reported that they are more likely to have engaged with our work on unsafe discharge (66%) in comparison with our work on complaints (48%). However, 69% of respondents still felt informed about our complaints work while 7% had chosen not to engage with this work.

Over half of all respondents had used information from our national complaints report in their work locally. This illustrates how we are now starting to be able to work as a network to simultaneously take forward policy issues at both national and local levels.

Local Healthwatch priorities

Initial analysis of local Healthwatch priorities shows that once again Mental Health and GP services feature strongly while social care is also starting to feature more prominently in their priorities. The following are the top ten health priorities for 2014-15.

1. Access to GPs
2. Hospital Discharge
3. Service changes issues and the impact of the Better Care Fund
4. Involvement of children and young people in health and care decisions
5. Quality of care homes / residential care
6. Access to children's and adolescent mental health services (CAMHS)
7. Access to adult mental health services
8. Dementia services
9. Domiciliary care
10. Complaints

Local Healthwatch are most likely to be working on GP and primary care services with only 2% of local Healthwatch having no plans for work in this area. 63% of local Healthwatch reported that they had either already undertaken, or were planning work on CAMHS.

Summary

From the intelligence return, we can see that priorities for local Healthwatch and our national priorities are starting to align. It is also clear that the support provided by the Healthwatch England team and templates are really valued. While we will continue to analyse the data and use it as we plan our support for 2015/16, we have identified the following challenges. The committee are asked to reflect on whether these are the right challenges for us to focus on.

- continuing to secure some high satisfaction ratings for some of our support;
- understanding the reasons why some local Healthwatch do not use the support available to them;
- demonstrating the difference we are making to people using health and social care services to local Healthwatch; and,
- considering our support to smaller local Healthwatch who appear less likely to utilise the support available to them.

Healthwatch Offer 2015/16

Why is there an offer to local Healthwatch?

Healthwatch England has several primary responsibilities including one stating that it must provide support to local Healthwatch to function effectively. Our strategic priorities for 2015/16 reflect our duty and commitment to the network. Priority 3 is developing the potential of the Healthwatch Network.

Throughout each year we collect information that informs the support required for the future via the data return. There is also a dynamic interchange of information between the network and Healthwatch England, largely through the development team that informs us of the network's needs. This year we are taking a very different approach to how we present the offer and this paper outlines the principles of this and presents a working example of what this will look like.

What are we doing about what local Healthwatch have told us?

From the intelligence return, we have heard that the network really value our contact and support. However, the briefings and training products provided have had a mixed response and there is a suggestion that accessing them or knowing about them may be a problem. We will need to understand more about why people don't access certain documents to understand how to support the network better. We have learnt more about the provision of guidance and support, and that the time at which local Healthwatch want to use these resources will vary. We are therefore providing local Healthwatch with an area to access the information when they need it.

We have heard that face to face contact is really important which is reflected in the feedback about the support delivered through one to one contact and meetings, network meetings and the Annual Conference. They have also told us that they would like more support in certain areas like using information.

To address this, our proposal this year is in principle the following.

We have adopted a framework to organise our support offer:

- Sustainability (green),
- Leadership (blue),
- Engagement (pink), and
- Impact (orange) (and colour coded them)

We also:

- Refreshed all the support packages we have produced - currently on the Hub and Yammer and put them all into one place under themed headings;
- Plotted the key activities in a local Healthwatch year;
- Chose themes aligned to the 4 headings for each quarter to make sure that our messages are delivered in an organised and timely way, for example Q1 will be Impact; and
- We are plotting the business planning activity that Healthwatch England will deliver this year.

We are now creating a calendar of events that will present our offer to the network month by month.

Members are invited to APPROVE.

AGENDA ITEM: 11

SUBJECT OF REPORT: Healthwatch England's relationship with NHS England - Briefing for the Committee on Healthwatch England's current relationship with NHS England

PRESENTING: Dr Katherine Rake OBE

PURPOSE: This briefing is for information and presents the Committee with an overview and update of the current relationship between NHS England and Healthwatch England over a range of work streams

RECOMMENDATIONS: To approve the Memorandum of Understanding with NHS England

RESOURCE IMPLICATIONS: N/A

RISK AND MITIGATION: N/A

EQUALITY AND DIVERSITY: No risks at present

Background

Through the Memorandum of Understanding (MoU), (draft attached), Healthwatch England and NHS England have agreed to work together more closely and to challenge each other when necessary. The purpose of the MoU is to formalise our working relationship with the end result aiming to help improve health and wellbeing outcomes for consumers.

This paper is for information and provides an update on aspects of our working relationship with NHS England, including:

1. Care.data
2. NHS Five Year Forward View
3. NHS Citizen
4. Commissioning - including:
   a) primary care co-commissioning
   b) CCG assurance
   c) specialised commissioning
5. GP contracts and shared contracts.

Senior-level relationship

Anna Bradley has now met twice with Simon Stevens, Chief Executive of NHS England to discuss our working relationship with NHS England as well as raise issues and concerns that are coming up from the network. In addition, Katherine Rake meets quarterly with NHS England senior staff, including Tim Kelsey (National Director of Patient Information), Ian Dodge (National Director of Commissioning), Neil Churchill (Director of Patient Experience), Giles Wilmore (Director for Patient and Public Voice) and Olivia Butterworth (Head of Patient and Public Voice).

1. Care.data

Care.data is a programme that NHS England is commissioning from the Health and Social Care Information Centre (HSCIC) that will build on existing data services and expand them

to provide linked data that will eventually cover all care settings, both in and outside of hospital.
Following on from the 'pause' in the roll out of Care.data in spring 2014 resulting from our raising concerns, we have been involved by playing the role of "Critical Friend" to the programme. We are also members of the Independent Advisory Group (IAG) and four local Healthwatch are taking part in the pathfinder phase which is due to end in April 2015.
The interaction between NHS England, Healthwatch England and local Healthwatch is also strengthened by regular bi-monthly videoconferences. These meetings enable us to provide additional feedback based on insights from the network and from ourselves and to better coordinate the activities of local Healthwatch involved in the pathfinder areas of the care.data programme.
In the coming months, as the Care.data programme progresses, we will continue to play a challenge role with NHS England to ensure the programme works for consumers of health care.

2. NHS Citizen

We have received a number of enquiries and concerns from the Healthwatch network regarding NHS Citizen – the patient engagement project of NHS England. As concerns include the potential duplication of its role with local Healthwatch, we have flagged, and will continue to raise this issue at our senior level NHS England quarterly meetings.

3. NHS Five Year Forward View

We have raised directly with Simon Stevens our concern that we were not engaged in the development of the NHS Five Year Forward View. The result was that we were subsequently consulted in the drafting of the Forward View planning document[1] ensuring that the role of local Healthwatch is reflected in how the Forward View can be implemented[2].
Our relationship with NHS England on the Forward View is now in a strong position, which is particularly welcomed as the Forward View implementation is at such an early stage. We will shortly be meeting with the newly appointed NHS England lead on implementing the Forward View, Samantha Jones. Once it is formed, we will also be part of the high-level cross-system planning group for the Forward View, as well as inputting into the New Care Model sites project.

4. NHS Commissioning

There are significant changes currently taking place in the NHS commissioning system. Our relationship with NHS England on commissioning focuses on ensuring that there is meaningful public engagement in commissioning as well as ensuring sufficient mechanisms are in place to scrutinise decisions and outcomes of commissioning.

a. CCG Assurance

In July 2014, we wrote to the Secretary of State using our statutory powers to highlight concerns raised by local Healthwatch in terms of the proposed Legislative Reform (CCG) Order 2014. This granted CCGs the statutory power to set up joint committees in common to make decisions on health services at a regional level, effectively overriding their requirement to engage local people.

Following this, we used our statutory powers to write to Simon Stevens to request an assessment of the assurance of CCGs involvement of local Healthwatch and the public in decisions about service change, (letter to Secretary of State). NHS England responded

[1] *The document describes the approach for national and local organisations, including CCGs, to make a start in 2015/16 towards fulfilling the vision set out on the* NHS Five Year Forward View.
[2] *p7 and 8 of* Forward View into Action: Planning for 2015/16

that CCGs had taken part in 360 degree feedback with local stakeholders and that they were satisfied with the level of engagement with representatives of local patient groups including local Healthwatch.

Since raising our concern through the use of our advisory powers, NHS England has engaged us much earlier in discussions around CCG assurance. As part of developing the new CCG assurance regime that will be implemented in April 2015, NHS England is keen to engage with Healthwatch – particularly around the assurance process and a process of special measures for CCGs requiring intensive support. Going forward, we will continue to monitor whether our concerns around the assurance process have been addressed including by using evidence gathered from local Healthwatch.

b. Co-commissioning of primary care services

Under the Next Steps to Primary care co-commissioning, NHS England is giving CCGs the opportunity to assume greater power and influence over the commissioning of primary care from April 2015. NHS England has involved us from an early stage consulting us as part of developing the Next Steps and Managing Conflict of Interest guidance and welcomed our input around local Healthwatch engagement and attendance at co-commissioning meetings.
We have received a number of queries from local Healthwatch about these changing arrangements and we welcome NHS England's continued commitment to inform the Healthwatch network of the changes. This includes in the form of a webinar which will provide the network with an opportunity to raise questions directly with those NHS England staff who lead the primary care co-commissioning changes. We will continue to work jointly with the primary care co-commissioning team and feedback the experiences of local Healthwatch in regard to the changes.

c. Specialised commissioning

Healthwatch England works both directly with the NHS England Specialised Commissioning Team, and through the specialised commissioning Patient and Public Voice Assurance Group (PPVAG) on which we have an observational seat. As with all of our commissioning work, our conversations with NHS England centre on ensuring patient engagement in specialised commissioning (and the current changes being made to this system), as well as flagging specific concerns the network has raised with specialised commissioning services.

Our relationship with PPVAG is productive and allows us to challenge the decisions that are being made by NHS England and work collaboratively with other patient champions to raise issues.

Our direct interaction with NHS England on specialised commissioning has largely focused on specific issues escalated to us by local Healthwatch. One issue relates to access to gender identity services. We escalated our concerns to NHS England through our formal escalation process with the result that Richard Jeavons, Director of Specialised Commissioning, attended a joint NHS England/Healthwatch England meeting to address our concerns. Our relationship around this escalation has been one of the challenger role and we will continue to push for our concerns to be fully addressed.

5. NHS Standard Contracts

The NHS Standard Contract is mandated by NHS England for use by commissioners for all contracts for healthcare services other than primary care. For the past two years we have been engaged by NHS England to input into the standard contract. In 2013, NHS England were receptive to our proposed changes to the 2014/2015 contract with the result being that the contract includes a requirement on providers to respond to reports and recommendations made by local Healthwatch, recognises the right of local Healthwatch to

Enter and View, and requires providers to act on complaints local Healthwatch make in relation to providers failing to disclose patient safety issues.

We were also invited to input into the draft contract for 2015/2016 and a parallel lighter grant agreement for voluntary sector organisations. Whilst our relationship with NHS England remains open, it was more of a negotiation this year to ask for our requirements around the role and relationship with the Healthwatch network to be reflected in the contract. Our main ask is to include a requirement to 'promote understanding of Healthwatch to patients as a resource to provide information and advice on local services, raising concerns or making a complaint and for the contractees to raise awareness of local Healthwatch.'

We believe that the NHS Standard Contract is an important tool to push for consumer concerns to be addressed. From 2015 we are proposing to NHS England that we get involved in the contract drafting process at a much earlier stage, with an initial meeting with NHS England occurring early summer 2015. This will be to share reflections from the network on the standard contract as well as share our view on areas of the contract we believe need strengthening to recognise both the role of local Healthwatch and the rights of consumers.

GP Contracts

NHS England has commissioned new standard primary care contracts in order to ensure that a consistent contractual framework is in place across the country. We were consulted as part of these changes (2015-16) and were greatly reassured to hear that NHS England plan to include a requirement in the new GP contract for this year to support Patient Participation Groups to make links with their local Healthwatch. We have received a useful indication from NHS England on how we can better input into negotiations around the contract so will be using our relationship with NHS England to push for greater requirements on GP's to promote understanding of Healthwatch as well as improving GP transparency in complaints handling.

Summary

We work with NHS England across a wealth of health-related areas. Our relationship is one of critical-friend, challenging and pursuing assurance on behalf of consumers, and at the same time being transparent and constructive in the information and experiences of health issues we share. When concerns have been critical enough that we have needed to "go to the top", our interaction with Simon Stevens and other senior NHS England staff has resulted in better engagement, involvement and communication of issues with us. We are now continuing to develop our relationship with NHS England with a focus on the outcomes we want to see NHS England achieve, rather than the process they take to get there. We are re-assessing the "tactics" we use with NHS England and how we can best use the opportunities engagement with senior level NHS England staff brings.

DRAFT

Appendix 1 - NHS England – Healthwatch England

Memorandum of Understanding

1. Joint Statement

NHS England and Healthwatch England share a common goal of ensuring that the interests of consumers are at the heart of everything we do. Through this memorandum of understanding, we agree to work together and to challenge each other when necessary. This will support our shared purpose of improving health and wellbeing outcomes for consumers, including patients, carers, families and communities.

The shared approach for working together will be characterised by openness, transparency, information sharing and timely engagement on issues of mutual interest and importance.

This agreement will sit alongside the other memorandums of understanding and partnership agreements that both NHS England and Healthwatch England have in place with other partners in the health and social care system.

This document is not legally binding and cannot constrain either organisation in exercising their respective roles and responsibilities as directed by the Secretary of State.

2. Roles and Responsibilities

NHS England

NHS England is an independent non departmental public body. NHS England's overarching role is to ensure that the NHS continuously improves outcomes for patients within the resources available. It fulfils this role through its leadership of the commissioning system.

Working in partnership with Clinical Commissioning Groups (CCGs) and other stakeholders it secures better outcomes for patients; promotes the rights and standards guaranteed by the NHS Constitution; promoting equality, reducing health inequalities and ensuring that the health and social care system operates within the resources available.

The NHS commissioning system requires NHS England to provide national consistency in areas like quality, safety, access and value for money whilst promoting the autonomy of CCGs to make decisions that are in the best interests of their community.

NHS England directly commissions some NHS services including specialised services, primary care services, healthcare for people in the justice system and services for members of the armed forces and public health services.

Healthwatch England

Healthwatch England was established in accordance with section 181 of the Health and Social Care Act 2012 with the purpose of acting as an effective, independent consumer champion making demonstrable differences to consumers of health and social care.

The health and social care reforms of 2012 set a powerful ambition of putting people at the centre of health and social care. To help realise that ambition, the reforms created a Healthwatch in every local authority area across England and Healthwatch England, the national body. Healthwatch England provides leadership and support to the network to help ensure that each local Healthwatch has a positive impact on local services. The network is strongest working together to share information, expertise and learning in order to improve health and social care services. The vision is working towards a society in which people's health and social care needs are heard, understood and met. Achieving this will mean that: people shape health and social care delivery; people influence the services they receive personally; people hold services to account.

As the consumer champion for health and social care, Healthwatch England: listens hard to people, especially the most vulnerable, to understand their experiences and what matters most to them; influences those who have the power to change services so that they better meet people's needs now and into the future; empowers and informs people to get the most from their health and social care services and encouraging other organisations to do the same; and works with the Healthwatch network to champion service improvement and to empower local people.

3. Shared Purpose

Our shared purpose is to secure the best possible health outcomes for consumers, patients and the public, with a particular focus on the most vulnerable.

We will work together to share intelligence and insight that help ensure people who use services are properly informed and to assist communities in championing improvements to their local services. In particular, we will focus on:

- The importance of the consumer voice as a signal of quality and safety;
- The need to shape services around people's needs; the need to involve people in decision-making about the services they personally receive and those that are provided to their local communities;
- The flow of intelligence and insight between both organisations that lead to improvements;
- Ensuring effective commissioning which takes into account local communities and the overall health needs of the community; and
- Working to secure appropriate responses to concerns and complaints.

4. Our approach to joint working

NHS England and Healthwatch England commit to transparent and open communication between our two organisations to support and oversee joint working.

a) Ways of Working

- Strategic - the organisations will work together to support each other in meeting our respective strategic objectives;
- Operational - the organisations will develop clear approaches to dealing coherently and effectively with a range of operational matters; and
- Cultural - the organisations will seek to promote common values, based on those in the NHS Constitution, and constructive behaviours.

b) Style and Behaviours

Where no legal constraints exist, the overarching approach to operational working will be characterised by:

- Openness and honesty;
- Transparency;
- Understanding of respective statutory roles, duties and powers, recognising the need to work collaboratively as well as individually;
- Engagement on issues of mutual interest and importance, including joint learning and development;
- Early and pro-active information sharing at a local, regional and national level.
- Trust: providing and being open to challenge; and
- Ambitious for patients and the public with a focus on ensuring the best possible outcomes.

c) Delivering Joint Priorities

<u>Practical working arrangements</u>
To maintain an effective working relationship, NHS England and Healthwatch England will ensure there is regular contact and close working. Together, we will work to ensure the local Healthwatch network is engaged with NHS England local area teams and work to identify areas of challenge and best practice in local working arrangements. Together we will determine how best to provide support and information to the network about major changes in policy and practice.

NHS England is working on how the rights set out in the NHS Constitution can be turned into tangible behaviours and actions. This is linked to work that Healthwatch England is conducting regarding consumer rights in health and social care.

<u>Statutory consultations</u>
Healthwatch England is a statutory consultee of the Department of Health on changes to the NHS Mandate which sets the frame for NHS England's priority areas of work.

Healthwatch England has the power to provide NHS England with information and advice on:

a) the views of people who use health and/or social care services and of other members of the public on their needs for and experiences of health and social care services, and

b) the views of local Healthwatch and of other persons on the standard of provision of health and social care services and on whether or how the standard could or should be improved

When Healthwatch England provides NHS England with advice and information, NHS England must inform the Healthwatch England Committee in writing of a response or a proposed response to the advice.

Further NHS England must consult the Healthwatch England Committee before it publishes guidance for Clinical Commissioning Groups on the discharge of their commissioning functions (or revised guidance that NHS England considers significant)..

5. Reviewing this agreement

This memorandum of understanding will be reviewed annually and may be revised sooner if both organisations agree that this is necessary.

Members are invited to APPROVE.

AGENDA ITEM: 12

SUBJECT OF REPORT: Enhanced Governance

PRESENTING: Sarah Armstrong

PURPOSE: To present the updated governance documents and to highlight the new roles, Sub Committees, and updated policies which have been proposed to enable the Healthwatch England Committee meet its governance requirements

RECOMMENDATIONS: Each role, terms of reference or policy will detail the decision needed from the Committee

RESOURCE IMPLICATIONS: N/A

RISK AND MITIGATION: This report gives appropriate recognition of the governance process in relation to the Committee

EQUALITY AND DIVERSITY: N/A

As we continue to mature as an organisation, we have taken the steps to ensure that there are policies, roles and groups that oversee our governance processes. At the October meeting, we explored the terms of reference for the Remuneration Committee, updated the Conflict Policy and introduced the Senior Independent Member role. We have addressed needs, strengthened policies; this is an ongoing process to ensure our governance is effective.

We have explored how these roles and our other governance roles complement each other, as such today we:

- introduce terms of Reference of the Finance and General Purpose Sub Committee;
- introduce the terms of Reference of the Procurement Group;
- clarify the role and remit of the Senior Independent Member;
- update the Whistleblowing policy;
- update the Conflicts of Interest policy; and
- introduce the Caldicott Guardian role

At the May meeting, we will continue our development of our governance assurances and will present the Complaints Champion role as well as a paper on political conflicts of interests.

1. Finance and General Purpose Sub Committee – Terms of Reference

Background

The purpose of the Sub Committee will be to have oversight and provide assurance to the Healthwatch England Committee in regards to the financial integrity of Healthwatch England. This will consist of but is not excluded to overseeing the process of:

- Budget preparation;
- Financial reporting and management;
- Procurement; and
- General administration.

We are currently reviewing the financial limits for Healthwatch England with CQC, this will be updated in the Scheme of Delegation and shared when finalised.

Purpose

To have oversight of financial management and business processes whilst providing assurance for the wider Committee.

Duties

Budget and business planning

- To oversee the process of the development and management of the budget to ensure propriety, efficiency and value for money in resource usage, and to provide assurance to the Committee on all of those matters
- To oversee the development and publication of the annual financial statement
- To review forecast against budget and make recommendations to the Senior Management Team and the Committee

Financial reporting and management including Annual Financial Statement

- To ensure that internal financial systems are adequate, reviewing the Scheme of Delegation and making recommendations to the Committee as appropriate
- To review the financial statement of the year - including comparisons with the previous year and current year budget, and seek an explanation for any issues arising
- To ensure that organisational expenditure complies with the Healthwatch England Standing Financial instructions

Assurance on business process

- To review the business continuity plan and crisis planning process – ensuring that business support services operate effectively. This will be presented to the Committee on an annual basis
- To provide assurance to the Committee about the organisation's procurement process

Membership and Support

- Members are to be made up of Healthwatch England Committee Members
- Additional members may be co-opted on a time-limited basis to provide specialist skills, knowledge and support. Co-opted members should not form more than one-third of the Sub Committee

- Support for meetings will be provided by the Chief Executive, Head of Operations and the Committee Secretary

Meetings

- The SubCommittee will meet quarterly
    - Other meetings will be arranged by the Committee Secretary at the request of the Chair of the Healthwatch England Committee
    - At least two members must be present for a meeting to be quorate.
- The Healthwatch England Committee or Chair may seek specific advice, requesting the SubCommittee to convene further meetings
- A forward programme of scheduled meetings will be established by the Committee Secretary

Reporting and accountability

- The Sub Committee is accountable to the Healthwatch England Committee
- The Chair of the SubCommittee will provide quarterly reports to the Healthwatch England Committee and should include the minutes of meetings held
    - These quarterly reports will also be shared with the CQC Board

Annual Review of Terms of Reference and Effectiveness

- The Sub Committee will review its own effectiveness at least every two years, and the Terms of Reference annually for 'fitness for purpose', and report its conclusions to the Healthwatch England Committee

Members are invited to APPROVE.

2. Procurement Group – Terms of Reference

Background

To make decisions about the level of resource required for an activity and to agree the procurement route to follow. To have oversight that the correct procurement processes are followed.

The activity of the Procurement Group will be overseen by the Finance and General Purpose Sub Committee.

To monitor that the procurement process adheres to government procurement policies concerning the use of public money in procurement, this includes but is not exclusive to Cabinet Office controls and the Treasury approval of expenditure.

To oversee compliance with the Scheme of Delegation, Standing Financial Instructions and government procurement policies.

To ensure that all business cases approved are compliant with Healthwatch England Scheme of Delegation authorisation levels and CQCs level of delegation.

Duties

To monitor that the procurement process adheres to government procurement policies concerning the use of public money in procurement, this includes but is not exclusive to Cabinet Office controls and the Treasury approval of expenditure.

To receive and scrutinise requests to procure contracts and business cases as indicated in the Healthwatch England Scheme of Delegation (currently under review).
To oversee and make recommendations in line with the Healthwatch Scheme of Delegation authorisation levels:

- Evaluate the procurement process and approve the award of revenue contracts up to the value indicated in the Healthwatch England Scheme of Delegation (currently under review)
- To review the contract once it has been awarded to ensure that it meets the approved business case specification

Membership and meetings

Members will be from the Healthwatch England Senior Management Team:

- Chief Executive (Chair)
- Head of Operations
- Head of Development
- Head of Oversight and Support
- Director of Communications and External Affairs
- Director of Policy and Intelligence

Meetings will be monthly as part of SMT meetings. Formal reporting responsibilities are detailed in the Healthwatch England Scheme of Delegation.

Reporting and Accountability

The Procurement Group operates within Healthwatch England's Scheme of Delegation, to ensure that issues are referred to the appropriate level of delegation.

The Chief Executive will be accountable for ensuring that decisions made by the Senior Management Team reflect appropriate consideration of:

- Equality, diversity and human rights
- Staff development
- Stakeholder interests and involvement
- Resources (money, staff, information and technology)
- Value for Money
- Statutory and governance reporting requirements
- Statutory and corporate legal requirements
- Strategic priorities
- Risks and issues impacting on the achievement of strategic priorities

Members are invited to APPROVE.

Members are invited to APPROVE the Terms of Reference for the: 1. Finance and General Purpose Sub Committee 2. Procurement Group

3. Senior Independent Member role

Good practice in governance is to have someone in the role of Senior Independent Director or in our case 'Member' or (SIM). This role provides Committee Members and the CEO and SMT with a space in which they can raise issues should they feel unable to raise them directly with the Chair. It is unlikely that these situations will arise, but in the event they do, the SIM will, it then falls to the SIM to raise those matters in confidence and with sensitivity to the Chair.

Role

The Senior Independent Committee Member is primarily appointed to resolves issues relating to the Chair and/or Chief Executive Officer (CEO). Examples of issues that might be taken to the SIM by Committee Members or the CEO are:

- The Committee have expressed concerns that are not being addressed by the Chair in the way they would expect;
- The relationship between the Chair and the CEO is difficult;
- A Committee Member or the CEO have cause to raise concerns about the Chair that it is impossible or very difficult to raise directly; and
- The integrity of the Chair is in question.

Duties

The Senior Independent Member's role is to:

- Serve as an occasional intermediary for other Committee Members and/or the CEO
- Act as corporate guardian, overseeing corporate complaints
- Provide occasional feedback to the Chair from Committee Members as part of a 360 degree appraisal
- Act on behalf of the Committee to review the implementation of the conflicts policy and corporate complaints handling
- Be available to stakeholders if they have concerns which they cannot raise directly with/ have already been through the normal channels of Chair, Chief Executive or the Senior Management Team but have not been adequately resolved

The Senior Independent Member will also:

1. Review corporate complaints, assess how these complaints are handled on an annual basis and manage the appeals process
2. Review the register of interests recorded (conflicts of interest) and the action taken to manage the conflict

Report to the Committee annually on the fulfilment of the responsibilities of the role

Term of Office:

- The term of office will be two years with the possibility of renewal for a further two years subject to Committee approval. The maximum term of office will be four years; it is anticipated that this role will be undertaken in conjunction with Committee Members' 2-3 days commitment per month; and
- Appointment or removal from office is a decision reserved for the Committee.

Members are invited to DISCUSS the role.

4. Whistleblowing Policy

Purpose

We are committed to working together to create a culture which is open and transparent. This should be an environment in which individuals are supported to report concerns and safety issues, and are treated fairly, with empathy and consideration, when they have been involved in an incident or have raised a concern.

This policy provides information on how members of Healthwatch England staff are able to raise a concern about dangerous, illegal or improper activity.

We will review this policy on a regular basis.

Policy

Whistleblowing occurs when an employee of Healthwatch England raises a concern about a dangerous, illegal or improper activity that they become aware of through work.

Who to contact

Wherever appropriate, concerns should be raised with the immediate line manager as soon as possible. If the staff member does not feel comfortable with this, they can raise their concerns with a member of the Senior Management Team. Concerns should then be raised directly as soon as possible with the Healthwatch England Chief Executive.

The Healthwatch England Chair and Healthwatch England Committee will oversee the process. The Committee will receive a summary report biannually of all concerns raised.

Investigating the concern

A staff member will be appointed as the investigating officer, who will contact the member of staff to confirm that they are handling the matter. They will provide their contact details and confirm whether any further assistance will be required. The member of staff will also be provided with a written summary of their concerns and how they will be handled.

Usually, within 10 working days of a concern being raised, the staff member investigating the concern will write to the member of staff raising a concern:

- acknowledging that the concern has been received;
- indicating how the matter will be dealt with;
- giving an estimate of how long it will take to provide a full response;
- saying whether any initial enquiries have been made;
- supplying information on support available to the staff member; and
- saying whether further investigations will take place and if not, why not.

All relevant parties involved in the disclosure of wrongdoing will be notified of the outcome of the investigation in writing.

Members are invited to APPROVE the updated policy.

5. Caldicott Guardian

Background

The Healthwatch England Caldicott Guardian is responsible for ensuring that Healthwatch England's use of personal information complies with the Caldicott Principles. The role will be to ensure that Healthwatch England satisfies the highest practical standards for handling patient identifiable information.

Purpose

The Healthwatch England Caldicott Guardian will act as the conscience of the organisation in balancing the benefits of data sharing for consumers whilst also enabling appropriate information sharing principles. For this purpose it is important that a senior staff member within Healthwatch England undertakes this role.

Duties

At a practical level, this will involve a number of key responsibilities, including:

- Detailing the protocol for information sharing between Healthwatch England and other organisations
- Dealing with information security breaches – generate learning and to identify areas for improvement of security measures
- Ensuring that all staff have signed up to the CRM Information Sharing Agreement
- Promoting a culture within the organisation, within which personal information is appropriately used, shared and protected
- Championing confidentiality and data protection and also ensuring that consideration has been given to these issues when making strategic and policy decisions
- Having oversight of Freedom of Information Act and Data Protection Act requests to ensure that access to information is appropriate.
- Providing advice and expertise on confidentiality and information governance issues
- Ensuring that internal policy, procedures and training are regularly updated and reflect good practice
- Acting as a reference point for staff seeking information on Caldicott and Information Governance issues.

Reporting and accountability

The Healthwatch England Caldicott Guardian has the responsibility to provide an adequate level of assurance to the Senior Management Team and the Committee.

This will mean updating and reporting to the Senior Management Team on a quarterly basis on how the Caldicott principles are embedded into day to day practice and strategic planning.

There will also be a bi-annual report to the Committee on the assurances on information governance.

Members are invited to DISCUSS.

6. Conflict of Interest Policy

Background

It is a principle that all public sector organisations are impartial and should adopt a transparent approach in all activities.

A conflict may arise due to financial, political, professional or personal business. One may also arise due to the interests of a close relative, partner, or other employment.

The management of any perceived or potential conflict is therefore critical to the reputation of Healthwatch England. Even the appearance of a conflict of interest can affect the reputational risk of Healthwatch England.
It is the responsibility of each individual to recognise situations where they have a conflict of interest and raise them.

Given the role of Healthwatch England there are some conflicts which are not tenable. These include being employed by or on the board of a provider or commissioner of services in the health and social care sector.

A conflict of interest arises where commitments are either compromised or may be compromised by a variety of situations. This may include:

- The personal gain or gain to immediate family, whether financial or not. (This may be the result of holding a position or having shares in a private company, charity or voluntary organisation who may work with Healthwatch England)

- Professional bias towards a particular decision.
  (In health and social care this could include loyalties to a particular professional body, society, or special interest group).

Purpose

This policy applies to all members of staff and all Committee Members. The aims of this policy are to:

- Provide guidance on identifying and declaring conflict of interest;
- Provide guidance, monitor and report on conflict of interests; and
- Inform on how conflicts will be managed.

For Committee Members:

Healthwatch England maintains a register, kept by the Committee Secretary which provides details of Committee Members' appointments, directorships, related employments and relevant financial interests. All new conflicts of interest must be raised with the Chair. Interests are updated on the Healthwatch England website, in line with quarterly Committee Meetings. No personal information (address, contact details etc. will be included on the website). All interests disclosed will be recorded in the minutes of the relevant Committee Meeting.

If the Chair deems it appropriate, the Committee member shall absent himself or herself from all or part of the Committee's discussion and/or voting on the matter. The discretion of the Chair will be used to agree the course of action in each situation.

For the Senior Management Team:

Healthwatch England will maintain a register, kept by the Committee Secretary; this was implemented in November 2014 and is updated when a new interest arises. The register of interests will also be shared on the Healthwatch England website. No personal information (address, contact details etc.) will be included on the website.

The discretion of the Chief Executive will be used to agree the course of action in each situation. An update of any conflicts declared by the Senior Management Team will also be shared with the Chair. In cases where the conflict affects the Chief Executive, this will be discussed and also shared in writing with the Chair when a new interest arises.

The courses of action adopted by the Chair and Chief Executive might include:

1. Not taking part in discussions of related matters;
2. Not taking part in decisions in relation to related matters; and/or
3. Standing aside from any involvement in a particular meeting or project.

We will keep a record conflicts of interests identified, the action taken and the Senior Independent Member will review this on an annual basis.

Members are invited to APPROVE the updated policy.

Members are invited to: APPROVE: 1. The Terms of Reference of the Finance and General Purpose Sub Committee 2. The Terms of Reference of the Procurement Group NOTE: 3. The Senior Independent Member role requirements APPROVE: 5. The updated Whistleblowing Policy 6. The Caldicott Guardian Role NOTE: 7. The updated Conflict of Interest Policy

AGENDA ITEM: 13

SUBJECT OF REPORT: Committee Meeting Forward Plan

PRESENTING: Esi Addae

PURPOSE: The Forward plan is presented for approval at each Committee Meeting to ensure that the Committee have ownership and oversight of the Healthwatch England decision making process.

RECOMMENDATIONS: To approve the Committee Meeting forward plan

RESOURCE IMPLICATIONS: N/A

RISK AND MITIGATION: N/A

EQUALITY AND DIVERSITY: N/A

DATE	LOCATION	MEETING	FORWARD AGENDA

13th May 2015	Sheffield	Committee Meeting	Standing Items:
			• Chair's Report
			• Chief Executive's Report
			  o Network update including support offer
			• Local Intelligence Report
			• Audit and Risk Sub Committee Report
			  o Update on financial audit
			• Committee Members update
			• Operational Update
			For discussion and/or decision:
			• Final Budget and Business Plan (TBC)
			• Service change
			• Monitoring, Evaluation and Learning
			• NHS Commissioned services
			• Consumer Index - TBC

22nd July 2015	Worcester / Gloucester	Committee Meeting	Standing Items: • Chair's Report • Chief Executive's Report o Network update including support offer • Local Intelligence Report • Audit and Risk Sub Committee Report • Committee Members update • Operational Update For discussion and/ or decision: • Accessing primary care services • 1st Special Inquiry – review of progress • Diversity and Inclusion (update)
4th November 2015	Norwich	Committee Meeting	Standing Items: • Chair's Report • Chief Executive's Report o Network update including support offer • Local Intelligence Report • Audit and Risk Sub Committee Report • Committee Members update • Operational Update For discussion and/ or decision: • Review of Governance Arrangements • Remuneration Committee • Consumer Index – post publication

Reports from the Finance and General Purpose Sub Committee will be added once scheduled.

Members are invited to APPROVE

AGENDA ITEM: 14

SUBJECT OF REPORT: Audit and Risk Sub Committee Chair's Report

PRESENTING: Jane Mordue – Chair, Audit and Risk Sub Committee

PURPOSE: This report will reflect the meeting of the Audit and Risk Sub Committee on 29 October

RECOMMENDATIONS: This report is for information

RESOURCE IMPLICATIONS: N/A

RISK AND MITIGATION: N/A

EQUALITY AND DIVERSITY: N/A

Report

The Audit and Risk Sub Committee monitors the operations of Healthwatch England for effectiveness and probity. Consideration is given to the areas of significant risk and challenge to ensure that operational, financial and reputational risks are carefully considered and appropriate mitigation is in place. As such we continue to challenge the Senior Management Team to support and strengthen Healthwatch England's governance.

The focus of the meeting on 29 October 2014 included:

- The budget and business planning process for 2015/16.;
- The internal audit on Information Governance
- An update on the Customer Relationship Management system; and
- The risk registers.

There will be a verbal update from the 22 January meeting. This meeting included:

- Discussion with the National Audit Office
- An update on Internal Audit – Information Governance and Financial
- Risk Management
- Discussion on the establishment of the Finance and General Purpose Sub Committee

The budget and business planning process for 2015/16

The Sub Committee were updated on budget negotiations with the Department of Health. It was highlighted that as the process continues, the Audit and Risk Sub-Committee will be provided with the appropriate assurances that the staff team and finance task and finish group have the adequate resources and procedures needed. The terms of reference for the finance and general purpose subcommittee are subject in a separate report and the group will have oversight of financial management and general administration items whilst providing assurance for the wider Committee.

The internal audit on Information Governance

The terms of reference and objectives of the internal audit were shared with the Sub Committee. This included:

- Understanding the policies and controls designed and implemented by Healthwatch England to deliver Information Governance in line with UK public sector good practice;
- Exploring the maturity and effectiveness of the control environment, specifically how well the information governance policies and controls are embedded in to Healthwatch England; and
- Exploring how Healthwatch England delivers Information Governance support to local Healthwatch.

The final report is expected in late February, which will give the Sub Committee the opportunity to continue to provide guidance and oversight.

The Sub Committee were assured of the training session that has been given to the staff team to identify the following:

- What personally identifiable data is?
- Where individual and organisational responsibilities lie?
- How the Information Governance is embedded in daily work?

An update on the Customer Relationship Management system

The Sub-Committee received and update on the project assurance process of the CRM system. It was highlighted that the availability of free text boxes on the CRM system would present a risk which would be mitigated by adequate training, guidance and checking. The SubCommittee were assured that the system like all other CRM systems has to have a descriptive element to be beneficial. Learning from the project management phase will be reflected on an ongoing basis. The Sub-Committee were updated that the senior management has oversight of the finances with regular reporting processes.

Strategic risk register

The Sub Committee were updated that the operational risk register had been updated and reviewed in lieu of risks which are no longer current. Risks had also been re-delegated amongst the Senior Management Team and shared Sub Committee Members.

Audit and Risk Sub Committee forward planning

We have agreed the following dates for Audit and Risk Sub Committee meetings:

Date	**Location**	Items
23rd April 2015	London 13:00 – 16:00	• Internal Audit plan for 2015/16 • Risk Register • Annual review of risk • Review - Audit and Risk SubCommittee
25th June 2015	Teleconference 14:00 – 15:00	• Review Accountable Officer Role • Review residual actions from the year • Risk Register
24th September 2015	London 13:00 – 16:00	• Risk register
19th November 2015	Teleconference 14:00 – 15:00	• Risk register

Members are invited to DISCUSS.

AGENDA ITEM: 15

SUBJECT OF REPORT: Members Update

PRESENTING: Committee Members

PURPOSE: This report aims to highlight the summary of Committee Members' contributions since the last Committee Meeting in October. The report is a summary of contributions from Committee Members. Individually Committee Members provide a voice for key groups in communities and bring forward the challenges and concerns they have heard. They also engage with local Healthwatch through events and regional meetings.

RECOMMENDATIONS: This report is for information

RESOURCE IMPLICATIONS: N/A

RISK AND MITIGATION: N/A

Report covers:

- What has been done on behalf of Healthwatch England this quarter?
- What has been the impact?
- What are the next steps?

Supporting Healthwatch England

Liz Sayce and Alun Davies led a Committee Workshop session in October on disability equality. The presentation explored how disability as a form of inherent and institutionalised discrimination has developed. Using facts and figures it showed how many Disabled people still experience exclusion in many areas of social activity including education, employment and in health and social care services. It considered the implications of this for Healthwatch England and local Healthwatch. It concluded that disability equality principles founded upon the Social Model of Disability must be part of Healthwatch England's diversity and inclusion work.

A number of Committee Members have been helping with the recruitment process for the Interim Director of Policy and Intelligence and John Carvel took part in the recruitment of the new Director of Communications and External Affairs.

Special Inquiry

Andrew Barnett hosted a dinner with Healthwatch England, the Campaign to End Loneliness and the Making Every Adult Matter coalition with other partners using the Special Inquiry as a starting point of engagement. The dinner was a great opportunity to encourage discussion and action, exploring innovative solutions to the issue of unsafe discharge. Afterward, Andrew shared his reflections of the dinner in his blog, highlighting the need for the 'whole-person' holistic approach and how existing good practice can be shared and replicated across the country and for different groups. The discussion also raised issues about "theories of change", and who additionally Healthwatch England might engage with in thinking through our role in championing service innovation and its spreading (including funders).

Department of Health and National Arm's Length Bodies Chairs' and Non-Executives' Seminars

John Carvel attended the seminar on talent development and succession planning which considered the role of the non-executive director in regards to talent strategies and succession.

Regional Meetings and Events

Pam Bradbury attended both the West Midlands and East of England commissioners meetings where round table discussions highlighted the number of contracts due for renewal and also the variation of budget setting locally.

At these meetings commissioners reflected that they would like to have a strengthened relationship with Healthwatch England as they felt they could support local Healthwatch to fulfil statutory functions and if necessary build specific objectives into contracts.

Anna Bradley, Liz Sayce and Deborah Fowler attended the local Healthwatch in London network meeting. There were updates from the Department of Health, the Regional Quality Surveillance Group, the NHS England Local Area Team and Monitor. Monitor agreed to send more information to local Healthwatch on their activities and consultations.

Jenny Baker attended the Thames Valley local Healthwatch meeting and reflected that attendees informally had mentioned that Healthwatch England Committee representation and perspectives at network meetings was valued.

Jane Mordue and Michael Hughes were in attendance at the Healthwatch Lincolnshire research feedback day on 1 December 2014. Healthwatch Lincolnshire had produced and presented 3 reports on GP access through the prism of 'Did not attend' statistics; on Children and Young People and on Pharmacy Services. There was a rolling audience of the key people involved in each section. Some of the reports were 'works in progress' but all generated good discussion and sharing of best practice. It was recognised as a great opportunity to see local Healthwatch in action. Speaking to staff, Jane noted that it was insightful to note the level of activity Healthwatch Lincolnshire was undertaking to find out more about local services. Michael reflected that the people represented were not the usual Chairs and Chief Executives of Healthwatch which gave an interesting perspective on finance and the future of the network. It was clear that there are large disparities in resources between local Healthwatch - but one consequence of the meeting was that more sharing developed.

Through feedback from some regional meetings, it is clear that there is an appetite for effective, assured communications for/ by local chairs including regular networking opportunities for peer support.

Quality Surveillance Groups

Deborah Fowler attended the Regional Quality Surveillance Group (QSG) meeting for London led by NHS England. It was an interesting first attendance to start to see how the Regional QSG fits into the regional landscape. There was a further steering group meeting to consider how the Regional QSG could work better with the three QSGs in London. There was agreement around the need for better communications and a much clearer focus on purpose and outcomes. Hopefully, this will yield results for the London region by improving the functioning and effectiveness of the Regional QSG, which could also support the sub-regional QSGs in their role. Deborah has been underlining the contribution that local Healthwatch can make, as there has reportedly been some nervousness about Healthwatch involvement among partners. It is hoped that any changes

will contribute to all partners feeling able to exchange confidential information, making these fora more effective. It should also mean that patient, service-user, and carer perspectives are more respected in these potentially important fora than they otherwise might be.
Jenny Baker had attended the Thames Valley QSG and reflected that although the reconfiguration of NHS England teams across bigger areas from April 2015 was in progress, the impact on the existing Thames Valley QSG group is not immediately clear. NHS England area teams are being rationalised with appointments to shadow senior management teams underway. There was consideration of whether Healthwatch representation and feedback at all regional/QSG areas (currently 4 and 27) across England should be a strategic aim? The question to consider would be whether there is more that Healthwatch England could do to ensure optimum and more integrated coverage?

Your Care Connected
On behalf of Healthwatch Birmingham, Solihull, and Sandwell Michael Hughes attended a meeting with "Your Care Connected". This is a local initiative designed to make better use of electronic records that the summary care system but without falling into the trap of Care.data. The system will allow clinicians in hospital to access medical records in GP surgeries for information about patients. Amongst the safeguards built in, are systems to ensure that only clinicians have access to the system, double opt-in (people opt in, in principle and then opt in again on each occasion their records are accessed), and sensitive information is excluded. We had a thorough discussion about safeguards, information for patients, and possible improvement to the system. Your Care Connected will also involve local Healthwatch more consistently in future.

Information Governance Oversight Panel
John Carvel shared with fellow Committee Members the Annual Report of the Information Governance Oversight Panel which highlighted the power of the evidence collected by the network. John reflected that the best examples of poor communication putting people at risk after discharge from hospital came from Healthwatch England, which gave Dame Fiona Caldicott (Chair of the Information Governance Oversight Panel) early access to some of the findings of the Special Inquiry.

Involve Conference
Michael Hughes attended the Involve Conference in Birmingham. Funded by the National Institute for Health Research, the role of the Involve Conference is to encourage patient and public involvement in health and to encourage the quality of the involvement.

Health and Wellbeing Boards
Pam Bradbury presented at the joint Local Government Association/Department of Health Leadership programme for Health and Well Being Board Chairs and Vice Chairs. Participants discussed their relationship with local Healthwatch and the value they had within their respective communities. However, the views and the strength of relationships ranged enormously. It was reported that some local Healthwatch had a strong presence in local communities whilst others reported their local Healthwatch to be disengaged.
Pam also attended the Central and East local Healthwatch meetings and whilst the majority of local Healthwatch present valued their place on the Health and Well Being Board there were a number who expressed to prefer not to have a noting seat. In at least

one situation, a local Healthwatch had not been invited as a full voting member of the Health and Well Being Board.
Paul Cuskin was part of a panel discussing how local Healthwatch and Health and Wellbeing Board Chairs work effectively on the board. This was part of the 'On the Board' event organised by the Local Government Association as a part of a series of events to support local Healthwatch to build capacity. It was discussed that the role of local Healthwatch will be to ensure that qualitative evidence, user, carer, patient and community voice are supporting the transformation agenda and playing an effective role in tackling local health inequalities. In addition to this, Paul attended a two-day residential course at Warwick University on Health and Wellbeing Board Peer Challenge. This event was found to be hugely rewarding in terms of working with health and social care professionals to look at the effectiveness of Health and Wellbeing Boards.

Integrated Care
Paul Cuskin in his role as Chair of Healthwatch South Tyneside presented to Jon Rouse, Director General, Local Government and Care Partnerships on the role of the network and how volunteers play a significant part in helping to shape local health and social care.

NHS Five Year Forward View
In the last quarter since the publication of the NHS *Five year Forward View* and Sir David Dalton's review of hospitals, John Carvel has considered the paradox in the debate about health and social care reform. On the one hand politicians of all parties insist that there must not be another top down reorganisation of the NHS. On the other hand, the most senior managers warn that the NHS will struggle to survive unless there are massive changes in the way health and care services are delivered. The managers avoid contradicting the politicians by proposing a menu of different options for change that can be implemented to suit local circumstances. The consequence is likely to be that the national service will look very different, depending on where you live. This raises some big questions for Healthwatch England. How can Healthwatch help to ensure that citizens are in the driving seat of change? How can we help each other across the network to understand the changes that are afoot and influence them?

News
Patrick Vernon was included in the Health Service Journal (HSJ) in their 2014 list of top health and care pioneers from BME backgrounds. Those included in the list have been highlighted amongst their peers as those who through their exceptional leadership abilities are inspiring others and helping to shape and deliver excellent care for all.

Members are invited to DISCUSS.

AGENDA ITEM: 16

SUBJECT OF REPORT: Operational Update

PRESENTING: Sarah Armstrong

PURPOSE: This report provides an update on the key areas of operational activity within Healthwatch England in Quarter 3 (October 2014 – December 2014)

RECOMMENDATIONS: This report is for information

RESOURCE IMPLICATIONS: N/A

RISK AND MITIGATION: N/A

EQUALITY AND DIVERSITY: N/A

Staff recruitment and development

Staff recruitment activity has continued and an update is provided in the table below. In the quarter we have been working towards reducing the number of short term/interim contracts and increasing the number of fixed term contracts. This offers both the organisation and the individual staff member much more stability; the notice period is longer, the contract length is more clearly defined, and staff members are entitled to increased annual leave and pension options. However, this has taken a substantial amount of time to understand the process for this, and to begin the successful conversion from interim to fixed term, as each contract has to be undertaken individually.

Fixed term contracts also show as 'green' in the table below:

	At the end of quarter 2:	At the end of quarter 3:
Vacant posts	There are 7 posts currently vacant	There are 7 posts currently vacant
Interim support for the post	There are 6 posts supported by interim staff	There are 4 posts supported by interim staff
Permanently recruited	There are 27 members of staff permanently recruited	There are 29 members of staff permanently recruited/on a fixed term contract
TOTAL	40 posts	40 posts

Of the 7 permanent posts that are currently vacant (and there is no one undertaking the role on an interim basis) here is a progress update:

1. **Head of Communications** - our recruitment process is currently live and interviews will be held in February;
2. **External Affairs Officer** – this has been paused until the new Director of Communications and External Affairs begins their role in early March so they can be part of the recruitment process;

3. **Media Officer** – this post has been successfully recruited to and a contract is in progress for a January 2015 start;
4. **Head of Public Affairs** – we will work with CQC to appoint a recruitment specialist to help fill this vacancy;
5. **Innovation and Good Practice Manager** – Interviews are being held for this role in January 2015;
6. **Research and Community Officer** – this post is currently on hold while we review the need for this post; and
7. In addition, our **Director of Policy and Intelligence** left in early January so recruitment will begin in quarter 4 to fill this role.

Of the four posts that are currently supported by interim staff here is a progress update:

1. **Director of Communications and External Affairs** – this post has been successfully recruited to and a contract is in progress for a March 2015 start;
2. **Executive Assistant for Chair and Chief Executive** x 2 - our recent recruitment round was unsuccessful and we will interview again in early February for both roles; and
3. **Systems Manager** – this post is being undertaken by a CRM specialist until the end of December 2014; we will then recruit to this post in quarter 4.

Performance in the quarter

Further to the last report there were five milestones carried over from quarter 2 that were in progress but had not been completed by the end of the quarter:

- Publish briefings on risks and concerns faced by people using health and social care - this is now completed;
- Coordinate the development and design of national standards on complaints advocacy - this 90% complete and is due to fully complete at the end of February 2015;
- Deliver media training to 80 local Healthwatch over Q1 and Q2 - this will continue until the end of the financial year and almost 60 local Healthwatch have undertaken this training;
- Analyse local Healthwatch annual reports and deliver further analysis of status of the network – this is now completed; and
- Assess the Networks' understanding of safeguarding and access to locally provided training – this is now completed.

There were also 16 new milestones to deliver within quarter 3. We have continued to demonstrate the progress of each using a 'RAG' (red, amber, green) rated view. This enables us to show milestones that have made a small amount of progress or that have been paused in red, to show milestones that are in progress but have not yet completed in amber, and those milestones that are almost complete or have fully completed in green.

The table below lists the progress of all of the new milestones in quarter 3:

0-20%	21-89%	90 – 100%	TOTAL
0	3	13	16

Of the three highlighted in amber (21-89%) here is further information about the progress:

- Deliver CRM to 32 local Healthwatch – this is a target which continues until the end of March – as the total is currently 20 we are confident this target will be met by the end of March;
- Determine approach to delivering additional safeguarding training – This is currently being reviewed and will complete in quarter 4; and
- Launch case study bank of methodologies for involvement and engagement within resource pack – A decision has been made that it is more effective to launch the resource pack all in one go rather than staged releases. Following this change in approach the resource pack is now due for launch at the end of March 2015.

Business and budget planning process

The business planning process for 2015-16 is well underway. This process has involved working closely with the Committee, Senior Management Team and our Operational Management Team. This has provided opportunities to reflect on what we have achieved in 2014-15 but also enabled us to understand the resources that are needed to fulfil the statutory responsibilities of Healthwatch England and the costs of delivering both our support to the network and our national advice and insight functions to meet our statutory functions.

We have worked closely with CQC finance colleagues to develop a system that can demonstrate the different aspects of our work, what they cost and provide a monitoring system which will enable easier and more effective reporting.

We will continue to progress this work and we await a decision on the outcome of our funding request to the Department of Health before our final business plan can be completed.

Organisational Learning

We have undertaken an extensive review about our organisational learning in preparation for the next delivery year. Key learning points include; our reputation and purchase in national media has grown, but it has taken us time to establish our tone of voice and further work is required to continue to develop this. Another key point is we have further work to do to ensure understanding of our function and our statutory role is universal across all partners. We have also worked hard to invest in the team to increase their effectiveness. We have undertaken training in the following areas in quarter 3; risk, information governance and leadership. All of the learning has been incorporated into our development of the business plan for 2015-16.

Diversity and Inclusion

A draft accessibility policy has been developed and reviewed. This policy has been developed by Alun Davies and is to ensure that all services and products are as accessible as possible. The Accessibility Working Group is operationalizing this in quarter 4.

The Enquiries Service

The Enquires service was transferred to Healthwatch England in January 2014. Prior to this, CQC colleagues at the National Customer Service Centre delivered this service.

We are now able to compare the number and nature of calls from quarter 3 in 2013 and quarter 3 in 2014 in the table below to demonstrate how this service has grown:

Breakdown of calls	October 2013	October 2014		November 2013	November 2014		December 2013	December 2014
Complaints	7	62		13	55		17	47
Concerns & views	10	13		8	8		1	10
Enquiries about Healthwatch England	53	68		46	66		29	42
Enquiries about local Healthwatch	8	21		11	16		14	13
Other enquiries	9	36		13	35		11	11
Whistleblowing	0	0		0	2		0	0
Sales calls	0	6		3	3		1	3
Total	**87**	**206**		**94**	**185**		**73**	**126**

We continue to monitor the volume and themes of email Enquires and the table below demonstrates this for the last quarter as well as the total email Enquiries received in Q3, 2013/14. Since introducing the telephone Enquiries service, we changed the way in which we receive emails. For example, we have separate inboxes for ongoing queries, such as, escalations from local Healthwatch, the Annual Conference 2015 and our Special Inquiry program.

Therefore the table below demonstrates the overall total but not the breakdown of the previous quarter in 2013/14. We wanted to include the totals to show that the recorded decrease in email Enquiries is due to the number of segregated inboxes. However, we also believe that more local Healthwatch are contacting their named Development Officer directly, are using Yammer and the Hub for finding resources and their increased confidence as they become more established.

Breakdown of type of email	Oct-13	Oct-14		Nov-13	Nov-14		Dec-13	Dec-14
Website/CRM/Hub/Yammer queries		9			14			11
Emails from local Healthwatch		71			71			46
Signposting/complaints regarding health and social care services		26			23			18
Events		12			8			7

Queries to specific Healthwatch England teams		8			9			6
HR/ recruitment		1			3			2
Complaints about Healthwatch England / local Healthwatch		3			2			4
Miscellaneous		12			16			8
TOTAL	**275**	**142**		**270**	**146**		**112**	**102**

Summary

This continues to be a complex part of our work as the nature of telephone and email enquiries covers a very broad range as detailed above. In quarter 4 we will move the telephone and email data to our CRM system so we can analyse trends and provide more detailed reports.

Finance report

At the end of December 2014 we had completed nine months of the financial year giving us a pattern of spend per month and per quarter, and an overall total. The overall financial position for December and for the year so far is detailed below:

Subjective	In month (£)			Year to date (£)		
Class	Budget	Actual	Variance	Budget	Actual	Variance
PAY	182,592	212,151	29,559	2,147,113	2,084,250	(62,864)
NON-PAY	95,995	64,198	(31,797)	1,229,338	1,264,145	34,807
Grand Total	**278,587**	**276,349**	**(2,238)**	**3,376,451**	**3,348,394**	**(28,057)**

Summary:

- Even though we are showing a small underspend (£28k) this is the first point in the financial year that we have been on track for both pay and non-pay;
- We reviewed the financial position in early December with our CQC accountant and although our budget overall is on track, there is more work to do to show the breakdown of spend between each our of cost centres in preparation for the end of year reporting; and
- This also means we need to work closely with the accountants to develop a better reporting system for next year, as detailed earlier in this report, particularly to be able to monitor the spend on multiple activities within one cost centre.

Media overview

In Quarter 3 Healthwatch England generated significant positive media coverage particularly focusing on complaints and in total generated double the amount of coverage we achieved in Q3 last year.

Highlights included:

- Anna Bradley's Huffington Post Column on access to in vitro fertilisation (IVF);

- Coverage from the Mail, Guardian, and ITV on the launch of Healthwatch England's complaints report – 'Suffering in Silence';
- Coverage from the Times and the Guardian of our call against the use of the term 'Bed Blocking';
- Coverage from the Times on 'Citizen Whistleblowers' and Anna Bradley's comment piece on the BBC;
- Coverage on ITV Good Morning Britain on improvement in discharge rates around Christmas time; and
- Coverage in the Times on New Year's Eve on local Healthwatch priorities for 2015.

We have reviewed our media coverage for the same period last year:

In 2013 Healthwatch generated:	**In 2014 Healthwatch generated**
Number of Articles: 46	Number of Articles: 356
OTS per head: 3.8	OTS per head: 26.3
Advertising Value: £430,202	Advertising Value: £4,684,192

In 2014 we have generated 356 pieces of coverage, which is almost 8 times as much as our previous year. It is clear that there has been considerable effort from the staff team to reflect the work of Healthwatch England in both national and regional media. Key highlights include our intervention over Care.data in February and March of 2014 which the BMJ listed as one of their top news stories of 2014 specifically referencing Healthwatch England and our call for single opt out. Complaints – right from the Atlas which secured us coverage on Today and BBC breakfast to the work we did with the network around the launch of our complaints report. In total the network has generated over 475 pieces of coverage carrying our messages around complaints.

Members are invited to DISCUSS.