HEALTHWATCH ENGLAND COMMITTEE MEETING PAPERS

Wednesday 22nd October
London

Venue: Novotel London West; One Shortlands; London W6 8DR

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AGENDA ITEM: 2

SUBJECT OF REPORT: Previous Committee Minutes

PRESENTING: Anna Bradley

PURPOSE: This report will reflect the minutes and actions of the Committee Meeting of 23 July 2014

RECOMMENDATIONS: The Committee are asked to approve the minutes and action log of the Committee Meeting of 23 July 2014

RESOURCE IMPLICATIONS: N/A

RISK AND MITIGATION: N/A

EQUALITY AND DIVERSITY: N/A

Previous Minutes of the Committee Meeting on 23 July in Nottingham

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

Apologies: Andrew Barnett, Paul Cuskin.

In attendance: Dr. Katherine Rake, Dr. Marc Bush, Sarah Armstrong, Deborah Laycock, Tim Schofield, Gerard Crofton-Martin, Kathy Peach.

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

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

AGENDA ITEM 2 – Previous Minutes
AGREED: The minutes of the meeting held on 14 May were reviewed and accepted as a true record of the meeting.

AGENDA ITEM 3 – Declarations of Interests
There were no declarations of interests.

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 were made:

- Attention was drawn to a letter that was written subsequent to the writing of the report. This was a formal advisory letter to the Secretary of State for Health relating to what Healthwatch England is calling super Clinical Commissioning Groups. The letter highlighted concerns about the Draft Legislative Order proposing the commissioning of Committees in Common, including concerns raised by local Healthwatch across the Manchester area. The letter flagged concerns about appropriate engagement with local Healthwatch and the issue of the governance, public and local accountability of decisions made outside the remit of one Clinical Commissioning Group and the related Health and Wellbeing Board. It was advised that the letter should not distract from future work on engagement with NHS England.
- The letter was welcomed and it was suggested that it should be cascaded in a positive way to the network.
- A Committee forward plan was requested to review upcoming work for the year.
    1. **ACTION – To provide a Committee Forward plan at the next Committee Meeting in October**

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

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

- An update on Care.data was requested after the issues raised by Healthwatch England to the Department of Health. Assurances were given that Healthwatch England's role on the independent advisory group continues and in that capacity continues to flag issues that are of concern to the public. These include a number of questions that are yet to be announced on the delivery of the programme. These affect trust and the lack of knowledge and awareness of the public on how to opt out.
- It was highlighted that the assurances of safe havens given by the Government on the data held under the remit of Care.data should also be reflected in the Department of Health Consultation.
- Congratulations were given to local Healthwatch for their hard work in contributing to the intelligence return.
- The relationship with Public Health England was flagged as an important way of gaining more information about public wellbeing.
- It was recognised that when Healthwatch England is working with the Local Government Association, there should be reflections on the learning from the previous commissioning cycle. They hoped that the next commissioning round is also supported by information from local Healthwatch.
- Discussions regarding the annual conference highlighted the need to share information from the annual conference with local Healthwatch.
    2. **ACTION – To produce a paper on Care.data covering the Department of Health proposal and the organisational approach for the next Committee Meeting**
    3. **ACTION – To provide links to the foreword written by the Secretary of State for the Annual Conference and the supporting material from the conference for**

local Healthwatch

AGENDA ITEM 6 – Escalation and Intelligence Report; Background Paper to determining our 2nd special project
Deborah Laycock, Policy Manager, and Dr. Marc Bush, Director of Policy and Intelligence, presented the report to the Committee.

Committee Members welcomed the Escalation and Intelligence Report and the background paper detailing next projects, the following comments were made:

- The clarification of the Escalation process for local Healthwatch was welcomed. It was also expressed that using 'Escalations' as a title is clear and unambiguous.
- Reflections were made about the range of escalated cases and there needs to be more clarity about when an issue is considered to have been escalated.
- It was highlighted that there is a need to recognise that systems have failed to add up the completeness of the needs of people with mental health problems.
- The need to add value and ask clear and relevant questions which inform the transformation of primary care, were identified as important additions from Healthwatch England.
- Assurances were asked for in regards to the next special programme to be unique and have a specific Healthwatch England perspective with real expertise from local Healthwatch, the Committee and members of staff.
- There was a recommendation for Healthwatch England to produce a first response for all issues raised to Healthwatch England as part of the Escalation process.
- They highlighted that in relation to the work on Child and Adolescent Mental Health Services, there should be more about understanding the experience of families; what are the questions that Healthwatch England should be asking supported by local Healthwatch.

AGREED: The Committee agreed the focus of the next special programme to be on Child and Adolescent Mental Health Services.

4. **ACTION: Full proposals for both Child and Adolescent Mental Health Services and Access to primary care will be presented to the Committee ensuring that Healthwatch England is adding value to conversations**

AGENDA ITEM 7 – The intelligence return from local Healthwatch
Gerard Crofton-Martin, Head of Oversight and Support, presented the report to the Committee.

Committee Members welcomed the Intelligence Return from local Healthwatch and the following comments were made:

- Concerns were expressed about the self-assessment nature of the return and how to measure the impact of local Healthwatch relationships.
- There was a suggestion of the triangulation of views from health and social care providers, and commissioners to assess the impact of local Healthwatch.
- Questions were raised about how Healthwatch England will be able to assess public engagement with local Healthwatch.
- A stakeholder's survey was suggested as a means of identifying stakeholder perception of

local Healthwatch.

- Discussions maintained that it would be helpful to evaluate the work of other federated organisations on how they assess external impact.
- Discussions led to the conclusion that the intelligence return from local Healthwatch should not inform what each local Healthwatch should look like.

AGENDA ITEM 8 – Public participation session

AGENDA ITEM 9 – Audit and Risk Sub Committee Chair's Report
Jane Mordue, Chair of the Audit and Risk Sub Committee, presented the report to the Committee.

The Committee welcomed the update and no comments were made.

AGENDA ITEM 10 – Members Update

- Jane Mordue presented an update from a meeting with the Department of Health subsequent to the report being written about individuals from the health and social care sector being nominated to the honours list. This was recognised as a way of distinguishing those who have gone the extra mile.
- The Chair clarified that invitations to individual members of the Committee should be shared with either herself, Katherine Rake, Susan Robinson or Esi Addae to allow for strategic decisions to be made about engagement.
- Jenny Baker asked about the engagement with statutory partners on the issue of specialised commissioning.
- Christine Lenehan clarified that there are gaps for small groups of people who do not fit into either local or national commissioning groups and that this should be something that Healthwatch England flags.
- John Carvel reflected that there should be more of a chance for Committee Members to attend other workshops during the Annual Conference.

5. **ACTION: To produce an overview of our current work on specialised commissioning**

AGENDA ITEM 11 – Operational Update
Sarah Armstrong, Head of Operations, presented her update to the Committee.

Committee Members welcomed the update and raised the following comments:

- They wanted an opportunity to review and reflect on the enquiries programme and the support the Healthwatch England team receive. They were assured that the Operations Team have received both safeguarding and confidential call training to support their work.
- Clarification was sought on how information from consumers is stored and shared. Committee Members were reassured of the work between the Information Sharing team at CQC and Healthwatch England staff and the procedures in place to safeguard information.
- There was an assurance that the staff team will continue to work with CQC colleagues to provide the Committee with accurate quarterly profiles of spend.

AGENDA ITEM 12 – Customer Relationship Management (CRM) system report
Tim Schofield, CRM Manager, presented the report to the Committee.

Committee Members welcomed the update and raised the following comments:

- It was suggested that there should be recognition of the risk of local Healthwatch not using the CRM system.
- The Committee highlighted the need to cater for the diversity of requirements within the network.
- Further clarity was sought on the training system in order to fully recognise the capacity of local Healthwatch to train others.
- They wanted to clarify the process of the migration of data and recognised that a significant challenge lay with migrating data from local Healthwatch where information is not held locally.
- The Committee delegated to the Senior Management Team further devolvement of a training programme for the CRM programme.

AGENDA ITEM 13 – Healthwatch England and NHS England Memorandum of Understanding
The principles of the Memorandum of Understanding between Healthwatch England and NHS England were presented for discussion.

The Committee made the following comments and observations:

- There was discussion about the need for the language to be more inclusive, of the need to engage people receiving services, and their role in having and informing their active choice and control.
- They wanted included in the developed Memorandum of Understanding an explanation of how NHS England will engage with local Healthwatch.

AGREED: The principles of the Memorandum of Understanding with NHS England were agreed. The Memorandum of Understanding will be developed and will return to the Committee for approval

AGENDA ITEM 14 – Healthwatch England and NHS Trust Development Authority
The Healthwatch England and NHS Trust Development Authority Memorandum of Understanding was presented for approval.
AGREED: The Committee agreed the Memorandum of Understanding with the NHS Trust Development Authority

AGENDA ITEM 15 – Healthwatch England and Monitor Memorandum of Understanding
The Healthwatch England and Monitor Memorandum of Understanding was presented for approval.
AGREED: The Committee agreed the Memorandum of Understanding with Monitor

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 Manning and Katherine Rake	Progress NHS England Memorandum of Understanding to completion	The draft principles were presented to the Committee in July. The staff team are working with their NHS England colleagues to agree the full Memorandum	In progress Superseded	In progress N/A
21/11/13	Sarah Armstrong	When full staff team in place, they are to be introduced to the Committee formally through a number of staff/Committee engagements	Committee Members will be invited to the November staff meeting and an informal session with staff after the December Workshop will be organised	Quarter 2	In progress
13/02/14	Susan Robinson	Establish a programme of visits to local Healthwatch	To organise a timetable of introductory events for Committee Members (for new Committee Members this will be included as part of induction programme)	Quarter 2	Completed
13/02/14	Marc Bush and Deborah Laycock	Contact local Healthwatch about their escalations and ask them to comment on their experience of Healthwatch England handling their escalated query or concern	The escalations handbook was updated in collaboration with local Healthwatch and a monthly update has been initiated. A webinar for local Healthwatch was held in August to further support local Healthwatch. The Senior Management Team will be finalising the oversight and decision making process for escalations in Quarter 3	Ongoing	In Progress

DATE	LEAD	ITEM	ACTION	DEADLINE	STATUS
13/02/14	Katherine Rake	Contact the Chief Executive of NHS England to discuss the next phase of Care.data	Healthwatch England are engaged in informing the phased roll-out and how the programme engages with local Healthwatch	Ongoing	In progress
13/02/14	Marc Bush	Support Healthwatch Reading with resources to help them in unsafe discharges	An invitation has been made to all local Healthwatch via email to engage with the Special Inquiry	On-going	Completed
14/05/14	Marc Bush	Schedule our policy and intelligence products for Healthwatch England and to integrate the escalation and intelligence report	The timeline of our policy and intelligence products were approved at the July meeting and the second integrated escalation and intelligence report is presented at this Committee Meeting	Ongoing	In progress
14/05/14	Sarah Armstrong	Produce a Diversity Plan	The Diversity and Inclusion update and plan is included for discussion and approval by the Committee at the October Meeting	Quarter 3	Completed
23/07/14	Esi Addae	Provide the Committee Forward plan at the next Committee Meeting in October	The Committee Forward plan is included in the October Committee Papers to highlight dates and upcoming work	Quarter 3	Completed
23/07/14	Sarah Vallelly	Produce a paper on Care.data detailing the Department of Health proposal and the Healthwatch England position for a Committee Meeting	A paper on Care.data and assured safe havens will be presented to the Committee at the October Meeting	Quarter 3	Completed
23/07/14	Kathy Peach	Provide links to the foreword written by the Secretary of State for the Annual Conference and the videos from the conference for local Healthwatch	The Secretary of State foreword for the Annual conference and other supporting materials from the Annual Conference has been uploaded to the	Quarter 3	Completed

DATE	LEAD	ITEM	ACTION	DEADLINE	STATUS
			Hub for local Healthwatch use		
23/07/14	Marc Bush	Produce proposals on Child and Adolescent Mental Health Services and Access to Primary Care to the Committee	The proposal for the project accessing primary care services was discussed at the September Committee Workshop. The terms of reference for the special programme on Child and Adolescent Mental Health Services are presented to the Committee for approval at the October meeting	Quarter 3	Completed
23/07/14	Katherine Rake	Provide an overview of our work on specialised commissioning	A proposal of the Healthwatch England approach to specialised commissioning will be discussed at the Committee Workshop in October	Quarter 3	Completed

AGENDA ITEM: 4

SUBJECT OF REPORT: Chair's Report

PRESENTING: Anna Bradley

PURPOSE: This report aims to highlight the Chair's activity since the last Committee Meeting on 23 July in Nottingham.

RECOMMENDATIONS: This report is for information

RESOURCE IMPLICATIONS: N/A

RISK AND MITIGATION: N/A

EQUALITY AND DIVERSITY: N/A

Introduction

In this quarter, the focus of my work has included the launch of our Complaints Report last week, and at the same time, our Annual Report was laid before parliament. This has also been a time of significant activity as we prepare for the launch of our Report on our 1st Special Programme which will be launched later in the year.

Annual Report launch

The launch of our second Annual Report to Parliament offered us a great opportunity to reflect on the achievements of both Healthwatch England and local Healthwatch. The report details the impact of the network in working collectively to get people's complaints taken seriously and make people's voices heard nationally and locally. With fantastic support from attendees we were able to demonstrate the value and impact of the network in the health and social care landscape amongst key parliamentarians, which included MPs who have been in conversations with their local Healthwatch to learn more about their work. Committee Members have helped us to achieve the appropriate tone in our annual Report; I would like to thank them for this. I will update the Committee during the meeting of my reflections of the launch event.

1st Special Inquiry

The work preceding our 1st Special Inquiry started when last year, local Healthwatch highlighted to us their concerns on unsafe discharge. We shared their concerns and agreed that this should be investigated at a national scale. Having worked with consumers, local Healthwatch and our advisory and inquiry panel the focus has been on the unsafe discharge of three groups; people with mental health conditions, homeless people and older people. Our people centred approach, our hosted conversations and workshops have given us a fantastic opportunity to listen to consumers, our advisory and inquiry panel as well as system players.

I met with Baroness Brinton, Liberal Democrat spokesperson on health in the House of Lords, and Rt Hon Paul Burstow MP, former Minister of State (Department of Health). Both Baroness Brinton and Mr Burstow were interested in the forthcoming recommendations from our special inquiry.

Finally, at the end of September, I contributed to the Academy of Medical Royal Colleges public policy review session. The session included representatives from across Medical Royal Colleges. I gave an overview about the role of Healthwatch as the consumer champion in health and social care while focusing especially on sharing the emerging findings from the Special Inquiry on unsafe discharge.

Healthwatch England Committee

Since our meeting in July, we continue to develop how we involve our Committee in our work. Continuing to seek their advice and guidance on major work programmes in operation now and upcoming projects, we continue to build on the information we gained from the skills audit. A plan has been developed for each Committee Member detailing their involvement both with the staff team, externally and with local Healthwatch. This is so that we have a clear plan of activities in the coming months. This is being tested and will be reviewed on an ongoing basis.

I also want to congratulate Pam on her role as a People Champion for NHS Leadership Academy. This role offers Pam a great oportunity to join the strategic discussions which feeds into the Strategic Advisory Board, and this connects the Academy to the wider health and social care system.

Reviewing the governance assurance for the Committee, it is essential that there is an effective and efficient framework to give needed assurance. As such we have developed further governance guidance to support the Committee and the staff team. During this meeting, we will explore the roles and polices surrounding:

- The Senior Independent Member Role;
- Remuneration Committee; and
- Conflicts Policy.

Strategic Partners

<u>Department of Health</u>

Following concerns escalated to Healthwatch England by local Healthwatch about local accountability arrangements, I exercised our statutory powers and wrote to the Secretary of State for Health. In my letter, I shared our concerns about the operational arrangements that were formalised under the Draft Legislative Reform Order on Clinical Commissioning Groups. Consequently, Healthwatch England is now working with system partners to ensure local decision making arrangements adequately reflect the views of the public.

External engagement

I continue to have a number of 1-2-1 meetings with key influencers in health and social care to build relationships with partners for Healthwatch England and the network and to update forthcoming areas of work. The primary focus of my external engagement during this period has been on highlighting our complaints programme and the forthcoming publication of the recommendations from our 1st Special Inquiry on unsafe discharge. I joined Healthwatch Derbyshire for their Annual General Meeting and thank them for being accommodating. It was useful to hear about their Annual Report which detailed their first year and how they have started to develop working relationships with providers, commissioners and the public.

Child and Adolescent Mental Health Services

I have been invited by Norman Lamb to participate in a taskforce set up to look at Child and Young People's Mental Health and Wellbeing. The inaugural meeting took place at the end of September to discuss the remit of the taskforce. I will continue to seek input from the Committee. The Terms of Reference for our programme on Child and Adolescent Mental Health Services is subject to a report.

Complaints Programme

In July, I met with Rt Hon Oliver Letwin MP, Minister at the Cabinet Office responsible for the reform of the public sector complaints system, to discuss the recommendations in our Complaints Report. We agreed to continue to meet regularly and to update on common areas of work themed on complaints reform. Katherine and I met with Liz Kendall MP, Shadow Minister for Health Care and Older People. Ms Kendall was particularly interested in our complaints work programme and also the important role local Healthwatch play in signposting consumers.

I was part of a panel discussing "Patient Power in the NHS". Hosted by Conservative Health, other speakers included the Secretary of State for Health, Rt. Hon. Jeremy Hunt MP, and Professor Jane Dacre President of the Royal College Physicians.

I also chaired a conference themed on Complaints Handling, Investigating, Resolving and Learning. Panellists included representatives from across the complaints sector including advocacy providers and the Patient Safety Ombudsman. As well as chairing, I also led a session on the Consumer Perspective. In my presentation, I highlighted the complexity of the system and shared the principles required for fundamental reform.

Accessing Primary Care Services

In September, I had a very positive meeting with Dr. Sarah Wollaston MP, Chair of the Health Select Committee. Dr. Wollaston was interested in a number of pieces of our work, particularly on our forthcoming work on the future of primary care. As a follow-up, we agreed to share regular updates with her office and we offered to provide advice and support where possible.

Members are invited to DISCUSS.

AGENDA ITEM: 5

SUBJECT OF REPORT: Chief Executive's Report

PRESENTING: Dr. Katherine Rake OBE

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

RECOMMENDATIONS: This Report is for information

RESOURCE IMPLICATIONS: N/A

RISK AND MITIGATION: N/A

EQUALITY AND DIVERSITY: N/A

Delivery on key activities

My report for this quarter will provide an update on:

- Annual Conference;
- Launch of our Complaints Report;
- Business and budget planning process;
- The Healthwatch network; and
- External engagement.

Annual Conference

The objective of our Annual Conference in July was to bring the network together to learn and see the strength of a strong and united voice in health and social care. We also focussed a major part of the conference on delivering training and support to the network. We had 390 attendees drawn from 130 local Healthwatch. We received 60 completed evaluation forms and I am delighted to say that the results were very positive;

- 93% of respondents provided positive feedback that overall the conference was 'very good';
- 98% of respondents reflected that the conference helped bring the network together; and
- 83% of respondents said that the conference helped equip them with the knowledge and skills needed to increase their impact locally.

These positive results underlined the strong sense I had that the conference had enabled us to develop a shared sense of purpose and to deepen the knowledge and understanding of the network as a whole as well as build relationships across the network.

We also received evaluations on the individual workshops which were supported and facilitated by staff and Committee Members with feedback being reported as good or very good. The workshops were part of our support offer to build upon local Healthwatch knowledge, skills and confidence in subject areas. The nine workshops scored the following positive percentage feedback from respondents:

Workshop	Percentage feedback
Making local voices heard at a national level	88%
A guide to complaints handling	77%
Income generation and the future of Healthwatch finance	66%
Signposting – the challenges and limitations	74%
Putting local people at the heart of service redesign	90%
Working with your local MP	75%
What to do when the inspectors are in town	83%
Health and well-being framework	79%
Volunteering in practice	88%

We listened to the issues raised by attendees at the Annual Conference and resolved issues raised either to us or to the venue. We have taken the learning from the annual conference and we have implemented an internal checklist to audit our procedures for events. Alun Davies, Committee Member, has provided accessibility training for staff and we continue to engage with local Healthwatch, Committee Members and staff on how we work to make our events accessible. We are also working on embedding the learning from the Annual Conference in our overall organisational evaluation and learning.

Launch of "Suffering in Silence" – Healthwatch England's report on the complaints system

On the 14th October, alongside our Annual Report, we launched our report on the complaints system "Suffering in Silence". This report is the result of detailed data gathering by Healthwatch England and local Healthwatch listening to the experiences of people – and their families, carers and friends. They expressed their concerns about their health and social care services. The report uses where possible the words of people who have had concerns but not felt able to raise a complaint, as well as those who have used the complaints systems.

The report draws on workshops held in Manchester and London, two national surveys and one self-selecting survey. The report also contains detailed cases from people who had significant concerns about complaints handling as well as those who had had positive experiences, and those who were still waiting for a resolution. We wanted to adopt a particular focus on people treated under the Mental Health and Mental Capacity Acts. This because being detained treated against their will or being deprived of liberty can put people in an extremely vulnerable position and make it even harder to raise concerns or make a complaint.

We drew on previous reports on the complaints system, but our focus on all health services, not just hospitals, and social care gave us a broader remit. While we developed a number of recommendations about the immediate steps that could be taken to improve the complaints system, our report also highlights the depth of change required to ensure that people receive swift and compassionate resolution to their complaints including, for example, a unified and simplified advocacy offer, measures to put people more in control of their complaints resolution and a simplification of the way complaints are handled. For this reason, we called for cross party support for reform and that legislative time be dedicated to this issue at the earliest opportunity.

Business and budget planning process

We are beginning the preparation for the business planning process for next year. This has involved the review of progress on delivery for the first 6 months of work with the Senior Management team. This gave us the opportunity to reflect on what we have achieved but also enabled us to understand the resources that are needed to meet specific deliverables. These discussions provided inputs for the Mid-year Spend Review which considered our likely year end position and commenced discussions about the 2015/2016 budget. This is also discussed further in the Operational Update.

Healthwatch Network Update

The Development team continue to carry out 1-2-1 visits, using semi- structured questionnaires based on the four key areas of support (impact, engagement, sustainability and leadership). We continue to provide tailored and bespoke support to local Healthwatch with over 60 visits since April. The informal feedback so far has been that local Healthwatch have appreciated the support of the Development team, in particular, the opportunity to reflect on their strategies and activities and to hear examples on how other local Healthwatch are tackling issues and to find out more about ways of accessing peer support within the network. A more formal evaluation of this work is planned as part of the next data return.

Healthwatch England were approached by Community Service Volunteers (CSV), who are working on a toolkit to support local voluntary sector organisations (including local Healthwatch) with involving children and young people as volunteers. We provided them with the support of local Healthwatch, case studies to illustrate how local Healthwatch have successfully involved children and young people, as well as an explanation of the role of local Healthwatch and Healthwatch England, and how we work to improve health and care services, including services for children and young people.
The process for Enter and View activities had raised some concerns with a few local Healthwatch being challenged by providers to provide a clear purpose and guide of the activity planned. To support local Healthwatch, we have revised our guidance pack and have developed an adaptable report template to help local Healthwatch meet our recommendations. These templates have been shared on Yammer and we continue to seek feedback from local Healthwatch on their Enter and View activity.

Five regional network meetings have been held across the regions with several more planned between October and December. Progress is being made to ensure that regional network meetings become more sustainable in the long run. Stakeholders are keen to meet local Healthwatch so network meetings are becoming very busy as system players become more involved at the local level. A training session by the National Service User Network (NSUN) to increase awareness on local mental health initiatives is being piloted this month in the East Midlands.

A summary of activity, grouped by the four support areas provided to local Healthwatch:

	Support needed	**Healthwatch England response**
Sustainability	Local Healthwatch income	• Supporting Healthwatch in understanding their income position and providing assistance as they negotiate contracts and income • Preparing to publish the 14-15 financial position
	CRM system	• Pilot and test a new CRM system collaboratively with a small number of local Healthwatch • Preparing for a further phase of roll out in the autumn
Impact	Best practice	• Awards presented at annual conference • Sharing good practice examples via the newsletter • Developed case studies for annual report and bank of case studies for use in all our work
	Media/raising awareness	• Media training delivered to 50 local Healthwatch
Engagement	Regional meetings/support	• These are now led by Development Officers and benefits include more collaboration and uptake of shared issues • Each region has a dedicated Development Officer
	Communication from/with Healthwatch England	• Revised webinars and newsletter • Escalation bulletin produced and circulated • Introduced Yammer, with an increase in licences per local Healthwatch • Bi annual data return completed by network
	Working with Statutory Bodies	• Delivered advice on relationship with CQC following local Healthwatch feedback • Preparation in training for advice on working with Monitor and the NHS Trust Development Authority
Leadership	Standardised documents	• Enter & View report templates being developed • We have published advice on developing Annual reports
	Healthwatch organisation development	Bespoke advice given: • Governance • Board development • Organisational development • Establishing as an independent social enterprise

	Volunteers	• A volunteer toolkit co-produced with the network and National Council for Voluntary Organisations

Since the July Committee meeting, the Development Team has seen some staff changes. Our new Development Manager Alvin Kinch started in August and a new Development Officer for Central Region has been recruited with a potential start date at the end of October. The Development Team continue to use Yammer to keep in contact with the network, respond to questions and signpost local Healthwatch to useful resources.

To date we have received 147 out of 148 annual reports from local Healthwatch following regular contact from the Development and Oversight and Support teams. We are aware of the unique situation of the remaining local Healthwatch to deliver their annual report and are supporting them to deliver this statutory requirement.

I participated in my first regional network meeting for the Northwest region hosted by Healthwatch Wigan. I was part of a session called 'An Audience with Roy Lilley'; this was a great opportunity to hear from both Healthwatch in the North West region and key national figures on major health and social care issues.

I visited Healthwatch Kent, where I was invited to the Kent Health and Wellbeing Board meeting. Chaired by Roger Gough, Cabinet Member for Education & Health Reform, Kent County Council, I was given the opportunity to see how local Healthwatch engage on their Health and Wellbeing Board. I also attended the Healthwatch Bromley Annual General Meeting, where I talked about how the work of local Healthwatch in championing health and social care needs links to the work of Healthwatch England nationally. I found all of these visits highly informative and I thank them for their hospitality.

Work with statutory partners

With support from my team, I have taken forward a number of activities with our statutory partners.

<u>Department of Health</u>
Healthwatch England is a statutory consultee on the Mandate document for NHS England, which sets the framework for NHS England's priority areas of work. Earl Howe wrote to seek our views on the Mandate and his letter and our response is attached at appendix A. This gives us further point of reference for our work with NHS England.

<u>Care Quality Commission (CQC)</u>
We have developed quarterly meetings with Chris Day and the inspectorate team, this has enabled us to develop how we work together to keep people informed about care services. Our work with the CQC inspectorate team is subject in a separate report.
I recently met with Andrea Sutcliffe, Chief Inspector for Adult Social Care. I continue to meet regularly with Eileen Milner, Head of Corporate Services to review services and working arrangements. Finally, David Behan, Chief Executive of CQC came to address the Healthwatch England team at a lunchtime learning session to provide an overview about

the role of CQC. The team found this session a useful opportunity to reflect on the working relationship and to learn more about how both organisations work together.

Monitor and NHS Trust Development Authority (TDA)
The Memorandums of Understanding for both Monitor and NHS TDA were agreed at the Committee Meeting in July. The teams are working together to provide the detail of the work plan.

NHS England
The team and I have worked with a NHS England on a number of issues throughout the last quarter. Further to our concerns about Clinical Commissioning Groups (CCGs) accountability mechanisms raised by Anna in her letter to the Secretary of State for Health, we have worked with NHS England to seek clarity about the process in place to oversee whether CCGs are fulfilling their statutory duty in relation to public engagement. In addition, we are also preparing to work with NHS England to develop guidance to underpin the new regulations in the Legislative Reform Order on Clinical Commissioning Groups.

We continue to work to shape and influence the roll out of the Care.data programme, as part of this, we are working with NHS England to support the four local Healthwatch involved in pilot areas and this subject in a separate report.

The Memorandum of Understanding which has been developed on the back of the principles agreed at the last Committee meeting is now with NHS England colleagues for comment on the text.

External engagement

I continue to meet with our regulatory counterparts, third sector bodies and other relevant organisations to build a clear picture of key issues for consumers and the network and also to identify areas of joint working, where applicable. I have met with, among others, the NHS Confederation, the Nuffield Trust, Citizens' Advice Bureau, the Point of Care Foundation and the Social Care Institute of Excellence each of whom has areas of interest in common with Healthwatch England. Finally, I presented to the Nursing and Midwifery Council in July to raise awareness of the work of Healthwatch England and the network.

Members are invited to DISCUSS.

Appendix A: Letter to Rt Hon the Earl Howe P.C.; Parliamentary Under Secretary of State for Quality (Lords)

Updating the NHS Mandate for 2015/16

Dear Earl Howe,

Thank you for your letter about the update to the NHS Mandate for 2015/16. I am writing back in our capacity as one of the statutory consultees of the Mandate.

I wanted to start by registering our appreciation for the early engagement and conversation on the NHS Mandate by your officials led by Gareth Arthur, your Deputy Director in the Department. This early engagement has allowed for a deeper and more productive exchange of ideas than last year and I am very pleased with the outcome.

We see the NHS Mandate as playing a crucial part in shaping the role and remit of NHS England and ensuring that existing commitments deliver on both the aspirations of the Government and the expectations of consumers in health and social care.

Having reviewed the plans for this update, we understand and support the Department's rationale for creating a more stable Mandate for 2015/16 to create clarity and certainty for the system at a time of political and economic change.

Parity of Esteem between Physical and Mental Health

In particular, we welcome and passionately support the proposed changes to the Mandate to ensure a parity of esteem between physical and mental health. This urgency is reflected in our own on-going special inquiry into discharge from hospital and the secure mental health estate, which shows that significant change improvements are required to ensure that people with mental health conditions are adequately prepared for discharge and have access to on-going support in the community.

As part of this work, we understand that your officials will be working with NHS England to explore standards around opening up access to psychological therapies and reducing waiting times, which in the 2014/15 Mandate you stated would have a particular focus on children and young people.

This is vitally important, given that 3 in 4 people with a mental health condition are unable to access the support they need and that our own special inquiry is finding that people have limited access to out of hours mental health crisis support. We also hope that this will lead to significant progress for children and young people with mental health conditions, and we will take a particular interest in this through our role on the new Department of Health Child & Adolescent Mental Health (CAMHs) taskforce.

Improving public and patient involvement

Beyond this, however, we have continuing concerns about the implementation of the current Mandate that we feel need to be addressed in the conversations about delivery of the 2015/16 update. These concerns centre on:

- Assurance of public and patient involvement in Clinical Commissioning Group (CCG) decisions about service change and redesign locally.

- Involvement and engagement of the public, people using NHS services, their family and carers in national commissioning decisions.

Firstly, in the 2014/15 Mandate you wrote that '*where local clinicians are proposing significant change to services, [the Department] want to see better informed local decision-making about services, in which the public are fully consulted and involved*' and included in the fulfilment of this objective '*strong public and patient engagement*'. Similarly, NHS England (in operationalising this mandate) included in their Assurance Framework and Operational Guidance (as part of Domain 2) a requirement for CCGs to involve local Healthwatch and the public in decisions about service change.

In our correspondence (attached to this letter) with the Secretary of State, and Simon Stevens on the Legislative Reform (Clinical Commissioning Groups) Order 2014 you will have seen our concerns about not having assurance from NHS England that CCGs have met their threshold for meaningfully involving the public and local Healthwatch in decisions about major service changes.

We have expressed the desire to see NHS England's detailed assessment of whether CCGs have met the assurance threshold for Domain 2 and whether CCGs are therefore compliant with the legislation and statutory guidance relating to public involvement in decision making (specifically the duties under s. 14Z2 of the National Health Service Act 2006, as amended by s. 26 of the Health & Social Care Act 2012 and the statutory guidance set out in Transforming Participation in Health and Care issued by NHS England in 2013). We await this assessment from NHS England and will continue to look to the Department to support our calls for this to be sufficiently addressed in the fulfilment of the 2015/16 Mandate.

Secondly, we are concerned about the omission of any parameters about patient and public involvement in both the current and proposed Mandates. As the consumer champion for health and social care, Healthwatch England believes that effective patient and public engagement is vital for the national commissioner of NHS services. We know that you will share our feeling on this, as this aspiration was at the heart of the Health & Social Care Act 2012 and the Government's expectations of the reform.

Whilst we do not believe the Mandate should specify involvement and engagement mechanisms, we do feel the NHS Mandate must contain the Department's ambitions and expectations of how NHS England (acting in its capacity as the national commissioning board) should involve the public and patients in decisions about national, direct and specialised commissioning.

In particular, we look to NHS England to clarify the purpose and impact of the different engagement mechanisms it is currently utilising and to ensure that they are making the most of the unique role of Healthwatch locally and are adding value to a complex landscape of patient and public engagement. We additionally look to NHS England for their assessment of the impact of their patient and public involvement mechanisms on commissioning decisions and would welcome conversations with them about how these mechanisms could be strengthened.

Future engagement

We very much welcome your invitation to continue conversations about the 2015/16 Mandate, and consider more substantive and ambitious updates in the future.

Beyond the 2015/16 update, we believe there is an urgent need for a more substantive re-crafting of the NHS Mandate. Whilst, we appreciate that the Mandate does not express the entirety of NHS delivery or ambitions, it does articulate the priorities that have been given by the Department in its role as the steward for the NHS in England.

Given this, we would welcome a more detailed conversation with your officials to help shape the Department's thinking about how future updates to the Mandate could reflect the priorities of the public, people using health and social care services their families and carers. Underpinning this would need to be a meaningful process of engagement with the public and a process of translating the Mandate into an accessible format that would enable a productive conversation with the public.

To this end, I will ask my team to continue their work with Gareth Arthur. In pursuing this, it would be helpful to have clarity over when in 2015 the Department anticipates the Mandate will be refreshed.

As ever if you require further detail on any of this letter do not hesitate to get in contact.

Yours sincerely,

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AGENDA ITEM: 6

SUBJECT OF REPORT: Care.data and Accredited Safe Havens

PRESENTING: Sarah Vallelly

PURPOSE: This report gives a progress update of Healthwatch England's work to date on the subject of Care.data, specifically by highlighting our response to the Department of Health consultation on the creation of Accredited Safe Havens (ASHs) and our media coverage - attached as appendix B and C to this report

RECOMMENDATIONS: To approve the principles which frame our work and inform our organisational positioning

RESOURCE IMPLICATIONS: N/A

RISK AND MITIGATION: N/A

EQUALITY AND DIVERSITY: N/A

Members are invited to DISCUSS and APPROVE.

Appendix B: Healthwatch England Response to Department of Health Consultation: Protecting Health & Care Information

We appreciate the opportunity to give Healthwatch England's response to the consultation on proposals to protect personal health and social care data.

Healthwatch was formed as part of the 2012 reforms of health and social care that set out the ambition of putting people at the heart of health and social care. There is a local Healthwatch in every local authority area in England and Healthwatch England is the national body. Healthwatch is unique in that its sole purpose is to understand the needs, experiences and concerns of people who use health and social care services and to speak out on their behalf.

Healthwatch England is the national consumer champion for health and social care. Healthwatch England has a particular interest in how the public is involved and consulted on the topic of personal data because the public are concerned with the information held about us, how it is collected, who has permission to use it, the purposes for which it is used, how and when it is disposed.

People should have access to their individual records and be able to change or verify the information held on them. Equally, the public expects timely, clear and effective communication about how personal data is safeguarded.

Summary of response to consultation

Healthwatch recognises that there are significant potential benefits to giving researchers access to patient data, and that sharing information effectively can significantly enhance care delivery. Similarly information shared proportionately, sensitively, and in a timely manner between different organisations involved in a person's care can improve their experience of care and health services. Healthwatch is a strong advocate of the Caldicott principles for the use of patient data by health and social care organisations.

Our network of local Healthwatch have alerted us to many concerns about personal data security and this has informed our work to date in this area. In October 2013 prior to the start of the Care.data programme Healthwatch Derbyshire used the network's formal procedure for escalating concerns to draw attention to problems around patient anonymity and data sharing. Then in January 2014 Healthwatch Herefordshire raised specific concerns on the proposed roll out of the Care.data programme. Healthwatch England consulted the rest of the network and found that one in four Local Healthwatch organisations shared the concern before it became a popular topic in the media. On the basis of this and in partnership with other organisations we successfully argued for a six month pause in the roll out of Care.data.

In the main this response covers the proposals for Accredited Safe Havens (ASHs). We also make important points about the nature of the consultation and about information governance standards that should increase patient and public confidence.

Healthwatch England welcomes the Secretary of State's strong commitment to people's right to object to personal data being transferred out of the GP's surgery for research purposes. In September 2013 he said that sharing information securely is a major part of making health services safer. "But if someone has an objection to their information being shared beyond their own care, it will be respected. All they have to do in that case is speak to their GP and their information won't leave the GP surgery"[1]. This commitment goes significantly beyond the principles in the NHS constitution. Despite the Data Protection Act and the Caldicott Principles this commitment is not yet a legal right to control personal data. We consider that the principle of the Secretary of State's commitment should underpin the broader protection of health and social care personal data. The assurances of the Government (as referenced above), the Partridge Report and the Health and Social Care Information Centre response on Care.data should apply to all the information to be collected and disseminated by the proposed ASHs. The right for objection should not be less valid if the information is being collected by an ASH or Health and Social Care Information Centre (HSCIC) – from a GP or a hospital or another provider.

It is not reasonable to expect patients to understand that their objection to their information being shared will be respected by one part of the NHS but not by another.

Overall key points:

- Safeguarding personal data is an issue that goes beyond the terms of this consultation. It is not clear why this particular consultation does not include Care.data. Any new regulations must also synchronise with the data safeguarding clauses in the Care Act, and be built on the principles of the Data Protection Act (and the underlying European Directives) and the Caldicott Principles. There should be a single regulatory framework for personal health and social care data, and a single regulatory body to oversee it. In the absence of a single framework there must be equivalence across the different regulatory frameworks.
- The timeframe proposed for enacting the proposed regulations (before the end of 2014) is unrealistic. We consider that more time needs to be allocated for proper scrutiny.
- We support the setting up of ASHs and sharing of data for clearly defined purposes. ASHs must be subject to a common regulatory framework that applies to all users of personal health and social care data: if that is not possible the framework for ASHs must be equivalence to other information governance systems.
- The consultation paper is not clear whether the accreditation of ASHs is a "one-off" process. To maintain patient and public confidence each ASH should be accredited for a fixed period (3-5 years) with annual audit and review, and a comprehensive reassessment before re-accreditation for another period is possible. Ideally the review period should be shorter in the early phase of implementing the ASH proposals.

[1] https://www.gov.uk/government/news/jeremy-hunt-confirms-commitment-to-balance-patient-safety-and-privacy--2

- It must be clear that accreditation occurs only for organisation whose purpose justifies the use of patient data and that organisations will lose their ASH status if they fail to comply with information governance standards.
- We have concerns about the proposed structure and plans for how the ASHs will operate and be monitored. For example it is unclear as to whether third party organisations may be able to pay for information held by the ASHs. Also unclear is whether GPs, hospitals and other providers will send information to ASHs on a voluntary basis, or whether they may be paid for it.
- Each ASH should be accredited for a specific purpose, for example research or financial management, rather than all the purposes listed in the consultation. This would enable assessment against purpose and avoid mission creep or aimless data trawling.
- Each ASH should have a designated individual to be accountable as information governance risk owner for the ASH (i.e. a Senior Information Officer with relevant experience and qualifications). We are concerned about any potential breaches of confidentiality and the penalties that are set out in the consultation are very light. The Information Commissioner's Office can issue a fine of up to £500K for serious breaches of data protection. We do not understand why the consultation proposes a smaller sanction (£5K) for breaches by the ASHs. This would infer that potential misuse of personal health and care data is not treated as seriously by the Department of Health.
- In the matter of data security we strongly support the 'one strike and out' principle. A serious breach should immediately lead to ASH status being removed.
- In accordance with the Caldicott 2 principle[2]s, (September 2013) and the Data Protection Act, people (patients and social care service users) should have a right to access the information that is held about them and the right to correct information that is incorrect (whether by commission or omission).

Accredited Safe Havens (ASHs)

In addition to answering the specific questions asked in the consultation we are using this opportunity to provider some of our general remarks on the subject of Accredited Safe Havens.

A more harmonised regulatory regime

We generally agree with the basic concept of the Accredited Safe Havens (ASHs), however, we believe that there is a need for a more unified and harmonized regulation on the protection of health and care information.

One goal of the consultation is to: "Establish clear rules on around the use of data that might potentially identify individuals disseminated by Accredited Safe Havens and the Health and Social Care Information Centre". We believe that it would be even more useful to have all personal health and care data uses regulated under a single regulatory regime. That regime should clearly follow the principles of the Data Protection Act and the Caldicott reports.

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251750/9731-2901141-TSO-Caldicott-Government_Response_ACCESSIBLE.PDF

Paragraph 10 of this consultation suggests that "the Care.data initiative is not covered by this consultation but data collected under the Care.data initiative could be disseminated to Accredited Safe Havens by the HSCIC, or passed on in accordance with section 4 on controls around broader use of care information". In addition in paragraph 11 specifies that: "a complementary secure data service, the Clinical Practice research datalink, has been established within the Medicines and Healthcare Products Regulatory Agency to service the specialised needs of the research and life communities".
We would like to see more detail of how the proposals will be put into practice so we can be confident that the proposed regulations on Accredited Safe Havens are not being used to bypass the safeguards that the government has promised for the Care.data (or vice versa).

Having a single regulatory regime for the collection and dissemination of patient-identifiable data would help to clarify the boundaries of each data collection project and improve the effectiveness and clarity of dissemination of information to the public on this complex issue.

Paragraphs 23 and 24 suggest a weakening of the 2002 regulations and the Care Act 2014 so that an ASH does not have to seek ethical approval or Secretary of State approval for each individual research project. We cannot agree to this unless each ASH is subject to the regulatory regime (regular audit and review, restricted purposes) that we propose. There is no adequate explanation or justification for why the 2002 Regulations (and the more recent 2014 Care Act provisions) should be side-stepped by the ASH system.

Right to object
Concerning the patients' right of objection for the use of their personal data, Paragraph 19 states that "In line with the NHS Constitution, if individuals object to data about them being used in this way, their objection should be respected and their data will not be used".

We believe that this gives a much weaker right to object compared to the guarantee provided by the Secretary of State stating that anyone objecting to the uploading of the GP record to Care.data will have that objection honoured. The NHS Constitution says (page 8): "You have the right to request that your confidential information is not used beyond your own care and treatment and to have your objections considered, and where your wishes cannot be followed, to be told the reasons including the legal basis." This right to request is not a right to have this request honoured. Longer term, Healthwatch England wants to explore options for establishing a legal right to object. For the purposes of this consultation, we insist that the ASHs cannot be used to collect and disseminate data about patients who have exercised their right to object under the Care.data programme.

Government's assurances on Care.data (see footnote 1, page 1) should apply to all the information to be collected and disseminated by ASHs and HSCIC. In addition consumers should have a right to clear information which enables them to choose whether or not to object.

Paragraph 24 of the consultation paper specifies that work on this is being carried out "in parallel with this consultation." We believe that work on this point should be a fundamental part of this consultation rather than being separate.

We want to see more details on how patients can register an objection to their general practice and hospital information being uploaded to an ASH. In particular we require further clarifications on the following points:

- Will the codes that GPs apply to patients' records for Care.data purposes apply for ASH purposes?
- How will hospitals, mental health and other providers apply objection codes to patient files, given their variable technologies?
- Are there to be Type 1 and Type 2 objections, as for Care.data?[3]

Our response to the specific questions in the consultation is below. We have focused on those most relevant to the role and remit of Healthwatch England.

Q1. Are these purposes the right ones? Are there any other purposes that it is acceptable for an ASH to use data for? Please set out what you think the purposes should be.

The list of allowable purposes specified in paragraph 26 is wide. Any accreditation of a specific Safe Haven should specify which of the purposes it is allowed to collect and process data for. If an ASH does not use all of the purposes that it is accredited for then its approval should be amended to remove the purpose(s) not used. No ASH should be accredited for all purposes.

Paragraph 20 specifies that "ASHs will be able to obtain data from bodies such as local providers. These local flows will also contain person-level data that is capable of being used to re-identify individuals". We suggest that the HSCIC should be informed about which information ASHs share between themselves.

Paragraph 25 states that: "These new Regulations will not stop any legal data sharing agreements, including those that require data at an individual level between Government departments". While we agree on this principle we believe that the public needs to be informed about how personal data are used between government departments for transparency.

The current consultation does not explicitly define whether GPs, hospitals and other providers will send information to ASHs on a voluntary basis, or whether they may be paid for it. This is a point we believe needs to be clarified.

[3] *Type 1 objection*: Patients can object to information about them leaving a general practice in identifiable form for purposes other than direct care, then confidential information about them will not be shared. *Type 2 objection*: Patients can object to information about them leaving the HSCIC in identifiable form, then confidential information about them will not be sent to anyone by the HSCIC.

Q2. Are there any other regulatory controls that you think should be imposed?

The consultation appears to create a "one-off" process for accrediting (or approving) ASHs. This is not acceptable, particularly as the consultation proposes that ASHs will be exempt from the safeguards in the 2002 Regulations and the 2014 Social Care Act. Accreditation should be for a time-limited period (preferably three to five years) with re-accreditation subject to an independent audit of information management (for example to NHS information governance standards and/or ISO/EC 27001:2013(en) standards).

We agree with paragraph 34 where it states that "approval could be removed if the body failed to comply with the controls outlined above, and that the approval will be renewed annually". Re-accreditation should be subject to an independent audit of information management (to NHS information governance standards and/or ISO/EC 27001:2013(en) standards).

In addition paragraph 34 refers to an annual "approval" process though it does not specify the mechanisms that would trigger "disapproval". In particular the failure to provide an independently audited annual statement of compliance with the Information Governance Toolkit (or failure to demonstrate compliance) should trigger temporary or permanent removal of accredited status.

The consultation is far too vague on what happens if an ASH misuses data. We require additional specifications of the possible sanctions to ASHs when they misuse their data. Sanctions should include the possibility of losing accreditation.

If an ASH is required to provide evidence on how it cleans irrelevant data then the evidence should be part of the conditions of accreditation and re-accreditation (and annual approval as in paragraph 34). The evidence should also be subject to a random independent audit (as already provided for later in paragraph 28).

It is important that clear regulations and guidelines on how an ASH will provide data to third parties are in place. All the regulations on data sharing with third parties should be developed in accordance to the Caldicott 2 principles and the Data Protection Act. The data release should be anonymised as much as possible[4]. In addition exchanged data should be encrypted. The exchange agreement should make sure that the data is destroyed once the data agreement period terminates. Audits should ensure that the data has been destroyed in accordance with information management principles.

The second point of paragraph 28 indicates that "an ASH would be acting with the benefit of any guidance on ASH working practices published by the HSCIC or the Secretary of State". This guidance must be produced before the Regulations are enacted and it should be specifically referred to in the Regulations and in the audit and review processes for ASHs.

[4] Information Commissioner's Office Code of Practice - Anonymisation: managing data protection risk (2012)

Paragraph 30 expects ASHs to reduce or eliminate handling of identifiable information. The accreditation process should require a progress report on reduction or elimination, and that ASHs should report each year (as part of the approval/audit) on the steps they have taken towards minimising identifiable data.

Paragraph 18 states that identifiers that are not necessary to the processing will have been removed (for example names and addresses). In addition paragraph 20 states that "Some of the information that ASHs would use could come from HSCIC in the form of standard minimum datasets containing person-level data from which some identifiers have been removed but which is capable of being used to re-identify individuals". Clarity on which identifiers will always be removed when an ASH provides data to third parties could be an important point to communicate to the public to gain trust.

In addition the ASH needs to ensure that it presents the required capacity and technical know-how to ensure that data security is satisfied. Each ASH needs the technical capability to understand that the use made by any third party will not lead to patient identification. Requirements on this should be developed by the HSCIC or by an independent auditor. The technical ability should relate also to all the controls specified in the regulation.

Paragraph 22 makes it clear that ASHs will multiply the number of datasets that contain patient identifiable data to different extents. We need to make sure that security measures are in place when storing the data and when communicating with third parties. This makes it clear that ASHs need to have the technical capabilities and know-how to manage those data. This technical capability could be assured by requiring that the officers of the ASH have a necessary professional qualification in information governance.

ASHs and the HSCIC should control the final information produced from users of patient identifiable data to ensure that the final output does not accidentally lead to patients being identified. This might particularly be the case when performing research on rare diseases or in rural areas. The ASH and the HSCIC should be aware of the final product of research and ensure patient anonymity and confidence is always satisfied. This could be ensured by establishing the figure of a Senior Information Officer in each ASH having the responsibility of the managing of information flows into and out of the organisation.

We request an additional clarification on Paragraph 31. This paragraph states that "as the capacity of the HSCIC increases, we will consider whether the HSCIC is itself a practical alternative to processing within an ASH". Will this imply that in the future the number of ASH will be strongly reduced? Are ASHs needed only until the HSCIC increases its capability?

We would also like to receive additional clarifications what happens to data if an ASH loses or gives up its accreditation.

Q3. What are your views on the maximum amount of the civil penalty that we should set for breach of the controls proposed above in relation to ASHs?

Paragraph 29 proposes a civil penalty for breaches of the guidelines. A better sanction would be temporary (until proof of compliance is produced and independently audited) or permanent withdrawal of a whole organisation's status of ASH.

We are concerned about any potential breaches of confidentiality and the penalties that are set out in the consultation are very light. The Information Commissioner's Office can issue a fine of up to £500K for serious breaches of data protection so why is such a small amount being proposed (£5K) for the ASHs? This would imply that potential misuse of personal health and care data is not treated seriously by the Department of Health.

Equally there is no recompense to an individual or an organisation – say a GP practice – that has been impacted by a breach in confidentiality and from a consumer perspective, this needs more consideration.

Q4. Should there be any restrictions as to the type of body which might become (in whole or in part) an ASH, for example, a social enterprise, a private sector body or a commercial provider (working under a data processor contract)? Please let us know what you think.

Our view is that there should be restrictions on the kind of institution that might become an Accredited Safe Haven. ASHs should only be:

- Organisations In the public sector,
- Charities or Community Interest Companies, and
- Universities and other institutions or Higher Education.

Organisations working in the private sector and serving primarily commercial purposes should not be entitled to become ASHs.

In addition we require that organisations that have acquired, or are interested in acquiring, the status of Accredited Safe Haven will lose that status if they move to the private sector. One example of this latter category would be Commissioning Support Units which are due to start moving into the private sector from 2015. This type of organisational change should trigger an automatic review of accreditation.

No organisation that undertakes activities that raise conflicts of interest should be eligible for ASH accreditation. The sale of personal health and care information to private insurance or medical companies by the forerunners of HSCIC led to serious concerns about Care.data. These type of episode severely reduced public confidence in data security.

Paragraph 35 refers to an independent scrutiny of (a) the process for establishing an ASH and (b) the need for these regulations. The regulation should also cover the processes that test / ensure that an organisation is fit to remain an ASH.

The kind of organisation that can gain an ASH status should be restricted to the organisations whose main or only functions are those listed in paragraph 26.

Q5. Is there a maximum number of accredited safe havens that you would consider to be acceptable? Please give your reasons

The number of Accredited Safe Havens should be small, but not too small that it restricts the potential to gain the health and care benefits. Having ASHs with specific parameters and restricted purposes – for example for research or financial transactional analysis - might make a larger number more acceptable.

There is already a national Accredited Safe Haven (the Health and Social Care information Centre) whose powers are determined by statute (the 2012 Act, supplemented re Care.data by the Care Act 2014.) In our view it would not be acceptable to set up an indeterminate number of other ASHs, which may operate at national or local level, perhaps in competition with each other, and with no indication of their size. Could an entire CSU be declared an ASH, giving all employees access to information In order to "improve patient services"? We would advise against this scenario.

There are already 56 organisations that are deemed to have met the requirements imposed under section 251 of the NHS Act 2006 to become temporary stage one Accredited Safe Havens, the majority being CCGs or CSUs. Their accreditation will last until October 2014 but it is unclear what the next steps are, how many of these will become ASHs longer term, whether it is assumed these organisations will automatically transfer, or how many more will be set up.

Q6. What are your views on the level of the civil penalty that we should set for providers who do not comply with this duty?

This aspect of the consultation refers to commissioners' access to data from service providers to effectively carry out the commissioning function. We are in favour of the duty. However, the regulations (or guidance) must make it clear that any information request and disclosure is still bound by a duty of confidentiality (extended to the commissioner) and the Data Protection Act. Equally we would like to see 'commissioning purposes' more clearly defined. Are there any limits or at the minimum a list of relevant activities? Information governance principles must still apply to the commissioner and in this respect we would like to see more synergy between different information governance regulations.

As an additional measure to the civil penalty concerning a provider's lack of compliance it could also be an option for the commissioner to recommend to the CQC that the provider's registration be reviewed.

Q7. Do you agree with the circumstances in which commissioners (case managers) should be able to obtain confidential patient information of an individual for whom they commission care?

Paragraph 45 is too general. It does not specify the purpose. Could it be a way to apply section 251 of the National Health Service Act 2006 for any kind of purpose using patient-identifiable data? We would like more clarity in order to understand what this entails.

Whilst the consultation is explicit that this section refers to data beyond the remit of ASHs, paragraph 48 would appear to infer that patient data will be shared and user between service commissioner and provider, despite any individual objection to this use of data and this is unavoidable. What is the value of opting out in this case? More clarity is needed and it is important that people's wishes and choices concerning privacy of personal data are honoured as far as possible. The public need to be clear about any scenarios where their specific wishes in respect of personal data security may potentially be contravened.

Q8. What controls do you think should be in place in respect of such access? Please provide details.

We think that the independent scrutiny (paragraph 48) should be jointly managed by the information commissioner and the CQC. Alternatively, if an independent reviewer (of this and of the ASH proposal) is set up, then we recommend that Healthwatch England is represented on its governing body.

Regarding access control specified under Case Management there should be a requirement that the commissioner and/or the person countersigning the request have an appropriate professional qualification.

After our protests, the Care Act 2014 gave additional assurances about the uses to which HSCIC could put the information collected via Care.data (mainly in section 122 of the Care Act.) One of these assurances was that the Health Research Authority's Confidentiality Advisory Group would decide whether any dissemination of potentially identifiable information is appropriate. Why not similar checks over dissemination by an ASH? The Government also promised "one strike and you're out" rule to govern CAG advice – requiring that an applicant requesting data has not misused this sort of data in the past. Why not a similar regime for ASHs? Paragraph 52 of the consultative document mentions CAG in relation to HSCIC, but the subsequent paragraphs don't in relation to ASHs.

Q9. What are your views of the controls set out above?

Again the opportunity to provide a single point for the regulation of data collection, storage and release is lost. Why are the proposed regulations on the role of the confidentiality Advisory group being progressed separately (Paragraph 52)?

The proposed standards in paragraph 57 provide no comfort for those of us concerned about the inappropriate / unethical use of data (paragraph 51)

The proposed penalties only apply to the receivers of information, not the providers (HSCIC or an ASH). This is inequitable. In addition to DPA penalties there should also be provision for suspension, restriction, or termination of ASH accreditation. Penalties on HSCIC should be extended to enable the Secretary of State to send in someone to sort things out (a breach of this sort should be a 'never event') In addition the civil penalty

should be supplemented by administrative sanctions involving temporary or permanent loss of access to HSCIC / ASH data.

We welcome the purpose of providing the existing Confidential Advisory Group (CAG) with an advisory role in respect of disclosures of data by HSCIC, as indicated in paragraph 52. In addition we ask, in line with the recommendations for action following the Partridge review[5], that patients and public representatives will be part of the new membership of the HSCIC data oversight committee, the Data Access Advisory Group (DAAG). It is fundamental that patients and members of the public have a representation in the CAG.

Again an effective penalty on third parties who breach the confidentiality of data is that they might be denied future access to data held by ASHs in the future.

Q10. What are your views on the level of the civil penalty that we should set for any breach of these controls?

In line with our responses on questions 3 and 6 we want to see a system of penalties that is commensurate with the seriousness of the breaches involve, and which complements the powers and sanctions of the Information Commissioner's Office. We do not consider a threshold of £5,000 to be sufficient.

Q11. Are there any other controls that you think should be imposed? If so, please set out what you think these should be.

Paragraph 57 of the consultation document refers. The first point refers to a possible event not likely to be actualised. Can this really be translated into the legal language of regulations? It would be simpler if the HSCIC or ASH placed a requirement on recipients to ensure that:

- They would not come into possession of information that would potentially identify individuals.
- They would not attempt to process information in order to identify individuals.
- They could demonstrate their systems to ensure compliance with the non-possession and non-processing requirements.
- They would open their systems to random audit by ASH / HSCIC (and the Secretary of State's, or the Information Commissioner's investigators).
- They would not release data onwards to third parties without the express permission of the HSCIC or the relevant ASH

Q12. Do you think any of the proposals set out in this consultation document could have equality impacts for affected persons who share a protected characteristic, as described above?

[5] "Data release review. Health and Social Care Information Centre. June 2014". http://www.hscic.gov.uk/media/14246/HSCIC-Data-Release-Review-PwC-Final-Report/pdf/HSCIC_Data_Release_Review_PwC_Final_Report.pdf

More detailed consideration is required in terms of protecting the rights of vulnerable people, particularly those (including children) who do not have capacity to give informed consent. There is nothing in the proposals about them, nor are there any links to other provisions in legislation that might protect them. This needs to be clarified.

Q13. Do you have any views on the proposals in relation to the Secretary of State for Health's duty in relation to reducing health inequalities? If so, please tell us about them.

The Secretary of State's ability to meet the duty will be weakened if there is a loss of public confidence in the handling of personal health and social care data.

Appendix C: Media – The Guardian, Tuesday 7 October, Randeep Ramesh

Link: http://www.theguardian.com/technology/2014/oct/07/care-data-patient-information-accredited-safe-havens

The 'accredited safe havens' scheme has similarities with the care.data scheme which was delayed earlier this year

Confidential patient information is to be housed in a network of regional centres across the country, in a proposal that critics say amounts to an attempt to reintroduce the national database of medical records that was abandoned earlier this year.

Harvested from GP and hospital records, medical data covering the entire population – and including information such as mental health conditions, diseases, as well as smoking and drinking habits – would be uploaded to the new "accredited safe havens" (Ash) scheme.

In August, the Department of Health said Ash was only intended to provide access to records that have been stripped of personal details.

However, patient watchdogs have raised the alarm over fears that the new system replicates all the worst aspects of the "care.data" scheme, which was a plan to digitise and centrally store the entire medical records of England in a single database.

Care.data was delayed earlier this year, weeks before it was due to be rolled out nationwide – which would mean medical records uploaded from almost 9,000 GPs surgeries – after privacy concerns over what the patient data might be used for and where it might end up.

Privacy campaigners say the plan for the regional centres revives talk of "pseudonymised information" being extracted from medical records. That refers to a process whereby some personal identifiers are removed but not enough to make information completely anonymous.

Healthwatch England, set up by the coalition as a consumer champion in health, said that in planning a series of regional data centres "officials have not learnt the lessons of the controversial care.data programme".

Anna Bradley, chair of Healthwatch England, said: "We applaud the secretary of state for taking the time to listen to and address patients' concerns over care.data. The assurances he put in place gave Healthwatch England more confidence in the way GP records will be used and how the right to object to having our own files shared will be implemented.

"But these additional assurances must be extended to all health and social care data sharing initiatives otherwise the Accredited Safe Havens project will end up being seen as 'Big Brother's little brother'. The public need to know that if they decide to opt-out of one medical record sharing programme, their wishes will be respected across all such projects."

Healthwatch said that ministers now "risks facing similar backlash unless same additional assurances for care.data applied to all data sharing initiatives".

Yesterday it was announced that 265 GP surgeries would continue trial the care.data scheme. Those who sign up to the pilots will have to send individual letters, emails or texts to all their patients.

GPs voted against care.data being rolled out across the country on the grounds that patients had to opt out of the system rather than opting in – and called for confidential patient data to be anonymised before it leaves surgeries. The NHS however has decided patients will still have to opt out rather than opt in to the scheme.

Tim Kelsey, NHS England national director for patients and information, said: "Since February we have been listening to the views of the public, GPs and other important stakeholders to hear their concerns about data sharing."

"We have heard, loud and clear, that we need to be clearer about the care.data programme and that we need to provide more support to GPs to communicate the benefits and the risks of data sharing with their patients, including their right to opt out."

Image of the Guardian article below:

National

The Guardian | Wednesday 8 October 2014

Confidential NHS patient data to be stored in regional centres

Randeep Ramesh

Confidential patient information is to be housed in a network of regional centres across the country, in a proposal that critics say amounts to an attempt to reintroduce the national database of medical records that was abandoned earlier this year.

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However, patient watchdogs have raised the alarm over fears that the new system replicates all the worst aspects of the "care.data" scheme, which was a plan to digitise and centrally store the entire medical records of England in a single database.

265

The number of GP surgeries that are continuing to test care.data, despite many campaigners arguing that it could be open to abuse

Care.data was delayed earlier this year, weeks before it was due to be rolled out nationwide – which would mean medical records uploaded from almost 9,000 GP surgeries – after privacy concerns over what the patient data might be used for and where it might end up.

Privacy campaigners say the plan for the regional centres revives talk of "pseudonymised information" being extracted from medical records. That refers to a process whereby some personal identifiers are removed but not enough to make information completely anonymous.

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AGENDA ITEM: 7

SUBJECT OF REPORT: Local Intelligence Report

PRESENTING: Deborah Laycock and Sarah Vallelly

PURPOSE: This report provides the Committee with an overview of escalated issues arising from the network and outlines plans to develop the local intelligence infrastructure. The report provides an overview of escalated issues arising from the network between July-September 2014 as well as an update on improvements made to the escalation process

RECOMMENDATIONS: N/A

RESOURCE IMPLICATIONS: N/A

RISK AND MITIGATION: A risk to the escalation process is that the staff time needed to deliver the process is too great to enable staff to also deliver other work streams. To mitigate this, discussions have begun on what support is needed for both the escalations and enquiries processes and the best configuration of resources to deliver these core processes. These will be brought to the Senior Management Team (SMT) in November when a decision will be made about how to resource escalations and create a joined up approach to escalations, enquiries and other concerns arising through the network. SMT will also consider refining the triage process to ensure that strategic cases are identified rapidly and given due resource to complete

Background

The escalation process is in pilot phase until the end of December 2014. In November the pilot will come for review to SMT when decisions will be made about resourcing; the triage process and a finalisation of the oversight and decision making process.
During the pilot we have found that escalations are highly variable in nature covering a huge variety of policy issues as well as concerns about providers. Frequently escalations have drawn attention to issues about local Healthwatch development and there has been some volume of inappropriate escalation, inevitable in such a new process. We have also identified that some considerable resource is required to identify what lies behind an escalated issue and that they require a case management process spanning the organisation. This is because the same issue may arrive in the organisation via various routes. The final section of this report sets out improvements that have been made to date in regards to ensuring the process is clear and transparent to local Healthwatch.

In the last quarter a considerable effort has been concentrated on improving communication with local Healthwatch including:

- An updated resource for local Healthwatch, launched in August. This provides an overview of what an escalation issue is, when to escalate an issue, how to escalate an issue and the process of what happens with an escalation once it is received by Healthwatch England.

- To coincide with the handbook, a webinar was held with 15 local Healthwatch to answer further queries and provide clarity on the escalation process. A lunchtime learning session was also held for Healthwatch England staff to provide an overview of the escalation process.
- In August, the monthly escalation update for local Healthwatch was also launched, alongside a dedicated escalation area on the homepage of the Hub. The monthly update includes two resources; a document that contains all open escalation cases, and headline details of the case and action taken by Healthwatch England to date. In addition, an archive document contains all closed escalation cases with details of final action taken to resolve the issue. These updates are being trialled at the moment to ensure that they are of use and relevance to local Healthwatch. Feedback so far has asked that more details of cases be included in the update, in-depth case studies be shared on how cases were resolved and direct links to the documents on the Hub be shared when promoting the updates on Yammer.

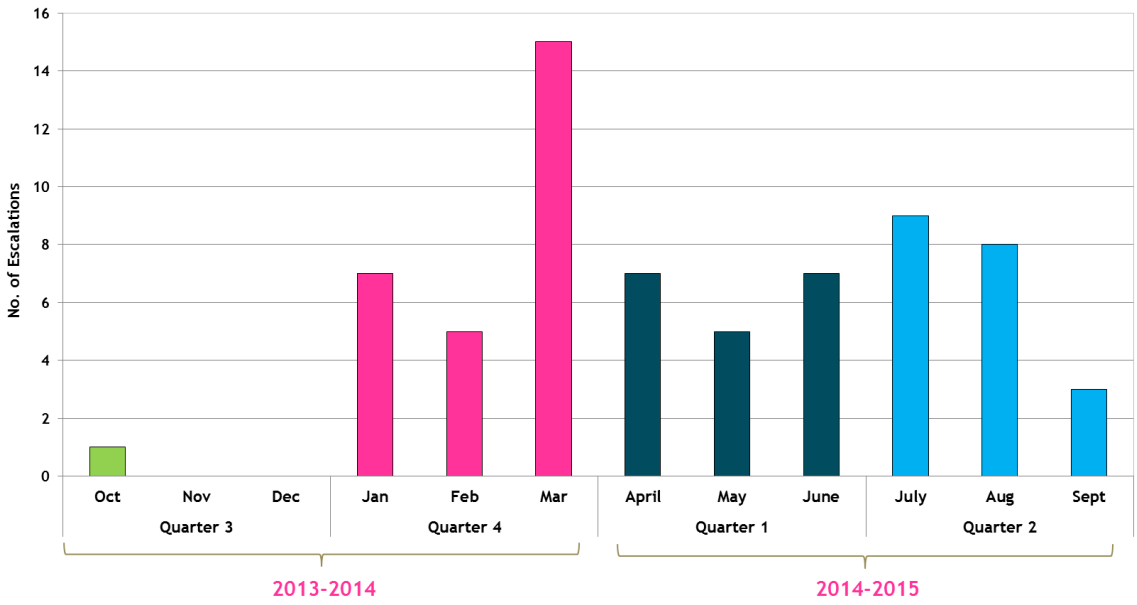
We have also been strengthening the way that relevant teams input into the escalation process through the Escalations Working Group. We now have sufficient cases to bring the outcome of this pilot to SMT in November.

In addition to the above, the Committee asked that our escalation work was brought together with our local intelligence analysis and enquiries. Given the pressure on resolving escalations, this process has taken longer than anticipated but some preliminary analysis of local Healthwatch reports is reflected below as is a timeline on key outputs from the local intelligence work.

Report - Escalated issues in Q2 2014/15 (July-September)

During quarter two we have received 20 escalations – all from different local Healthwatch. The graph below shows that we have received 67 escalations to date.

Escalations from Local Healthwatch



As requested by the Committee, we have brought to the front of this section the escalations that need to be flagged to the Committee for their attention, and updates on the escalation cases presented during the last Committee meeting.

1. **Committees in Common**

At the previous Committee meeting, we asked the Committee to note the use of our advisory powers in terms of the changes proposed under the Draft Legislative Reform (CCG) Order. Based on the escalation (within the Manchester area), we wrote to the Secretary of State to highlight our concerns that major models for service reconfiguration were being discussed in closed session and there was insufficient planning for public engagement by joint Committees spanning more than one Clinical Commissioning Group (CCG) area. We subsequently raised concerns to the Secretary of State about CCGs sufficiently meeting the level of assurance required for involving local Healthwatch and the community in decision making, and the statutory guidance on engaging the public meaningfully in commissioning decisions.

On 9th September, the Healthwatch network also brought the voice of consumers to the heart of Westminster when Parliament debated the Draft Legislative Reform Order on CCGs. This led to a very strong debate in the chamber where the concerns from both local Healthwatch and Healthwatch England were raised by a number of Members from across the House. These included:

- Concerns about the failure of joint Committees to engage the public and respect local accountability mechanisms
- The impact of voting arrangements made by joint Committees on decision regarding local services
- What assurance there will be to ensure CCGs are fulfilling their statutory requirements to engage the public

The Rt Hon Norman Lamb, Minister of State for Care and Support, acknowledged the concerns raised by the network and assured members there will be guidance and support given to CCGs to ensure they meet their statutory obligations for engaging the public.

Healthwatch England will continue to support local Healthwatch in areas affected by the existing and new arrangements and will be sending a revised briefing on the legislative reform order to the network. We will continue to use our channels to influence discussion about the assurance process.

Furthermore, we will work with the Department of Health, NHS England and the Local Government Association, to ensure adequate safeguards are put in place in the governance arrangements for joint commissioning. This would assure the public that there is a mechanism to address breakdowns in accountability or blocking of local Healthwatch statutory functions. We feel this is particularly important given that many of these collaborative commissioning arrangements will involve major reconfiguration programmes.

We have also received a number of escalations from the network regarding poor public involvement in reconfiguration plans that will be included as case studies for the service redesign project. This includes Warrington (reconfiguration of services without public consultation) and Suffolk (alleged bias in CCG consultation for their preferred option to reconfiguration). The Healthwatch England service redesign project aims to give local Healthwatch the foundations they need to understand and perform their role in service transformation, reconfiguration and integration. This also includes supporting local Healthwatch to enable them to determine the quality of public engagement and challenge as appropriate.

In regards to the Better Care Fund (BCF), we wrote to Jon Rouse, Department of Health Director General to give an overview of local Healthwatch engagement in the process, the challenges they have encountered and examples of what engagement in the planning phase has looked like in practice. Jon reported that there is a correlation between the BCF plans that Department of Health anticipate to be the strongest and those areas working with their local Healthwatch teams. He has also shared our concerns with the Better Care Fund Taskforce (the multidisciplinary national BCF team).

2. Independent investigation of deaths in secure mental health settings

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

Healthwatch England formally escalated the issue to NHS England. We asked for clarity on the focus and timings of a review of the facility that NHS England had committed to undertake. NHS England replied setting out that the review (part of the quality assurance process of the provider) will be reporting in November 2014. NHS England re-committed to local Healthwatch involvement in the ongoing quality assurance process of the facility including attendance of Quality Assurance Oversight meetings.

We also shared details of the case at a senior level with the Care Quality Commission (CQC). This was with the local inspection team to make sure that they were fully aware of the concerns and could share them with them with the team planning the hospital inspection. The local team undertook an unannounced inspection prior to the main inspection as a result of the information shared by us. Healthwatch Northamptonshire were fully engaged in the work that CQC were undertaking and also shared information, some of which was as a result of Enter and View activity. We also escalated our concerns to senior managers in CQC – Chris Day being our main contact so that they could facilitate internal discussions about this case and make sure that all the local Healthwatch connected to the inspection of this provider could be approached for local intelligence. We also contacted the lead inspectors ourselves with the contact details of local Healthwatch.

The inspection of this provider has now been undertaken and we await the full report, this was the first large Mental Health provider inspection so it was timely that we and local

Healthwatch were able to shape the inspection by sharing information. We are now organising a roundtable discussion with CQC and Healthwatch Northamptonshire to discuss the outcome of the recent CQC inspection of the facility and learn from this experience. We have also facilitated the inclusion of the experience of Healthwatch Northamptonshire in the current Equality and Human Rights Council (EHRC) inquiry into deaths in custody (see below for more details).

This escalation raised concerns about the underlying process for investigating deaths that occur in mental health settings. Since the last Committee Meeting, we have spoken with key organisations with a role or interest in investigations and have sought to clarify the current process of investigations.

Key points

- There are concerns regarding the robustness of internal investigations undertaken by mental health providers, and outstanding questions on how decisions are made on whether an independent investigation is necessary.
- NHS England is releasing an updated Serious Incident Framework (SIF) that includes clearer guidance around deaths in mental health settings.
- CQC are vocal on this issue and have strengthened its role in ensuring that learning from serious incidents is implemented. As part of the inspections process CQC will be checking that providers have a robust system in place to respond to and learn from serious incidents including deaths.
- Currently case law has set out that Coroners Inquests satisfy Article 2 (of the European Convention on Human Rights) requirements into independent investigations, however the Equality and Human Rights Commission is carrying out an inquiry to ensure that investigations into deaths carried out by health providers are indeed in line with the Convention.
- Deaths in police/prison custody have a different process for independent investigations. Whilst all deaths go to the coroner for investigation, all deaths will also be investigated by an independent body – Prisons and Probation Ombudsman (PPO).

This is a complex and crowded area and a policy briefing is currently with the Director of Policy and Intelligence who will make a recommendation to SMT about how best to pursue this issue and the resource implications of different routes.

3. Flu vaccination programme in children

In August Healthwatch Kirklees escalated to us a concern around inequalities emerging in the current flu immunisation programme in children. The programme now provides vaccination to all 2, 3 and 4 year olds with pilots also occurring in primary and secondary schools.

There are two forms of vaccination. A nasal spray which contains porcine gelatine and an injection which is deemed to have a lower efficacy but that does not contain any porcine products. The flu programme in children only administers the nasal spray.

A statement from national and international figures from the Jewish and Muslim communities supports the use of the nasal spray vaccine. However, it is up to local faith leaders including local Imams to decide what advice they will give to their local community regarding the use of medicines containing gelatine.
In Kirklees, the local group of Imam's, including the local hospital Islamic chaplain; do not support the use of the nasal spray vaccine resulting in a substantial section of local children at risk of not receiving the vaccine.

There is concern that at the design stage of the flu programme, advice was not sought from community groups on how to design the programme to best meet the needs of everyone in the local community. We now know that this same issue – non-acceptance of the nasal spray vaccine because of its porcine ingredient was highlighted as an issue in the flu programme last year, yet no action seems to have been taken and the same issue therefore arises this year.

We wrote to Public Health England (PHE) highlighting the inequality that had arisen in the flu programme and the need to ensure alternatives to the nasal spray are available to those who will not accept it. We asked the degree to which the Inequalities Impact Assessment undertaken for the flu vaccination programme addressed the porcine nasal spray issue. In addition, we asked:

- How were local faith leaders (remembering that decisions are made locally in the Muslim community) included in the design stage of the national flu vaccination programme to ensure that the programme addressed the needs of this community?

- What level of flexibility has been given to local authorities to tailor the flu vaccination programme to their local population?

- What urgent steps are PHE taking, as the flu vaccination programme has already started, to address the inequalities that arise from the lack of options and choice local Muslim communities have to protect their children from influenza.

In addition, we raised the issue at the Children's Health and Wellbeing Partnership meeting and shared full details with the Department of Health Director General Jon Rouse who was concerned that lessons had not been learnt when the same issue was raised last year during the flu programme.

Public Health England responded to our escalation standing firm that no alternative vaccination to the nasal spray will be offered in the child flu programme. It also seemed that PHE were far too late in realising a problem existed regarding the use of the nasal spray in certain communities. We will be responding to PHE reconfirming that the situation as it stands is that there is a section of our society who are being denied the flu vaccination because their needs were not sufficiently considered in the design of the programme.

Healthwatch Kirklees have now been invited to attend a DH/PHE/NHS England workshop chaired by a Deputy Chief Medical Officer which is focused on understanding the current

position in regards to the use of porcine gelatine flu vaccination and uptake among different population groups and what engagement has occurred. It is concerning that no members of the public from the Muslim community seem to have been invited to the workshop. Following the workshop, we will be working with local Healthwatch to decide next steps to be taken in this escalation case.

4. **Accessibility of gender identity services**

Local Healthwatch have escalated to us various issues around gender identity services – particularly linked to lack of access to these services. These include:

- Mis-communication locally on who commissions the service
- Mis-communication on funding available for the service
- Considerable delays in accessing this service – years in some cases
- Individuals being put on waiting lists as "money has run out" for the service
- Unclear timelines and changes in timelines on when treatment will occur
- Insufficient support whilst waiting for treatment
- Lack of communication and contact from providers of the service
- Individuals "falling out" of the access pathway and struggling to re-access the service
- Wider concerns with the treatment of the transgender community by health professionals

The initial escalation was received from Healthwatch Torbay but a further 6 local Healthwatch shared evidence of similar concerns.

We formally escalated this issue to NHS England and are awaiting a response (due by 15th October). We also met with Ann Sutton, NHS England Director of Commissioning, to provide her with more information on the issue. Ann indicated that a Task and Finish Group had been set up by NHS England to address the failures in access to gender identity services. Once the NHS England response is received, we will consider the next steps for taking forward this escalated issue.

5. **Concerns with quality assurance of non-regulated services**

We have received two escalations raising concerns about quality assurance mechanisms in non-CQC regulated services. Healthwatch Nottinghamshire is concerned about a lack of quality assurance of support services that do not come under the definition of "personal care". The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 defines personal care as:

Physical assistance given to a person in connection with:

- eating or drinking
- toileting
- washing or bathing
- dressing oral care

- the care of skin, hair and nails (with the exception of nail care provided by a chiropodist or podiatrist)

Non-personal care activities include lunch clubs, meals on wheels, day care, and help with shopping or domestic work. Local authority safeguarding teams have reported difficulty in inspecting and taking action against such providers as they are neither CQC registered nor contracted directly by the local authority.

In addition, Healthwatch Richmond is concerned that 'supported living environments' are insufficiently regulated placing residents at risk. Supported living environments refer to a range of services designed to help people retain their independence within their local community. These are often classed as private residences that receive care via a domiciliary care agency. They do not need to be registered with CQC as a care home and CQC are unable to inspect them. A number of these premises were previously registered as care homes but have since changed their status to become private residences.

As the use of personal care budgets – particularly via direct payments - increases, these escalations raise questions on how budget holders can ensure that the services they are purchasing are of a high quality. This includes questions regarding what the process is when a safeguarding issue occurs, and the mechanisms for raising complaints and seeking redress where services are not of a sufficient quality.

As a first step, we are raising the issue with CQC nationally to explore whether the current regulatory framework allows sufficient oversight of services purchased by personal health or care budgets.

Appendix D contains an overview of all escalated cases from July-September 2014 as well as all other currently open escalation cases.

Reports released by local Healthwatch

In terms of understanding the issues being investigated by the network which were not brought to our attention through the escalations process, we have also undertaken a rapid review of 35 reports which have been sent to us over the previous quarter to gain an understanding of the issues which are being faced at a local level. It is important to note these reports have been proactively sent to us from local Healthwatch, and so are not representative of the complete activity of the network as a whole. We will, in future, develop a consistent means for collecting and analysing all reports from all local Healthwatch.

Nearly a third of the reports focussed on access to GPs, either as a response to the GP Patient survey (Healthwatch Waltham Forest) or focussing on a particular part of the problem in terms of accessing GPs such as charging for letters (Healthwatch Leeds), experiences of getting an appointment (Healthwatch Surrey) or the 'out of hours' telephone messages (Healthwatch Hampshire). This demonstrates the appetite for the forthcoming research project into work on entry to primary care, and reflects both the relevance and complexity of the issue throughout the network. There have also been two

reports that specifically look at engaging young people in understanding health and care services (Healthwatch Devon) and in understanding the experiences of young people using Health and Social Care services (Healthwatch Blackburn with Darwen). Other issues raised in reports included perceptions of Ambulance Services (Healthwatch Suffolk), talking to parent carers of children with Special Education Needs (Healthwatch Waltham Forest) and Accident & Emergency attendance (Healthwatch Shropshire).

Issues arising from enquiries

A key source of information for building our understanding of local intelligence is the use of information which comes through the enquiries to Healthwatch England. While enquiries are not a representative mechanism for measuring concerns faced by the whole population, they do provide us with insight into some of the issues being faced on the ground. The following table presents the top 5 enquiries received between July and September 2014, over a period where 197 enquiries in total were received:

Issue	Number of enquiries
GPs	46
Hospitals	44
Dentists	24
Mental Health	17
Complex (enquiries received which crosscut several themes or do not relate to any of the themes)	14

The most prevalent issue was GPs, accounting for nearly a quarter (23%) of enquiries received. Concerns raised around GPs included people feeling they are not receiving the attention they need from their GPs, people having difficulties accessing GPs, and being unclear on medication provided from GPs. This is reflective of the escalation originally raised by Healthwatch Worcester, about the difficulties people face in using NHS Choices in making decisions on choosing local GPs. We have also received a similarly high proportion of enquiries about hospitals (22%) around lack of join up in referral from GPs to hospital services, complaints about waiting list times and the quality of treatment received while staying in hospital.

Update on improving the escalation process – next steps for local intelligence

As outlined in the previous local intelligence report the Committee have asked that we develop an approach for putting the information from escalations into the context of broader local intelligence and fully realise an evidence based approach. This will serve to enrich the analysis and also to look at the full range of information flows into Healthwatch England and highlight emerging issues which may become more significant later on. There is still much work to be done in this area. That said, there are some key attributes that we need to develop to ensure our local intelligence infrastructure is fit for purpose which are summarised below. We plan to come back to the Committee in Q4 with a more developed plan and implementation timeframes.

Key aspects of local intelligence outline plan

Key feature	Purpose	Timeframe
Systemised analysis of all incoming information flows to Healthwatch England	To triage issues and develop an 'early warning system' which may flag significant issues	Plan in place by Q4 2014/15 Test and roll out 2015/16
Text analysis / key themes of research reports from local Healthwatch	To systematically capture key themes, recommendations and findings from research and insight activities carried out by local Healthwatch	Approach tested and developed Q3 2014/15
Broader thematic, trend and contextual analysis of escalations	To build trend analysis around key themes from escalations and track how they have progressed. This can only be achieved when a significant amount of data from escalations has been collated; currently numbers are too small to conduct detailed, meaningful analysis	Ongoing & incremental – fully realised in 2016/17
Develop and test *'data driven decision making'*	Work with statutory partners and other agencies to test and develop approaches for using system generated data intelligently across local Healthwatch, enhancing their ability for understanding their local conditions and prioritising work	Started in Q3 2014/15
Mapping capability	To represent data sets geographically in themed maps that can be overlaid to build understanding of socio-economic operating conditions of local Healthwatch	Outline plan Q4 2014/15

The local intelligence architecture will be built incrementally over time but the above table gives an indication of the work involved and the steps that need to be taken to progress this aspiration. In Q2 we began work with NHS England and NHS Choices to look at the usefulness and value to local Healthwatch of the MyNHS site launched in late September which aims to bring many sources of data around health and social care together in one place. We also established a 'Horizon scanning" / Long Term View internal working group to triage emerging issues coming in that may not be picked up via formal escalations, enquiries or other routes but have potential to crystallise in future.

Members are invited to DISCUSS.

Appendix D - All escalation cases received July-September 2014

Escalated issue	Local HW escalating issue	Healthwatch England Actions and next steps
NHS Continuing Healthcare (CHC) The issues raised are related to the delays in CHC assessments, the backlog that would need to be cleared and the recording of information needed to assess people's needs retrospectively. Other concerns have been raised including: • Assessment process too complex • Discharge process causing time-related issues (patients have to wait until they are nearly recovered to be assessed) • Lack of information and explanation for the individuals • Artificial distinction between social and health needs • Specialised professionals' opinions being downplayed in hospital • Lack of specialised professionals' involvement in community • Difficulty for patients to provide 'evidence' of care needs • Mechanistic decision-making during the needs assessment without professional judgement • Lack of empathy demonstrated by assessors • Regular reviews process too difficult and stressful for patients with non-improving conditions • Process for appealing against the decision too complex.	HW North East Lincolnshire (supporting information from HW Northamptonshire, HW Swindon)	Healthwatch England has followed up with local Healthwatch in order to gather more information. We will liaise with Anne Beales (Special Inquiry Advisory Group member) who would like to find out regional variations in how long people wait to receive CHC payment. We are also carrying out more desk research into the range of issues related to NHS CHC and sharing information on the issue with the Special Inquiry Team as CHC has also been highlighted in evidence to the Inquiry.
Statutory Sick Pay Percentage Threshold Scheme abolition Following the abolition of the Statutory Sick Pay (SSP) Percentage Threshold Scheme (PTS) in April 2014, disabled people with their own care staff are no longer able to claim the SSP for their carer if absent due to illness. They are also no longer eligible for the new Employment Allowance. This affects people with personal care budgets.	HW Cheshire West and Chester	HWE is in correspondence with the Low Income Tax Reform Group and the Care and Support Alliance who have an interest in this issue.

Pharmacy-managed repeat prescription service Luton CCG has decided to stop the pharmacy managed repeat prescription service. This service has been estimated by the CCG to affect 60,000 out of a population of just over 200,000.	HW Luton	This issue is presently before the local overview and scrutiny board. It has also been escalated to the local NHS area team and the Chief Pharmaceutical Officer of NHS England.
Impact of loss of Minimum Practice Income Guarantee (MPIG) Some GP surgeries are at threat of closure due to financial unsustainability caused by the possible loss of MPIG.	HW Tower Hamlets HW Cumbria	Since this issue has been escalated there have been national developments which have been communicated to the two areas. This issue is still being investigated in terms of impact to the network and we have done a call out via our engagement channels. There has been only one response to date. The issue in Tower Hamlets is resolved as the NHS England Local Area Team decided to freeze the withdrawal of MPIG policy.
Take up of flu vaccination Recommended vaccination for children is a nasal spray that contains porcine gelatine. For Muslim communities and other members of the community who do not want to have gelatine there is no alternative being provided.	HW Kirklees	Please see update in the previous section of this report.
Accessibility of Gender Identity Services There is a lack of surgeons able to carry out this service and there are wider issues about the treatment of trans individuals by the system.	HW Telford and Wrekin HW Torbay We have also received information from: HW Nottingham HW Devon HW Hertfordshire HW Central West London HW Liverpool	Please see update in the previous section of this report.

NHS Choices website NHS Choices website does not have sufficient (and accurate) information on GP surgeries to make an informed decision on which GP surgery to register with.	HW Sefton HW Haringey (we have also received a past escalation from HW Southend)	We worked with NHS Choices to hold 2 webinars and produce an FAQ document for local Healthwatch setting out clearly what information GPs (and other service providers) must post on Choices, whose responsibility it is to keep information up to date and the process by which information can be updated. As the commissioner of the NHS Choices website, we are also feeding back to NHS England the concerns that local Healthwatch have raised regarding NHS Choices. We have also put out a media story on the related issue of dentist information on NHS Choices. http://www.healthwatch.co.uk/news/trouble-finding-nhs-dentist-youre-not-alone The webinar also led to local Healthwatch requesting that their details are made available on NHS Choices website. We are currently working with NHS Choices to discuss this.
Inaccurate information on Healthy Start Scheme Concerns around inaccurate information on local distribution points for healthy start vitamins, a lack of local distribution points, and wrong information on local retailers that accept vouchers.	HW Southend	HWE have contacted NHS Business Solutions who run the website to clarify who is responsible for updating information on the website. We will also be sharing our concerns with the NHS England data transparency team.
Social Care: Quality Assurance There is a potential gap in regulation of services purchased through personal budgets where services do not provide 'personal care' and therefore are not CQC registered, and where the service concerned has no contractual relationship with the Local Authority. This may leave vulnerable people with nowhere to go to raise serious concerns about such a service.	HW Nottinghamshire	We will be discussing this escalation with CQC nationally as part of wider concerns around regulation of services purchased with personal budgets.

Electronic Prescription Service Patient safety concerns connected with the electronic prescription service now being rolled out across the country. There is no standardisation of the way in which the various pharmacy system suppliers display messages which are often important to patients.	HW Stockport	HWE has followed up with NHS England on activity they have committed to resolve this issue. We are currently awaiting a response.
Unregistered services providing personal care An organisation was providing personal care services even though they were not registered with CQC.	HW Derbyshire	We escalated this to CQC who took a witness statement from HW Derbyshire but the case has since closed. Since CQC spoke to the owner of the provider they are satisfied that the service is no longer providing personal care. CQC are however concerned about poor quality of care so have escalated this to the police and local safeguarding team.
Recall of medicines There are delays in sharing important alerts with patients.	HW Worcestershire	This case was actually resolved locally by LHW prior to escalating. As Healthwatch England has carried out initial research into the issue, it is developing a brief document on the recall of medicines process and issues faced locally in Worcestershire. This will be made available to all LHWs. We have also shared the experience of HW Worcestershire with the Medicines Healthcare Regulatory Authority (MHRA).
Maternity Services Liaison Committees (MSLCs) Inconsistent funding of MSLCs across Cambridgeshire causing concern locally about engagement of maternity services	HW Cambridgeshire	We are exploring the role of MSLCs and will be making contact with the Royal College of Midwifery. There will be work done to identify how effective MSLCs are. Concern has also been raised locally about the Friends and Family test as a means of engagement with maternity services which we will explore further.

Regulation of domiciliary care A number of previous care homes are now registered as private residences and not subject to CQC regulation raising concerns about the quality of care for vulnerable people.	HW Richmond	We will be sharing concerns from local Healthwatch to CQC nationally. This will help us to explore what the national CQC position is on the regulation of supporting living environments before deciding next steps.
Patient-led assessments of the care environment (PLACE) audit patient assessors Some Trust buildings are owned privately. In these cases recommendations arising from PLACE audits are not prioritised leading to demotivation in PLACE volunteers.	HW West Sussex	This case was screened as needing action locally so has been passed onto the development team to support Healthwatch locally.
Gap between CQC and NHS England decisions Local GP surgery has been told by CQC that its facilities are not fit for purpose. It has put a business case forward to the Local Area Team to move the practice, however the response it received from the Area Team - 'funding decisions for all practices are on hold until new national guidance has been finalised' - is preventing them from moving.	HW Surrey	This case was screened as needing action locally so has been passed onto the development team to support Healthwatch locally.
Lack of consultation into development of GP networks Local HW are "informed" of decisions and developments of GP networks rather than being meaningfully involved in shaping decisions.	HW Hillingdon	HW Hillingdon is continuing to resolve this locally with progress being made. HW Hillingdon will let us know if they feel that local routes to resolution are exhausted and HWE can look at taking this up at a national level.

All other currently open escalation cases

Escalated issue	Local HW escalating issue	Healthwatch England actions and next steps
Fairer Charging Initiative Concerned with a lack of consultation and explanation of the implications of the initiative on elderly people and individuals with disabilities.	HW Solihull	Provided information on the impact of the Care Act on Fairer Charging Initiative as will lead to big changes. Awaiting guidance on whether further support is required.
Delays in social care assessments Include long waiting lists for adult social care assessments. HW Cambridgeshire is concerned about the existence of a further wait for a care package to be arranged (the 'pending list'). HW Isle of Wight believe these delays result in a 'quantity not quality' approach.	HW Cambridgeshire, HW Isle of Wight, HW Bristol	HWE has carried out desk research to identify the main reasons why delays in social care assessment may occur. In order to have a national picture of the issue, HWE is currently investigating whether people in different areas are facing delays using the Hub and Yammer. HWE is investigating next steps to address the issue.
Ambulance Arrival to Clear Targets This is the time it takes an ambulance to hand over a patient when arriving at hospital. Targets are not being met in the East of England region. Data has shown that up to 1000 hours have been lost in one region to ambulances waiting to handover patients.	HW Luton	To ascertain if this is a regional or national issue we are sourcing data to build a national picture of arrival to clear times. Initial research shows that data made public by Ambulance Trusts is not consistent nationally. Most data released is in response to Freedom Of Information requests. A call out to the network has also been done to see if this is an issue raised with other local HW. We have asked NHS England to: • Clarify availability of data on to clear times by region and clarification as to if and how this could be made publicly available • Clarify whether NHS England is aware of an issue with delays in to clear timings nationally • Explain any plans NHS England have to help trusts to improve their ability to meet arrival to clear targets.

Implementation of NICE guidelines Inconsistent and non-transparent decisions made by CCGs on implementation of NICE guidance - particularly relating to knee replacement surgery and IVF treatment.	HW Hillingdon, HW Central West London	We will be writing a joint resource for local HW with NICE and Regional Voices which sets out legal status of NICE guidelines and responsibilities on CCGs. Release date TBC.

AGENDA ITEM: 8

SUBJECT OF REPORT: The remit for the special project on Child and Adolescent Mental Health Services (CAHMS)

PRESENTING: Marc Bush

PURPOSE: This report aims to reflect on the work to date and to consider the remit and principles for the special project on Child and Adolescent Mental Health Services (CAHMS)

RECOMMENDATIONS: This report is for the approval of the remit and to consider the approach following the recommendations of the Children and Young People's Mental Health and Wellbeing taskforce

RESOURCE IMPLICATIONS: N/A

RISK AND MITIGATION: N/A

EQUALITY AND DIVERSITY: N/A

Members are invited to DISCUSS and APPROVE.

AGENDA ITEM: 9

SUBJECT OF REPORT: Diversity and Inclusion Update

PRESENTING: Sarah Armstrong

PURPOSE: This report provides an update on this area of work and considers the next steps of operational activity within Healthwatch England

RECOMMENDATIONS: To approve the plan and to decide how we proceed monitoring the progress of this work – the options are detailed in this paper

RESOURCE IMPLICATIONS: N/A

RISK AND MITIGATION: N/A

EQUALITY AND DIVERSITY: This report is part of our overall commitment to Equality and Diversity

Background

During Quarter 4 of 2013/14, the Committee tasked a small sub-group to discuss and propose parameters for Healthwatch England's approach to Diversity and Inclusion. The members of this group are; Alun Davies, Jane Mordue, Patrick Vernon and Liz Sayce.

This led to the Committee including a statement in the Healthwatch England strategy, demonstrating a commitment to produce a Diversity and Inclusion Plan each year. This plan will support the Business Plan, and will set out our work annually to demonstrate that we are working in an inclusive way and for the diverse communities across England.

It was agreed that that this plan would underpin:

- our direct work at a national level;
- our support to the network;
- our communications and engagement approach;
- our approach to monitoring evaluation and learning;
- our recruitment and employment policies for Committee and staff; and
- how we prioritise our work.

The committee agreed to the principle of mainstreaming our diversity and inclusion activity, but recognised the need to have a standalone plan, which is independently monitored and reported upon.

Below are our proposals of how diversity and inclusion will be reflected in our programme of activity this year (2014/15).

Some activities are already underway, so the table also provides an update on how activity has been mainstreamed.

Activity	Description	Date agreed	Lead	Progress made
Monitoring and checking our business processes	• Monitoring the diversity of our staff and committee members.	From Feb 2014	AG	This was implemented and has since been updated to include more detailed information relating to disability and sexual orientation monitoring. This new format will go live in late October 2014.
	• Reviewing existing business processes to ensure compliance with relevant legislation (including the Equality Act 2010).	Quarter 2014/15	SA and AG	This will be undertaken in quarter 4 in preparation for the new financial year.
Increasing the accessibility of our work	• Reflecting on learning from the annual conference and establishing accessibility guidelines for our events.	Quarter 2/3 2014/15	HP	This review has taken place and a report produced. All events will have an 'accessibility check' completed to ensure the venue can meet attendees' needs.
	• Developing and implementing an accessibility policy to cover printed publications, web, digital work etc. • Ensuring all major external publications are translated and published in EasyRead. • Reviewing the accessibility of our online activity and action plan.	Quarter 3 2014/15	Comms / Staff working group	We have established a working group and a first draft of the policy has been completed. This will be reviewed in October. From October, we have included an accessibility statement on our website confirming different formats can be requested for all new documents. The Annual Report has been developed in EasyRead format and is downloadable from the website.

Up-skilling our staff and committee	• Undertaking diversity training with the Committee and staff team. • Delivering a workshop session for Committee Members.	September 2014 Quarter 3 2014	AG / AD AD and LS	This has been completed for 28 staff members and will be undertaken again for new members of the team in quarter 3/4. Alun Davies provided training for the staff team in September. This will be delivered by Alun and Liz on 21 October.
Building the confidence and skills of local Healthwatch	• Undertaking a joint research and training project with Mencap and local Healthwatch to build confidence in working with people with learning disabilities. This also will deliver on our commitment to the Winterbourne Concordat.	1st report due in Quarter3 2014	GB	The first draft of the project outline has been received from Mencap. SR is meeting with Mencap in October to progress this.
Increasing our understanding of the impact of reforms on marginalised communities through consumer profiling	• The intelligence team will be creating a set of internal consumer profiles that will identify the risks that marginalised groups or communities face in health and social care. These will be used by the organisation to assess the impact of policy proposals or changes on these groups.	To begin in Quarter 3 2014	SV / VT / NS	This work is scheduled to begin in Quarter 3 2014.

Investigating the experiences of marginalised communities through our project work	• Targeted work with people who come under the Mental Capacity Act and/or Mental Health Act to understand their experiences of raising a concern or making a complaint in health and social care.	October 2014 - as part of our Complaints Report	CP	We held focus groups in London and Wiltshire with people who had complained, or tried to complain, while being treated under the Mental Health Act. We commissioned research with people who had complained while being treated under the Mental Capacity Act, and their friends, families, carers and advocates. This work has fed into our report on consumer experiences of the health and social care complaints system.
	• Reaching out to seldom-heard consumer within marginalised communities in our special inquiry investigation into discharge from institutional settings, i.e. homeless people who use mental health services.	Summer 2014, reporting in November 2014	IA / AL	We have successfully reached out to over 1000 individuals as part of this work. Working with our user-led advisory group we ran focus groups to explore their experiences.

Ensuring marginalised communities have a say in national commissioning decisions	• Contributing to the work of the Specialised Services Patient and Public Voice assurance group of NHS England to review the effectiveness of public involvement in decisions about national specialised commissioning.	From Autumn 2014	MB	We are working with the Patient and Public Voice assurance group to understand the current re-profiling of specialised commissioning and will provide an update in the next report.
	• Undertaking a 2nd special project investigating the experiences of people using Child and Adolescent Mental Health services (CAMHS) and contributing to national policy and media debate to resolve the crisis.	From Dec 2014	CP	A paper on the CAMHS special project will be presented at this Committee meeting. Anna Bradley is also now a member of the CAMHS Taskforce - a high level group that is co-Chaired by Jon Rouse, Director General at Department of Health.

Further considerations

Following on from the last diversity and inclusion task and finish group, there is one further consideration:

1. The group suggested more engagement with the network through training and also using incentives such as awards at the next annual conference – we are reviewing this with our Development Team.

Recommendation

We recommend this group continues until the end of the financial year to oversee this work, and provide reports on progress to the wider Committee. This approach will enable the group to undertake a stocktake in preparation for the new delivery year. This has already been included on the forward plan for the agenda in May 2015.

Members are invited to DISCUSS and APPROVE.

AGENDA ITEM: 10

SUBJECT OF REPORT: Working relationship with the Care Quality Commission (CQC)

PRESENTING: Susan Robinson

PURPOSE: This report provides an update on the working relationship with CQC

RECOMMENDATIONS: To discuss and the working relationship with CQC and to approve the next steps

RESOURCE IMPLICATIONS: N/A

RISK AND MITIGATION: The risk continues to be that local Healthwatch are be unable to participate fully in inspection programmes and are unable to present the voices of their local community

EQUALITY AND DIVERSITY: N/A

Members are invited to DISCUSS and APPROVE.

AGENDA ITEM: 11

SUBJECT OF REPORT: Service Change Project

PRESENTING: Susan Robinson

PURPOSE: This report provides an update on work so far and the approach for the next phase

RECOMMENDATIONS: To agree the project plan

RESOURCE IMPLICATIONS: N/A

RISK AND MITIGATION: The risk to local Healthwatch stems from Healthwatch England being unable to support them in dealing with service change e.g. integration or reconfiguration agenda

EQUALITY AND DIVERSITY: N/A

Members are invited to DISCUSS and APPROVE.

AGENDA ITEM: 13 (a)

SUBJECT OF REPORT: Enhanced Governance - Proposal for the role of Senior Independent Member

PRESENTING: Sarah Armstrong

PURPOSE: To approve the appointment of a Senior Independent Committee Member (SIM)

RECOMMENDATIONS: This report is for 1) approval of the role profile attached and 2) to approve the process of nomination and appointment of a Senior Independent Committee Member

RESOURCE IMPLICATIONS: N/A

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

EQUALITY AND DIVERSITY: Each Committee Member can either nominate themselves or another person, making the process fair

Scope

Good practice in governance is to have someone in the role of Senior Independent Director or in our case 'Member' or (SIM). The idea of this role is that it provides Committee Members and the CEO and SMT with a space in which they can raise issues should they feel unable to raise them directly with the Chair. It then falls to the SIM to raise those matters in confidence and with sensitivity to the Chair. We do not have any known issues of this sort, but better to be prepared, which is why we propose to create the role of the 'Senior Independent Member' as described below in the role description. Because we do not expect this role to be onerous, we have included responsibility for oversight of conflicts and corporate complaints, since these are areas in which an independent perspective will be helpful to us all.

The nature of the role makes it very important that the individual taking this on is trusted and respected by all those who might have reason to call on them and to the Chair.

Process

We propose that Jane Mordue (as Chair of Audit and Risk Sub-Committee) should be nominated to manage this process, since as the Chair of the Audit and Risk Sub Committee she cannot also be the Senior Independent Member.

Once the role profile has been approved by the Committee, Jane will circulate it to the Committee inviting nominees to this role. Each Committee Member will then be invited to

vote for the member. There will be a 7 day period for nominations and a 7 day period designated for voting.

Jane will let the Chair know which Committee Member has the highest number of votes and they will be announced to the whole Committee and Staff.

Role Description – Senior Independent Committee Member (SIM):

The Senior Independent Committee Member is primarily appointed to provide a means by which issues relating to the Chair or Chair and Chief Executive Officer (CEO) can be raised and hopefully resolved internally. Examples of the kinds of things that might be taken to the SIM by Committee Members or the CEO are:

- The Committee have expressed concerns that are not being addressed by the Chair in the way they would expect;

- The relationship between the Chair and the CEO is difficult or particularly close and exclusive of the Committee;

- A Committee Member or the CEO have cause to raise concerns about the Chair that it is impossible or very difficult to raise directly; and

- The integrity of the Chair is in question.

It is anticipated that these issues will rarely, if ever, be raised. We have therefore included a number of related functions for this post holder that sit comfortably with someone who is trusted by the Committee, CEO and Chair to always act in the best interests of the organisation and be a champion of its values.

Purpose

The Senior Independent Member's role is to:

- Serve as an occasional intermediary for other Committee Members and/or the CEO;

- Provide occasional feedback to the Chair from Committee Members as part of a 360 degree appraisal; and

- Act on behalf of the Committee to review the implementation of the conflicts policy and corporate complaints handling.

Role

The Senior Committee Member will:

- Act as a trusted intermediary when necessary between Committee Members and/or the CEO and the Chair;

- Be available to stakeholders if they have concerns which have been through the normal channels of Chair, Chief Executive or the Senior Management Team but have not been adequately resolved or for which such contact is inappropriate;

- Act as a last internal contact for whistle-blowers who feel unable to raise concerns through normal Healthwatch England channels;

- Review the implementation of the conflicts and corporate complaints policy on a quarterly basis; and

- Report to the Committee annually on the fulfilment of the responsibilities of the Senior Independent Member.

Term of Office:

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

- Appointment or removal from office is a decision reserved for the Committee. Nominations will be received by the Committee Secretary and a vote will be managed by the same.

Members are invited to DISCUSS and APPROVE.

AGENDA ITEM: 13 (b)

SUBJECT OF REPORT: Enhanced Governance - Conflict of Interest Policy

PRESENTING: Sarah Armstrong

PURPOSE: The Committee are asked to review the updated Conflict of Interest Policy as part of the enhances governance process

RECOMMENDATIONS: The Committee are asked to approve the Conflict of Interest policy

RESOURCE IMPLICATIONS: N/A

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

DIVERSITY AND EQUALITY: N/A

Principles

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

A conflict of interest is any situation in which a member of staff or Committee Member's personal interests, or interests that they owe to another body, may (or may appear to) influence their impartiality and independence or direct their decision making. The interest may be financial or non-financial.

The management of any perceived or potential conflict is therefore critical to the reputation of Healthwatch England. Even the appearance of a conflict of interest can affect the reputational risk of Healthwatch England.

It is the responsibility of each individual to recognise situations where they have a conflict of interest, or might be reasonably perceived by others to have a conflict.

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

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

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

Identification of risk

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

- The personal gain or gain to immediate family, whether financial or not. (This may be the result of holding a position or having shares in a private company, charity or voluntary organisation who may work with Healthwatch England).
- Professional bias towards a particular decision.
  (In health and social care this could include loyalties to a particular professional body, society, or special interest group).

It is important for when evaluating a potential conflict of interest, to consider how it may be perceived by others.

"Would a reasonable person, knowing the facts, consider that the interest prejudiced, or could give the appearance of prejudicing, the staff member or Committee Member's ability to participate in a disinterested manner?"

Monitoring and Managing risk

For Committee Members:

Healthwatch England maintains a register, kept by the Committee Secretary which provides details of Committee Members' appointments, directorships, related employments and relevant financial interests. All new conflicts of interest must be raised with the Chair. Interests are updated on the Healthwatch England website, in line with quarterly Committee Meetings. All interests disclosed will be recorded in the minutes of the relevant Committee Meeting.

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

For the Senior Management Team:

Healthwatch England will maintain a register, kept by the Committee Secretary; this will become live in Quarter 3 and will be updated when a new interest arises. The register of interests will also be shared on the Healthwatch England website.

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

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

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

Members are invited to DISCUSS and APPROVE.

Appendix E – General notice of Interests to be registered

I,_____

of_____

a Committee member/staff member [delete which is not appropriate]

of Healthwatch England, give notice that

EITHER

I have no interests that are required to be included in the Register of Interests.

OR

I have set out below under the appropriate headings the interests that I am required to include in the Register of Interests, and I have put 'none' where I have no such interests under any heading.

(Please delete as applicable)

	Please also include date registered.
Category 1: **Remuneration from employment, office, trade, profession or vocation** You must show every employment, office, trade, profession or vocation that you have to declare for income tax purposes. Give a short description of the activity concerned – for example, 'Computer Operator' or 'Accountant'. Committee Members must give the name of their employer. If employed by an organisation, give the name of the organisation paying your wages or salary, not that of the ultimate holding organisation. Where you hold an office, give the name of the person or body that appointed you. In the case of public office, this will be the authority that pays you. In the case of a teacher in a maintained school, the local education authority; in the case of an aided school, the school's governing body.	
Partnerships and unremunerated directorships You must give the name of every firm of which you are a partner and every company for which you are an	

unremunerated director. Give a short description of the activity concerned.	
Category 2: Sponsorship You must declare the name of any person or body that has made any payments to you in the last year towards your expenses as a Committee member/ in another role.	
Category 3: Contracts with Healthwatch England You must register all relevant and material interests in contracts of which you are aware, which are not fully discharged, and which are: Contracts for the supply of goods, services or works to or on behalf of Healthwatch England. Between Healthwatch England and either yourself or an undertaking in which you have a beneficial interests or of which you are a director or partner. *You need not say what the financial arrangements are, but you must say for how long the contract is.* You must list any contract relating to the occupation of land where (to your knowledge) the landlord is Healthwatch England, a social care or NHS organisation.	
Category 4: Ownership of land Ownership of an interest in land by you or your spouse, registered partner or domestic partner. You must include any land in which you have a beneficial interest (that is, in which you have some proprietary interests for your own benefit) that is specifically used for Healthwatch England's purposes. You must give the address or a brief description to identify it. You must also include any land from which you receive rent, or of which you are the mortgager, which is specifically used for the provision of social care.	

[*"Land" includes any buildings or part of buildings.*] *You are not required to make a declaration on this form under this heading in respect of any property, which you occupy residentially as owner, lessee or tenant.*	
Category 5: Interests in Organisations & Securities Please list the names of any organisations, industrial and provident societies, co-operative societies or other bodies corporate in which you have an interest in shares or securities. Please include shares and securities in which you have a beneficial interests but which are held in the name of other people.	
Category 6: Membership of public bodies You need only name the organisation(s) of which you are a member.	
Category 7: Miscellaneous interests You may use this category to set out the details of any interests that you wish to register voluntarily.	

DECLARATION

I recognise that it is a breach of the Committee Standing Orders and/or Healthwatch England Conflict Policy to:

(a) provide information that is materially false or misleading or

(b) omit information which must be given in this notice or

(c) fail to give further notices, within 21 days, of any changes to
- (i) Update any information given in this notice or
- (ii) Declare any interests that I acquire after the date of this notice.

Signed…….. Date…….

Received…… Date…….

AGENDA ITEM: 13 (c)

SUBJECT OF REPORT: Enhanced Governance - Proposal for the Terms of Reference for the Remuneration Committee

PRESENTING: Sarah Armstrong

PURPOSE: To approve the Terms of Reference for the Remuneration Sub Committee

RECOMMENDATIONS: This report is for 1) approval of the Terms of Reference attached and 2) approval of the appointment of Committee Members to the Remuneration Committee

RESOURCE IMPLICATIONS: N/A

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

EQUALITY AND DIVERSITY: N/A

Background

The proposal of the Remuneration Sub Committee of Healthwatch England will be to focus their support on four areas:

- Recruitment of senior staff members;
- Retention of senior staff members;
- Reviewing the pay structure for senior staff members; and
- Providing guidance on performance monitoring frameworks.

Terms of Reference

Purpose
To ensure the four areas have oversight and to provide assurance for the wider Committee.

Duties

- To review the recruitment processes for the recruitment of senior staff members when a vacancy arises - this will be in line with the guidance provided by CQC at the time.
- To provide oversight on improving and increasing retention of the Senior Management Team and consider succession planning.
- Review the pay structure for senior staff and ensure this meets the CQC standard, but also provide feedback to CQC on this process.
- Provide advice and guidance on using performance monitoring frameworks to assess performance of senior staff members.

Membership and Support

- Members to be made up of Healthwatch England Committee Members.
- Additional members may be co-opted on a time-limited basis to provide specialist skills, knowledge and support. Co-opted members should not form more than one-third of the Sub Committee.
- Support for meetings will be provided by the Chief Executive, Head of Operations and the Committee Secretary.

Meetings

- The Sub Committee will meet biannually.
    - Other meetings will be arranged by the Committee Secretary at the request of the Chair of the Healthwatch England Committee.
    - At least two members must be present for a meeting to be quorate.
- The Healthwatch England Committee or Chair may seek specific advice, requesting the Sub-Committee to convene further meetings.
- The Sub Committee will take steps to preserve the confidentiality of conversations and any related documents, in matters which involve the personal information of individual employees.

Reporting and accountability

- The Sub Committee is accountable to the Committee.
- The Chair will provide biannual written or verbal reports, or more frequent as appropriate, to the Healthwatch England Committee.
    - These should include the minutes of meetings held.

Annual Reviews of Terms of Reference and Effectiveness

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

Members are invited to DISCUSS and APPROVE.

AGENDA ITEM: 14

SUBJECT OF REPORT: Committee Forward Plan

PRESENTING: Esi Addae

PURPOSE: To present the Committee forward plan for 2014/2015.

RECOMMENDATIONS: To note the Committee forward plan

RESOURCE IMPLICATIONS: N/A

RISK AND MITIGATION: N/A

EQUALITY AND DIVERSITY: N/A

DATE	LOCATION	MEETING	FORWARD AGENDA
4th February 2015	Brighton	Committee Meeting	Standing Items: • Chair's Report • Chief Executive's Report • Audit and Risk Sub Committee Report ○ Update on Information Governance • Committee Members update • Operational Update For discussion and/or decision: • Business and budget plan • Healthwatch offer 2015/16 • Remuneration Committee

13th May 2015	Sheffield	Committee Meeting	Standing Items: • Chair's Report • Chief Executive's Report • Audit and Risk Sub Committee Report • Committee Members update • Operational Update For discussion and/or decision: • Final Budget and Business Plan (TBC) • Service change • Monitoring, Evaluation and Learning • Diversity and Inclusion
15th July 2015	Worcester / Gloucester	Committee Meeting	Standing Items: • Chair's Report • Chief Executive's Report • Audit and Risk Sub Committee Report • Committee Members update • Operational Update For discussion and/ or decision: • Consumer Index • Accessing primary care services • 1st Special Inquiry – review of progress

4th November 2015	Norwich	Committee Meeting	Standing Items: • Chair's Report • Chief Executive's Report • Audit and Risk Sub Committee Report • Committee Members update • Operational Update For discussion and/ or decision: • Review of Governance Arrangements • Remuneration Committee

Members are invited to NOTE.

AGENDA ITEM: 15

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

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

PURPOSE: This report will reflect the meeting of the Audit and Risk Sub Committee on 3 September

RECOMMENDATIONS: This report is for information

RESOURCE IMPLICATIONS: N/A

RISK AND MITIGATION: N/A

EQUALITY AND DIVERSITY: N/A

Report

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

The focus of our meeting on 3 September was on the preparation for the Mid-year Spend Review with the Department of Health as well as reviewing the financial position. We received an update on the internal audit programme for the year. Two audits are planned; on information governance and on financial reporting. We also heard from a CQC representative to review our financial position. I am pleased to report that henceforth the Committee will receive accurate quarterly management accounts from our CQC colleagues. We had the opportunity to reflect on how risk is managed within the organisation and reviewed the assurance model. Finally, we agreed our forward plan for the upcoming year.

The Audit and Risk Sub Committee has given consideration to whether a Finance Sub-Committee is needed. For this year's budget, a small stand-alone group will be trialled and the longer term viability will be tested.

Mid-year Spend Review

We challenged the team to ensure that enough time and support would be attributed to the preparation for the Mid-year Spend Review. We were assured that the Mid-year Spend Review is the beginning of the budget and business planning period.

Update on CQC budget and accounts

We were apprised that at future meetings, we will receive an accurate report by budget heading of the financial position, including a breakdown of pay and non-pay items. The team, with CQC colleagues, have been tasked to provide an overview of the budget for the next meeting which will include spend in month, forecast position, breakdown by cost centre and risk areas. This will also include the year to date position.

Internal audit process

We were joined by our internal auditor, Chris Gallagher from PWC, to update us on the proposed Information Governance audit. He is conducting a similar audit first for CQC and we were assured that the process for CQC will be adapted and the learning from their process will be reflected in the terms of reference and plan for Healthwatch England. He will discuss the audit with our Caldicott representative, Committee Member, John Carvel. The objectives will be to assess the current policies and key controls as well as reviewing the cultural aspects of information governance. We are agreed that the aim for Healthwatch England is to attain an effective information sharing system which has an effective control system with local Healthwatch.

Risk management and assurance model

The team updated us on the elements of risk and an assurance evaluation tool was provided. We decided that it was time again for the whole Committee to appraise the strategic risk register in line with the key objectives and priorities of Healthwatch England. We have reviewed the assurance model provided by the team and will use this as a dashboard for governance assurance.

Audit and Risk Sub Committee forward planning

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

Date	**Location**	Items
29th October 2014	Teleconference 2pm (1hour)	• Reviewing the internal audit plan for information governance
22nd January 2015	Teleconference 2pm (1hour)	• Reviewing the learning from the audit reports • Risk Register
23rd April 2015	London 1pm – 4pm	• Internal Audit plan • Risk Register • Annual review of risk • Review - Audit and Risk SubCommittee
25th June 2015	Teleconference 2pm (1hour)	• Review Accountable Officer Role • Review residual actions from the year • Risk Register

24th September 2015	London 1pm – 4pm	• Risk register
19th November 2015	Teleconference 2pm (1hour)	• Risk register
2016		
21st January 2016	Teleconference 2pm (1hour)	
21st April 2016	London 1pm – 4pm	
23rd June 2016	Teleconference 2pm (1hour)	
22nd September 2016	London 1pm – 4pm	
17th November 2016	Teleconference 2pm (1hour)	

Members are invited to DISCUSS.

AGENDA ITEM: 16

SUBJECT OF REPORT: Committee Members Update

PRESENTING: Committee Members

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

RECOMMENDATIONS: This report is for information

RESOURCE IMPLICATIONS: N/A

RISK AND MITIGATION: N/A

EQUALITY AND DIVERSITY: N/A

Report covers:

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

Committee Members will also verbally update on other matters which have come to their attention in their other roles.

Committee development

Since the last Committee Meeting in July, there has been further exploration of how Committee Members are involved with local Healthwatch and with Healthwatch England staff. A development plan highlighting engagement with local Healthwatch and strategic involvement within key projects is being developed for each Committee Member. This is a new process which we continue to refine.

Supporting Healthwatch England

Committee Members responded to and inputted into the Healthwatch England Annual Report which was laid before parliament last week. Committee Members have also been involved in providing strategic oversight for key areas through task and finish groups, as detailed below. This has been done in a manner of ways and has enabled the staff to gain the expertise of the Committee.

Task and Finish Groups

Since the last Committee Workshop, a number of task and finish groups have been developed to offer expertise to the staff team on key areas of work. Committee Members have been involved in conversations discussing:

- Accessing primary care services;
- The Consumer Index;
- Local Healthwatch finances;
- Health and Care Information;
- The business case assessing complaints advocacy; and
- Child and Adolescent Mental Health Services.

Special Inquiry

Committee support for the work into the Special Inquiry continues with Michael Hughes, Patrick Vernon and Andrew Barnett taking part in the Inquiry Panel meeting. Committee Members reflected that the Special Inquiry hosted conversation on 22nd September was a real success. Patrick Vernon highlighted that the hosted conversation gave attendees the opportunity to learn from service users who used their experience of negative and positive aspects of unsafe discharge. The learning, reflections and challenges shared during the hosted conversation will be used to shape the recommendations.

Diversity and Inclusion sub group

The Diversity and Inclusion sub group met to discuss the Diversity and Inclusion plan and how it is embedded in the overall strategy of Healthwatch England. There was also discussion on how to embed the Diversity and Inclusion plan within business plan. Alun Davies provided accessibility training for the staff team, with very positive feedback from the team. Alun Davies and Liz Sayce will lead a workshop session on Equality and Diversity at the Committee Workshop and the Diversity and Inclusion update is the subject of a report.

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

John Carvel and Liz Sayce attended the Chairs and Non-Executives' session on whistleblowing. This session followed the National Audit Office report on whistleblowing and aimed to give a better understanding of whistleblowing and how it fits within the legislation and gave some practical guidelines. The session involved discussions on the respective responsibilities of the Department of Health and Arm's Length Bodies as well as the impact on the wider health and social care system.

National Information Governance Committee

John Carvel is the Healthwatch England representative on the National Information Governance Committee (NIGC), a Sub Committee of the Care Quality Commission (CQC).

John reported that the NIGC has achieved a breakthrough during the last quarter by persuading the CQC board to include issues of confidentiality and information sharing as a mandatory element in healthcare inspection. For the first time this key aspect of service to consumers in hospitals, GP surgeries and community health services will get proper scrutiny and be given the status of a Key Line of Enquiry.

With support from Healthwatch England staff, John was able to share with NIGC some emerging findings from the 1st Special Inquiry into difficulties people experience on discharge from hospital, care homes and secure mental health settings. They include inadequate information sharing between different parts of the health and social care system.

NHS Equality and Diversity Council

Patrick Vernon as the Healthwatch England representative on the NHS England Equality and Diversity Council attended the July meeting which highlighted work by the council on the consultation of the National Workforce Race Equality Standard. The Council brings together key organisations and people to visualise the steps needed for a health and social care system that is individual, fair and celebrates diversity.

Meetings and Events

John Carvel took part in a debate in Oxford on the care.data programme, organised by Healthwatch Oxfordshire on September 10th. The other speakers were John Appleby, Chief Economist at the King's Fund speaking in favour of care.data, and Phil Booth, coordinator of medConfidential speaking against. John reflected that although it is too soon to be confident about the impact of this work, the principle of communicating clearly so as to allow people to make an informed choice on whether they want to opt out of allowing their data to be used for other purposes, appears to be gaining support.

Local Healthwatch

Committee Members have been supported by the Development team to attend regional meetings with local Healthwatch. Paul Cuskin as Chair of Healthwatch South Tyneside, presented to Jon Rouse, Director General, Social Care, Local Government and Care Partnerships as part of his national pioneer visits. The presentation focused on the role of local Healthwatch and how volunteers play a significant part in helping to shape local health and social care services.

Michael Hughes, in his role as part of the Birmingham Special Educational Needs and Disability Information, Advice and Support Service (SENDIASs) has arranged for Healthwatch Birmingham to sit on the Management Board.

Pam Bradbury attended the Eastern Network meeting which an opportunity to strengthen the network by having Committee Members in attendance, to learn more about the locality and also to contribute. Pam shared the current work on how people access their primary care needs during the meeting. Pam has also been successfully appointed as a

People Champion for the NHS Leadership Academy. This offers a great opportunity for Pam to bring her experience to support and share with others especially those who provide health and social care services to patients, carers and communities. Jenny Baker is now one of the 10 local Healthwatch representatives on Health and Wellbeing boards as part of a national fully funded mentoring programme via the Local Government Authority and has been assigned a national NHS Director as a mentor to enable learning and to gain more insight about working with Health and Wellbeing Boards.

Jane Mordue attended the Healthwatch Bucks Annual Report Launch invited by Chair, Jenny Baker. Jane regarded the meeting as excellent. There were key addresses from Councillor Patricia Birchley (Chair of the Health and Wellbeing Board for Buckinghamshire) and from Lou Pattenden (Chief Executive of the Aylesbury Vale Clinical Commissioning Group), Jane reflected that they had both clearly caught the mood of putting the patient and user first.

Jenny Baker, by invitation, attended and spoke at the Healthwatch Wokingham Board meeting as well as worked with the Development Team in developing and a sharing a 'meetings in public' policy for Healthwatch Bucks. Jenny is also now one of the 10 local Healthwatch representatives on Health and Wellbeing Boards taking part in a funded mentoring programme via the Local Government Authority. This role will enable continual learning and offer Jenny the opportunity to gain more insight about working with Health and Wellbeing Boards.

Deborah Fowler highlighted interesting issues and updates from London regional meetings she has attended. Of note was poor information from local NHS advocacy services, and she has encouraged people to speak to their commissioners about what will happen when this service ends in April 2015. Deborah updated that on her role as Chair of Healthwatch Enfield, had been involved in the follow-up to a Care Quality Commission (CQC) inspection of a local hospital under its new inspection regime. This was reflected as very interesting and the inspection seemed to have been thorough. There was also reflection that there was more learning on how communication from the inspection process is shared with the public.

News

Patrick Vernon wrote an article for the Guardian's Healthcare Professional Network blog on cancer inequality and black men, http://www.theguardian.com/healthcare-network/2014/aug/05/black-men-inequalities-cancer-care?commentpage=1, which has received feedback from health care professionals and patients on the issues around the primary care approach to cancer prevention.

Members are invited to DISCUSS.

AGENDA ITEM: 17

SUBJECT OF REPORT: Operational Update

PRESENTING: Sarah Armstrong

PURPOSE: This report provides an update on the key areas of operational activity within Healthwatch England

RECOMMENDATIONS: This report is for information

RESOURCE IMPLICATIONS: N/A

RISK AND MITIGATION: N/A

EQUALITY AND DIVERSITY: N/A

Staff recruitment and development

Staff recruitment activity has continued successfully to ensure we reach our permanent organisation quota of 40 staff members. The table below shows a comparison of the position at the end of the last quarter and the current position:

	At the end of quarter 1:	**At the end of quarter 2:**
Vacant posts	There were 9 posts vacant	There are 7 posts currently vacant
Interim support for the post	There were 10 posts supported by interim staff	There are 6 posts supported by interim staff
Permanently recruited	There were 21 members of staff permanently recruited	There are 27 members of staff permanently recruited
TOTAL	40 posts	40 posts

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

1. **Head of Communications** - our recent recruitment round was unsuccessful and the job description is being re-developed and it will be re-advertised in quarter 3
2. **External Affairs Officer** – this role has been re-developed (it was previously a Partnerships Officer role) and interviews will be held in quarter 4
3. **Media Officer** – this role has been graded and the business case approved so will go live in quarter 3

4. **Head of Public Affairs** – interviews take place in October
5. **Development Officer** - this post has been successfully recruited to and a contract is in progress
6. **Innovation and Good Practice Manager** – the job description for this new post has been developed and will be graded before being advertised in quarter 3
7. **Research and Community Officer** – this post is currently on hold while we review the recruitment timescale

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

1. **Director of Communications and External Affairs** – this vacancy is currently live and interviews will take place in November
2. **Executive Assistant for Chair and Chief Executive** - this post has been successfully recruited to and a contract is in progress
3. **Personal Assistant for Chair and Chief Executive** – our recent recruitment round was unsuccessful and we will consider next steps in quarter 3
4. **Business Manager** – this role will be advertised in quarter 3
5. **Communications Officer (Digital)** – this was successfully recruited to and is a fixed term contract for a year
6. **Systems Manager** – this post is being undertaken by a CRM specialist until this project is complete; we will then recruit to this post in quarter 4

Of the 13 posts listed above, there are two contacts in progress with confirmed start dates in quarter 3, and interviews will take place for a further 6 roles in quarter 3. The six interim staff members will continue during this period to provide stability.

We have been unable to recruit to two roles and we are reviewing why we were unsuccessful and what we can do differently. We have advertised a number of roles on a fixed term basis and we are reviewing the length of the contracts as this might be a more attractive offer to candidates and encourage more responses to our recruitment rounds.

Since the last meeting, a new process has been implemented regarding the recruitment process for interim staff. This new process involves the completion of a detailed business case for each post defining why the post is needed and what the impact/risk would be not to have this post agreed. This has slowed down the recruitment of interim staff significantly as it took time to identify the process (this came into effect in June) and it was resolved in early October. We will use this new process from the beginning of quarter 3.

In addition, the recruitment process for the Director of Communications and External Affairs was halted as we needed to gain approval from CQC's Procurement team and then appoint a suitable agency. CQC were undertaking this process for their own senior appointments so we were advised the quickest way to undertake this was to join their process. An agency has now been appointed and the vacancy is currently live but we anticipate it will be late in quarter 4 before a new Director will be in post.

Staff Survey

Further to the last report we have undertaken activities to address issues that were raised in the staff survey that was completed in June. Staff members raised questions about the overall management and effectiveness of the organisation, they asked for greater clarity of what we do as an organisation, and said they would like to be more involved in making decisions and more empowered in their implementation.

The table below highlights some of the activities undertaken to address the issues raised:

What we said we would do	Who is leading this	What has happened so far
Provide transparency about how SMT (Senior Management Team) operates, improve communications from SMT and invite staff to attend SMT meetings.	SMT and Private Office	The agenda is available for all staff, a short report on the meeting is emailed to all staff after each meeting and staff are invited to attend a meeting - so far four staff members have expressed an interest in attending.
Improved internal communication to develop understanding of the purpose of our projects, our activities, and the environment we work in.	SMT	This will be covered in the full staff meeting in late October. In addition, there have been individual team meetings to clarify team needs and capture suggestions. The weekly all staff meeting has been re-structured to raise awareness of the key projects and to provide staff with a weekly update of progress made. We have developed a Project Initiation Document that outlines the key details about why a project is developed, what the key milestones are and what the overall outputs and outcomes will be. Staff members will understand more about the purpose of projects and what will be achieved.
More regular communication about the mission, vision and values and what this really means in action and work with the Communications team to create Vision, Mission and Values posters for our office and meeting rooms.	SMT and Comms team	Posters have been printed and displayed. SMT reviewed how to make the mission, vision and values meaningful for staff in August – this work will be delivered to all staff in late October at the full staff meeting.
Talk to staff about how they would like to be more involved in decision making.	SMT	Katherine has undertaken a series of lunches with staff to answer questions about how we work and hear ideas/feedback.

We have begun the planning for the next staff survey as we agreed we would undertake a survey again in quarter 3 to assess how changes implemented were being received. A report will be provided in the next meeting.

We have identified a small financial resource, and successfully undertaken the procurement process, so we can offer bespoke support to managers within the organisation. The group of managers is diverse – we have some new managers as well as experienced managers, with differing levels of responsibility and accountability, and we want to work with them to increase their confidence in the following areas:

- How to motivate and lead a diverse and growing team
- How to instil the values of Healthwatch England in team members
- How to develop team delivery plans and individual plans
- How to monitor and measure performance of those plans
- How to work with stakeholders and develop positive relationships

We will also create a bespoke handbook outlining key principles relating to the areas identified above. This will be an excellent tool for them to refer back to when needed, and for future managers joining the organisation.

This investment will also continue to address issues raised in the staff survey. For example, managers will have further clarity about the values of the organisation and how they relate to their team members.

Finally, we continue to develop a deeper understanding of the organisation through all of this work. We are committed to investing in the wider team to ensure we understand their needs and their connection to the organisation. In the October staff meeting we will be working closely with all staff members to identify how they relate the organisational values to their individual and collective work.

Performance in the quarter

Further to my last report there were two milestones carried over from quarter 1:

- Deliver our complaints report and publish and disseminate to system players - This report was moved to quarter 3 and was delivered on 14 October

- Deliver our quarterly Consumer Insight Panel findings – Following consumer feedback we have agreed we will invest in one activity which will focus on primary care. This work will be ongoing for the rest of the year

There were 19 new milestones to deliver within quarter 2. We continue to demonstrate the progress of each using a 'RAG' (red, amber, green) rated view. This enables us to show milestones that have made a small amount of progress or that have been paused in red, to show milestones that are in progress but have not yet completed in amber, and those milestones that are almost complete or have fully completed in green. The table below lists the progress of all of the milestones in quarter 2:

0-20%	21-89%	90 – 100%	TOTAL
0	5	14	19

Of the five highlighted in amber here is further information about the progress:

- Publish policy briefings on issues and concerns faced by people using health and social care –the following briefings will be provided in quarter 3; Children and Families act, update on Duty of Candour, Immigration Act briefing
- Analyse local Healthwatch annual reports and deliver further analysis of status of the network –the first part has been completed and the further analysis will be produced in quarter 3
- Deliver media training to 80 local Healthwatch over Q1 and Q2 – delivery continues and over 50 local Healthwatch have accessed this training so far
- Assess the Network's understanding of safeguarding and access to locally provided training – the initial assessment has been done to understand the needs and we have identified a potential provider to deliver training where needed
- Full roll out of new performance and management systems – the systems have been developed and following an extensive review of the milestones with SMT this work will be completed in quarter 3

Quarter 2 – July to September 2014

	What it means	Milestones – What we will do	Percentage complete
Priority 1 Addressing current concerns about health and social care	This is our work on complaints, inspections and escalation	• Support and encourage escalation from across the network and feedback impact, including issuing new guidance to the network • Deliver a report on escalation to our Committee • Publish policy briefings on issues and concerns faced by people using health and social care • Inform CQC's mental health inspection process and inspection of children's hospitals and undertake further support (dependent on programme funding)	100% 100% 50% 100%
Priority 2 Getting services right for the future	This is our work on special reports and inquiries, service change work and consumer insight and index	• Coordinate the development and design of national standards on complaints advocacy (dependent on programme funding) • Launch service change project (inc. Better Care Fund and reconfiguration); establish peer community • Finalise approach to consumer index • Agree focus for second special programme	90% 100% 100% 100%
Priority 3 Our work with the network	This is how we will support, facilitate and lead the Healthwatch network	▪ Deliver our national conference ▪ Deliver through conference workshops training on financial sustainability; volunteering; escalation; complaints handing; signposting; service redesign; local influencing; working with CQC inspections; working with Health and Wellbeing boards; volunteering ▪ Launch and disseminate a volunteers toolkit for the network ▪ Analyse local Healthwatch annual reports and deliver further analysis of status of the network ▪ Deliver media training to 80 local Healthwatch over Q1 and Q2 ▪ Deliver additional tailored support for targeted Healthwatch ▪ Deliver support, guidance and tools ▪ Assess the Network's understanding of safeguarding and access to locally provided training	100% 100% 100% 80% 65% 100% 100% 50%
Priority 4 Being an effective organisation	These are the activities that we do to ensure our organisation is effective	▪ Deliver public Committee meeting in Nottingham ▪ Deliver analysis for Mid-year Spend Review ▪ Full roll out of new performance and management systems	100% 100% 75%

The Enquiries Service

In this quarter we have had over 1200 enquiries via telephone and by email. As a comparison, there were just over 1300 enquiries in the previous quarter. However, the trends are very different across the months - this is shown in the dashboard and highlights a spike in activity in April. We have reviewed this and we think this is related to the three big stories hitting the media in February and March; care.data, Accident & Emergency, and our work on the complaints atlas. This stimulated interest from the network and consumers and therefore increased the contact levels during the first quarter.

In comparison, in this quarter, the numbers have been more consistent across the three months. We continue to carefully monitor the volume and complexity of calls and enquiries to ensure we have enough resources allocated to the delivery of the service.

The breakdown of volume and themes of telephone enquiries for the quarter is below:

	July 2014	August 2014	September 2014
Telephone calls	215	254	213

Breakdown of type of call	**July 2014**	**August 2014**	**Sept 2014**
Complaints	66	68	63
Concerns & views	2	7	3
Enquiries about Healthwatch England	103	119	93
Enquiries about local Healthwatch	9	18	23
Other enquiries	23	32	24
Whistleblowing	0	0	0
Sales calls	12	10	7
Total	**215**	**254**	**213**

Following the last report, where we gave a more detailed overview of the telephone enquiries, we have provided a more detailed overview of the email enquiries for the quarter. There were 522 emails in the quarter and the themes are presented in the tables below:

	July 2014	August 2014	September 2014
Emails	212	165	145

Breakdown of type of email	July 2014	August 2014	Sept 2014
Website/CRM/Hub/Yammer queries	7	11	14
Emails from Local Healthwatch	99	58	45
Signposting/complaints regarding health and social care services	38	26	19
Events	12	14	29
Queries to specific Healthwatch England teams	36	15	14
HR/recruitment	2	7	3
Complaints about Healthwatch England/local Healthwatch	3	7	6
Miscellaneous	15	27	15
Total	**212**	**165**	**145**

Summary
This continues to be a complex part of our work as the nature of enquiries covers a very broad range as detailed above. Since beginning our work on complaints and special projects the number of enquiries has continued to increase as this has raised interest from consumers, local Healthwatch and other organisations. We continue to monitor this to ensure we have the resources needed to deliver this service effectively.

Finance report

The information below details our position at the end of September 2014, showing the breakdown of our spend from April to September inclusively.

The first part of the table (in lilac) highlights the budget available for the month of September, and the second part of the table (shown in blue) highlights the year to date position:

Budget in the month	Actual in the month	Variance in the month	Year to date Budget	Year to date Actual	Year to date Variance
372,468	358,149	(14,318)	2,386,691	2,300,233	(86,458)
372,468	**358,149**	**(14,318)**	**2,386,691**	**2,300,233**	**(86,458)**

The budget from April–September was £2,386,691 with spend of £2,300,233. Although a small underspend of £86,458 (3.6%) is currently showing, this is not a true reflection. There are two reasons for this; outstanding purchase orders awaiting payment and procurement approval for two activities has been delayed. Also, staff recruitment has been delayed due to the new implementation of the business case approval process (as

detailed earlier in this paper) and this also presents a delay in budgeted amounts becoming actual spend.

The expenditure is split between pay and non-pay as follows:

	Budget	Actual	Variance
PAY	1,566,844	1,435,157	(131,686)
NON-PAY	819,847	865,075	45,228
	2,386,691	**2,300,233**	**(86,458)**

Summary

We continue to monitor this very closely. We have worked with the CQC accountants to ensure the budget is accurately reflected. We have recently re-profiled the budget from quarterly to monthly, and introduced two new cost centres, and the next step is to re-profile the cost centres to ensure the budget is shown accurately.

Our current projections suggest that we will end the financial year at a break even position and we have adjusted our expenditure plans to ensure that this is achieved. However, demonstrating this position has been difficult due to the way the CQC financial system is built. We continue to explore what, in the absence of an audit, can be done to give us an accurate year end position. We are working closely with the CQC accountants on a monthly basis to ensure we get as close as possible.

Mid-year Spend Review

The Mid-year Spend Review took place in early October. The purpose of the review was to:

a. establish a shared view of the expected year end position
b. identify any risks, including potential underspend
c. assess the value for money being achieved from the increase in core funding

It also provided an opportunity to have early discussions about future resource requirement and identify factors for consideration in business planning for 15-16, and to discuss our approach to Programme funding for 15-16.

The business planning process for 15-16 begins immediately and we will need to provide details of our anticipated resource need for 15-16 by the end of October. The next steps are to work closely with the Committee to develop this to ensure this deadline is met.

Members are invited to DISCUSS.