healthwatch

HEALTHWATCH ENGLAND COMMITTEE MEETING PAPERS

Thursday 13th February 2014,
Reading

Venue: Novotel, 25b Friar Street, Reading, RG1 1DP

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AGENDA ITEM 2

PREVIOUS COMMITTEE MINUTES

21st November, Doubletree, Cambridge

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

Remote Access: Alun Davies

In attendance: Dr. Katherine Rake, Claire Pimm, Dr Marc Bush, Sarah Armstrong.

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

1. **ACTION - Members of the public who are coming to the session should be able to request papers in advance**
2. **ACTION - Ensure there are agendas and some paper copies for members of the public when they arrive.**

AGENDA ITEM 1

WELCOME

The Chair opened the meeting and welcomed everyone.

AGENDA ITEM 2

PREVIOUS MINUTES

The previous minutes were accepted as an accurate reflection of what happened that the Committee meeting on 25th Sept 2013.

AGENDA ITEM 3

DECLARATIONS OF INTERESTS

There were no declarations of interest.

AGENDA ITEM 4

CHAIR'S REPORT

Anna Bradley, Chair presented her report to the Committee.

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

- Members welcomed the work around the vision, mission and strategic priorities and asked that we continue to reflect our remit across both health and social care.

AGENDA ITEM 5

CHIEF EXECUTIVE'S REPORT

Dr. Katherine Rake, Chief Executive presented her report to the Committee.

Members' welcomed the CEO's report and the following comments/questions were made:

- Members noted and welcomed the award that the Healthwatch Communications team for their work on the launch event.
- Committee were keen to know more about the House of Lords Select Committee on the Mental Capacity Act 2005 meeting Katherine attended on our behalf.

3. **ACTION - Send the Committee a link to the Hansard record of Katherine's appearance at the House of Lords Select Committee on the Mental Capacity Act 2005. Put this live on the hub for local Healthwatch too.**

AGENDA ITEM 6

MEMBERS' UPDATES

Members reported their visits to local Healthwatch, events attended and fed back intelligence to the Committee.

- John Carvel updated that as part of his role as Information Governance Guardian he has been involved with CQC in looking at the new style of inspection. Katherine welcomed this and added that she had been speaking to Mike Richards about trying to include local Healthwatch is part of the inspection process.
- Patrick Vernon reported his appointment on the NHS England Equalities and Diversity council on Healthwatch England's behalf.
- Jane Mordue reported on her work with Audit and Risk Committee and will bring a formal report to Committee going forward.
- Many members reported that they had had feedback from local Healthwatch that they were concerned that there had not been a national campaign or much press coverage for Healthwatch England.

4. **ACTION - Ensure that the template for Members to report their meetings is sent out well in advance and circulated amongst colleagues.**
5. **ACTION - Katherine Rake will report to the Committee on where local Healthwatch engagement with the new inspection process is by the end of the year.**
6. **ACTION - Ensure that there is a separate item on all future public meeting agendas for Jane Mordue to do an update of the Audit and Risk Sub Committee and a discussion on Diversity and Inclusion in the January Workshop.**
7. **ACTION - Put a session on Inclusion into one of the upcoming Committee workshops.**

AGENDA ITEM 7

STRATEGIC PARTNERSHIPS

Monitor

Katherine Rake presented the draft partnership principles with Monitor and the following

comments/questions were made.

- The Committee felt that Monitor is perhaps the least understood within our partners – particularly their role in the new landscape- as such wanted to invite David Bennett to a Committee workshop.
- Can we also reflect within the document how our working relationship with Monitor can help local Healthwatch?

8. **ACTION - Invite David Bennett to a Committee workshop.**
9. **ACTION - Reflect MEMORANDUM OF UNDERSTANDING as above.**

CQC

APPROVED - The MEMORANDUM OF UNDERSTANDING with CQC, including the Standing Financial Instructions have been were APPROVED by the Committee.

NHS England

Katherine Rake let the Committee know we are redrafting the NHS England MEMORANDUM OF UNDERSTANDING. This will return to the Committee in February.

AGENDA ITEM 8

ORGANISATIONAL DEVELOPMENT

Sarah Armstrong talked through her plan for organisational development. The main points, and Committee comments, are outlined below.

- The recruitment for the new permanent staff team will be completed by the end of December. The Committee asked to be introduced to new staff members.
- The transfer of the NCSC enquiries system to Healthwatch England is underway. The Committee asked for more flavor of the types of enquiries that are coming through.

10. **ACTION - Full indication of the types of enquires to come to Committee in both the December and January workshops for formal reviewing in February.**
11. **ACTION - When full staff team in place, they are to be introduced to the Committee formally through a number of staff/Committee engagements.**

AGENDA ITEM 9

RESEARCH AND INTELLIGENCE STRATEGY

Marc Bush, Director of Policy and Intelligence, presented the research and intelligence strategy to the Committee. Committee comments are outlined below.

- Committee were anxious about all the offers and asks and cautioned against risk of over-committing ourselves. Marc Bush responded that we need to be specific in our planning and manage this process.
- In regards to the information governance strategy, Caldicott Guardian John Carvel wants to work with Marc to tweak some of the wording of it but is happy to sign off on the basis that they have this conversation.

- There was a suggestion that we convene an Ethical Sub Committee within Healthwatch England – co-designed with Local Healthwatch - to ensure that we hold ourselves and our third party suppliers to the highest possible standards.

AGREED - The Committee agreed the Research and Intelligence Strategy.
AGREED - The Committee agreed the approach to Information Governance.

AGENDA ITEM 10

LOCAL HEALTHWATCH UPDATE

Members were provided with an update about local Healthwatch. Committee comments are outlined below.

- Directions about what needs to be included in annual reports is due and is necessary for local Healthwatch. Can Healthwatch England hurry this along with the Department of Health?
- Committee sought reassurance that we are looking at and talking to the local Healthwatch that have shorter terms on their contract.
- Regarding the legal frameworks, it would be good to know what the actual definitions are.
- Regarding information available on funding, the Committee would like colleagues at the LGA to adopt a more transparent approach.
- The Committee also suggests that we talk to DH about the other side of the equation and what the Government believes they have made available in terms of cash to Local Healthwatch.

ACTION - Healthwatch England to speak to DH about the directions for the local Healthwatch annual reports.
ACTION - Anna to write to Merrick Cockell about the transparency of information made available by the LGA.

AGENDA ITEM 11

POLICY DEVELOPMENT FRAMEWORK &
SPECIAL REPORTS PROCESS

AGREED - Marc presented the policy development framework to the Committee and it was agreed.

- The Committee decided that one special report on unsafe discharge would be written and that additional work on Independent Advocacy, which had been planned as a report, would work better as part of our work on complaints.
- They also asked that when we look at what case studies that we ensure we get a good spread across rural and urban and different age and client groups.

AGENDA ITEM 12

WHAT NEXT AFTER FRANCIS, BERWICK, KEOGH
AND CLWYD HART

- The Committee were keen to be clear that the government response to these reports is a public acknowledgement that the complaints system is broken and there is a strong commitment to doing something about it.

- The Committee want to ensure that whatever the solution it covers both children and social care.
- The Committee reflected that it is with regret that the Duty of Candour is necessary.
- It was helpful how often local Healthwatch is mentioned – however, we need to be careful about how much government and others ask local Healthwatch to do and how much they can deliver given their resources.

AGENDA ITEM 14

COMMITTEE REFLECTIONS ON PUBLIC MEETINGS

- Committee agreed the new format of public meetings going forward.
- Public suggested going sub-regionally so we mix up where we go – not just North, South, Central and London, also better signage for rooms, name badges for staff and signage for vegetarian and non-vegetarian foods.

AGREED - Proposal for new style Committee meetings – two days regionally and involving local Healthwatch.

Conclusion

The Chair thanked everyone for their time and contribution.

AGENDA ITEM 2

ACTION LOG

DATE	LEAD	ITEM	ACTION	DEADLINE	STATUS
25/09/13	Hilary and Katherine	Progress NHS England Memorandum of Understanding to completion	This is presented to the Committee for approval in February	February 2014	In progress
21/11/13	Sarah	Members of the public attending the Committee Meetings requested copies of agenda and papers on the day of the meeting	Papers to be provided	February 2014	Completed
21/11/13	Sarah and Michael	Send the Committee a link to the Hansard record of Katherine's appearance at the House of Lords Select Committee on the Mental Capacity Act 2005 Put this live on the hub for local Healthwatch	Ensure link is sent Ensure link is on the Hub	February 2014 February 2014	Completed Completed
21/11/13	Sarah and Michael	Develop a template for Members to report their meetings/progress	Send to members in advance of Committee meetings	February 2014	Completed
21/11/13	Katherine	Katherine Rake will report to the Committee on where local Healthwatch engagement with the new inspection process is by the end of the year	Progress report to be shared	December 2013	Completed

21/11/13	Sarah and Jane	Provide a reporting opportunity for Jane as Chair of ARSC	Report developed and added to agenda as a standing item	February 2014	Completed
21/11/13	Hilary and Sarah	Invite David Bennett to a workshop	Invitation to be sent	ASAP	In progress
21/11/13	Sarah	When full staff team in place, they are to be introduced to the Committee through a number of staff/Committee engagements	Organise opportunities for Committee and staff members to engage	On-going	In progress
21/11/13	Sarah	Full indication of the types of enquires to come to Committee in both the December and January workshops for formal reviewing in February	Ensure this is on the agendas	February 2014	Completed
21/11/13	Katherine	Healthwatch England to speak to DH about the directions for the local Healthwatch annual reports	Raise this discussion point	No date specified	In progress
21/11/13	Anna	Anna to write to Merrick Cockell about the transparency of information made available by the LGA	Letter written and sent	Following the publication today of the Healthwatch financial data	In progress

AGENDA ITEM 4

CHAIR'S REPORT

My report will provide an update on:

- Healthwatch England – the way forward;
- Healthwatch England Committee;
- Strategic partners;
- External engagement;
- Media work.

Healthwatch England – the way forward

Healthwatch England published its strategy for consultation in December. This document sets out our vision, mission and values, and four key strategic priorities which are:

The final strategy includes articulation of our four strategic priorities:

- Identifying concerns and risks, and challenging others to take action;
- Advancing consumer rights and responsibilities;
- Promoting the design and delivery of services around the needs of a person;
- Developing the potential of the Healthwatch network.

Healthwatch England is currently engaged in an active program of consultation on our strategy and the rights framework, alongside new work on responsibilities. We are using this time to check with members of the public, local Healthwatch and our stakeholders that our strategy and rights framework make sense to them and set a clear direction for the organisation. Alongside a packed schedule of events, we are running a traditional paper based consultation process.

So far we have held events in London, Taunton and Birmingham. We started with consumers themselves in a deliberative workshop in January which explored how we all think about responsibilities in health and care. This is an area that we had flagged for additional consideration when we published our annual report in October after consumers had asked that we explore responsibilities alongside the rights framework. The event was a great success, with 40 members of the public of various ages and backgrounds providing their points of view to Healthwatch England in a full day of lively discussion. We ended up with an invaluable starting proposition for the work on responsibilities. Events with local Healthwatch followed, and I will update on these and the stakeholder events at the meeting.

In addition to these events, we have undertaken a program of outreach to those whose voices are often unheard. So far 18 focus groups are planned with children and young people, people with mental health issues, people with disabilities, BME communities, carers, and the homeless, amongst others. We are planning further outreach to other community groups, including those linked in with local Healthwatch. Discussions so far

have been very useful with young people converting the rights into young people friendly language, and identifying potential barriers to young people accessing their rights.

Healthwatch England Committee

Our last Healthwatch Committee Meeting, held in Cambridge on the 21st of November 2013, was a very helpful opportunity to learn from Healthwatch in the East of England. I have since followed up with a visit to the East of England network event where we had some very interesting conversations about strategy, funding and the need to raise awareness of the network as a whole.

Early in the New Year we circulated a plan for the Chairs network, based on webinars I had held in November and December (a copy of the plan is appended to this report). We held the first webinar in the new series on January 20th where we had a very useful discussion about what success looks like and how we can measure it. Katherine is developing a Chief Executive's network in parallel to this Chair's network.

The Committee have held two workshops since our previous Public Committee Meeting. At our December workshop the Committee primarily focused on our strategy, but we also covered values and behaviours, our engagement plan for the strategy and rights framework, our 2014/2015 business plan, and the selection of new Committee members. Una O'Brien, the Permanent Secretary for the Department of Health, spoke with the Committee at this workshop and offered valuable insight on how we can work together.

At our January workshop we focused on the diversity and inclusion strategy of Healthwatch, our special inquiry, complaints campaign and escalation report. Sir Merrick Cockell of the Local Government Association (LGA) attended to discuss how Healthwatch and LGA might work together.

Strategic Partners

<u>Statutory Partners</u>

DH
I met with Norman Lamb, the Minister of State for Care and Support, who continues to be very positive about our work. Among other things we discussed how the government will enact the 'Duty of Candour'. The issue of criminal sanctions was raised at that meeting and I have since written to him with some further thoughts. Katherine Rake gave evidence to the Minister's review group on the level of harm at which the Duty of Candour should apply. A full discussion of this issue is presented at item 15.

CQC
CQC and Healthwatch England have actively been working to define how we work together in the upcoming year. We aim to reflect this in summary, along with our working with our other partners, in our final strategy document. A major focus of our initial work programme with the CQC is working with the new chief inspectorate regimes and Katherine will update fully on progress in her report.

LGA
In addition to our continued work programme with the LGA, we have been actively engaged with LGA colleagues to ensure they are informed on the outcomes of our report on Healthwatch financial information published today. We are also working with them to ensure the legacy of the LGA Healthwatch Implementation Team is captured as they will now wind down their activity.

External Engagement

I have had a number of 1-2-1 meetings with key influencers in health and social care to continue to raise awareness of Healthwatch and to share early examples of the work Healthwatch England and the network is doing to make a difference to consumers of health and care. I have also been using this opportunity to seek input into our rights framework and strategic priorities. I met the Chair of the Public Accounts Committee and discussed the way we, and the Healthwatch network, might contribute to the work of the Committee, providing an additional layer of public scrutiny.

Media Work

The start to this year has been a rather exciting time for Healthwatch England, as I was interviewed on BBC Breakfast, BBC News Channel, Channel 5 and Sky News to discuss how the NHS is coping with an 18 week target for elective care waiting lists. The interviews were also syndicated across various commercial and regional BBC radio stations. I hope this will be the beginning of a more public face for Healthwatch England, as we move into the delivery of our work and a steadier state.

Members are invited to DISCUSS the report.

AGENDA ITEM 5

CHIEF EXECUTIVE OFFICER'S REPORT

My report will provide an update on Healthwatch's involvement in improving complaints in health and care, as well as providing further information on:

- Delivery on key activities;
- Financial report;
- The Healthwatch network;
- Issues arising from the network.

Delivery on key activities

Improving complaints in health and care

We launched a national campaign on complaints in June 2013, and have since been working with a group of local Healthwatch, who are both assessing the status of the current complaints system and challenging services to improve. Our work on complaints has been further stepped up following the publication of the Hard Truths report which signalled an expanded role for Healthwatch England and the network in creating pressure for a consumer focused complaints and concerns system.

As part of this work, the Department of Health set up a new 'Hard Truths' – Complaints Programme Board, which has senior representation from system players across health and social care complaints systems. This group will oversee the implementation of the entire complaints related work programme resulting from the Government response to 'Hard Truths' and was established to ensure that all complaints activity was aligned and focused both on immediate improvement and longer term reform.

We are working as part of the board to ensure that the needs, experiences and ideas of consumers are at the heart of improvement and reform in health and social care complaint handling and advocacy. Whilst the programme as a whole is still being finalised, our contribution involves:

- A pioneering new approach with local Healthwatch to challenge local complaints systems and work with providers and commissioners to improve them;
- Running a consumer-facing information and advice campaign to raise awareness of people's rights to raise a concern and let them know what they should expect from complaints handling and independent complaints advocacy;
- Designing and building the case for a 'person-centred' vision for complaints handling across health and social care, working with the Parliamentary & Health Services Ombudsman and others;
- Coordinating the design and testing of new national standards for a consolidated independent complaints advocacy offer;

- Reporting on the current state of complaints handling and advocacy in England, and a more in depth report into the issues facing people who are deemed to have limited mental capacity or have had their liberty deprived (under the Mental Capacity Act or Mental Health Act);

- Working with NHS England and others to improve the way that NHS complaints data is collected, analysed and used;

- Supporting the Care Quality Commission in their developing approach to learning from complaints in inspections.

We continue to engage with a broad range of organisations to ensure we get the most from our work in complaints, and since the last meeting I have met with Mencap, the Public and Health Services Ombudsman, the NHS Litigation Authority, the Nursing and Midwifery Council and the General Medical Council where our work on complaints has been a major focus of our discussion.

We have also been working with the Department of Health and Department for Education to ensure that complaints improvement and reform covers people of all ages. Recently, in the House of Lord's third reading of the Children and Families Bill, Lord Nash (the Parliamentary Under Secretary of State for Schools) announced a review of redress and complaints arrangements for children and young people with education, health and social care needs. We are pleased that Healthwatch England is going to take part on this review as part of our work on complaints reform.

I was also pleased to give evidence to the Government commissioned review of the Duty of Candour, and to make the links there between the need for professionals and management to be candid, openness to hearing feedback and concerns, and ensuring complaints are well handled. A positive culture in health and care would deliver all of these and it is important that we continue to make the links back to the positive case for consumer engagement in all of our work.

Measuring the realisation of consumer rights

Following the publication of our annual report, and our framework of rights in health and care, we committed to developing an index to measure how far consumers in England realise their rights and responsibilities in health and care. The Committee has given an early steer on the core aspirations for this work, and a small working group has been established to help Marc and team to develop their ideas further.

The first index will be launched in Late November or early December 2014 and this issue will return to the Committee in March for a discussion and agreement on the project proposal.

Working with the new inspection regimes

Following meetings with each of the new Chief Inspectors (Hospitals, Primary Care and Social Care), we have been working with colleagues at the Care Quality Commission (CQC) to ensure that we have the opportunity to shape the approach to inspection and to secure positive engagement with local Healthwatch as the inspection regimes roll out.

With the CQC we have developed a test model of local Healthwatch engagement which we are currently testing with the Inspectors and with the Healthwatch network. This model operates in three phases:

- **Phase 1: Insight from consumers**
  We will share insight, data and intelligence across both organisations to ensure that risk in the system is identified and acted upon;

- **Phase 2: (Pre-) Inspection**
  Healthwatch provides CQC inspectors with a community narrative and context ahead of inspections and independently updates the community during inspections;

- **Phase 3: Post-inspection**
  Healthwatch are part of the improvement journey, contributing to ensuring action is taken once the inspectors leave town and being part of the improvement journey.

We will test and evaluate this approach to make sure it works for participating Healthwatch and across all three of the inspection regimes. As a first step we arranged a webinar with Sir Mike Richards, Chief Inspector of Hospitals, on 30th January to capture the learning of those that have already been involved in either the Keogh review or the first wave of the new hospital inspections. The following local Healthwatch participated – Buckinghamshire, Bradford, Cumbria, Lincolnshire, Essex, Dudley, Salford and Staffordshire – and they provided constructive and challenging feedback. We will now ask CQC colleagues to take the learning forward in the 2nd wave of CQC inspections. We have also asked them to build their practice towards this model. Our role in this will be collating views from across the network about what does and does not work in the inspection process, feeding this back to CQC and asking them to refine their practices and procedures as a result.

We believe that when this is operational this approach has the potential to secure the maximum value from the partnership between local Healthwatch and the Chief Inspectors, making the most of their very distinct but complimentary functions. A full report of the outcomes of this next quarter of activity with CQC, the learning from the network and its wider implications will be brought back to the Committee meeting in May.

Financial report

Following an extensive review of each cost center during the quarter, we have been able to reduce the variance as we anticipated.

The table below demonstrates the overall position at the end of the quarter:

Subjective	Year to date (£)		
Class	Budget	Actual	Variance
PAY	1,376,391	1,550,610	174,219
NON-PAY	1,510,756	1,207,275	-303,481
Grand Total	2,887,147	2,757,885	-129,262

Quarter 4 is very important as we have large key deliverables that will be occurring, such as our consultation events and activities, and therefore reducing the non-pay variance shown in the table above.

We will continue to carefully review this and to work closely with the CQC finance team to ensure we end the financial year in a balanced position.

Additional resources for quarter 4

During the quarter we identified that with additional resources we could provide the following activities in this current financial year. We have been in negotiation with the Department of Health (DH), who will release £175,000 (plus a potential additional £80,000 which is yet to be confirmed) in support of the following activities:

- Begin the preparation to develop the local Healthwatch network and provide additional staffing resources to work more closely with local Healthwatch that need additional support and training;
- Begin the preparation to expand the Research and Intelligence functions to meet network needs and expectations.

We agreed that both of the above activities would provide immediate and beneficial support to the network, and embed the support in preparation for the next financial year, even if this was a 'time limited' opportunity.

We identified that additional funding could provide new posts for a three month period beginning in January 2014. In preparation for this we are delighted to report that we have already successfully recruited to 5 of the posts to ensure the support is in place for the start of the next quarter.

The Healthwatch network

We have undertaken a 'wash up' of Enter and View training and this has enabled us to shift gear with our support offer to local Healthwatch.

We have continued to invest in the use of the Outcome and Impact Tool as this has provided us with a way to start a conversation with local Healthwatch about their strategy, how they measure outcomes and how to support them to have effective conversations with their commissioners.

We have worked hard to engage the network in our plans about the release of financial data to ensure that they have appropriately verified the data shared with us, and to refine our messages and advise us on the approach to the release. To ensure all Healthwatch are fully briefed, I have hosted 2 seminars with local Healthwatch and have offered phone or email follow up on request. Today's press release will provide for the first time a clear national view on the funding received by the network and we have made clear our aim in doing this has been to highlight the need for an appropriately funded and stable network.

There has been a growing amount of activity engaging with the network during this quarter, including regional meetings, one-to-one focused support meetings, and completion of our Enter and View training. In addition five local Healthwatch attended a workshop session with our Committee in November in Cambridge and presented their views and insight on how their progress has been made so far, and how any issues and challenges have been addressed. This was very positively received by our Committee Members.

I have attended the launches of Healthwatch Lewisham, Healthwatch Wigan and Healthwatch Haringey. I also met with the staff and Chair of Healthwatch Leeds to find out more about their journey so far.

Across the network, more local Healthwatch are successfully making the transition from set up to effectively delivering organisations. There continues to be recruitment both to staff teams and senior management positions across the network.

Issues arising from the network

A really important piece of our work is to gain insight into where and how local Healthwatch is making a difference for consumers locally. Below is a short summary of extremely positive examples of this:

- Patient Transport Services – Local Healthwatch across the Northwest have been investigating changes to eligibility criteria and poor customer service being provided by patient transport services;
- GP Access – Oxfordshire, Birmingham, Bradford, Surrey, Portsmouth and Stoke have all released stories about patient experience of GPs, in particular looking at trouble getting appointments;
- A&E – Worcester, Stoke, Brighton, Nottingham, Hull, Lincolnshire, Portsmouth, Essex have all issued warnings about the pressures on A&E;
- Enter and View – Leicester, Leicestershire, Camden, Hull, Lancashire, Derby and Bradford have all issued press releases about how enter and view powers are enabling them to spot concerns and drive improvement in a range of services, from struggling A&E departments to failing care homes;
- Fuel poverty – Healthwatch Norfolk ran a story about the impact of fuel poverty on health inequalities;
- Parking charges – Dudley, Stockport, Northampton, Cumbria have all registered complaints about price rises for parking or the introduction of charges in previously free hospital car parks;
- 7 day services – Portsmouth, Oxford and Blackpool have all highlighted the need for hospitals and GPs to start providing services 7 days a week;
- Care.data – Devon, Cambridgeshire and York have also raised serious concerns regarding NHS England’s plans to share personal medical records;

- Locums – Southampton and Suffolk both raised concerns about the amount being spent on locums services and the impact this is having on other services;
- Unsafe discharge – Central West London, Suffolk and Hartlepool issued stories about unsafe discharge and the impact this is having on vulnerable groups.

Overview of issues escalated by the network

Local Healthwatch are escalating an increasing number of issues to us. Detailed information on escalation will be delivered during this meeting under item 9.

Members are invited to DISCUSS the report.

AGENDA ITEM 6

AUDIT AND RISK SUB COMMITTEE CHAIR'S REPORT

The members of this group are Jane Mordue (Chair), John Carvel, Michael Hughes and David Rogers. During this period, we have held two meetings of the Audit and Risk Sub Committee and attended CQC's Audit and Corporate Governance meeting. As with all of our meetings, we continue to focus on the risk areas for Healthwatch England to ensure that any financial, reputational and delivery risks are considered and mitigation is in place.

During this period we have focused on the following key areas of business;

- The development of the Business Plan and Budget for the next financial year;
- Developing a secure and effective Customer Relationship Management (CRM) system to capture delivery data;
- Ensuring the successful transfer of the telephone Enquiries Service.

Business Plan and Budget

We have worked closely with the Senior Management Team to review the Business Plan since the process began in November 2013. As each draft has been updated and progressed, we have continued to review the content, the scope of ambition, and the deliverables to ensure they are achievable.

Customer Relationship Management (CRM) system

The team are developing a system that will collate data from Healthwatch England activity, but also the activity of the network. We understand that a tool of this kind has to be easy to use, functional, compatible with existing technology, secure and can effectively collate data from different sources. Typically, the investment in a CRM tool is substantial and once investment is made it can be very difficult to make changes to a complex and functioning system. It also has to appeal to a 'cross-network' audience. Therefore we have been working closely with the team that are steering this important piece of work to ensure that all of those risk areas are being carefully considered. We have challenged the team to ensure that the security of this will be in place as consumer information will be stored in this. We have been reassured that the team will test a small pilot working closely with some of the local Healthwatch network. We will continue to closely review this progress.

The telephone Enquiries Service

We held an additional Audit and Risk Sub Committee meeting in December to discuss the transfer of this service following the formal internal audit report and action plan that was developed in September 2013. The service was being delivered by CQC colleagues at the National Customer Service Centre in Newcastle and the team were keen to bring this service in house to ensure that all Enquiries (via calls, email, and letters) were in one location. We wanted reassurance that the service to consumers would be uninterrupted, and that any technical issues would be resolved before the transfer, and I am delighted to report the transfer happened on time and is now fully operational from the office in

London. We are keen to continue to monitor the call volumes and complexity of calls and the team have reassured us of this.

Members are invited to DISCUSS the report.

AGENDA ITEM 7

OPERATIONAL UPDATE

Introduction

This report provides an update on the following four operational areas during the last quarter:

- Staff recruitment and development;
- Recruitment of Committee Members;
- Transfer of NCSC Enquiries Service;
- Quarterly Metrics of Enquiries, NCSC Calls Log and Media Opportunities.

Staff recruitment and development

We have continued to progress with staff recruitment activity to ensure that all Healthwatch England staff roles are undertaken on a permanent basis. The list below demonstrates the activity in this last quarter:

- Permanent staff in post/contracts in progress at the end of the quarter – increased from 11 to 22 in this quarter;
- Number of posts still to recruit for – 9;
- Total – 31.

Of the 9 roles listed above, here is a short update on the progress of each role:

- We agreed to review job descriptions for 4 posts to ensure that the scope of the role was correct before making a decision on permanent appointment;
- We wanted to stagger the starting dates of new staff so we could carefully manage induction needs for the new team. We've held back 4 posts until quarter 4 (these vacancies are currently live);
- One post became vacant after an internal candidate successfully gained a promotion.

As planned, all recruitment activity that was planned for quarter 3 successfully took place.

Further to the last operational report, we have continued to work with our staff team to understand more about their staff development needs – understanding what further learning/support needs they require to fulfill their role. We have agreed the following training for this quarter for all staff:

- Understanding how we can achieve positive change in our work (this was completed in January) and developing a theory of change;

- Developing confidential listening skills (this is planned for February);

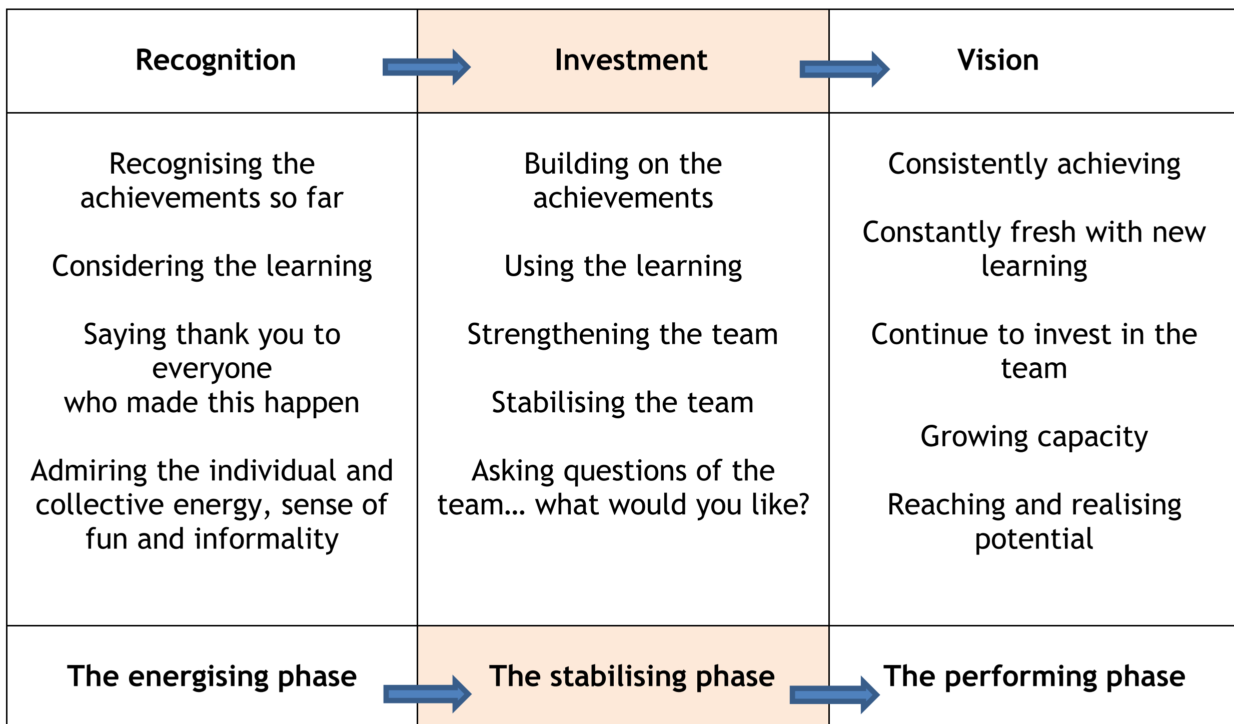
- Safeguarding good practice for children and adults (this is planned for March).

As new members of our team join, we have been reviewing induction needs to create an induction programme that supports new team members to successfully gain confidence in their role.

Monthly full staff meetings continue to take place, and in the last meeting the team were introduced to the business plan for next year to gain their input and understanding. Less formal monthly learning sessions have begun this quarter to enable staff to know more about important topics such as the role of the Department of Health sponsor team and the recruitment process, but in a short and succinct way.

The overall programme of staff development continues as planned following our senior management team development day last summer. At that stage, we identified there were three distinct phases for our team that represented where we were as an overall staff team and where we were heading to.

The diagram below demonstrates these 3 phases:



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

During this quarter we have taken time to reflect on this in more detail as we are now preparing for phase three and creating the conditions that enable our team to perform consistently well.

Recruitment of Committee Members

We have begun the process for recruiting Committee Members to fill the current vacancies and ensure that the transitional members who will move on at the end of the financial year will be replaced.

In the quarter we have learned from existing members about their experiences and developed a skills audit so we can gauge what skills will be needed and build this into the recruitment process. This is the first time we have undertaken an activity of this scale and it enabled us to also consider how we could utilise their skills in different ways.

Below we have inserted a table that demonstrates the impressive breadth of skills that are present within our current Committee. Additionally, the table highlights areas we can specifically include within the recruitment process of future Committee Members:

Governance and Strategy

Skill	Financial Audit	Risk Management	Change Management	Governance	Strategic Planning	Information Governance
No. of Committee Members	6	5	8	10	9	3

Operational Oversight

Skill	Lobbying and Campaigning	HR and Training	Financial and Procurement	Project Management
No. of Committee Members	5	6	2	7

Skill	People Management	Quality Assurance	Communications/ Media/PR	Policy	Research	IT/Systems
No. of Committee Members	7	6	8	7	4	0

Context

Skill	Consumer/ User	Children and Young People	Mental Health	Public Health	Local Authorities	Diversity and Inclusion	Social Care	Regulation
No. of Committee Members	8	6	5	5	6	7	7	4

The new Committee members will be in place from April 2014. The table below demonstrates the timeline for this activity;

Process	Anticipated completion date	Completed?
Review Role description	19 December 2013	YES
Prepare role advert	19 December 2013	YES
Begin skills audit process	Week commencing 23 December 2013	YES
Complete skills audit process	Week commencing 6 January 2014	YES
Advert goes live	Week commencing 24 February 2014	
Closing date for applications	Week commencing 10 March 2014	
Interviews and offers	Weeks commencing 17 and 24 March	
Induction begins	From April 2014	

Transfer of NCSC Enquiries Service

The Enquiries service (for telephone calls and postal enquiries) was delivered by the Care Quality Commissions 'National Customer Service Centre' (NCSC) team based in Newcastle. The email Enquiries service is delivered in house by Healthwatch England. In addition, we also directly receive telephone calls and postal enquiries from organisations and members of the public raising issues and concerns.

It was agreed by the Senior Management Team (SMT) to bring all of the Enquiries service to one location – Healthwatch England in London, to ensure a consistency in approach/response and that all Enquiries can be monitored and measured from one location.

We are delighted to report that we have successfully transferred this service on time and it is now operational from the London office. The recruitment process for the Information Officer post has been completed. The Information Officer began her role at the start of this current quarter and she monitors the call volumes and complexity of calls using the system that was developed by NCSC colleagues.

We have also undertaken a more detailed review of the nature of the calls to demonstrate the types of telephone enquiries that are coming in to the team. The table below demonstrates this:

	October 2013	November 2013	December 2013
Complaints/concerns	16	22	17
Queries regarding local Healthwatch or local providers	29	15	27
Other calls regarding events/sales	41	56	30
TOTAL number of calls	**86**	**93**	**77**

We have continued to invest in staff training and development in this area as this is a growing area of our business and it is important that we are clear about our offer to consumers who contact us directly. The confidential listening training planned for February will further increase the team's confidence in this area. Our offer to consumers is three-fold; we are here to listen to their experiences of health and care services, to direct them to their local Healthwatch for support, and to log their experiences as this informs our overall evidence base of trends in health and care.

We are in the process of developing a CRM (Customer Relationship Management) system. This will enable us to have a safe and secure method of building our evidence base. This will be compatible with existing systems and available to local Healthwatch. We will begin to test this with a small group of local Healthwatch so we can ensure the functionality is correct before testing this on a larger scale.

Data on our communication activity

The Metrics table below details other activity in the quarter relating to contact with stakeholders and consumers.

As discussed previously, we are keen to ensure this presents the most effective overview of this activity, and we have recognised scope for improvement and we are currently testing out different options for media monitoring in particular. We will continue to work on this and in the interim the table demonstrates the activity alongside the previous quarters for comparison, refining this for the next financial year.

Quarterly Metrics of Enquiries, NCSC Calls Log and Media Opportunities

	Quarter 1			**Quarter 2**			**Quarter 3**		
	April	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**
Unique website visitors	14,574	12,274	11,327	10,130	8,262	8,651	14,529	10,789	7,663
Twitter followers	1,271	1,590	1,670	1,892	2,038	2,232	2,610	2,875	3,120
Media Opportunities to read/see									
National	3,749,577	3,547,000	3,542,000	1,231,142	886,951	257,000	79,308,803	34,137,724	22,986,899
Regional	5,506,544	5,180,000	5,160,000	5,526,794	5,093,034	4,953,501	5,285,955	4,798,665	3,802,549
Newsletter									
Subscribers	2,556	2,751	3,063	3,200	3,094	3,176	3, 150	3,200	5,668
Open rates	42%	45%	N/A	N/A	32%	N/A	N/A	N/A	N/A
Service Centre Enquiries									
Calls	322	245	211	202	120	124	86	93	77
Emails	390	177	242	191	286	281	275	270	112

Further information regarding media opportunities during the quarter

October was a bumper month for Healthwatch media coverage. The launch of our Annual report was covered extensively on page 1 and 2 in the Times and the BBC News Online homepage. There was also follow-up coverage in the Guardian online. Our response to the Clwyd Hart report was also covered by the Times, the Telegraph, the Mirror, BBC Radio 4 – You & Yours and World at One. Other media activity included a response to a report by the GMC on complaints which was picked up by the BBC, the Daily Mail and the Daily Express.

In **November** our position on the Government's response to the Francis recommendations was covered by the Times. Our response to the CQC's State of Care report was also picked up by BBC News Online and the Independent. We also launched Anna Bradley's Huffington post blog and published our first two pieces on the complaints system and the Duty of Candour. Finally, Katherine Rake appeared on ITV Daybreak discussing the issue of GP opening hours and the need for GPs to be more flexible to meet the needs of consumers.

In **December** the work of Healthwatch over the last year was covered in reference to the wider changes in health and social care by both the Telegraph and the Guardian. There was a piece in the Sun on the cost of missed hospital appointments to the NHS with local Healthwatch calling on people to take greater responsibility. We also published Anna's third Huffington blog post on the launch of our consultation.

Members are invited to DISCUSS the update.

AGENDA ITEM 8

MEMBERS' UPDATE

Members' updates are usually presented verbally at this meeting, however we thought it would be helpful for all members to provide a framework for this. Therefore we have presented two questions to members to ascertain more information about their activities they have undertaken on behalf of Healthwatch England in this period.

The two questions were:

1) What have you been doing on behalf of Healthwatch England this quarter?

2) What have you learned?

Below is a summary of members' contributions. In addition, we have provided a more detailed report from one of our members as this demonstrates the breadth of activity our members undertake on behalf of Healthwatch England.

Individually the Committee members represent and provide a voice for key groups in our communities, and have made sure at a national level that their issues, challenges and concerns have been heard by Healthwatch England. They also engage with local Healthwatch through events and regional meetings. This enables us to learn more about the progress of the network.

What have you been doing on behalf of Healthwatch England this quarter?

- Making sure at a national level that children's issues are on the agenda;
- Working on diversity and equality and raising issues on mental health. In particular round the whole agenda on parity of esteem in ensuring that mental health is treated the same as physical health;
- Undertaking speaking engagements, for example, at the UK CAB network of HIV and AIDS organisations and activists;
- Networking with voluntary sectors;
- Working at a local level on various projects, for example, developments of new medical centres;
- Have researched topic proposals for DH Health Services and Deliver Research;
- Taught Birmingham Master of Public Health students on 'the voice of the patients and users;
- Spoken at the South West Alliance of Neurological Organisations, which is an umbrella group representing about one million people in South West England with conditions such as Parkinson's Disease, stroke, epilepsy, Motor Neurone Disease, brain injury etc;

- Represented Healthwatch on the National Information Governance Committee, which is a CQC Committee that is charged with monitoring issues such as maintaining patients' confidentiality and ensuring that information is shared appropriately among health and care professionals to ensure joined-up care.

What have you learned?

- That people representing consumers of services that are organised regionally/nationally through specialised commissioning are still struggling to understand the reformed architecture of the NHS. The contacts they had with Strategic Health Authorities and Primary Care Trusts no longer work. They want to know how to make use of Healthwatch England's influence on specialised commissioning. The question for Healthwatch England is how we listen to such sources of great expertise about consumers' current experiences of health and social care – both through local Healthwatch and directly from regional and national organisations;

- That there are some good areas of practice that we can build on, that nationally the systems are confused and how Healthwatch is becoming a help to that;

- That we're a national voice and need to make sure the voice is reflective and inclusive of consumers in England;

- That health bodies at least seem much more open to local ideas and ready to engage in debate on health provision that would suit patients;

- Uncertainties regarding the prospect of elections this year and next;

- Appreciating the complexity and diversity of the inter relationships between local Healthwatch, Healthwatch England, local authorities and government departments;

- How academic researchers rarely consider the consumer viewpoint in devising research proposals;

- That the representatives of national bodies such as NHS England, CQC and Health and Social Care Information Centre are extremely interested in our ability to provide up-to-the-minute examples of issues raised by consumers;

- How the NIGC is influencing the questions to be used in the new-style hospital inspections.

Special Report from Committee Member Jane Macfarlane

During January I have been talking to some local Healthwatch in my area and would like to highlight some points.

It strikes me more now than it did earlier of the very diverse nature of local Healthwatch as they move towards the close of the first year of operations, implementing their governance arrangements and getting on with the job. Those I have spoken to are extremely focussed on their roles and responsibilities, and achieving outcomes locally. I feel it vitally important that Healthwatch England invest heavily in the Network to support the growth of a mutually beneficial and productive channel for public voice.

Better Care

There is some involvement with local Healthwatch in developing plans for the Better Care applications. I attended one event facilitated by local Healthwatch primarily aimed at the Third Sector. More questions were raised than answers provided by the attending local authority. Generally people were concerned about:

- Very tight timescales;
- Lack of any public engagement;
- Future sharing of patient/service user details between all concerned;
- Processes for dealing with concerns and feedback;
- Implementation of the plans.

In this case a report on the concerns raised at the meeting is being prepared by the local Healthwatch.

Other areas report similar involvement and concerns. I am sure that people will be concerned about these changes and also have valuable contributions to make. It strikes me that the way to make integration work well is to start with people not end with them.

Complaints

HW Cumbria has been working with the Overview and Scrutiny Committee on a review of complaints processes in the county. This work may be useful to include in our own work, I understand this is currently on going.

Enter and View

One local Healthwatch is in the process of conducting a series of visits to care homes these are unannounced and conducted by staff.

The role of Local Healthwatch on National Service Reconfiguration

As we know there is on-going work around Children's Congenital Heart Services but local Healthwatch are not clear about their role in this type of service reconfiguration. Obviously it is of major interest to local Healthwatch where services are provided in their area but those using services come from far and wide.

Regional Network

In my area the notion of a single regional network, I feel, would be counterproductive. Travel time across this area is often in excess of three hours making a centralised meeting both expensive in terms of time and money. Sub regional meetings would be more logical in terms of relevance and are likely to produce better engagement and involvement. In some areas sub regional networks have been developed by local Healthwatch themselves out of need to work together on service reconfiguration or to discuss shared services or by the regional voluntary sector organisations. I am aware of some negative feedback from some of the meetings organised by other third sector organisations. I feel quite strongly that Healthwatch England should be facilitating the development of these networks.

Webinars

I have had some feedback on webinars, which has been quite positive but attendees can feel lost and unheard at times.

Restructure

One local Healthwatch is re-thinking their structure and staffing having found out more about what is needed.

Discharge

Healthwatch Lancashire has had some feedback on discharge that would be of interest to our review as well as work on appointments, benefits of peer support and accessible services.

Members are invited to DISCUSS the update.

AGENDA ITEM 9

ESCALATION REPORT

Responding to local Healthwatch escalations

1. Purpose of the paper

This paper updates the Committee on Healthwatch England progress in identifying, and responding to, issues of consumer concern escalated by local Healthwatch.

It builds on the framework for escalation that was discussed and agreed at the June 2013 public Committee meeting and reflects our learning from taking local Healthwatch escalations over the last six months.

2. What are escalations?

Part of the remit of local Healthwatch is to undertake activity to identify, highlight and resolve threats and risks to consumers of health and social care.

In many cases, local Healthwatch are able to resolve a case or concern locally or regionally through the powers they have and the activity they undertake to Enter and View or be involved in improving local services.

Sometimes, they will need to escalate a case or issue to another agency, organisation or forum to ensure it is resolved. These local forums or agencies might include:

- Health & Wellbeing Boards;
- Clinical Commissioning Groups (CCGs) or Commissioning Support Units (CSUs);
- Clinical networks and clinical senates;
- Local NHS England area teams;
- Local Authority commissioners;
- Local Monitor teams;
- Quality Surveillance Groups (QSGs);
- Local Care Quality Commission (CQC) teams;
- Local Ofsted teams;
- Clinical networks and clinical senates;
- Professional regulators or practice forums of royal colleges;
- Local Education and Training Boards (LETBs);
- Relevant information, advice or advocacy services;
- Appropriate safeguarding or policing authority (depending on the nature of the concern and whether it triggers a safeguarding issue or alleged offence).

If local Healthwatch submit reports or make recommendations to local decision makers, they must acknowledge the escalation and, in their decisions and actions, have due regard to the views, ideas or suggestions contained within it.

3. What happens if the issue can't be resolved locally?

Where the local team is part of a national body (i.e. NHS England local area teams or local CQC teams) the risk or concern should be internally escalated to national teams as is deemed necessary.

For example, if a local Healthwatch raise a concern with the local CQC team directly about the safety of a hospital service, this should be escalated internally through CQC and trigger subsequent action. This might include further work to determine level of risk in the setting or trigger an inspection.

Case study: influencing Care Quality Commission hospital inspections

In October Healthwatch Bradford conducted a series of Enter and View activities on their local A&E at Bradford Royal Infirmary, which uncovered serious concerns. These included over-crowding, insufficient staffing and patient privacy. Healthwatch Bradford escalated their concerns to the local CQC team who internally informed the team leading the inspection at the hospital. In response, the inspection activity focused on A&E activities and Healthwatch Bradford are already picking up positive improvements.

4. What happens when the concern is about a national decision or policy?

In some cases local Healthwatch will not be able to resolve the issue locally. This might be because:

- The issue involves a decision, policy or commissioning that is determined at the national level;
- The issue is systemic and requires a significant policy or directional change at a national level;
- The issue is a threat or risk to consumers and requires urgent action to be taken by a national player.

A core part of Healthwatch England's statutory remit as a consumer champion in health and social care is to use data and intelligence, particularly from local Healthwatch, to identify risks to consumers. This role has been heightened as a result of the Government's response to the Francis Inquiry.

To enable us to do this, local Healthwatch must share with us not only the concerns being raised at a local level, but specifically escalate to us the risks that require a national resolution. They can also specify in this escalation whether they think we should be undertaking a special report or inquiry to explore this risk further.

We can then use our informational and advisory powers to ensure that national statutory players across health and social care take action on the risks that have been escalated. We also have the power, with the permission of the Secretary of State, to prepare and publish revised standards for health and social care services that would address these consumer risks.

5. Can we draw any conclusions from the early escalations?

To date, we have had a small number of escalations from local Healthwatch and the full list is contained below:

- The Prescription of Sodium Valproate during pregnancy leading to Fetal Anti-Convulsant Syndrome;

- Commissioning decisions, as opposed to medical requirements, limiting access to Bariatric surgery;
- Impact of Medical Assessments for Claimants of Disability or Sickness Benefits;
- Operation of NHS England's complaints process;
- Use of individuals' data and its disclosure to approved third parties, such as BUPA, and the process of informing the public about this initiative to give a reasonable opportunity to opt out;
- GPs charging patients for letters in support of the patient's claim to the Department for Work and Pensions;
- Information about NHS dentists taking on patients that is held on NHS choices being incorrect;
- Access to GP practice data on complaints;
- NHS 111 access for people who are deaf, hard hearing or deaf blind;
- Lack of consultation by CCGs;
- Lack of a 'pre-complaint' service for people who want to solve a primary care problem rather than have a say about it;
- Waiting lists for adult social care assessments.

It is too early to identify any trends emerging from the escalations however; access to services, complaints handling and use of data are all emerging as important national issues. We have already seen some significant impact from these early escalations.

Case study: standing up for people's right to choose and be informed

In October 2013, Healthwatch Derbyshire raised concerns about the NHS England proposals relating to the use of patient data and information (care.data). We tested the strength of this concern through our regional network meeting and in one to one conversations through the development team, which identified wider concern about the proposals. We shared these with NHS England.

In January 2014 we followed up these concerns with local Healthwatch and found that 1 in 4 now had subsequent concerns about the information and communications that were being set to consumers. In particular, Healthwatch York, Healthwatch Cambridgeshire and Healthwatch Stoke did work locally to highlight these concerns. They collectively highlighted that consumers were unable to make an informed decision about whether or not to opt out of the programme.

As a result, we used out our information and advisory powers to write to David Nicolson (CEO of NHS England) calling on them to delay the roll out until consumers can make an informed decision. We received significant local and national media coverage, which helped to shape the national debate around care.data.

We are now in discussion at an executive level with NHS England about next steps and the information people will need to make an informed choice.

6. What have we been doing to strengthen our approach to local Healthwatch escalations?

Since the last Committee Meeting, we have been exploring a new approach to strengthen the way we identify and respond to escalations. We are doing this to reflect the systematic approach we need to take in dealing with escalations.

So far we have:

- Designed and are testing a new process for dealing with issues escalated from local Healthwatch;
- Begun testing a new approach to collecting and capturing data about escalated cases;
- Established an internal escalation group responsible for triaging local Healthwatch escalations and ensuring we deal with them in a timely and appropriate manner and ensure action is taken by system players.

As part of this new approach, the escalation group have translated the criteria given by the Committee so we can assess the urgency of escalated cases and to enable Healthwatch England to triage them effectively. At escalation group meetings we now determine whether:

1. There is, or will be, an immediate risk to the health, safety, quality of life or wellbeing of a consumer or group of consumers;

2. There is a risk that abuse, neglect or criminal offence has occurred, or will in the near future;

3. Similar, risks or concerns have been raised or escalated by local Healthwatch or individual consumers;

4. We have identified similar risks and trends in local Healthwatch, third party or national data sets;

5. The escalation requires a national intervention to be resolution or intervention.

We will tailor our actions depending on which of these criteria triggers an escalation.

Once the escalation has been triaged, the escalation group considers the appropriate for Healthwatch England to take. These might include:

1. Acknowledging the issue but take no further action;

2. Gathering more information about the risk or specific case (i.e. searching the InfoBank, assessing the extent of risk through the wider network, undertaking research or analysis);

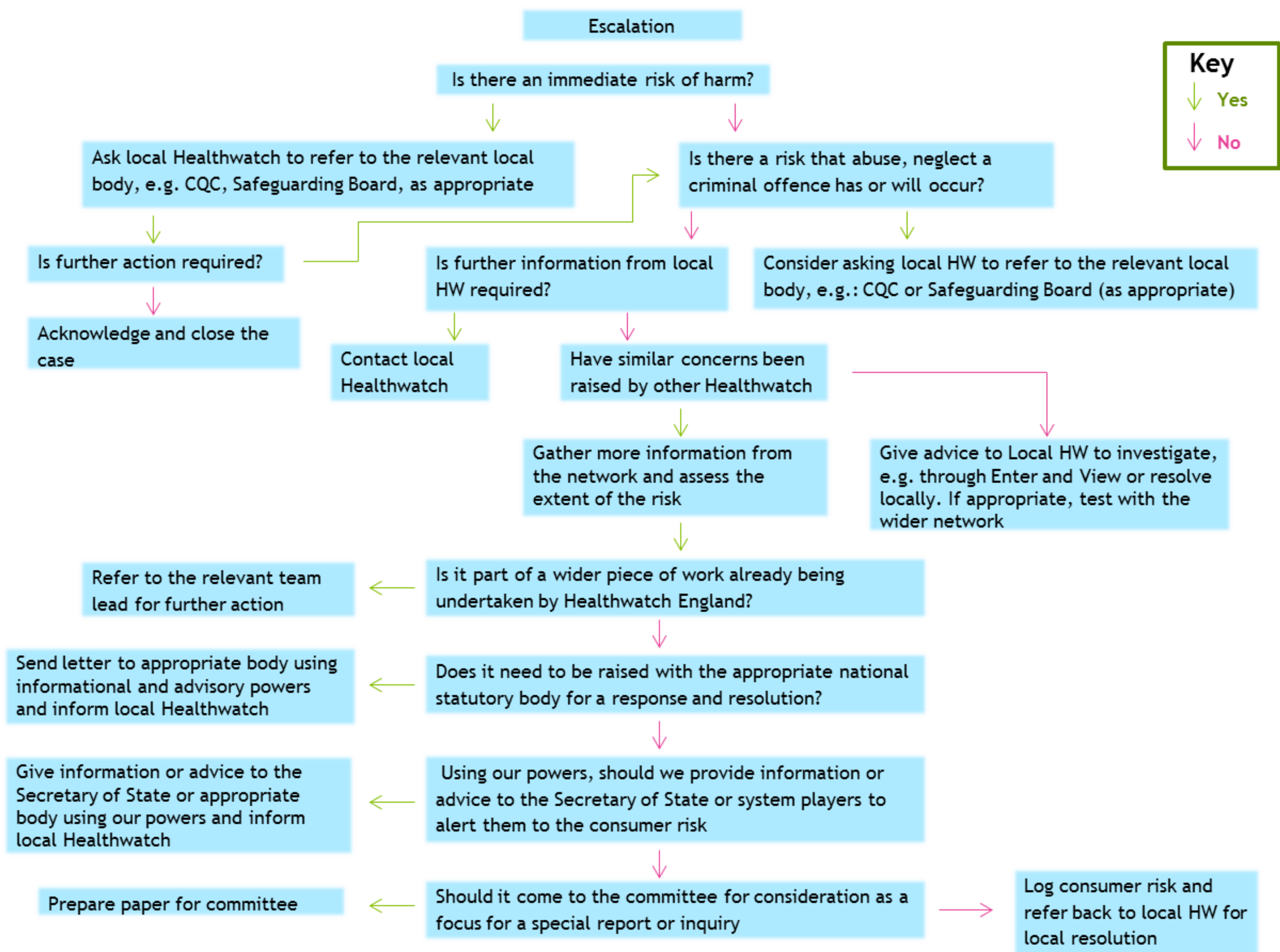
3. Giving advice to local Healthwatch to enable them to resolve locally (i.e. advising them to escalate to their local CQC team or to alert the relevant safeguarding officer);

4. Raising the risk or concern with the appropriate national statutory body for a response and resolution;

5. Using our informational and advisory powers to write to the Secretary of State or system players to alert them to the consumer risk;

6. Bringing them before the Committee for consideration as a focus for a special report or inquiry.

The decision tree diagram below gives an overview of the process the escalation group will go through:



7. What are the next steps?

We will continue to strengthen our approach to escalations by:

- Updating guidance to local Healthwatch to give clarity about how they can escalate a concern, what they can expect from the process and how it links to their, and our, statutory responsibilities;

- Developing policies and undertaking training for Healthwatch England staff on both whistleblowing and safeguarding issues;

- Proactively exploring areas we anticipate will be escalated in the future from local Healthwatch (i.e. specialised commissioned services and reconfiguration of local services);

- Exploring and rigorously test a streamlined approach to escalation through the pilot for the new Healthwatch CRM;
- Working to align our approach to escalations and enquiries for consumers.

A summary of consumer risks escalated to date can be found in Annex A.

Members are invited to DISCUSS and NOTE the report.

ITEM 10

STRATEGIC PARTNERSHIPS

Introduction

NHS England

Further to our last report, we continue to progress our relationship with NHS England and move into a more operational mode. The Memorandum of Understanding provides further clarity on the relationship and we are now agreeing a joint programme of work and priorities for the relationship.

The Memorandum of Understanding with NHS England is a standalone document which is presented to the Committee for approval.

Monitor

We anticipate that the final Memorandum of Understanding will be presented to the Committee in May 2014.

Members are invited to DISCUSS and APPROVE the Healthwatch England and NHS England Memorandum of Understanding (Annex B).

ITEM 11

BUSINESS PLAN AND BUDGET 2014-15

Introduction

Further to our last report, we continue to progress with developing the Business Plan and budget for next year. Our aim for 2014-15 is to show the impact and value of Healthwatch in everything we do.

The Business Plan and budget are based on a specification of the resources required to fulfill our statutory responsibilities. We have presented the case that this should be met by core funding, and the resources required to deliver different products year on year which can reasonably be considered time limited programme costs.

Subject to final budget negotiations, we will then develop a detailed activity plan with the wider staff team. Currently, the managers' group is now being given the opportunity to shape and test the activities with their teams. The senior management team has recognised that this is a unique opportunity to instil cross team working and leadership across all levels of the organisation.

We are also considering the specific programme and project support required to set up appropriate and proportionate management systems internally that will ensure that there is clarity on delivery, overall and budgetary responsibility that will enable multiple teams to be involved. Links between the activity plan and individual objectives will also need to be strong and we have a fresh opportunity to design this process anew for the organisation also.

Next steps

This process will continue and reach conclusion this quarter. Therefore the next step is to fully consider two areas; success measures and areas of risk. We would like to explore how we will know we have been successful and what measures should be put in place to demonstrate this, and to identify the key areas of risk that would present a reputational, financial or delivery risks.

Members are invited to DISCUSS the following two questions in relation to the Business Plan (Annex C): 1) How will we know we have been successful and what measures should be in place to demonstrate this? 2) To identify the key reputational, financial or delivery risks?

ITEM 12

STRONGER TOGETHER:
THE LOCAL HEALTHWATCH STRATEGY

Context

Healthwatch was born at a time of great change in the way health and care services were provided. We were created with a powerful ambition of putting those who use services at the centre of health and care. The Healthwatch network is made up of local Healthwatch across 152 localities and Healthwatch England, working together on a national and local level. We are a network of independent and interconnected groups focused on a shared purpose of supporting people who use health and social care services.

Healthwatch England is the independent national consumer champion in health and care. We have been given significant statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services. We champion the needs of children, young people and adults and have a national perspective. Our role is to say where change is most needed.

Healthwatch England leads, supports and oversees the work of the Healthwatch network across the country and it is our task to make sure that the whole is greater than the sum of the parts.

Local Healthwatch gathers the views and experience of local communities to give them a stronger voice to influence and challenge how health and care services are provided within their locality. They provide advice, information and support and they pass information and issues to Healthwatch England, Care Quality Commission and other local Healthwatch. Local Healthwatch organisations are commissioned by local authorities according to local needs and priorities, and as a result they are diverse in the size, form and set up.

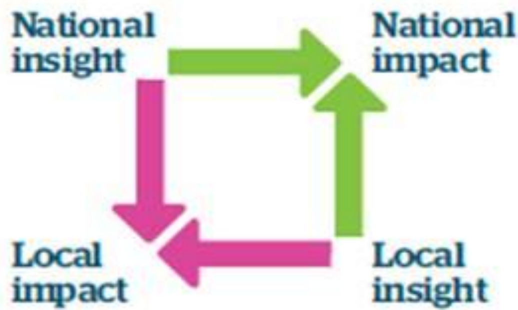
Healthwatch is a young network, one that has been in existence for less than a year and our challenge is to work together to fully realise the network's potential. Healthwatch are commissioned and performance managed by local authorities. The result is that Healthwatch England does not have a direct management relationship with the local Healthwatch. Rather the model is for Healthwatch England to add value by offering support, through platforms to share learning and knowledge, by providing shared services and by facilitating joint working among network members.

This paper will outline our strategic approach and support offer to develop and strengthen an effective network that delivers real change for people in their communities. However, all of our strategic priorities will create and develop the network, for example, joint campaigning on improving the complaints system or collective work on service change and design.

Vision for the network

Our vision is for an effective and resilient network that has a shared purpose and identity that is supportive, resilient and resourceful and makes a positive impact for people who use health and care services. The value of the network is realised when we bring the power of the local and national together as shown below. The eyes and ears of Healthwatch across the country provide us with local insight, flagging issues of concern

or areas of good practice. Healthwatch England takes this onto a national stage, ensuring that those that have the power to make change happen across the country are informed of the concerns of the network and aware of the impact they are making at a local level. Our national work and intelligence gathering is shared with the network, so that Healthwatch locally understand how national changes are shaping their local services. Armed with the national evidence, local Healthwatch can use their influence to help improve services for their local communities.



Aim

Our aim is to build the potential of the network to become an independent and influential amplifier of the consumer voice to effect real change in the design and delivery of services.

Objectives

- To identify and share good practice and provide peer support across the network, developing a culture of self-assessment and continual learning;
- To support local Healthwatch to have the confidence, capability and capacity to prioritise and address issues that matter most to people, promoting consistently high standards of delivery;
- To support the network to build a stronger understanding of issues and develop common strategies for influencing services;
- To establish a process for collecting a comprehensive and up to date picture of the network to establish the health of the network and identify areas in need of support.

Principles

In delivering our objectives, we will always work to the following principles:

1. We will work in partnership with the network across all our strategic priorities and to make an impact both locally and nationally;
2. We will always start with the needs of consumer and communities and take into account the work of the whole of the network;

3. We will value each other's knowledge, celebrate and share good practice, whilst holding ourselves to the highest standards;
4. We will support learning within the network, adding value and learning from sharing local expertise to build a sustainable future;
5. We will listen to the network and work on its behalf challenging those in power and will not be afraid to point out where things have gone wrong;
6. We will work to ensure that all the work and policies of the network promote and uphold diversity and inclusion.

How we will work with the network

Over the past year, we have provided a range of support, training and services to the network and have learnt how to engage and develop this growing network. The way of working discussed below reflects this learning and continual feedback from the network about the best forms of support for them.

Building our communities and expertise

We will provide a programme of engagement with the network, through a variety of channels, including face to face and online. We will run a series of events across the regions. These will include a series of network meetings in each region, partnership days with the local voluntary and community sector, annual conference, and with other interest groups.

We will provide communities of interest, identity, practice and place. We have emerging Chair and Chief Executive networks and we want to extend this to cover particular issues. We will establish communities to cover particular consumer groups, for example, children and young people, or those with a particular expertise, for example, research. This will enable service specific communities as needs arise, both led by local Healthwatch concerns at a regional or national level, for example, on ambulance services or specialised commissioning, and led by us to encourage work in areas of particular policy concern, for example, complaints advocacy.

This will enable the network to develop a stronger understanding of issues, develop common strategies for influencing services, and work on shared areas of interest, to share good practice and to provide peer support.

Efficiency and effectiveness

We will work to develop standards of practice across the network, ensuring that the network is delivering a consistent, quality service. We will assess where services can be provided more cost effectively centrally and, subject to resources, will "buy in bulk" for the network ensuring that the network is engaged fully in shaping and developing new services. We will ensure that good practice is promoted between and among local Healthwatch and that we bring learning from statutory partners and voluntary sector groups into the network.

We will gather information about the network, and collate and analyse the annual reports of the local Healthwatch to inform our annual report to Parliament. We will undertake a comprehensive data gathering exercise twice a year, and will gather information on a range of issues. This will enable us to develop an understanding of how the network is doing and what we can do to support it better. We will build understanding of the impact and effectiveness of the network with the health and care system, our statutory partners, the Government and, using the media, with the public.

Capability and capacity building

We want to build the capability of the network to address the scope of issues within its reach. This requires providing support and skills development.

We need to offer capability building that responds to the needs expressed by the network as well as to fulfil skills gaps in functioning and standards identified by Healthwatch England, for example, providing quality advocacy services.

We are applying the learning from the 2013 programme of Enter and View training and will apply the successful principles of co-production of content, high quality and accurate materials and regional events.

The programme of training will include training volunteers, support for volunteers, escalation, leadership and media relations. We will consult with the network about other topics, so that the development of the training and capability building programme meets their needs. We will use the expertise and skills of other agencies where appropriate, and will provide training and capability building support that is unique to the Healthwatch network and is not provided elsewhere.

These will be provided via a range of methods, including face to face, webinar, online, train the trainer events, shared learning events, task and finish groups, materials and resources.

We will implement and test out a new model of engagement for local Healthwatch with the new inspection regimes for hospitals, social care and primary care.

We will develop tools, support materials and training so that local Healthwatch can engage effectively with service redesign in their area.

Realising and promoting our impact

We want to support the network to maximise its impact, through developing clear priorities and measures of success. We will tell the story of the impact that the network is having on a national and local level and to raise the profile of the work of the Healthwatch network.

This will include media activity, digital and web activity, our influencing work and promotional activities. We will work with the network to develop these based around themes and issues of importance to the network, such as service redesign, abuse in care homes, A&E or access to GPs. We will work with the network to develop case studies to celebrate good practice and effective or innovative pieces of work, and highlight them

in our influencing and other work. We will support local Healthwatch to work with media in their localities and will run training and support for them to do this.

What are the risks?

Risks	Mitigation
That the network believes there is a conflict between our leadership and our desire to promote a self-sustaining network.	We will provide clarity about the role of Healthwatch England and our support offer and the value it adds.
There is a loss of credibility and frustration from local Healthwatch in our leadership which results in disengagement.	Promote the increased offer and support from Healthwatch England, through the Development team, meetings and communication channels.
There is a potential damage to brand and public trust if a number of local Healthwatch fail.	Our increased knowledge, data, relationships and engagement with the network means we have a good overview of the network and can identify potential issues and intervene.
That we are unable to gather a true picture of the health of the network and therefore target our support effectively.	Our increased knowledge, data, relationships and engagement with the network means we have a good overview of the network and can target our support accordingly.
That the network requires more support than we are able to provide.	Promote the increased offer and support from Healthwatch England, through the Development team, meetings and communication channels.
That bad practice is spread as a result of peer review between weak peers.	Our increased knowledge, data, relationships and engagement with the network means we have a good overview of the network and can identify potential issues and intervene.
There is limited team capacity to effectively deliver on our objectives.	The offer is can be scaled according to resource and additional resources have been requested from Department of Health.

What will success look like?

Outcomes

- We will have a rich source of information and clear picture of the network;
- The health of the network will be measured (providing a benchmark for the future) and the right support delivered;
- There will be clear evidence and case studies of the network sharing good practice and providing peer support, and can demonstrate the effect from cascading support and training, for example the Enter and View training is locally self-sustaining;

- The network will be able to demonstrate confidence, capability and capacity to prioritise and demonstrating high standards of delivery;

- There will be clear evidence that the network understands the local issues and have developed common strategies for influencing services.

What we will deliver

The following gives an indication of our offers to the network. Following the Committee's input a full programme will be developed and tested with the network.

• Building our communities and expertise	• Deliver support to local Healthwatch to engage across their communities, e.g. provision of materials to support their work with people with learning disabilities • Develop communities of interest, identity, practice and place are established, including Chairs and Chief Executives' network • Deliver regular Healthwatch regional events, Healthwatch network events, local Partnership Days and Healthwatch conference
• Efficiency and effectiveness	• Customer Relationship Management system rolled out across the network, enabling improved data sharing and analysis • Data collection delivered giving indications of state of health of network • Annual Report demonstrates the impact of the network, and analyses returns from local Healthwatch
• Capability and capacity building	• First stage implementation of models of engagement with CQC and Chief Inspectors in the new inspection regime • Training in e.g. escalation, leadership and governance, media • Deliver support on service change, including reconfiguration and service closure and the integration of health and care services
• Realising and promoting our impact	• Communications strategy shared with the network • Case studies developed • Sharing information with the network about national influencing and special inquiry progress

Next steps

- Further develop the detailed programme of activity and support for the network;

- Test the offer with local Healthwatch, securing their views on prioritisation;
- Assess and allocate resources for the support of the network;
- Develop a monitoring and evaluation programme for our work with the network, improving feedback mechanisms to measure satisfaction with, and impact of, our offer

Members are invited to DISCUSS and APPROVE the strategy.

ITEM 13

DIVERSITY AND INCLUSION STRATEGY

The development of the strategy continues to progress. We have set up a small, dedicated working group and the members are; Jane Mordue, Alun Davies, Patrick Vernon and Dave Shields. Led by Katherine and supported by Sarah, we have established:

- Why this work is important to us;
- Core principles about how to ensure it supports all aspects of our work;
- How we will take this forward.

Members are invited to DISCUSS and APPROVE the strategy.

ITEM 14

SPECIAL INQUIRY REMIT

Members are invited to DISCUSS and APPROVE the remit.

ITEM 15

DUTY OF CANDOUR

Background

1. What is our existing position on a Duty of Candour?

A statutory Duty of Candour applying to all health and social care staff and organisations is crucial to promoting consumer rights and should be implemented without delay.

The duty must:

- apply to all health (including mental health) and social care services and should cover both the public and private sectors;
- apply to individuals to mark out those who wilfully cover up incidents, do not provide honest accounts or obstruct others from being candid themselves;
- apply to any moderate or higher harm which has come to a person as a result of poor treatment or wrongful omissions of care.

Criminal sanctions for covering up information about serious incidents could be important in avoiding the escalation of the situation and further abuse, neglect and preventable death occurring.

However, our legal advice suggests that there are a number of avenues that could be pursued using existing tools such as maladministration, obstructing an inspection, misconduct in public office, professional disciplinary procedures relating to fitness to practice and contractual sanctions. Only if these options are found wanting should a new offence be introduced.

The full background to the Duty of Candour is contained in Annex D.

2. Who have we informed of our existing position?

Since we agreed our interim position on the Duty of Candour we have:

- Used our informational and advisory powers and written to the Rt. Hon. Norman Lamb MP, Minister for Care & Support with our position on Duty of Candour and specifically the question of whether to apply criminal sanctions;
- Met with the Minister and Rt Hon. Jeremy Hunt MP, Secretary of State for Health, to discuss Healthwatch priorities, including Duty of Candour and Hard Truths;
- Given oral and written evidence to the joint review of Prof. Norman Williams (President of the RCS) and David Dalton (CEO of Salford Royal Hospital) commissioned by the Secretary of State into proposals to enhance the Duty of Candour in the NHS.

3. What further positions do we need to agree to finalise our position?

The Healthwatch England policy team have been developing our position on Duty of Candour based on the Committee's steer and now need to finalise our position so that we can publish our final position and inform the Minister and Secretary of State's final decision.

Below is a summary of the key outstanding areas we need a position on and a proposal for what the response should be. These proposals are based on our analysis and are intended to inform the discussion the Committee has at the public meeting in February 2014.

Francis recommends that the duty should be triggered when a person 'believes or suspects' that treatment may have caused harm, do we think this is the right trigger?

Members are invited to DISCUSS the recommendation that the duty should be triggered when a person 'reasonably suspects'.

Should we agree with Francis and Berwick that 'near misses' should not be included in the duty?

Members are invited to DISCUSS the recommendation that the 'near misses' should be omitted from the duty, as it would be difficult to apply in practice as harm did not occur. Members are invited to DISCUSS if we think information and data about 'near misses' should be used by staff, management and boards to learn from practice and improve services.

How should failures to perform an act that led to harm (omissions) be dealt with?

Members are invited to DISCUSS the recommendation that a definition that focuses on failure to provide a generally accepted standard of care, which lead to harm.

Many interventions have 'known complications', which the person will be informed of and have consented to should this be taken into account when assessing the application of the duty?

Members are invited to DISCUSS the recommendation consent and knowledge of potential complications should be treated as a factor in fulfilment of the duty.

Should sanctions be imposed and what would the nature be (given we have rejected new criminal sanctions)?

Members are invited to DISCUSS if significant caution should be taken in pursuing criminal sanctions and if we should instead propose a focus on either civil sanctions in the forms of fines, or professional and employment sanctions as the primary methods of enforcement.

Liability arising from the duty will alert people to harm they may not have previously been aware of and will impact behaviour and practices (particularly

with proposed changes to indemnity insurance), so how should we treat disclosures?

Members are invited to DISCUSS the recommendation that Duty of Candour disclosures would not be used in civil or criminal actions (though the facts could be) and clearer oversight of compliance as it is inappropriate for a potentially opposing party to counsel the other (because of severe conflicts of interest).

Further information:

- Background information can be found in Annex D;
- Detail behind this proposal can be found in Annex E.

Annex A: Summary of consumer risks escalated to date

Below is an overview of the early escalations from local Healthwatch.

Fetal Anti-Convulsant Syndrome

Name of the local Healthwatch	Individual consumer
Date of escalation	26 June 2013
Date(s) relating to the risk or concern	30th Aug: Raised with MHPRA 14th Oct: Response from MHPRA
Description of the risk or concern	Prescription of Sodium Valproate during pregnancy to control epilepsy can lead to Fetal Valproate Syndrome which is a type of Fetal Anti Convulsant Syndrome. Although the manufacturer of Sodium Valproate issued warning on patient information leaflets and there had been an update to NICE guidelines and a BNF update, the Medicines and Healthcare products Regulatory Agency had not issued a warning
Source of the risk or concern	An individual affected by the issue
List of agencies or individuals involved	Medicines and Healthcare products Regulatory Agency (MHRA) European Medicines Agency (EMA)
Action(s) taken to date by local Healthwatch to seek local resolution	None, but Healthwatch England alerted them to the case
Related reports or recommendations by the local Healthwatch	None
Description of any expectations of local Healthwatch	The individual wanted Healthwatch England to raise the issue as she felt she was not being listened to by statutory bodies
Action taken	We provided information and advocacy to the MHRA who took this on board. Following subsequent escalation to the EMA, the MHRA is now looking at the use of Sodium Valproate during pregnancy

Access to Bariatric surgery

Name and contact details of the local Healthwatch	Healthwatch Bradford
Date of escalation	16 August 2013
Date(s) relating to the risk or concern	30 Aug: Contacted NHS England 14 Oct: Response from NHS England 14 Oct: Healthwatch Bradford updated
Description of the risk or concern	Healthwatch Bradford highlighted that individuals qualified for bariatric surgery under medical rules but NHS England rules dictated that these individual needed to undertake appropriate exercise classes prior to surgery to reduce or manage weight. In some locations, the local authority does not offer these exercise classes. Therefore, one commissioner of services (NHS England) requires service users to undertake an activity prior to surgery which another commissioner of services (the local authority) does not offer. This traps service

	users in the middle, unable to comply with the requirements imposed NHS England.
Source of the risk or concern	Individuals raising it with the local Healthwatch
List of agencies or individuals involved	NHS England (NHS E) Local council
Action(s) taken to date by local Healthwatch to seek local resolution	Felt the issue arose from a national commissioning decision from NHS E and so had not taken local action
Related reports or recommendations by the local Healthwatch	None
Description of any expectations of local Healthwatch	That Healthwatch England ask NHS E to look into it and resolve the issue
Action taken	Healthwatch England raised the issue with NHS E and they recognised that there are issues with access to multidisciplinary weight management services in a number of areas in the country, including within the Yorkshire area. NHS E set up a meeting with the various commissioning agencies to discuss how this might be collectively resolved as quickly as possible

Fitness to work assessments

Name of the local Healthwatch	Healthwatch Lancashire
Date of escalation	20th September 2013
Date(s) relating to the risk or concern	None
Description of the risk or concern	Healthwatch Lancashire raised concerns about Medical Assessments for Claimants of Disability or Sickness Benefits. In particular they noted the worries about work assessments on people with mental health and other complex needs
Source of the risk or concern	East Lancashire Citizens Advice Bureau (CAB) report on experiences of service users
List of agencies or individuals involved	None
Action(s) taken to date by local Healthwatch to seek local resolution	None
Related reports or recommendations by the local Healthwatch	Recommendations in the East Lancashire CAB report Not fit for purpose are: • The Work Capability Assessment (WCA) should be reviewed with a view to assessing its suitability in identifying those with limited capability for work. Many clients received zero points when they clearly have issues that impact on their ability to work; • The descriptors used to award points for mental health should be reviewed; • Where mental health conditions are present a

	specialist in mental health should carry out the WCA; • There should be clear feedback from the Tribunal Service to the DWP to provide guidance to their decision making, so that there is a reduction in the high proportion of decisions which are subsequently overturned at appeal; • Improve DWP staff training to ensure the decisions that are made use all of the medical reports available and not just rely on the ATOS report; • Improve DWP staff training, to ensure claimants understand their right of appeal and raise their awareness of other benefits they may be entitled to. This is of critical importance to prevent financial hardship; • ATOS staff need urgent training, to address their behaviour towards claimants when we have a situation where so many clients describe them as rude, insensitive and uncaring; • Better procurement arrangements are needed to ensure value for taxpayer money over future medical services contracts. The current contract is clearly not fit for purpose.
Description of any expectations of local Healthwatch	That Healthwatch England sees if the findings resonate with other Healthwatch groups throughout the country and that Healthwatch England contribute to the debate
Action taken	Healthwatch England sent a letter to Dr Paul Litchfield who his leading an independent review of the Work Capability Assessment outlining these concerns

NHS England's complaints process

Name of the local Healthwatch	Healthwatch Gloucestershire
Date of escalation	3rd October 2013
Date(s) relating to the risk or concern	4th October raised with NHS E 21st October response from NHS E 22nd October updated Healthwatch Gloucestershire
Description of the risk or concern	Healthwatch Gloucestershire raised concerns about NHS England's complaints process. As a commissioner of primary care services, members of the public should be able to complain to NHS England about those primary care services commissioned by NHS England. However, instead people were being signposted to the primary care service or

	even to PALS. Healthwatch England received assurances about the actions being taken to improve NHS England's handling of complaints.
Source of the risk or concern	Feedback from PALS to the Healthwatch
List of agencies or individuals involved	NHS E Local PALS
action(s) taken to date by local Healthwatch to seek local resolution	Not known
related reports or recommendations by the local Healthwatch	None
Description of any expectations of local Healthwatch	Local Healthwatch wanted Healthwatch England to clarify the approach NHS E is taking to handling complaints
Action taken	Healthwatch England sought further clarification about how NHS E's complaints process is being implemented in practice when an individual contacts them to raise a complaint about primary care services. NHS E confirmed that calls come into Redditch and are triaged within 24hrs with safe guarding and clinical safety issues pulled out and acted on. If it is a complex or national issue the complaint will stay with the Leeds based team. If it is a local issue, it will be passed to NHS England area team to resolve. The area teams have their own separate processes and approaches and NHS England confirmed there was variation in approaches and they could not comment on how an individual local area team acted on complaints. NHS England confirmed that where an individual does not give consent to share information with the provider, that the complaint falls but that NHS England still notes this intelligence. Healthwatch England is now working with NHS E as part of the Department of Health's Hard Truths complaint programme board to align improvement and reform activity across the system.

Access to individuals anonymised data

Name of the local Healthwatch	Healthwatch Derbyshire
Date of escalation	11th October
Date(s) relating to the risk or concern	None
Description of the risk or concern	Healthwatch Derbyshire raised concerns about the proposal (care.data) to extract information from IT systems within general practice, marry it up with patient information from other provider IT systems all at the Health and Social Care Information Centre, and then use the information to help the

	NHS make better choices. The Healthwatch was concerned that some people were uncomfortable with several elements of the process, including the disclosure of anonymised data to approved third parties, such as BUPA, and the process of informing the public about this initiative to give a reasonable opportunity to opt out, which should be the patient's choice. There was also a concern that the proposed information about this process was unclear and people could not make an informed choice about whether they should remain opted in, or opt out.
Source of the risk or concern	Local patient group meeting
List of agencies or individuals involved	NHS England
Action(s) taken to date by local Healthwatch to seek local resolution	None
related reports or recommendations by the local Healthwatch	None
Description of any expectations of local Healthwatch	To raise the concern with NHS England
Action taken	We tested the strength of this concern through our regional network meeting and in one to one conversations through the development team, which identified wider concern about the proposals. We shared these with NHS England. In January 2014 we followed up these concerns with local Healthwatch and found that 1 in 4 now had subsequent concerns about the information and communications that were being set to consumers. They collectively highlighted that consumers were unable to make an informed decision about whether or not to opt out of the programme. As a result, we used out our information and advisory powers to write to David Nicolson (CEO of NHS England) calling on them to delay the roll out until consumers can make an informed decision. We received significant local and national media coverage, which helped to shape the national debate around care.data. We are now in discussion at an executive level with NHS England about next steps and the information people will need to make an informed choice.

GP charging for letters

Name of the local Healthwatch	Healthwatch Cornwall
Date of escalation	22nd October 2013
Date(s) relating to the risk or concern	None

Description of the risk or concern	Healthwatch Cornwall raised the issue of GPs charging patients for letters in support of the patient's claim to the Department for Work and Pensions for disability or sickness benefits which is causing considerable distress for people. It is the responsibility of the claimant to provide a medical letter in support of their claim, which has been written by a health professional, and GPs are charging up to £70 for this service, which if the patient is not yet in receipt of the benefit is not affordable for them. The local Healthwatch also highlighted the guidance from the Local Medical Committee advising doctors not to provide medical evidence to the Department of Work & Pensions (DWP) and ATOS and the subsequent problem this may cause.
Source of the risk or concern	People using GP services feeding back to local Healthwatch
List of agencies or individuals involved	Local Medical Committee NHS England DWP
Action(s) taken to date by local Healthwatch to seek local resolution	The LMC guidance to GPs states that the LMC considers that it is not appropriate for the GP to be asked for letters of support or letters to confirm care needs. GPs are not resourced to provide this service. Time taken up with paper work is time taken away from direct patient care. Healthwatch Cornwall raised a formal letter to NHS England on July 3, 2013, requesting a formal response from NHS England around any action which may be taken to alleviate the financial pressure on the patient to provide this information to the Department for Work and Pensions. NHS England's letter of July 17, 2013, responded to the formal letter by stating its commitment to scheduling a meeting with ATOS to *"make the whole process more consistent and clearer to patients and GPs"*. The Devon, Cornwall and Isles of Scilly NHS Area Team have advised, Oct 16, 2013, that they been in touch with the National Support Centre about these issues and are taking action to meet up with the Medical Director of the DWP to discuss how they can work together to refine the process and make it more sensitive to the issues of mental illness.
Related reports or recommendations by the local Healthwatch	Healthwatch Cornwall recommends that: • Healthwatch England use their national status to investigate if Cornwall is the only region with this concern; • Healthwatch England requests a formal meeting with the DWP to highlight this specific issue affecting patients.

Description of any expectations of local Healthwatch	As above
Action taken	Healthwatch England has sent a letter to Dr Paul Litchfield who his leading an independent review of the Work Capability Assessment outlining these concerns and request a meeting with us and the local Healthwatch

NHS dentists taking on patients

Name of the local Healthwatch	Healthwatch York
Date of escalation	29th October 2013
Date(s) relating to the risk or concern	18th Nov: Raised with NHS E 20th Nov: Response from NHS E 26th Nov: Local Healthwatch updated
Description of the risk or concern	Healthwatch York raised their concerns that the record of NHS dentists taking on patients that is held on NHS choices is not up to date
Source of the risk or concern	Not known
List of agencies or individuals involved	Age Concern York Local Dental Committee (LDC) NHS England
Action(s) taken to date by local Healthwatch to seek local resolution	Contacted LDC who said this information is only available through NHS choices and not in any other format.
related reports or recommendations by the local Healthwatch	Not known
Description of any expectations of local Healthwatch	Healthwatch England to confirm if the list is up to date and to see if we can get an electronic copy that can be cascaded to local Healthwatch
Action taken	Healthwatch England asked NHS England to confirm if the list is up to date and for an electronic copy that can be cascaded to local Healthwatch. NHS England responded that they were reliant on surgeries updating all the information that goes on NHS Choices. NHS England was reliant on the NHS choices database and did not have a separate electronic list

Access to GP practice data on complaints

Name of the local Healthwatch	Healthwatch Camden
Date of escalation	29th October 2013
Date(s) relating to the risk or concern	11th Nov: Raised with NHS E 18th Nov: interim response from NHS E
Description of the risk or concern	Healthwatch Camden asked to see the number of complaints, complaint subject, and the percentage of complaints upheld, at a practice level to help develop their understanding complaints across their borough. Publically available data was too general to be of much use
Source of the risk or	Healthwatch officer

concern	
List of agencies or individuals involved	NHS England Local practices
Action(s) taken to date by local Healthwatch to seek local resolution	Had being approaching GP practice on an individual basis to attempt to obtain the information
Related reports or recommendations by the local Healthwatch	Not known
Description of any expectations of local Healthwatch	Healthwatch England asked for this information from NHS E to share this data with local Healthwatch
Action taken	Healthwatch England asked NHS England for this data and are still in discussion with them on this issue. NHS England confirmed that they would need to liaise directly with local teams to get data as it was not held centrally. Upon further investigation, NHS England reported that there may be some data available in March when Local Area Teams require data from GPs on this issue, but it would not be collected in a consistent format across the network, nor would it be centrally available. In the past, GP's routinely reported this information to Primary Care Trust's (PCT) in their annual returns. The current reporting categories still refer to PCT's and other outdated models. NHS England is currently in the process of going out to tender for a new CRM system to handle complaints, though stated that even with the new system, complaints may still not be centrally available. NHS England invited us to contribute to their preparing of the tender by recommending what data should be captured by the new system. Healthwatch England is now working with NHS E as part of the Department of Health's Hard Truths complaint programme board to align improvement and reform activity across the system.

Access to NHS 111 for people who are deaf, hard hearing or deaf blind

Name of the local Healthwatch	Healthwatch Staffordshire
Date of escalation	5th November 2013
Date(s) relating to the risk or concern	18th November: Raised with NHS E 9th December: Response from NHS E
Description of the risk or concern	Healthwatch Staffordshire raised the issue that NHS 111 is inaccessible to a majority of deaf, hard of hearing or deaf blind people who prefer to use their mobile phones for texting. NHS 111 can only be used via minicom or Text phone which is still inaccessible to a majority of people who are deaf, hard of hearing or deaf blind. BSL is also not available on NHS Choices.

Source of the risk or concern	Local groups including DEAFvibe that the Healthwatch has been working with
List of agencies or individuals involved	DEAFvibe DH Commissioning Support Unit (CSU) NHS E
action(s) taken to date by local Healthwatch to seek local resolution	DEAFvibe had received a response from NHS choices email but which was not felt to address the points that had been raised. The local Healthwatch had therefore referred this matter to our local CSU re the commissioning of 111 services, but as NHS 111 is commissioned regionally but based on a national service specification it was being escalated to Healthwatch England.
related reports or recommendations by the local Healthwatch	None
Description of any expectations of local Healthwatch	That Healthwatch England raise this with NHS E to see if the specification can reflect the concerns
Action taken	Healthwatch England raised this with NHS England who agreed this would be a priority area for improvement in the design of the future NHS 111 service. NHS England have set up meetings with various groups around deaf, hard of hearing and deaf blind requirements. NHS England have also agreed that Healthwatch should be involved in the design of the new NHS 111 service specification.

Lack of consultation in service change

Name of the local Healthwatch	Healthwatch Stockport
Date of escalation	9th December 2013
Date(s) relating to the risk or concern	20th January 2013: Response to local Healthwatch
Description of the risk or concern	Healthwatch Stockport has raised the issue of the lack of consultation on the possible changes to the commissioning of cancer services in Greater Manchester and Cheshire and has written to Monitor on this matter. Monitor is already investigating a complaint around this issue from University Hospital of South Manchester and Stockport NHS Foundation Trust. This is a particularly important concern for Stockport as Stepping Hill Hospital, the hospital currently providing urology services in the borough, may well lose provision of cancer services, thus causing potential problems for the community. Consultation on matters of this nature is mandatory and it is disappointing that Healthwatch Stockport has not been recognised as a relevant body in the consultation process. This is not an isolated incident, as the same situation has arisen in the past, requiring the raising of similar concerns with other bodies.

Source of the risk or concern	The core group of Healthwatch Stockport (which advise the board)
List of agencies or individuals involved	Not known
Action(s) taken to date by local Healthwatch to seek local resolution	Not known
Related reports or recommendations by the local Healthwatch	Not known
Description of any expectations of local Healthwatch	Healthwatch Stockport wishes to advise Healthwatch England of these apparent failings, in general, in the hope that some action can be taken to avoid such problems escalating to wider scale across the country
Action taken	Contacted local Healthwatch clarifying the requirements in relation to public consultations. We plan to put out a general call to the Healthwatch network, asking if other local Healthwatch have had similar issues of exclusion from service redesign. We also hope to alert other local Healthwatch to the recent guidance recommending their inclusion in public consultation on service changes. If this problem appears to be a general issue, we would work with NHS England and the Department of Health to improve public involvement guidance for Clinical Commissioning Groups and ensure that public voices are heard.

Lack of ability to raise concerns about a service

Name of the local Healthwatch	Healthwatch Camden
Date of escalation	13th January 2013
Date(s) relating to the risk or concern	None
Description of the risk or concern	The lack of pre-complaints services in Camden for consumers who wish to raise a concern about their GP. Such a service, similar to PALS in NHS Trusts would enable people to resolve the concern, as opposed to it becoming a complaint
Source of the risk or concern	Do I have my say? Finding information about making a complaint at Camden GP Surgeries: a mystery shopping project
List of agencies or individuals involved	Camden GP surgeries Camden Clinical Commissioning Group (CCG)
Action(s) taken to date by local Healthwatch to seek local resolution	Results shared with Camden GP practices and Camden CCG
Related reports or recommendations by the local Healthwatch	That Healthwatch England work with NHS England to review the effectiveness of the complaints process in primary care, including general practice and to recommend improvements in it That Healthwatch England work with NHS England and other partners to review the support available for people making

	complaints in primary care and to clarify the role of local Healthwatch in this
Description of any expectations of local Healthwatch	Healthwatch England to raise with NHS England as part of the complaints work
Action taken	Healthwatch England will raise this concern with the Department of Health's Hard Truths complaint programme board at its next meeting to determine a resolution

Waiting lists for adult social care assessments

Name of the local Healthwatch	Healthwatch Cambridgeshire
Date of escalation	13th January
Date(s) relating to the risk or concern	None
Description of the risk or concern	Healthwatch Cambridgeshire has established that there are long waiting lists (in some cases up to a year) for adult social care assessments. Once assessed, there is a further wait for a package to be arranged – the 'pending list'. Healthwatch Cambridgeshire has had reassurances that the County Council are actively seeking to reduce this and that everyone is appropriately triaged. But they are obviously concerned and have escalated to the council's adult wellbeing and health overview and scrutiny Committee. The local Healthwatch think this needs to be looked at nationally. Healthwatch Cambridgeshire is wondering what other areas experiences are and are requesting a report on progress.
Source of the risk or concern	CEO and Chair of Healthwatch Cambridgeshire
List of agencies or individuals involved	Local adult wellbeing and health overview and scrutiny Committee (OSC)
action(s) taken to date by local Healthwatch to seek local resolution	Healthwatch Cambridgeshire has raised the issue with OSC
Related reports or recommendations by the local Healthwatch	None
Description of any expectations of local Healthwatch	The local Healthwatch would like Healthwatch England to consider an assessment of the national position
Action taken	Currently under consideration

Annex B: Healthwatch England and NHS England Memorandum of Understanding

NHS England and Healthwatch England
Memorandum of Understanding

'How we work together'

Our commitment

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, to support our shared purpose of improving health and wellbeing outcomes for consumers, patients, carers, families and communities.

This memorandum is not a legal document; it is intended to provide a common understanding between NHS England and Healthwatch England of our shared vision, objectives and values and the key areas where we will work closely together and challenge each other to improve outcomes. It does not constrain either organisation in carrying out its roles and responsibilities as set out in the Health and Social Care Act 2012 and under direction from the Secretary of State.

Our organisations

NHS England
NHS England is an independent body which operates at arms-length to the Government. It is responsible for improving patient outcomes; promoting the NHS Constitution; promoting equality and reducing health inequalities and ensuring that the NHS operates within the resources available.

Healthwatch England
Healthwatch England is established as a committee of the Care Quality Commission (CQC) to act as an effective, independent consumer champion making real differences to consumers of health and social care.

The role of Healthwatch England is to challenge the service providers to provide high quality health and social care; support the development of local Healthwatch to act as a consumer champion, to engage with local communities and work in partnership with local service providers, and to raise awareness of both good practice and areas on concern in the provision of health and social care in local communities.

Our shared purpose

We will work together towards our shared goal of high quality health and social care. Our shared priority is to secure the best possible health outcomes for consumers, patients and the public, particularly the most vulnerable, looking beyond traditional boundaries to prioritise consumers in every decision. This will include:

- supporting the development of effective local Healthwatch organisations;

- leading the healthcare system in developing a culture where patients and consumers can participate throughout the system; and
- focusing on improving the experiences and outcomes of consumers and patients, through recognising the importance of the consumer voice as a signal of quality and safety, and responding to feedback and complaints to improve services in health care.

Values and Behaviours

- **Ambitious for patients:** Actively engage with patients and with the NHS to focus on improved services and outcomes for patients, families and carers.

- **Constructive:** Be open and honest in our conversations. Actively seek solutions through consensus whilst respecting challenge and independence.

- **Sharing a vision:** Collaborate on the 'end state' for what we are trying to achieve with respective roles made clear from the start.

- **Enduring and forward looking:** Recognise the need to work collaboratively as well as individually and ensure we deliver to a high-standard.

- **Respectful and supportive:** Support each other in our engagement and communications with the patients and with the NHS.

- **Professional:** Recognise the need to work collaboratively as well as individually and ensure we deliver to a high-standard of work. Respect our separate statutory responsibilities and Healthwatch's role as an independent consumer champion, whilst working together in the best interests of consumers and patients.

- **Transparent:** Share work and information in a timely manner. Be open about our work both with each other and with patients, families and carers. Share information, intelligence and insight into experiences of health and care services in an open and constructive way.

- **Trusting:** Providing challenge and being open to challenge.

Our joint priorities

NHS England and Healthwatch England will agree a shared workplan on an annual basis. This will be reviewed on a 6 monthly basis. The workplan will include the following areas:

- Ensuring that local Healthwatch and Healthwatch England have effective, constructive and challenging relationships with NHS England at all levels of the system, through engaging with the Healthwatch network in national consultation, and specialised and direct commissioning.

- Joint campaigning on the work of Healthwatch England and NHS England to encourage greater public influence, particularly for the most vulnerable and for those that experience the worst health outcomes.

- Developing mutual intelligence strategies that maximise the impact of intelligence gathered from local Healthwatch, including through the alignment

and greater sharing of data and including a Healthwatch data section on the NHS England Dashboard.

- Sharing learning about good patient and public participation.

- Working together to support the development of an effective complaints system for patients including sharing intelligence, giving regular feedback and improve how complaints are listened to and acted upon.

- Working together on the development of key policies and programmes in NHS England and identifying coalitions of interest, including upcoming policy development (including the future and development of commissioning) and upcoming events (including the Healthcare Innovation Expo 2014).

Governance arrangements

Senior level governance

NHS England and Healthwatch England will meet at a senior level, through:

- Twice-yearly meetings between the Chairs of NHS England and Healthwatch England to monitor the quality and discuss the strategic direction of the relationship between our organisations;
- Twice-yearly meetings between the Chief Executives of NHS England and Healthwatch England, including the National Medical Director and the Chief Nursing Officer, to agree priorities and discuss key issues between our organisations;
- Quarterly meetings between the Directors of NHS England and Healthwatch England, including the Directors on Policy, Patients and Information and Commissioning Development.

In addition, NHS England and Healthwatch England will have in place a reciprocal agreement for the Chair (or Board Members) or Chief Executive of NHS England to present at the Healthwatch England Committee meeting once per year and for the Chair or Chief Executive of Healthwatch England to present at the NHS England's public board meetings.

Day to day working relationships
We will develop positive and proactive day-to-day working relationships between our organisations across the breadth of our shared priorities identified above. We will operate a matrix model to ensure that Healthwatch England can engage across the organisation. The Public Voice team at NHS England will support these relationships. Operational meetings will take place between members of the public voice team and Healthwatch England staff a minimum of 4 times per year.

Communication
NHS England and Healthwatch England will communicate regularly. We will be open and proactive about sharing information and inviting contributions and engage regularly between the relevant staff teams at the operational level. Both organisations will seek to engage and inform the other at the earliest possible opportunity and wherever possible ensure that key developments are communicated in advance of public announcements consistent with the 'no surprises' values of transparency and supportiveness.

Review
This working agreement will be reviewed annually.

…………………. Date

Dr Katherine Rake

Chief Executive
Healthwatch England

…………………. Date

Simon Stevens
Chief Executive
NHS England

Annex B – Healthwatch England Business Plan

healthwatch

Healthwatch England

Business Plan 2014-15

Our Vision and Mission

Our vision is to create a world in which consumer rights and responsibilities in health and care are understood and delivered.

Our mission is to be the national consumer champion in health and care.

We will achieve this by:

- Understanding what matters most to consumers, especially those least included, by always starting with their needs and rights;
- Influencing those who have the power to change design and delivery of services so they better meet the needs and rights of users;
- Leading the Healthwatch network to ensure their local insight has national impact and our national insight has local impact.

Our Priorities for 2014-15

Our aim for 2014-15 is to show the impact and value of Healthwatch in everything we do.

We have identified four strategic priorities for 2014-15 to deliver on our vision and mission:

- Identifying concerns and risks and challenging others to take action;
- Advancing consumer rights and responsibilities;
- Promoting the design and delivery of services around the needs of a person;
- Developing the potential of the Healthwatch network.

Our Values

We have adopted five values to inform our work at Healthwatch England.

These are:

Inclusive

- We start with people first.
- We work for children, young people and adults.
- We work across health and care.
- We work for everyone, not just those who shout the loudest.

Influential

- We set the agenda and make change happen.
- We are responsive. We take what we learn and translate it into action.
- We are innovative and creative. We know that we can’t fix things by sticking to the status quo.
- We work with our network of local Healthwatch to make an impact both locally and nationally.

Independent

- We are independent and act on behalf of all consumers.
- We listen to consumers and speak loudly on their behalf.
- We challenge those in power to design and deliver better health and care services.
- We are not afraid to point out when things have gone wrong.

Credible

- We value knowledge.
- We seek out data and intelligence to challenge assumptions with facts.
- We celebrate and share good practice in health and care.
- We hold ourselves to the highest standards.

Collaborative

- We keep the debate positive and we get things done.
- We work in partnership with the public, health and care sector, voluntary and community sector.

Healthwatch England Strategic Priorities

1. Identifying concerns and risks and challenging others to take action

This priority will be met through:

- The escalation of consumer risks and concerns;
- Engaging with the Inspection regimes;
- Identifying national trends and areas of concern and using our special inquiry powers;
- Promoting our own complaints handling.

1. Healthwatch England will ensure **risks and concerns of consumers are escalated.** This will involve delivering training to the network and providing on-going support in escalation procedures. In addition it will require Healthwatch England proactively to analyse the information bank to identify issues of concern and undertake analysis to report on what has been escalated. A critical element of this work will be working with partners, including using advisory powers, to inform and advise necessary changes in practice.

2. Healthwatch England will support the network to **engage and shape the new inspection regimes.** This work will enable us to deliver engagement from Healthwatch tailored for the different approaches, and scale, of each of the inspection regimes. Healthwatch England will provide a clearing house for learning among Healthwatch and a driver of improvement in the inspection process in its advisory role to CQC. The engagement of Healthwatch England will ensure in particular that the network is equipped to support local service improvement post-inspection.

3. Healthwatch England will use multiple sources of intelligence and insight to identify **national trends in consumer risks and areas of concern**. This will inform Healthwatch England's work and help build the evidence base across the whole Healthwatch network. Healthwatch England undertakes special reports and inquiries solely or jointly into substantive and systemic areas of public concern. Our first special inquiry of the year will focus on people who are discharged from hospital, nursing or care homes or other secure settings without adequate assessment of their on-going needs or sufficient support.

4. Healthwatch England will further develop its processes of managing and handling of **public enquiries, concerns and complaints.** The enquiries received to date have been complex and sensitive. Good handling requires training in safeguarding, information governance and health and care issues and the development of effective signposting. Investment in enquiries handling will also ensure learning from these individual cases is driven through the organisation and in particular informs the Policy and Intelligence function.

2. Advancing consumer rights and responsibilities

There are four strands to this priority for 2014/15:

- Demonstrating how the complaints and concerns system must change to better meet consumer needs;
- Promoting understanding of otherwise seldom heard, marginalised or excluded communities;
- Developing the consumer rights framework and an index to measure how far rights are being realised;
- Reporting annually on the views and experiences of consumers as well as on the status of the Healthwatch network.

1. In 2013-14, we looked at the current complaint system through the eyes of the consumer: this showed that consumers do not have confidence in the current system which is too often complex, slow and unresponsive. This year, **we will work to secure changes that improve the handling of feedback, concerns and complaints**. We will do this by supporting the Healthwatch network to challenge providers and commissioners to improve their complaints system. We will provide information for a consumer that sets out their rights to raise a concern and what they should expect from complaints and advocacy services. We will work with the Parliamentary & Health Services Ombudsman and others to create a vision for complaints centred on people. We will lead work on complaint handling and advocacy, with a focus on creating a set of national standards for independent complaints advocacy.

2. We will provide a focus on the experiences and priorities of marginalised or excluded communities to inform the work of Healthwatch England and to ensure that the network is fully aware of, and responsive to, the issues affecting diverse communities. This will include providing training and an evidence base that enables Healthwatch across the country to understand and engage fully across the community. Healthwatch England will begin to provide intelligence and information to ensure that the network operates effectively, to understand the needs of their local community, and has the tools to engage, including seldom heard communities.

3. We will develop a **consumer rights index for England,** to measure how far people realise their rights. We will promote the use of the consumer rights framework among local Healthwatch and across the health and care system and starting with the public's input, we will also develop and test an accompanying set of consumer responsibilities in health and care.

4. We will delivery our **statutory annual reporting** functions by publishing the views and experiences of consumers of health and care and we will report back for the first time on the impact and status of the Healthwatch network.

3. Promoting the design and delivery of services around people's needs

Ensuring services are designed around people's needs and with appropriate involvement of consumers will ensure that we get services right for the future. Healthwatch England will deliver this by:

- Supporting the Healthwatch network to use its local influence to best effect;
- Supporting local Healthwatch to work effectively with consumers to understand their rights through information and signposting;
- Exercising Healthwatch England's advisory powers formally and informally to ensure that consumer concerns are heard at a national level;
- Influencing the debates about, and consumer involvement in, service design. This will include the transformation, reconfiguration and integration of health and care services.

1. Healthwatch England will support the network to **use local influence** to best effect, making a positive impact on service design and delivery. As part of this, we will support local Healthwatch to use their seat on the Health and Well Being Boards and other commissioning and quality oversight groups to best effect.

2. We will support local Healthwatch to work with consumers to understand their rights through effective **information and signposting** services as well as by providing targeted campaigns to raise awareness, for example around complaints.

3. Healthwatch England will exercise its formal and informal advisory roles, to ensure that providers, commissioners and regulators are focussed on consumer needs when designing services. This will enable us to **voice consumer concerns on major national debates** on a set of priority issues.

4. We will support Healthwatch to engage **in major debates about service change**, including where services are being redesigned, restructured, merged or closed. We will provide leadership on the debate about the integration of health and care services and will support local Healthwatch to influence and inform local delivery of the Better Care Fund.

4. Developing the potential of the Healthwatch network

Healthwatch England will develop the potential of the Healthwatch network by supporting them, providing leadership, facilitating their own peer support, learning and networking and overseeing the functioning of the network.

1. Our support offer will be targeted at developing the capability and capacity of the network. We will continue to invest in their training and development and in particular support them to understand their local health and care context so that they are best equipped to make an impact on behalf of their local communities. We will also provide centralised services where it is cost effective to "buy in bulk". In addition to achieving savings, these will help promote consistency of service across the network.

2. We will facilitate the network and catalyse their resources by providing the platforms and spaces for them to connect around common issues of concern, learn from one another and develop and sustain communities of interest that enable expertise to be fostered in, for example, children and young people, dementia, mental health or domiciliary care. We will support the coordination of Healthwatch at a regional or national level to encourage work on services that cross boundaries or are decided at a national level. We will encourage work in areas of particular policy concern – for example complaints advocacy.

3. Our leadership function will focus on promoting and sharing good practice among the network and developing and promoting standards of delivery. We aim to encourage a focus on social impact among all Healthwatch. We will support the network to develop a learning and evaluation culture and commissioning independent evaluation of the network's effectiveness.

4. We will gather robust quantitative and qualitative evidence about Healthwatch in practice. Beyond data about how the network is functioning and who the network is reaching, we want to share practice examples across the network. We will support local Healthwatch to show how they are working to make a difference to their local communities.

5. Delivering value for Public Money

Even with our limited resources, we value the importance of being able to punch above our weight in our efforts to champion the cause of consumers in health and care. Our responsibility for this extends to the network and we will focus our efforts on creating transparency about the financing of Healthwatch England and the network and on promoting good standards among local Healthwatch.

Another way to create cost savings nationally is in our model of support of the Healthwatch network. Providing leadership, training and practical communications and policy support, realises an overall efficiency in the ability for all Healthwatch

to deliver on their statutory responsibilities. To quantify this efficiency, Healthwatch England will be modelling the level of savings achieved to date and those that we will deliver through this current business plan.

We will continue to work with the Care Quality Commission to maximise efficiency through shared services and to identify any further efficiency savings which could be sourced through the year and in preparation for 2015-16. This includes establishing service level agreements with the Care Quality Commission for the provision of IT support, Human Resources support, finance, legal and procurement services. We will also look to choose the most cost-effective, value-for-money agreements for services that we must source externally.

In the longer term, an approach based on the consumer and one that searches for solutions will ensure that public resource is spent in the way that best meets consumers' needs. Putting consumers' voice at the centre of health and care will help ensure that institutions are responsive to needs. We recognise that the consumers' voice is a unique signal of quality and safety and listening and acting upon consumers' views is a critical element of improving the delivery and performance of the services.

6. Working with our Partners

We have identified the importance of working in partnership with the health and care sector, and voluntary and community sector, as one of our five organisational values. Working with our partners in the health and care system is one of our most important foundations to achieving our strategic priorities and how we may get the most from our limited resources.

In our first year our focus was to build strong working relationships with our strategic partners, and raise our profile with charities and professional associations working in health and care. This included signing agreements with the Department of Health, the Care Quality Commission, the Local Government Association, NHS England and Monitor setting out how we will work together with openness, collaboration, cooperation and communication.

In 2014-15, we intend to build on these good relationships, and develop joint work programmes based on our common interests with Public Health England, Health Education England, NICE, the NHS Trust Development Authority and the Social Care Institute for Excellence. Our priorities in this work are to focus on activities in which we can voice consumer concerns on major national debates.

We will continue our work with charities, the voluntary sector and professional bodies, to work to ensure consumers are at the heart of health and care. This includes organisations such as the General Medical Council, Ofsted, the Nursing and Midwifery Council, the Royal College of GPs and Royal College of Physicians, British Medical Association, National Association of Primary Care and Which?

We will also be working with stakeholders to establish a greater awareness of consumer rights. This work will be done through both formal and informal advisory roles, with the focus to ensure that providers, commissioners and regulators are focused on consumer needs when designing services.

7. Promoting inclusion

We are compliant with the Public Sector Equality Duty: as a statutory committee within the Care Quality Commission we promote the values published in its Equality, Diversity and Human Rights Policy. At Healthwatch England, our staff enjoy working in an environment where they are valued, involved, supported and feel safe from discrimination.

We will build upon the legally enforceable equalities framework and go further. Our first organisational value is 'Inclusive' and we will promote this through a Diversity and Inclusion Strategy to inform all operations of the organisation. The development of this key document is being undertaken by the Chief Executive and Head of Operations of Healthwatch England, and supported by the expertise of select Healthwatch England Committee members to ensure that the principles included in the strategy draw on best practice.

We encourage similar values across the Healthwatch network, promoting equal opportunities, engagement with their local communities, including seldom-heard communities, and encouraging the involvement of volunteers from a wide range of backgrounds and experiences.

Annex D: Background to the Duty of Candour

1. Introduction

Candour has been defined as "the volunteering of all relevant information to persons who have, or may have, been harmed by the provision of services, whether or not the information has been requested, and whether or not a complaint or a report about that provision has been made."[1]

Calls for a statutory Duty of Candour date back to 1985, when court cases highlighted the lack of any legal duty to disclose harm in the medical arena.[2] Since then, various laws have increased transparency with regard to medical data. "The Data Protection Act 1998 allows a patient to make an application to see his/her medical records. The Access to Health Records Act 1990 allows the patient's personal representatives access after death."[3] Despite these developments, there is still no legal duty to volunteer information, only to comply with requests for it.

In 1999, the General Medical Council (GMC) introduced a professional duty to explain the reasons for a child's death to parents, prompted by the Robbie Powell case.[4] The Health Select Committee supported the professional obligation over the statutory duty, and recently recommended adding it into commissioning practices:

"that a Duty of Candour between commissioners and providers be introduced into commissioning contracts; that a Duty of Candour to patients from providers should be part of the terms of authorisation of foundation trusts by Monitor; and that commissioning authorities should be placed under a Duty of Candour to their local populations and their Local Healthwatch organisations."[5]

The Department of Health (DH) has disputed the necessity of a statutory duty, asserting that the professional and contractual duties are sufficient. In February 2012, the Government supported this reasoning with GMC research showing that transparency systems were improving, and pointed to both the contractual duty to raise problems and the introduction of Responsible Officers obliged to ensure that staff were fit to practise.[6]

2. Current laws and regulations relating to the Duty of Candour

The NHS constitution has a goal of openness and transparency with patients, but it is not presented as a binding duty upon NHS staff.[7] DH (particularly with regard to coroners' reports),[8] the NHS Litigation Authority (NHSLA)[9] and other bodies also encourage openness and transparency in their work. There is a statutory duty to report a range of safety incidents to the National Patient Safety Agency (NPSA) or Care Quality Commission (CQC).

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[1] The Mid Staffordshire NHS Foundation Trust Public Inquiry, Chaired by Robert Francis QC. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (February 2013) (hereafter, "Francis report"), at 22.1. Available at: http://www.midstaffspublicinquiry.com/report

[2] *Lee v SW Thames Regional Health Authority* [1985] 2 All ER 385, 389 (CA); *Naylor v Preston Area Health Authority* [1987] 2 All ER 353, 360, as cited in Francis at 22.103-22.104.

[3] Francis report at 22.107.

[4] Robbie Powell was a 10-year-old child who died from Addison's disease. Robbie was misdiagnosed with a different condition, and his medical records were variously tampered with and lost. Action against Medical Accidents has advocated naming the statutory Duty of Candour for Robbie. More information on his case can be found at: http://www.avma.org.uk/data/files/robbies_story__updated_july_2008.pdf

[5] Francis report at 22.125.

[6] Francis report at 22.143.

[7] NHS Constitution, page 8. Available at: http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/the-nhs-constitution-for-england-2013.pdf

[8] Guidance for Access to Health Records Requests, (February 2010) Department of Health, at 26.

[9] Francis report at 22.135

3. The professional Duty of Candour

The duty as it is currently stated comes from a variety of sources. The former Council for Healthcare Regulatory Excellence (now the Professional Standards Authority (PSA)) historically supported a statutory Duty of Candour for organisations, in addition to the duties placed upon professionals. They are presented here by profession.

- Doctors: the GMC regulations, *Good medical practice*, specify under "Show respect for patients," that:

    - 'You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you should:

- put matters right (if that is possible)
- offer an apology
- explain fully and promptly what has happened and the likely short-term and long-term effects.'[10]

- Nurses: Nursing and Midwifery Council regulations call for nurses to "be open and honest, act with integrity and uphold the reputation of your profession", to give "a constructive and honest response to any who complains about the care they have received", to "act immediately to put matters right if someone in your care has suffered harm for any reason" and to "explain fully and promptly to the person affected what has happened and the likely effects."[11]

- Managers: the Code of Conduct for NHS Managers requires that they should "seek to ensure that…patients….are involved in and informed about their care." This code does not apply to Foundation Trust employees.[12]

- Opticians: do not have a specific Duty of Candour.[13]

- Osteopaths: are required to be open and honest in their dealings, do not have a specific Duty of Candour.[14]

- Dentists: do not have a specific Duty of Candour.[15]

- Chiropractors: the code makes general statements about openness and honesty, but creates no specific Duty of Candour.[16]

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[10] General Medical Council, Good medical practice, at 55. Available at: http://www.gmc-uk.org/guidance/good_medical_practice.asp

[11] Nursing and Midwifery Council, The code: Standards of conduct, performance and ethics for nurses and midwives, at 7. Available at: http://www.nmc-uk.org/Documents/Standards/The-code-A4-20100406.pdf

[12] Department of Health, Code of Conduct for NHS Managers, at 4. Available at: http://www.nhsemployers.org/SiteCollectionDocuments/Code_of_conduct_for_NHS_managers_2002.pdf

[13] General Optical Council, Standards in Conduct. Available at: http://www.optical.org/en/Standards/Standards_in_conduct.cfm

[14] General Osteopathic Council, Osteopathic Practice Standards, at D7. Available at: http://www.osteopathy.org.uk/uploads/osteopathic_practice_standards_public.pdf

[15] General Dental Council, Standards for the Dental Team. Available at: http://www.gdc-uk.org/Dentalprofessionals/Standards/Documents/Standards%20for%20the%20Dental%20Team.pdf

[16] General Chiropractic Council, The Code of Practice and Standard of Proficiency. Available at: http://www.gcc-uk.org/good-practice/

- Pharmacists: do not have a specific Duty of Candour.[17]

- Other registered health and care professions: do not have a specific Duty of Candour. [18]

4. Francis report

The Francis report drew substantial attention to the Duty of Candour, looking to the impact of the lack of transparency at Mid-Staffordshire. The inquiry took testimony from Dr Bill Moyes, the former Executive Chairman of Monitor, who noted that the culture of the NHS seems focused on not embarrassing the Minister or the hospital, rather than protecting patients.[19]

The Mid-Staffordshire Trust made a number of false statements of its mortality figures and in its application for Foundation Trust status to promote its own goals and avoid embarrassment. The report also noted many instances in which the coroner was given corrected reports, which had been altered to omit pertinent information and conflicting opinions. The Trust (accurately) argued that it had no legal duty to release all relevant reports on deaths, including Serious Untoward Incident reports.

Francis made a series of policy recommendations in favour of a statutory Duty of Candour. He particularly notes the problems with the professional duties:

- The ways in which that requirement is currently recognised are piecemeal and disjointed, and inevitably do not cover the whole of the ground which should be addressed. Thus, while doctors and nurses have similar (but not identically phrased) obligations placed on them, with similar sanctions available, NHS managers are subject to a much vaguer obligation, and no definable sanctions to back up even that. There is no clearly defined uniform obligation imposed on FT (non-clinical) managers and none at all on their counterparts in the independent sector. Organisations have even less well-defined duties in this regard. Unless steps are taken to evidence the importance of candour by creation of some uniform duty with serious sanctions available for non-observance, a culture of denial, secrecy and concealment of issues of concern will be able to survive anywhere in the healthcare system.

- An overarching Duty of Candour should be defined and enshrined in statute, accompanied in serious, defined situations by criminal sanctions. The duty requires a status higher than a performance standard as it needs to permeate and inform everything that is done when providing healthcare to the public. Observance of the duty can be policed by a regulator with powers in the last resort to prosecute in cases of serial non-compliance or

[17] General Pharmaceutical Council, Standards of conduct, ethics and performance. Available at: http://pharmacyregulation.org/sites/default/files/Standards%20of%20conduct%20ethics%20and%20performance%20July%202012.pdf

[18] Health & care professional council, Standards of conduct, performance and ethics. Available at: http://www.hpc-uk.org/assets/documents/10003B6EStandardsofconduct,performanceandethics.pdf

[19] Francis report at 20.95.

> serious and wilful deception. There is no reason why the CQC cannot do this if given that task: it can be supported by monitoring undertaken by commissioners and others. This does not require every statement made to be vetted for accuracy, but does require the investigation of matters when a complaint is made.[20]

Francis defined candour as "the volunteering of all relevant information to persons who have, or may have, been harmed by the provision of services, whether or not the information has been requested, and whether or not a complaint or a report about that provision has been made."[21] He proposed "A statutory obligation should be imposed to observe a Duty of Candour:

- On healthcare providers who believe or suspect that treatment or care provided by it to a patient has caused death or serious injury to a patient to inform that patient or other duly authorised person as soon as is practicable of that fact and thereafter to provide such information and explanation as the patient reasonably may request;
- On registered medical practitioners and registered nurses and other registered professionals who believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare provider by which they are employed has caused death or serious injury to the patient to report their belief or suspicion to their employer as soon as is reasonably practicable.
- The provision of information in compliance with this requirement should not of itself be evidence or an admission of any civil or criminal liability, but non-compliance with the statutory duty should entitle the patient to a remedy…
- There should be a statutory duty on all directors of healthcare organisations to be truthful in any information given to a healthcare regulator or commissioner, either personally or on behalf of the organisation, in compliance with a statutory obligation on the organisation to provide it."

5. Berwick

- The Berwick report touched on the Duty of Candour briefly, agreeing that patients should have all their questions answered truthfully and information should be volunteered about serious incidents. However, the report did not agree to "an automatic 'Duty of Candour' where patients are told about every error or near miss, as this will lead to defensive documentation and large bureaucratic overhead that distracts from patient care."[22]

[20] Francis report at 22.160.
[21] Francis report at 22.1.
[22] Berwick review into patient safety. *A promise to learn - a commitment to act: improving the safety of patients in England*; at 34. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

6. Clwyd-Hart

The report noted evidence given in favour of whistle-blowing support and a Duty of Candour,[23] and recommended a Duty of Candour in general terms.[24] It did not delve into the area substantially.

7. DH response to Francis

Openness and transparency were a major part of DH's response to Francis and other reports. The key proposals for change were:

- The introduction of a statutory Duty of Candour on healthcare organisations and their directors in the Care Bill.

- A registration requirement for health and social care providers registered with the CQC to uphold the Duty of Candour (noting the already-existing contractual Duty of Candour for NHS Trusts and Foundation Trusts). Boards must also give "full and honest" statements about organisations.

- The creation of a criminal offence for supplying false or misleading information under a statutory or other legal obligation (including performance information) for directors and "senior individuals" (the specifics have yet to be clarified). DH's current intention is to "limit the application of this offence in the first instance to providers of NHS funded secondary care and, more specifically, to the patient level information on outpatient, elective and accident and emergency activity that they are required to provide to the Health and Social Care Information Centre."

- Changing professional standards for doctors and nurses to require them "to be candid with patients when mistakes occur whether serious or not."

- NHS staff and organisations must give truthful information to regulators and oversight bodies, and the CQC would be responsible for policing the duty.

- DH will continue to promote NHS guidance against gagging or confidentiality clauses, and require a new clause in staff contracts which informs them of their rights to make protected disclosures.

- Trusts which have not upheld the Duty of Candour may have their indemnity cover for a claim reduced or removed, and may have to reimburse the NHSLA for compensation paid out.

- A public statement that health organisations must uphold the value of candour.

[23] Department of Health. (October 2013). Report of handling of complaints by NHS hospitals in England by Ann Clwyd MP and Professor Tricia Hart, *A review of the NHS hospitals complaints system: putting patients back in the picture* (hereafter, "Clwyd-Hart review"); at 30. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/255615/NHS_complaints_accessible.pdf

[24] Clwyd-Hart review at 35.

- DH will publish draft regulations on a Statutory Duty of Candour for further consultation.

The response notably did not embrace a general statutory Duty of Candour, nor a criminal offence for untruthful statements made by healthcare professionals. Much of the work in the DH response focused on candour to regulators. While this is important, it also seems implicit: providing false information to regulators would certainly be a violation of existing duties and criminalised under current laws as an analogue to perjury on sworn documents. These provisions may be generally positive, but they do get at the fundamental problem that was meant to be considered by the Duty of Candour.

The precise level of harm triggering the Duty of Candour is still under consideration with DH. The Secretary of State has asked for expert advisors to help him determine whether the duty should be set at ‘serious’ harm or death, or some other level. A duty to report only serious harm or death would be of very limited value, because people and their families are almost always aware of this level of harm. We drafted a letter advising that the level of harm be pitched at least as low as ‘moderate’ levels of harm; the AvMA has also written to express its support of setting the level at moderate harm.

Annex E: Detail behind the proposal

What is the detail behind these proposed positions?

a. Duty of Candour

A statutory Duty of Candour applying to all health and social care staff and organisations is crucial to promoting consumer rights and should be implemented without delay.[25]

The duty gives effect to the right to information and education, a basic and necessary starting point for all consumer rights. Withholding important information from people about their health or care denies them the respect they are entitled to.

Without all relevant information, people are also deprived of their rights to effectively choose what do to about their treatment and care. It also denies them the ability to seek compensation if they are entitled to it, as well as to obtain emotional closure on a harm suffered.

Complete information about one's health and care is also necessary to the right to be involved, and to be an equal partner in one's health and wellbeing. Candour helps to build an effective relationship between providers of health and care services and consumers by treating people with respect. Further, if people cannot feel assured of the candour in health and care, their right to be listened to will also be diminished. Organisations and individuals will also not to be able to learn from their mistakes if consumers are denied the information needed to take actions when things go wrong.

Because of these factors, we see candour as an important way of reinforcing the right to a safe, dignified and quality service. A lack of candour can effect consumers' health and wellbeing by preventing them from acting as they would have had they been in possession of all information.

b. Lack of sufficient existing protection

While many professional codes of practice and contractual duties across health and social care mention candour and openness, we are concerned that these did not act as effective safeguards in the past and will not act as sufficient deterrents in the future. In its extensive review of professional duties of candour, the Professional Standards Authority noted the limits of what professional regulators can do to encourage compliance with the duty, and even day-to-day behaviour in general.[26]

Additionally, many who work in health and care are not regulated by a professional body. Though previous work on the Duty of Candour has been tightly focused on doctors, with some attention to nurses,[27] managers and other staff should be equally obligated to ensure that people receive honest information about their care.

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[25] See also, Professional Standards Authority, October 2013. *Can professional regulation do more to encourage candour when care goes wrong? Learning from academic research to support advice to the Secretary of State*, at 7.24 (hereafter 'PSA report'), noting how a common "standard would eliminate any uncertainty about the importance of candour, thereby helping to resolve tensions arising from divergent professional approaches." Available at: http://www.professionalstandards.org.uk/docs/default-source/psa-library/candour-research-paper---final.pdf?sfvrsn=0

[26] PSA report at 8.8-8.9, "it is less clear that the regulators exert much influence over registrants' fulfilment of this duty."

[27] PSA report at 4.1.

It is important that an explicit statement of intent is made at the outset, so that the public are clear that organisations and individuals who wilfully cover up incidents or obstruct others from being candid will be punished. A statutory duty alone will not be the full resolution of the problems which have been highlighted in recent reports: a wider cultural intervention is needed to promote greater openness, transparency and candour in both health and social care.[28]

Much of the attention on the Duty of Candour has been directed towards medical, and particularly hospital settings, but the duty must be part of a wider movement towards transparency in all forms of care. The mental agony which can be caused by being treated without dignity, or care which leads to physical injury (such as bed sores or atrophy), constitute serious harm. Care consumers may be more aware than health consumers of the shortcomings in their care, but they should still be entitled to an honest explanation of where things have gone wrong, and an apology where harm has been caused.

Finally, we must note that the Duty of Candour is fundamentally counterintuitive: we are asking professionals to encourage and support people in taking adverse actions against them. Typically in legal systems, it would be inappropriate for a potentially opposing party to counsel the other because of the severe conflict of interest. As such, we must consider carefully how to implement a duty which does not ignore the personal interests of the people asked to uphold it.

c. Defining levels of harm in the duty

The duty must apply to any moderate or higher harm which has come to a person as a result of poor treatment or wrongful omissions of care.[29] People should be entitled to truthful, open and complete information about all aspects of their care, and there should be no arbitrary threshold of degree of harm which a person must befall before they are told what has happened. However, in framing an enforceable duty, we must take care to create a workable regime that does not subject professionals to be confused about the meaning of the term 'harm'.

As such, we recommend that the duty apply to all moderate harm incidents and higher as defined by the NPSA, a substantial increase from the current reporting to the CQC of severe harm and death only.

Table 1: NPSA definitions of harm

No harm	Impact prevented – any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care Impact not prevented – any patient safety incident that ran to completion but no harm occurred to people receiving NHS-funded care
Low	Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS-funded care
Moderate	Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care

[28] PSA report at 1.6, noting the importance of professional judgment in ensuring norms, and the potential for perverse effects created by overregulation.
[29] See also PSA report at 3.5-3.6.

Severe	Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care
Death	Any patient safety incident that directly resulted in the death of one or more persons receiving NHS-funded care[30]

d. Defining "harm" itself

Harm must be defined within statute, clearly and broadly, to prevent organisations from attempting to flexibly define conditions as not being 'harmful'. Harm does not necessarily equate to mistakes or wrongdoing, as many complications of treatment or medication are anticipated and predictable, but people must always have a full accounting of how they have been affected by treatment.

Additionally, it is crucial to recognise that harm extends beyond one's physical health into wellbeing and quality of life. An unnecessary stay in hospital can be harmful; restraint or other deprivations of liberty can be harmful; being treated without dignity in a hospital or care home can be harmful. The definition must regard these actions equally, and recognise the many ways a person can be harmed.

e. Applying the duty to individuals and organisations

We welcome the intention for the duty to apply to organisations across health and care, and agree that candour must be at the heart of all health, mental health and social care services, not just hospitals. However, there is a need for a serious conversation about the form of the organisational duty. (This is addressed further in the questions below).

Candour is crucial for all health and social care staff, both in the public and private sectors. The duty must apply to individuals to mark out those who wilfully cover up incidents, do not provide honest accounts or obstruct others from being candid themselves. The duty must be a consistent one across organisations and professions, so that the public and professionals know what information people are entitled to know about their care.

f. Applying sanctions and establishing liability

There should be a strong message about the seriousness of violations of the duty to both individuals and organisations, which criminal sanctions could potentially provide. However, we are concerned that individual criminal sanctions, particularly when applied to front line staff, could perpetuate a climate of fear that could lead to less openness regarding safety issues. The form of institutional criminal penalties also requires careful consideration to ensure the effects of the sanctions appropriately influence organisational behaviour.

Establishing criminal liability for covering up information about serious incidents could be important in avoiding the escalation of the situation and further abuse, neglect and preventable death occurring. However, our legal advice suggests that there are a number of avenues that could be pursued using existing tools such as maladministration, obstructing an inspection, misconduct in public office, professional disciplinary procedures relating to fitness to practice and contractual sanctions. Only if these options are found

[30] This scale was developed by the NPSA. Available at: http://www.npsa.nhs.uk/corporate/news/npsa-releases-organisation-patient-safety-incident-reporting-data-england/

wanting it would be worth thinking about introducing a new offence relating to the Duty of Candour.

g. Ensuring wider cultural change

While we have no doubt that most professionals in health and social care are honest with consumers about complications and mistakes, cases of non-disclosure and silence in the face of unsafe practices have been far too widespread to write off as "a few bad apples" in the system. We must deeply examine why health and social care providers have kept vital information from people to know how to best promote openness.
Professor Sir Liam Donaldson offered the mantra 'To err is human, to cover up is unforgivable, to fail to learn is inexcusable'[31] as he suggested a combination of lowering penalties for error and sharply increasing penalties for non-disclosure. The Duty of Candour helps to shift the balance of personal considerations towards disclosure by creating penalties for obfuscation and dishonesty, but we must also consider removing incentives against disclosure.

h. Lowering the risk of harm

To fully realise the Duty of Candour, there must be lower risks for the substantive admission than for a failure to comply with the duty. While the risk of the substantive admission will vary based on its nature, we must create a culture where rapid correction of and openness about a mistake reduces professional risk and liability. Suggestions from Professor Donaldson included making staff exempt from disciplinary procedures when they have reported adverse events or medical errors (except where crimes or professional competence is involved) and creating a legal privilege for adverse events report (except where they have not been disclosed to the person). These measures are meant to increase the reporting of adverse incidents, particularly in relation to a professional's own mistakes.

Lowering risk must include a lack of retaliation against staff for being honest, but must also take into account the social stigma and indirect pressure to protect colleagues. In the cases of Julie Bailey and other Mid-Staffs whistle-blowers, the personal pressure and abuse they received was devastating to their quality of life. Bullying and abuse by peers and co-workers must be rooted out against whistle-blowers. There may be a role for Local Healthwatch in this process: if whistle-blowers are being pressured or bullied, Local Healthwatch could be at the facility, demanding answers as to why this poor treatment has been allowed to continue.

Staff must also be protected from blame for systemic failures. The Root Cause Analysis model has to be fully embraced, and if there are failures, all the reasons for the failures must be investigated. The answer cannot simply be that staff should work harder to make up for systemic gaps – employees must be receiving adequate time and support for their work and be given tasks appropriate for their skill level.

The Professional Standards Authority has also suggested that guidance can be rewritten to promote a less stark view of mistakes. In current guidance, mistakes and harm are portrayed as rare events, when they are both common, and to some extent, inevitable. By accurately reflecting how common mistakes are, we can reduce staff's fears about reporting when things go wrong.

[31] Sir Liam Donaldson speaking at the launch of the World Alliance for Patient Safety in Washington DC on 27 October 2004.

i. Improving internal complaints processes

Health and social care staff possess more information about organisations and other staff than any other group, and their feedback can provide a crucial means of spotting problems early. The lack of gagging clauses in contracts is a good first step, but the cultural change must go much further.

The Duty of Candour should be used as a gateway for healthcare staff to report the problems they see around them. The duty should embrace reporting accidents and harms waiting to happen, such as unsafe staffing levels, lack of training, and resource issues. While the duty to report potential harm is more challenging to define, it could provide a powerful source of information and monitoring.

Staff must also believe that something may change as a result of speaking up. Many healthcare staff suffer from burnout as a result of working in chronically under-resourced system with little appetite for change. Staff complaints about safety issues should be taken as seriously as consumers' complaints, and staff should receive follow-up about what actions have been taken to investigate and remedy the problem.

j. The role of professional education

The Professional Standards Authority noted the key role of education in promoting cultural change. While candour and transparency are taught to students, these habits are often driven out by the predominant culture that young doctors, nurses and other professional staff experience in their first years on the job. Training must continue with junior staff and others to preserve the lessons of openness they learned as students.

Providers should begin planning now to ensure that staff are trained to comply with the duty, and that appropriate oversight exists to give meaning to the organisational Duty of Candour. Guidance must be clear and written for easy use by front-line staff, and professional regulators can play a role in ensuring that training covers common situations which arise in different professions, eliminating ambiguities.

k. Should the duty be triggered when a person believes of suspects harm?

Francis recommends that the duty should be triggered when a person "believes or suspects" that treatment may have caused harm. Suspicion is a vague term, and needs clearer definition. 'Reasonably suspects' may be better, as it requires there to be a factual basis for suspicion. 'Reasonable' has a legal meaning in other contexts and seems a sensible starting point, though the term would need to continue to be defined in the courts.

l. Should near misses be included in the duty?

We suggest that we omit near misses from the duty, concurring with Francis and Berwick.[32] The term is hard to define because, by definition, the harm did not occur. The question of how 'near' a near miss must be lacks a satisfactory answer, and would be very difficult to apply in practice. Information about near misses provides learning opportunities for the staff or organisation, but they have no benefit to the person in the instant case because there was no harm.

[32] Francis recommends against including near misses at 22.157; Berwick recommends against at 34.

Including near misses could also negatively impact medical and care education. Junior doctors and other trainees do examinations and procedures under the supervision of their seniors, who routinely prevent trainees from causing harm. If there was an obligation to report trainees' mistakes that were fixed without harm, there could be a substantial chilling effect on their ability to gain the experience they need, particularly for more challenging conditions.

m. How should failures to perform an act that led to harm (omissions) be dealt with?

While failure to follow recommended courses of treatment is a straightforward example of an omission leading to harm, the breadth of potential harms which could be caused by omissions must be considered, particularly in regard to care. Any number of things which have been omitted might have caused harm – had there been 1:1 nursing care, people might have avoided complications or been treated faster.

Omissions are particularly significant in relation to management and board members, whose organisational decisions may lead to omissions in staffing and resources which cause harm. Ultimately, the question of how and to whom the duty applies will be for the courts, but regulations can help to shape how omissions are viewed in practice.

We should be careful avoid an overly philosophical approach, as omissions are by their nature infinite in number and scope, but we should still see harm as something that arises both from action and inaction. We would recommend a definition centred on failure to provide a generally accepted standard of care, leading to harm.

n. Should 'known complications' be factored into the fulfilment of the duty?

Many medical procedures and drugs have known complications, which the person will typically be informed of and consented to prior to treatment. Should this consent process, which can often be fairly cursory, constitute fulfilment of the duty for harms which later arise as a result of the treatment?

We recommend that prior consent should be a factor in fulfilment of the duty, as it gives people a greater role in choosing what risks they are willing to take. However, we may want to use this as an opportunity to look at possible improvements to the consent process, with a focus on supported, informed consent which is appropriate for the person.

o. Should other sanctions be imposed, and what should they be?

We must consider what sanctions would be appropriate to back the statutory Duty of Candour. The primary options would be criminal penalties, civil sanctions, fines, professional disciplinary actions or employment consequences. The duty as it stands on doctors and nurses is currently only enforced through professional and employment sanctions.

We reached out to a number of Local Healthwatch interested in complaints work to ask their opinion. While we received a limited response, the ones who wrote to us expressed opposition to an overly punitive set of sanctions surrounding the duty.

We would recommend significant caution around criminal sanctions, both for individuals and organisations. For individuals, criminal sanctions could lead to substantial fear and concern around use of the duty. Additionally, it would be challenging to show beyond a reasonable doubt that a person knowingly withheld information from patients in all but the most egregious of cases. Therefore, we would align with the Francis recommendation

to apply criminal sanctions for obstructing another in the performance of the duty, knowingly misleading patients or relatives, or knowingly misleading a regulator.

Further, people who commit the new crime of wilful negligence would be obligated to turn themselves in under the duty. By adding the criminal penalties on the Duty of Candour, it seems the existence of the two crimes violate the right to remain silent (while professional sanctions for silence would not).

We would recommend either civil sanctions in the forms of fines, or professional and employment sanctions as the primary methods of enforcement. There will be a substantial range of conduct which constitutes harm, from unnecessary blood draws to serious injury and death, and sanctions should be proportionate to the violation of the duty. Fair, calibrated sanctions will help to reduce fear around the duty and increase buy-in from health and care staff, improving their effectiveness. Particularly as we work for achieve cultural change around candour, it is important to work to educate and inform those who have violated the duty to improve their future behaviour, rather than putting people in a defensive stance.

For organisations, we would recommend against criminal sanctions, as the primary criminal penalties which could be taken against a hospital or other provider would be financial. In this context the funds would ultimately be coming from taxpayers, which defeats the purpose of the sanction. For-profit enterprises can be adequately punished by loss of profits, but the analogy fails when applied to organisations funded by the public. Additionally, while some smaller organisations could be punished by being forbidden to bid for CCG commissions, large hospitals and other major centres could not be excluded without serious hardship for the communities they serve.

We need a range of sanctions to cover both deliberate and widespread actions (where disbarment from bidding for commissioning may be appropriate) and failure to sufficiently monitor a rogue individual, but we would recommend that organisational sanctions be limited in use and reserved for egregious cases. In other cases, the duty would likely be more appropriately applied to individuals within the management and governance of the organisation, based on their actions or omissions in relation to the Duty of Candour.

p. How should we treat organisational knowledge of harm?

As organisations must be candid to those they treat or care for, the duty potentially forces a closer monitoring requirement. Does anything in a report or note constitute "knowledge" on behalf of the organisation? Alternatively, is the organisation only represented by its managers? If the standard for the duty for senior management is that they must have knowledge of the harm, there is a danger of wilful blindness among non-front-line staff.

While there are currently duties to report serious safety issues to the CQC, the proposed duty to report moderate harm requires much broader knowledge. The question of organisational knowledge is particularly difficult because board members are not given carte blanche to inspect private records, or to see many aspects of hospital functioning. It is unrealistic to assume that senior management or board members will be monitor individual records, but management could be accountable for reviewing trends and patterns, and looking for staff members with persistently high complication rates. In those cases, management should have a duty to investigate and ensure patients are receiving full explanations of any complications.

The structure of organisational knowledge must be puzzled out to a much greater extent. It is insufficient to apply the duty without the means and responsibility for senior management to uphold it. We do not think we have a solution at this point in time, but recommend that we flag the need for clear guidance about what internal oversight is needed for the duty in our public position, with the key questions:

- Are any individuals personally responsible for the organisational Duty of Candour?

- What is the organisation deemed to know for the purposes of the duty?

- What steps must responsible individuals take in order to ensure the organisational duty is complied with?

q. How should liability be established and how should we treat disclosures of harm?

We recommend that our response address some issues relating to liability with regard to the Duty of Candour. Liability arising from the duty will impact individual and organisational behaviour, particularly with the proposed changes to indemnity insurance and pooling.

It is often recommended that Duty of Candour disclosures would not be used in civil or criminal actions for the individuals or organisations involved.[33] However, even if the statement cannot be used, the facts can be. Alerting people to harm will increase the risk of liability, as they will potentially be aware of a cause of action they may not have previously known about. Liability considerations are likely to be a counterweight against candour for staff and managers, militating against their complying with the duty. Our response must take the personal costs of complying with the duty into account, rather than assuming people will follow the duty even if it leads to their being sued.

The proposed privilege against use of the statements could also be highly discordant to people. If a health or care professional has admitted harm, but that statement is somehow off-limits in proceedings, people may feel that professionals are again playing by their own rules.

It is fundamentally counterintuitive to make potentially liable health and social care providers responsible for alerting people to potential causes of action and assisting people to seek redress against the provider, as Francis recommends. Typically in legal systems, it would be inappropriate for a potentially opposing party to counsel the other, because of the severe conflict of interest.

For these reasons, it is very important for there to be oversight of the duty to ensure compliance. For front-line staff, this should come from management (though not without complications, as management would have incentives to avoid organisational liability, potentially at the expense of the staff member), and for management, this should come from the CQC.

Additionally, we recommend being supportive of provisions which reward those who comply with Duty of Candour in litigation. Similarly to the provisions recommended above regarding protecting staff from disciplinary procedures where they have reported adverse

[33] Francis report at 22.163.

incidents, staff who report harm to patients, quickly and in good faith, should potentially be partially indemnified in personal lawsuits by the NHS Litigation Authority.

The duty could also lead to perverse incentives for both organisations and individuals in trying to define certain conditions as not being ‘harm’, and therefore not triggering the duty to disclose. Staff may worry about recording observations of harm for fear that it would create a paper trail which might later be used against them. Clear guidance is important in avoiding these problems, but it is possible that the duty could increase defensiveness regarding conditions which questionably cause harm.