Healthwatch England Committee Meeting
Held in PUBLIC

Online

Minutes and Actions from the Meeting No. 31 – 10th June 2020

Attendees

- Sir Robert Francis – Chair (RF)
- Phil Huggon – Vice Chair and Committee Member (PH)
- Andrew McCulloch – Committee Member (AM)
- Danielle Oum – Committee Member and Chair of Healthwatch Birmingham (DO)
- Lee Adams – Committee Member (LA)
- Helen Parker – Committee Member (HP)
- Amy Kroviak – Committee Member (AK)

Apologies

- None recorded

In Attendance

- Imelda Redmond – National Director (IR)
- Gavin Macgregor – Head of Network Development (GM)
- Chris McCann – Director of Communications, Insight and Campaigns (CM)
- Hollie Pope – Programme Events Manager (Hop)
- Julie Turner – Deputy Head of Network Development (JT)
- Ben Knox – Head of Communications (BK)
- Felicia Hodge – Committee Administrator (minute taker) (FH)

Item	Introduction	Action
	The Chair opened the meeting.	
1.1	**Agenda Item 1.1 – Welcome and Apologies** The Chair welcomed everyone to the meeting and asked the Committee members and Healthwatch staff to introduce themselves for the benefit of the public. Members of the public were encouraged to use the chat facility for questions and comments for the Committee. No apologies noted.	
1.2	**Agenda Item 1.2 – Declaration of Interests** There were no declarations of interest.	
1.3	**Agenda Item 1.3 – Minutes from 11th March 2020 Committee Meeting** The minutes were **APPROVED** as complete and accurate	

	Actions - please see updated action log	
1.4	**Agenda Item 1.4 – Chair's Report** The Chair paid tribute to Healthwatch England (HWE) staff for the way they seamlessly transferred operations from the office in Buckingham Palace Road to working from home. The Chair updated the committee on his activities since the last meeting: • Despite working from home, he has continued to attend meetings on behalf of Healthwatch England, HWE meetings and CQC weekly Board meetings, in addition to private meetings. Whilst he would not normally speak about CQC business in this environment, he thought it worth mentioning in HWE context that tremendous effort has been made through CQC to get near real time figures and information particularly from the care homes and social care sector, where information was lacking in the early stages of the pandemic and the full mortality rates from care homes was not being incorporated into statistics. There is now a periodical publication of insights into what has been happening. The emergency support framework which is being developed means that information can be obtained quicker and used as a tool in risk assessment, something that Healthwatch England (HWE) may wish to consider in another context. • The Chair reported that he was able to raise Healthwatch England's concerns about the shortage of intensive care and ventilator capacity directly with the Government's Chief Medical Officer and the Chief Scientific Officer and had a constructive engagement about this, although he expressed concerns that the policy around who gets priority has not been developed should there be an emergency. • The Chair also informed committee that he has written a statutory letter of advice to the Chairs of Local Healthwatch and Commissioners about methods of working during Covid-19. He mentioned that he has written two blogs in which he discussed a new joint campaign with CQC, key policy priorities and support for the network over the coming months and will shortly be writing another about some of the issues people have faced during the pandemic and welcomed feedback about them. • The Chair reported that he had written a letter to Matt Hancock (Secretary of State for health and Social Care) on behalf of the Committee about the developing concerns around the contact tracing app informing him of the public's view on the storage, sharing and use of data and the serious concerns we had about the situation with the development of the app. • The Chair informed the Committee that he had appeared on BBC Newsnight discussing the treatment of Whistleblowers. • He informed committee that HWE will be having regular meetings with the Department of Health and Social Care (DHSC) about a future ongoing strategic collaboration. • He mentioned that he is due to appear before the Health Select Committee for Health and Social Care to discuss issues around patient safety, COVID and looking to the future. He expressed his concerns about the NHS and social care being able to cope with the backlog post-COVID. • The Chair mentioned that he had conducted appraisals of his colleagues and they of him and stressed the importance of appraising senior staff and leaders. **The Committee noted the report.**	
	Agenda Item 1.5 – National Director's Report IR briefly introduced her written report and highlighted areas of note. She reiterated the Chair's tribute to HWE staff for turning from being office based to home working quite seamlessly at the start of the Covid-19 pandemic. She referred to the excellent engagement across the network and the fact that 580 people had attended events put on by HWE. During the past three months, she had seen more network	

leaders than she would normally have seen and gave credit to the network for adjusting their working practices and doing their very best in these difficult times.

IR reported that HWE had already decided that Equalities was going to be a major focus this year and have drafted a Diversity and Equalities plan. A dialogue has started within HWE and they want to have the same dialogue with the network with the focus on reducing inequalities. She stated that all work HWE undertake will be looked at from an inequalities angle to ensure that the right people are spoken to and that we hear the voice of people seldom heard from. IR mentioned that HWE are conscious of the "Black Lives Matter" movement and issued a statement saying, "We as an organization, HWE want to stand up to racism and hear what we can do to reduce inequalities".

IR mentioned that HWE staff had completed a staff survey and that good lessons were learnt from it. The committee had discussed an action plan to take forward which will be shared with the staff at their next staff meeting.

IR reported that she had been asked to be a member of a task force that the Secretary of State for Health and Social Care was setting up to oversee the action plan for social care in relation to Covid-19.

IR confirmed that most of HWE work had been Covid-19 related over the last few months and informed the committee that the insight we were receiving from the public and through Healthwatch was regularly fed into the Department of Health and Social Care (DHSC) and NHS England. An insight report is widely circulated every ten days and as a result of Healthwatch intervention, changes have been seen. Examples include using British Sign Language to get advice out to the Deaf community, where they were unable to access information on subjects that concerned them such as shielding; providing guidance to the network and highlighting blanket Do Not Attempt Resuscitation (DNAR) notices to DHSE and PHE resulting in them issuing guidance to clinicians to cease the practice.

IR highlighted that monitoring the impact of Care Act easements has become an HWE priority. The impact on people due to rapid hospital discharge is also a priority. HWE have had conversations with Equalities and Human Rights commissions who have shown an interest in this, as well as the Nuffield Trust and 60 local Healthwatch have been engaged with helping us to do this work.

IR expanded on what the Chair had mentioned in his report about NHS contact and tracing app. HWE has written to the CEO of NHSX and to the Secretary of State to outline the concerns that the public had about shared data and data privacy. HWE was bought in on conversations early and have consistently been voicing concerns about how data will be used, accessed and retained. The review of non-emergency patient transport (NEPT) continues and HWE have been involved in advising the NHSE on the development of guidance on NEPT during the COVID crisis. She updated the Committee that the publication of the review of clinical standards, particularly around the waiting time in A&E has been delayed due to Covid-19 but may now include patient experience and that six local Healthwatch has done in-depth work on this.

IR highlighted the concerns of many of the local Healthwatch about how they engage in the new structures of the NHS, including ICS or STP and the regional offices. This causes difficulties as Healthwatch is organised at a local authority level. She expressed the advantages of working at a local authority level as it can result in getting into the right communities, which would be more difficult to do at a higher level. However, not all STPs have bought in to the public voice and local Healthwatch, so HWE will focus on how we can be more influential and is due to meet with DHSC soon. There are also issues created with the merger of CCGs covering larger geographical areas. On the other hand, we will now have Primary Care Networks which will mean working at a very local level.

IR informed the Committee that consultation on the NHS mandate was suspended because of Covid-19 but HWE will be working with DHSC to do a thorough engagement as soon as reasonably possible.

IR highlighted the events that HWE had organised such as supporting and managing volunteers remotely, sessions with Board members and chief Officers and call handling with the Samaritans. She said how pleased she was that there had been such great engagement with the network. To date over 580 people had attended the online training and events

	IR introduced Hollie Pope (HoP) who presented the idea of bringing the entire national conference online. She recommended to the committee: • The format for the conference has been changed to an online event that will take place over the week of 2-6 November and will be entitled **Healthwatch Week**. It will include a range of keynote speakers from across the health and social care sector and a diverse and inclusive conference programme to suit all colleagues across the network. There will be no restrictions on the number of attendees at each event. • The exhibition area will consist of a range of partner organisations that attendees can engage with online. • The conference is being promoted as a great opportunity for attendees to virtually meet each other. It will be based on what HWE can do for the network and to share learning. The network awards will be moved to an online offer and will be pared down. She explained she had an advisory group to help improve on the plans to shape the agenda for the conference and the awards and agreed to put the details on Facebook. PH said that it was great to have the conference back and that he would like to see funds used to help regional networks. HoP explained that availability of funds would depend on the delivery of the sessions and if external delivery required outsourcing. More details will be known following conversations taking place over the next couple of weeks IR reported that the restructure of HWE network team was now complete and went through the positions and responsibilities of the team. The changes are in response to needs identified by Healthwatch, including support on demonstrating impact and effectiveness. IR invited questions on her fuller report from the Committee. AM asked if we had heard much about 'shielding' IR responded that shielding was the most viewed subject on HWE website. She explained that she was part of a task group that looked at advice to clinicians on shielding and was also working with DHSC on the development of additional guidance to people who were shielding, which is due out soon. GM mentioned guidance should not overlook whole households of people who are shielding. This is an area the HWE has raised with DHSC and NHS England in their workshops. LA asked IR about a meeting she had had with someone from Saudi Arabia. IR explained that the contact had come through the Government Office for International Trade. IR noted the DIT had identified opportunities for international collaboration and Healthwatch had to consider if it had capacity to do this. She suggested that it forms part of the discussions on future strategy. **The Committee noted the report.**	
1.6	**Agenda Item 1.6 – Committee Members Update** The Committee members had nothing to report	
1.7	**Agenda Item 1.7 – Presentation Healthwatch Response to COVID-19** CM presented a review of HWE and the network's approach to Covid-19 over the last three months. He explained that the initial response was to protect staff and the public (including volunteers) and made an early decision to postpone all public and staff events and engagements. Planned campaigns were paused, a cross team crisis group was set up and dedicated sessions on HWE internal and external websites share information about Covid-19. The focus has been on: 1. Quality timely information to the public based Government advice 2. Information to the network to distribute to the public 3. Advice to the network on getting how to get engaged locally 4. Feedback loops for the public	

	CM reported that 121 local Healthwatch had shared their insight about Covid-19 and that 112 separate Covid-19 issues have been logged. In addition, 29 local Healthwatch reports have been uploaded to the National Reports Library and six Insight Reports have been disseminated to stakeholder CM informed the Committee that we had seen 140% increase in the use of the staff network website and the 180% increase in the downloading of guidance and resources. Feedback from the network has been very positive. CM talked about the channels through which we are sharing our insight such as DHSC, NHS England, NHSX, CQC, PHE, Association of Directors of adult Care Services, the NHS Confederation, national charities and think tanks. Information has been fed into the National Audit Office and that stakeholders have welcomed the insight. CM mentioned that the Chair had appeared on Newsnight to talk about the growing concerns over PPE and that the Chair had also appeared on" Radio 4 PM" to talk about safeguarding and the impact of Covid-19 on the care system. There was also a statement featured in "The Independent" about how the NHS is responding the growing backlog of operations. This has demonstrated that we are making our voices heard. **The presentation was well received by the Committee.**	
1.8	**Agenda Item 1.8 – Intelligence and Policy Report for Q4** CM introduced the report that covered the period from January – March 2020 which contains information about primary, secondary, mental health and social care and the top questions that people were seeking advice about. It also contains deeper dives into the lack of support that people experience when they are waiting for treatment DO sought to clarify the right use of language in that the Covid-19 pandemic had a disproportionate impact on socio-economically disadvantaged communities and people of Black, Asian and minority ethnicity (BAME) origin, rather than on diverse communities, as the use of the wrong language changes the meaning which makes it difficult to address the situation. CM agreed and confirmed that HWE has been much more precise in their language in how we are reacting to this issue and that we will be looking at how the BAME communities and socially dis-advantaged communities are affected. JL added that HWE are very aware of the need from the Covid-19 prospective to focus on the impact on BAME communities and socially disadvantaged communities and this is being addressed through a survey design and qualitative analysis that is being prepared with the help of the Equality and Human Rights Commission who are assisting in framing the questions and helping to reach out through their networks to specific groups. There have been conversations with local Healthwatch about how we can engage more broadly with BAME communities and the effect of Covid-19 and will update the Committee on this shortly. LA mentioned that she found the report very helpful and was concerned to learn that people were not receiving the information and support they needed when waiting for an operation or had a chronic condition. **The Committee noted the report.**	
1.9	**Agenda Item 1.9 – Delivery and Performance update for 2019/20** IR explained that the performance report was a look back at a successful year and confirmation of HWE's commitment to scheduled work which will be included in the annual report. She mentioned that changes made to our strategy two years ago are coming to fruition. The changes have resulted in HWE seeing far more success in policy impact than we've seen previously, and it is still building. HWE evidence is being taken more seriously and we are being brought into issues at an early stage. She mentioned that the end of year deliverables against set Key Performance Indicators showed some ambers, but no reds. She stated that she was happy to take questions. The Chair asked IR if she was confident that the things that had been put back because of Covid-19 would be completed in the next period or would it depend on Covid-19.	

	IR responded that she was confident that they would be completed and had been included in the business plan approved by the committee in March and underlined by the work plan. Some projects agreed in the workplan would be suspended due to COVID to free up capacity to respond and to meet the emerging challenges. BK followed this by saying that HWE introduced a stronger focus on nationally led advice and information, concentrating on what people were sharing with us through our intelligence. Thereby, we have a more accurate view of demand for advice and information from our online channels and it is in real time. The focus has been on Covid-19 but moving forward we can do more and have spoken to the network to establish what we can be producing in response to some of the gaps created because of Covid-19. There is a discussion of how to measure this across the whole network. DO was encouraged that following the Chair's letter, local Healthwatch are really focused on advice and guidance, so the figures are expected to increase. **The Committee noted the report and found this very useful and the format helpful.**	
2.0	**Agenda Item 2.0 – Funding Analysis for local Healthwatch** Julie Turner (JT) – Deputy Head of Network Development and Gavin Macgregor (GM) – Head of Network Development both introduced themselves and gave brief explanation to the background to the funding situation in the network and some of the challenges. JT explained that there are two funding streams for local Healthwatch: • The main-stream – from Central Government DHSC via Local Government • Direct Grant - Local Reform Community Voices (LRCV) grant HWE collect detailed information on Healthwatch funding and contract terms. Since 2013 Central government funding getting to Healthwatch has decreased from £43.3m yearly to £25.5m mainly due to pressures put on local Government budgets. It should be noted that the rate of reduction varies across different networks and in 2020 this ranges from 1% - 46%. JT reported that funding cuts have resulted in staffing reductions and leadership capacity reducing the ability to influence. We have also seen a reduction in the provision of advice and information given due to reduced working hours of Local Healthwatch. JT mentioned that local councils have become more reliant on the Local Reform and Community Voices (LRCV) grant to fund local Healthwatch - 71 Healthwatch get most of their funding from this source. There is an issue about the lack of transparency around Local Authority budgets. JT informed the Committee that consideration was given to advocating all Healthwatch funding coming through LRCV with the added requirement that the Local Authority reported back to DHSC on their funding, as this might have helped transparency, but the risk of this was the future of direct grants may be uncertain. In the current environment it will be difficult to mitigate risk which is local and constantly reducing. Added to this notification of the LRCV grants have been provided late resulting in providers having to draw on reserves until the funds are received, increasing the risk to HWE. JT reported a positive trend toward local authorities issuing longer contract terms. Out of 25 tendered contracts last year, 20 of them had better terms from 3 – 5 years minimum contracts and most have extensions the overall contract terms of 5, 6 or 7 years. Healthwatch England could advocate for a minimum of three years contracts being stipulated in regulations. JT stated funding cuts in local authorities are resulting in a high turnover over of commissioners and an increase of inexperienced replacements. This increases the risk of limited understanding of Healthwatch by commissioners. However, HWE does try to limit the risk by providing an extensive programme of events for commissioners and local authorities to help them to maximise investment into Healthwatch and will be reaching out to areas where we know that there is a tender exercise or contract extension due.	

	The early results impacting from the introduction of the quality framework and feedback from Local Authority commissioners has been very encouraging in helping strengthen the Healthwatch case for investment. However, we have yet to understand the financial risks due to Covid-19. HWE do a lot of negotiations behind the scenes with commissioners but can escalate to more senior officers within the council. HWE do try to get a local resolution but can and have used its powers formally on occasion, but it should be noted that HWE has no control over local Authorities budgets. Although legislation states that Local Authorities are required to report on the effectiveness and value for money arrangements, they have for Healthwatch, it does not appear to stipulate who they need to report to, which would have presented an opportunity to strengthened transparency. The Chair thanked JT for a thorough and insightful piece of much needed work. He acknowledged the battle to increase transparency by Local Authorities and stressed his concerns that funds are being paid out by Central Government are not monitored. He asked if we could find out by Freedom of Information request. JL responded that we have tried but we cannot get the information because it doesn't exist. It is part of a general grant, the Local Authorities themselves do not know how much they receive to fund local Healthwatch. HP agreed that it was a brilliant piece of work and saw a real opportunity to deepen it further and stated that it was something that she would support. She acknowledged that as part of HWE strategy work, it's a risk that we cannot control despite the efforts of the Chair and other staff. We must consider a future in the short to medium term where HWE can ensure flexibility in our own effectiveness. IR mentioned that she has asked for this to be the issue of the first strategic meeting to be held with the Department of Health and Social Care Task Force. She has also asked for representatives from the Ministry of Health Communities and Local Government to be present at that meeting as it requires a cross government solution. **The Committee noted the report and thanked JT and GM.**	
2.1	**Agenda Item 2.1 – Audit, Finance and Risk Sub Committee Meeting Minutes** Referring to the minutes, DO (Chair of HWE Audit, Finance & Risk Sub-Committee (AFRSC)) reported that the budget for 2019/20 was fully spent and the overspend mitigated. A few budget virements were noted as being in line with organisational strategy and business needs. She informed the Committee that the AFRSC would closely monitor the programme management of the grants distributed to Local Healthwatch. She mentioned that the sub Committee also had an overview of the 2020/2021 budget and the risk register and recommended the budget and the risk register to the Committee for approval. DO stated that the Committee were impressed with HWE's approach to risk management. They were assured by the business continuity planning and took a deep dive into Healthwatch funding, which was earlier discussed at this meeting. DO reported that they had a look at the Staff Survey results and the sub-Committee was given an update on the work being undertaken to improve HWE's equalities data. LA asked if a review had been carried out on the outcome of project funding noting what the projects had achieved and whether HWE received value for money for the grants they provided. DO stated that although the committee had not looked at the deliverables within the local Healthwatch grant giving programmes, it could be incorporated at sub-Committee level as a programme is being developed around that to manage the spend, and this could be widened to capture the deliverables. IR confirmed her agreement and it was decided that the sub-Committee would review the data prior to full committee involvement. DO requested that an item be placed on the sub-committee	

	agenda at the next meeting to look at value for money from grant funding and how we provide assurance generally. **ACTION IR/GM** – To look at deliverables within the local Healthwatch grant giving programme to ensure that HWE is getting value for money to be presented at the next AFRSC meeting. **ACTION FH -** to include an agenda item at the next AFRSC meeting for the sub-committee to look at the issue of value for money and how we provide assurance generally. To be discussed before going to the full committee. **The Committee noted the minutes and approved the budget**	**IR/GM** **FH**
2.2	**Agenda item 2.2 – Risk Reports** The Chair sought for clarification on risk **SR01** (*Failure to provide the Network with sufficient support and advice on funding and commissioning will affect our reputation with Healthwatch and stakeholders and affecting our USP and impact*) as to whether or not in DO's view the mitigations made any real difference to the risk. DO responded that the risk was already at 15 which would suggest that the mitigation is having an impact outside HWE's appetite. She went on to clarify that not all mitigations shown in red was outside HWE control. It could mean that HWE could be doing more if resources were available. **The Committee approved the Strategic Risk register.**	
2.3	**Agenda Item 2.3 – Forward Plan** There was nothing to be added at this time	
	Comments from the public ***Karen Kelland (KK) – Healthwatch Rochdale volunteer with the Enter and View Team*** • KK explained that she has a background in healthcare and has been volunteering as a patient partner for 8 years. She lives with a chronic condition and has been looking for an organisation to be a patient voice. She wanted to know if Healthwatch is moving forward as a respected leader of patient's voice and what are their plans. • The Chair responded that he is president of the Patient's Association and that Healthwatch England and the Patients Association liaise on a regular basis. He mentioned that they reach out to other relevant patient organisations on a regular basis depending on the issue but saw challenges in putting everything into one framework as all patients have different interests. • IR told of how HWE started conversations with NHS England about putting on a joint conference that would bring together patient organisations and patient representatives. Although this hasn't happened yet, it is one of the priorities that will be looked at over the summer and there will be a conversation about the role of HWE can play in engaging people to have a joined-up approach and a sense of belonging to one movement. • KK went on to say that she thought that it was as much about being respected and a key part of quality improvement and quality assurance and that people want to be part of the mechanism in their standards of care. She explained that there were good examples of this on the front-line but was more difficult higher up in corporate structures. • IR and KK agreed to have a private conversation after the meeting to explore KK's concerns and ideas further. ***David Thompson (DT)- Healthwatch Northumberland*** • DT had two concerns emanating from the Primary Care Commissioning Committee in Northumberland.	

	• The first related to NHS England allowing GPs to stop all work with patient participating groups, to stop collecting and reporting about patient experiences and to delay responding to complaints from 19th March. He asked, "if there were any moves to have that direction rescinded anytime in the near future?" • The second point he raised was that there are concerns by the Primary Care Commissioning Committee that the development of technological advances for distant GP consultation has moved ahead more rapidly than the public has been made aware of the developments and understanding of how they can participate in the consultations, particularly people who are challenged by IT, are hard of hearing or have sight problems. • IR conceded that some PPG work and complaints was suspended but agreed that we need to know when it was going to re-commence. She explained that unfortunately, JL who would have been able to provide more detailed information had to leave to attend another meeting and offered to put a message out through the chat, once she has had an update from him. • On the other point about the rapid development of digital technology in primary care, IR explained that HWE are currently scoping a major piece of work to do this year on this subject and the impact on people who are digitally excluded. She agreed that the NHS was not forthcoming with information about this despite HWE asking them to communicate and engage with the public about the changes. She thanked DT for raising the issue. There were no further questions from the public.	
	AOB There was no other business to discuss	
	The Chair thanked everyone for attending. The Committee and IR asked attendees for feedback on the meeting and to put comments in the chat as it was the first online Committee meeting. The chair closed the meeting at 15:31 pm.	
	Due to Covid-19 the next meeting will be held via Teams Meeting in September 2020. Further details to follow.	