Healthwatch England 9th June 2021

Meeting #35 Committee Meeting held in Public

Location: Teams Meeting

11:15	Public Committee Meeting – Agenda item	Presenter	Action
11:15	1.1 Welcome and apologies	Chair – RF	
11:17	1.2 Declarations of interests	Chair - RF	
11:20	1.3 Presentation on Integration Index	Jacob Lant Kat Broadhill Sandie Smith Cambridgeshire & Peterborough and West Sussex Healthwatch	For NOTING
11:50	1.4 Minutes of meeting held in March, action log, review of agenda and matters arising	Chair - RF	For APPROVAL
12:00	1.5 Chair's Report	Chair - RF	VERBAL
12:15	1.6 National Director's Report	IR	For NOTING
12:30	1.7 Committee Members Update	ALL	VERBAL
12:35	Lunch		
13:00	1.8 Strategic Risk register	JC	For APPROVAL
13:15	1.9 Business Items a) Equalities Diversity and Inclusion Action Plan 21/22 b) Delivery and Performance Report Update	CM IR	For DISCUSSION
13:45	2.0 Audit, Finance and Risk Sub Committee Meeting Minutes & Risk report	DO	For NOTING
13:55	2.1 Forward Plan	CHAIR	For NOTING

14:00	AOB		
14:10	Questions from the public		
	Date of Next Meeting 8th September 2021		

Healthwatch England Committee Meeting
Held in PUBLIC

Online

Minutes and Actions from the Meeting No. 34 - 9th March 2021

Attendees

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

In Attendance

- Imelda Redmond – National Director (IR)
- Gavin Macgregor – Head of Network Development (GM)
- Chris McCann – Director of Communications, Insight and Campaigns (CM)
- Joanne Crossley – Head of Operations (JC)
- 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 Committee members and other attendees. There were no apologies for absence. The Chair welcomed Francesca Micalizzi and Roberta Bottai from the Directorate for Citizenship Rights and Social Cohesion Service Quality Sector, who were observing the meeting from Tuscany, Italy.	
1.2	**Agenda Item 1.2 – Declaration of Interests** There were no declarations of interest.	
1.3	**Agenda Item 1.3 – Minutes and actions from 9th December 2020 Committee Meeting** The minutes from the meeting held 9th December 2020 were accepted without amendment. **The action log was noted** – action log IR reported that Item. 20191113-1.4 regarding how local Healthwatch deal with people treated far from their home and in closed environments continues to be suspended and we continue to liaise with CQC, but this work may not commence. The committee asked that the issue is kept in view to ensure that people get their voices heard.	

1.4	**Agenda Item 1.4 – Chair's Report** The Chair gave a verbal update in which he reported that we have seen an increase in the number of people accessing the information and services Healthwatch England (HWE) and Local Healthwatch (LHW) provide and highlighted some of these such as patients discharge from hospital, COVID 19, DNR, access to GPs and dentistry. He informed the committee that he had met with Jonathon Ashworth MP (Shadow Secretary of State for Health and Social Care) as a follow up to a letter that he had written about the White Paper and draw his attention to what people were telling us and to discuss Healthwatch's role in the Government White paper and ICS. He told that HWE was active in promoting a place for HWE and LHW in the new environment that the legislation will produce. The chair referred to the Assessment of NHS England (the NHS Commissioning Board) 2019 to 2020 report and the importance given to Healthwatch in the report. He also told of his interview on Radio 4 about dental care which appeared across news bulletins locally and nationally. The Chair mentioned that he remains proud to be the Chairman of Healthwatch England. **The Committee noted the report.**	
1.5	**Agenda item 1.5 – National Director's Report** IR presented the National Director's report updating the committee on some of the main activities that have been worked on since the meeting in December 2020 and asked the committee to note the report. IR reflected that it had been a year since the last face to face committee meeting and thanked the committee for their support and her staff team for making this the most successful year ever for Healthwatch, despite the challenges created by the COVID pandemic. IR reported that we continue to provide regular updates on what we are hearing on COVID-19 and that the focus has been on issues around inequalities which will be embedded in our strategy. She informed the committee that over the next year we will be looking at issues around racism and the seldom heard from voices and she gave an overview of some of the activities Healthwatch has been engaged in over the past quarter. The following activities and issues were highlighted: • The findings of a poll conducted around the vaccination rollout including confusion around information on how to obtain the vaccine and that Black people were more hesitant of transport needed to get to a vaccine centre, than having the vaccination. Research is ongoing to explore the reasons for other vaccine hesitancy in the Black, Caribbean, Black African, Bangladeshi and Pakistani communities. • The findings of the Rapid Hospital Discharge report have been shared with a series of stakeholders including MPs and peers and HWE are pleased to note the inclusion of "Discharge to Access" in the Government's white paper. Discussions with DHSC continues to ensure this element of the bill draws on our findings. • Support provided to NHSE and the Elective Care Task Force on how best to deal with the backlog of elective care and to consider inequalities and priorities when building back post pandemic. • In partnership with the Association of Directors of Adult Social Services (ADASS) and the Care and Support Alliance, raised concerns about the care homes guidance published in December 2020 with Matt Hancock, Secretary of State for Health and Social Care, and Helen Whately the Minister for Care. • The work with the committee and the network around our brand values • The Digital Transformation project of which 10 Local Healthwatch are piloting, with results expected in September 2021. **The Committee noted the report was impressed by the work of Healthwatch in this fast-moving environment.**	
1.6	**Agenda Item 1.6 – Committee Members Update** The Committee members had nothing to report.	

1.7	**Agenda Item 1.7 – Reviewed Strategy** IR sought approval from the committee for the record that the Chair and National Director had agreed sign-off of the Reviewed Strategy in January 2021. The formal document will be produced at the end of the month. **The Committee approved the Reviewed Strategy.**	
1.8	**<u>Agenda Item 1.8 (a) – Annual Plan & KPIs 2021/22</u>** IR presented the draft business plan for 2021/22 which outlined the top line deliverables HWE aim to deliver in YR1 of our reviewed strategy. The committee were asked to approve the plan. IR explained the contents of each section of the document as follows: 1. High level outcomes and KPIs against our strategy objectives 2. What needs to be done to achieve the outcomes 3. The budget **Section 1** The committee asked for the KPIs under section 1 to be reviewed as they considered some to be milestones and other to be targets. IR explained that Q3 would see the result of the pilot and when a decision would be made if to press ahead with the investment in the following financial year. Regarding **Section 1, No 3,** whilst the committee understood the barriers in the first year around Black and Asian people, they considered this to be a target, rather than a KPI. They sought clarification of how HW intend to achieve this target. CM responded the focus of a network wide campaign had not yet been decided and the network will be involved in the design of the campaign. The committee saw an opportunity to strengthen Joy Beishon's work in this area. Relating to **Section 1, No 4,** the committee suggested that given the changing landscape, a review of the process of who is defined as a stakeholder is needed to define the percentages and some adjustment to questions and gradings may be required. **Section 1, No 5** was not considered to be a KPI by the committee, but a measure of other's perceptions of how we are seen. They stated that a definition of milestones is relevant and asked for this to be reviewed. **Section 2** **Objective 6, No 24** – IR confirmed that there will be a skills review of the committee members to identify the competencies we are trying to attract for committee member recruitment in the next financial year. **Objective 6, No 25** – The committee requested the wording be changed from "*Will we reduce our management costs by at least 10%*" to "***We will reduce our management costs by at least 10%***". The committee suggested that there is a need to focus on language throughout and when referring to equality, diversity and inclusion and the need for the rationale behind any changes in language. **The Committee approved the plan.** **<u>Agenda Item 1.8 (b) – Draft Budget 2021/2022</u>** IR presented the draft budget for 2021/22 for approval based on the following assumptions: 1. That the end of year projected outturn for this year will be carried forward for next year. 2. We are assuming a similar pattern of working in the coming year as this year, mostly working online, no face-to-face conference.	

	3. That we will have 14 desks at Stratford, but this may be too many and we are negotiating a reduction. Over-head costs will be reduced. 4. That there will be a full complement of staff for the full year. This won't be the case, there is bound to be staff turnover during the year and so we will have additional funds to reallocate at a later date 5. Staff pay rise @ 2.5% 6. We will have a 2% cut to our budget 7. That for the coming year we will double run our Computer contracts whilst we pilot the new ways of working IR explained the expenditure in detail and that there could be a change in grant expenditure. The Chair of the Audit, Finance and Risk sub-Committee (AFRSC) confirmed that they had scrutinised the budget and looked at the likely mitigations at a recent meeting and were happy to recommend it to the committee for approval. The committee questioned whether the proposed expenditure for staff travel and subsistence was enough. IR responded that it was unlikely that much travel will commence before Q3 and that there will probably be a reduction on pre-pandemic travel thereafter, but this will be kept under review and monies can be shifted if travel costs need to be re-forecasted. The committee noted that there may be a possibility of underspend in this year's budget and asked for an update on grant funding and any adjustments made since the AFRSC meeting. IR informed the committee that the agreed increase to the Digital transformation funding from £153K to £200k, was not yet reflected in the figures. IR confirmed that the current year's risk register had been reviewed by the sub-committee on Friday and it was recommended that the risk register and risk appetite that relates to the new year's strategy and business plan is reviewed at the next committee workshop. **The Committee noted that Non-Pay would be flexible in the 1st quarter and approved the budget**	
1.9	**Agenda Item 1.9 Network Development Plan** GM presented an early draft of the full support offer available to local Healthwatch to help them assess what help would best support them, how to access it and help HWE improve how we support them based on the needs identified by them, incorporating work relating to delivery of Healthwatch England's Strategy and Business Plan 2021-2022. The committee were asked to note the draft plan. GM explained that in developing the plan, we have listened to feedback from the network and that they require as much notice as possible to build activities into their plans and need to see the totality of the plan in order to see which areas of their organisation can benefit from our support. The approach we take with support is sometimes delivered by HWE but is more often by giving a small grant to an organisation such as local Healthwatch and drawing on their expertise to deliver it to the network. Examples are the secondment of Joy Beishon for the work around inequalities and Margaret Curtis on policies and processes. The support offer is based around the Quality Framework and what LHW have told us they want help with. The intention is for it to be published and be available to the network on the refreshed Healthwatch website. In order to engage in continual improvement, we will encourage the network to feedback on an ongoing basis and will formally obtain feedback through a satisfaction survey from the network in April. The committee thought that it was a well written report and a reflection of the great work that has been done and the position that Healthwatch is in and what we can offer. They suggested that this is an opportunity for specific asks from the network and the payback we would expect on our investment, i.e the sharing of data through our digital transformation investment. They asked how HWE felt about the progress made around the work and what areas needed addressing. GM responded that there was a clear sense of direction, but at different speeds. There is appetite around the effectiveness of the Quality Framework and impact but obtaining focus due to other pressures is an element of getting change for the future, particularly for smaller organisations. HWE doesn't yet have a full picture of where the network is on EDI, but this is being addressed. If HWE can show the difference we are making, it will make our case for support stronger, but this will depend on funding, commissioning and geographical locations. Healthwatch like the interaction with the committee and welcome it.	

	The committee noted the draft plan and offered their help in any way in support of the plan.	
2.0	**<u>Agenda Item 2.0 (a) – Equalities Diversity and Inclusion (EDI) Action report Q3</u>** CM presented the EDI report to the committee updating them on the activity on Equalities Diversity and Inclusion up to mid-February 2021. The committee were asked to note the report. CM stated that this work is the theme that runs throughout for all the work that we do and we continue to have burgeoning partnerships with organisations around the issue of race giving particular attention to NHS Observatory on Race, who have been receptive of our approach to them. CM highlighted the policy and influencing work that has taken place around inequalities and the work that has taken place around the vaccinations with the focus on attitudes and views shared by the Black, Asian and Ethnic Minority communities, which has been fed back to stakeholders including NHSE. As a result, NHSE are now capturing demographic data at vaccine centres. CM gave an overview of the work that is being done with the network to support them and ensure that they understand their duties relating to EDI. This included a series of workshops, action learning tools and focus groups to name but a few. He explained how the message is communicated to the network through the website, reports, information that can be translated by the user into 50 different languages and through campaigns. He informed the committee that an Equalities Impact Assessment is being used on all our projects and we are beginning to see where the gaps are due to the work that Joy Beishon is doing. The committee expressed concerns that the window of opportunity to be impactful in this area could run out, but CM assured them that this would not be the case as it is written into the workplan for the coming year that we are committed to make equality, diversity and inclusion front and foremost in everything we do and this will be on a permanent basis and Joy is helping to inform the course that we take. The committee requested greater understanding of the work being done around the lack of trust regarding the vaccine rollout and the contribution Healthwatch can make to it, particularly in terms of access. CM responded that HW are working with Traverse, who they worked in partnership with on the Dr Zoom campaign. 100 interviews with representative groups are being conducted to establish what the issues are. It is hoped that the results will be published within the next couple of months, but the work on vaccinations will continue to be monitored. Whilst the committee welcomed the focus on the work being undertaken, they were not assured by what was presented relating to HWE as an employer and wanted to see the outcomes. They did not feel that unconscious bias training would have any positive benefit. **The committee noted the report.** **<u>Agenda Item 2.0 (b) – Delivery and performance Report Q3/Q4 (Dec 20 – Feb 21)</u>** IR presented the Delivery and Performance Report summarising the delivery and performance against HWE Business Plan and KPIs as at the end of February (2021) for discussion by the committee. The report included the progress of HWE business plan activities for 2020/21, February highlights and what to expect at year end. The committee was asked to note the report. **The committee noted the report without comment.**	
2.1	**Agenda Item 2.1 – Audit, Finance and Risk Sub Committee Meeting Minutes** Referring to the minutes of the AFRSC meeting held on 5th March 2021, DO (Chair of HWE Audit, Finance & Risk Sub-committee (AFRSC)) reported the following and asked the committee to note the minutes: • Chair's Action was taken between meetings for the digital contribution from CQC. • £75% of the 2020/21 budget had been spent, but there was a possible underspend of £130k of which it was agreed that £50k of this could be used to increase the digital spend.	

	• Draft budget for 2021/22 had been reviewed. • The risk review for the last quarter had been noted and they are looking forward to the new risk register where the total risk facing the organisation will be reviewed. The sub-committee had asked for the COVID Risk register to be integrated into the main risk register and the committee will be looking at risk appetite at the next workshop. **The committee noted the minutes.**	
2.2	**Agenda Item 2.2 – Forward Plan** The Chair presented the Forward Plan for the next 12 months containing the standard agenda items. The committee asked for the following items to be included: June – Impact of the Bill following the White paper Sept - Digital Transformation progress The committee asked for the LHW presentation to be put back as the first item on the agenda so they can showcase some of the work that they do. The chair also asked IR to consider as part of the ND Report for one of her teams to be given the opportunity to showcase the work they do for Healthwatch England. IR agreed to include key milestones against the revised strategy and a look back on the current year. **The committee noted the plan**	
	AOB Please see agenda item 2.0(a) above.	
	Comments from the public There were no comments from the public.	
	The Chair thanked everyone for attending The chair closed the meeting at 15:50 pm.	
	Due to COVID-19 the next meeting will be held via Teams Meeting 9th June 2021. Further details to follow.	

HEALTHWATCH ENGLAND PUBLIC COMMITTEE MEETING – ACTION LOG

9th September 2020

Agenda Item	Lead	Reference	Comment	DEADLINE	STATUS
20191113 1.4	Imelda Redmond	**Matters Arising:** To bring back comments regarding how local Healthwatch deal with people treated far from their home and in closed environments	CQC are doing some significant work on this and we are in conversation with them. This work has been suspended due to COVID-19.	Mar 2020	Suspended

9th March 2021

Agenda Item	Lead	Reference	Comment	DEADLINE	STATUS
			No Actions from this meeting		

AGENDA ITEM: 1.6

AGENDA ITEM: National Director's Report

PRESENTING: Imelda Redmond

PREVIOUS DECISION: N/A

EXECUTIVE SUMMARY: This report updates the Committee on some of the main activities that we have worked on since the last meeting in March.

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

We last met in March and below I set out our major pieces of work we have been engaged in this quarter.

1. Responding to COVID-19

1.1 Covid-19 Stakeholder Updates

Given the importance of the vaccine programme to the overall management of the pandemic, over the last three months we have continued to focus our stakeholder briefings on the roll out. This means we have now produced six dedicated briefings on the vaccine, sharing the views and experiences of over 15,000 people with key decision makers. Points highlighted between March and May include:

- Research has shown that people are significantly more likely to share a negative experience than a positive one when giving feedback, so our evidence often reflects this tendency. This situation was definitely true of what we were hearing on vaccines early on and what we shared in the first three briefings. In good news though, the balance of feedback has now shifted with more positive than negative experiences being shared with us. Overall, positive sentiment towards the COVID-19 vaccine roll out has generally been increasing month on month.
- At the beginning of this reporting period, we were also seeing specific frustrations around the priority groups – in particular housebound people who were struggling to secure a home visit. After us highlighting this, NHSE re-issued guidance to GPs encouraging them to do home visits where necessary and also recommending they take a broader definition of the term 'housebound' to include those who considered themselves unable to travel due to the pandemic restrictions.
- Issues around the second dose of the vaccine have become a much more frequented topic of feedback. For some it is about communication, so

people are not sure when they will be contacted or can't get in touch with their GP to book. For others it is about access with people waiting over 12 weeks or being given a different vaccine for their second dose. In some cases, we have seen people waiting up to 15 weeks and no real systems put in place to help or reassure them.

The insights we have been sharing are being regularly used by the DHSC and NHSE to update the FAQs to the system about the vaccine roll out and adjust communication efforts as necessary.

1.2 Vaccines research among African, Bangladeshi, Caribbean and Pakistani Communities

Whilst feedback about the vaccine overall has been very positive, we know uptake is still significantly lower among specific communities. With the risk that this could become more common as we move in to vaccinating populations of younger, largely healthier people who may see less need to get the vaccine, we decided to carry out a dedicated piece of qualitative research to explore low confidence in the vaccine.

We partnered with Traverse (a social research organisation) and the NHS Race Observatory to carry out this project and have shared insights as we have done with DHSC, NHSE, PHE and Cabinet Office officials.

The following findings are not a guide on how to convince people to take the vaccine but provide an insight in to how we create an environment where people feel confident making that decision for themselves.

The full report has been provided in the committee papers.

Key findings:
We spoke to 95 people in-depth about this and explored their deeply personal views. Their comments should not be used to make generalisations about the wider communities but do provide actionable insights for Government and the NHS.

- **Allowing for agency** - People strongly value being able to make their own decisions about such emotionally charged and/or complex issues. Reducing individual's agency by suggesting taking a vaccine is their 'duty' may actually be having the counter effect to what was intended. This is something that those spreading misinformation latch onto, restoring a sense of agency by constantly telling individuals to "do their own research and

make their own mind up." Whilst it is important to stress the reasons behind the necessity for taking a vaccine, people cannot feel forced into it.

- **Addressing Ambiguity** - Participants appreciated that immunology is a complex topic, and the COVID-19 pandemic/vaccine has been an incredibly fast-moving picture, but they want this fact to be recognised in communications they are receiving.
  It is true that no one yet knows the long-term impact of the vaccine as it has only been around six months. But this point needs to be addressed head on and evidence presented why long-term impacts are not anticipated. Don't just skate over ambiguity as people with latch on to it as evidence they are not being told the whole picture.

- **Localising the approach** - Individuals have higher levels of trust in people they have tangible links to as well as those who have tangible links to the vaccine roll-out itself. For example, individuals had higher levels of trust in front line NHS staff delivering the vaccine, their family GP as well as friends, family and local religious/community leaders. Targeted messaging to communities via someone they have little tangible connection to can have the counter-effect. For example, there was widespread dislike for Black and Asian celebrities promoting the vaccine as they were said to have little medical knowledge.

- **Independence of institutions** - For individuals who feel like they have been historically let down by government institutions, they are less likely to trust their communications. And while participants generally trusted the NHS, this was not the case when it was seen as a branch of the government. Having some separation between government and NHS in communications as well as independent voices to promote the vaccine may be impactful.

- **Transparency is key** - We found people were doing their own extensive research and it is important not to underestimate their desire for transparency. The more transparent a source is the more trustworthy it was felt to be. Participants also admitted they could not possibly synthesise all the information on vaccines, but they want to know all information is readily available for the public.

  See the report attached for further detail.

1.3 Because We All Care Campaign

We have now finished the final evaluation of 'Because We All Care', the campaign we launched in July 2020 with CQC to help provide rapid feedback on health and care services at a national and local level during the pandemic.

The campaign focussed on users of care most likely to have been affected by service disruptions (older people, individuals with long-term conditions and carers) and positioned feedback as a positive act that people could take to help the response to COVID-19.

The digitally led campaign saw: a social media reach of over 16M; 781 media mentions, support from over 500 NHS, social care, charity and other organisations (including 128 local Healthwatch); and over 544K social media engagements.

'Because We All Care' resulted in over 54,382 people sharing their stories online with Healthwatch England and the Care Quality Commission via our online forms (Over 36K for CQC and over 18K for Healthwatch England) from July 2020 to April 2021. Healthwatch England also saw a 68% increase year-on-year in people using our website to contact their local Healthwatch.

The campaign, which is the most successful run by CQC and Healthwatch to date, saw public feedback increase 25% year on year and helped flag insight on various issues, including our series of reports highlighting the problems people face accessing NHS dentistry. We also hit our core audiences with 79% of responses from people aged over 50, 64% of responses from people with long-term conditions and 30% of responses from carers.

Key lessons from the campaign include:

- The benefit of pooling expertise and learning between CQC and Healthwatch teams.
- The value of having a campaign, messaging, and resources that partners can use to promote feedback to them can be used at a national and local level.
- The power of using social media to engage people and capture feedback at a relatively low cost.

1.4 Hospital Discharge

Following our report last autumn we have continued to work on hospital discharge matters. In particular we have continued positive discussions with NHSE about changes to the guidance that would place greater recognition on the needs of those who do not require formal support but cannot simply be discharged with no support either.

In March we also led a joint effort along with Carers UK, Age UK, Red Cross, NHS Confed, NHS Providers and the LGA to write to the chancellor to call on him to extend dedicated funding to support Discharge to Assess. This helped to secure an announcement post the budget for an additional £594 million to be awarded to support hospital discharge arrangements over the next six months.

1.5 Care Home Visits

We have continued to monitor the government's changes to visiting policies, following previous letters in partnership with the Association of Directors of Adult Social Services (ADASS) and the Care and Support Alliance, highlighting concerns to the Secretary of State and Minister for Care.

Following these letters and our work representing service users on the National Advisory Group to the Government's care home visiting pilot scheme, national guidance continues to allow more and more indoor visits from more and more 'named visitors' – with the latest guidance increasing the number of named visitors from two to five.

Other key changes we have helped to support include changes to visits outside of homes (without subsequent self-isolation), the pause to visits following an outbreak being reduced from 28 days to 14 days, and residents no longer being required to self-isolate after visiting a GP, dentist or day centre.

1.6 DNACPR

In mid-March, CQC published its review of DNACPR – Connect, respect, connect. The report acknowledged issues raised by the Healthwatch network that contributed to the review, but also noted concerns about ongoing issues.

2. Key non-COVID-19 activity

2.1 Queen's speech

Key points raised in the Queen's speech on health included:

- A focus on the national recovery from pandemic
- Protecting the health of nation – by continuing the vaccination programme and additional funding to support the NHS
- NHS legislation to empower the NHS to innovate and embrace technology
- Patients to receive tailored and preventative care closer to home

- Measures to support the health and wellbeing of the nation - including tackling obesity and improving mental health

The focus on social care was much lighter with just a commitment that "proposals for reform will be brough forward"

Other points of interest include:

- UK to become a lead the world in life sciences pioneering treatments for medical conditions like cancers
- Public funding for research and development – legislation for an advanced research agency
- Rail and bus connectivity improvements
- Measures to address racial and ethnic disparities
- Simplifying procurement in the public sector
- Legislation to support the voluntary sector to reduce unnecessary bureaucracy and releasing additional funds for good causes.

2.2 Draft Health Bill

We understand through our engagement with the Bill Team at DHSC and colleagues at NHSE that the Government's intention is still to bring forth the bill into the house in June with the aim of securing Royal Assent by the autumn and implementation from April 2022.

We have continued to make a strong case that that the functions and powers vested in Healthwatch at a local level in the 2012 Act are replicated at system level in the Bill and that this will need to be adequately resourced.

In terms of how this would look in practice, we have outlined that Healthwatch should be represented at both the ICS NHS Body and the Health and Care Partnership to ensure user voice is adequately represented in all decisions.

We have also argued that arrangements should be put in place that require ICS Boards to publicly present their own independent evidence and justification when deviating from a recommendation made by the partnership board. This is the best way to ensure a diverse range of voices will be heard in the decision-making process at ICS level.

We will now be concentrating on working with the DHSC and NHSE on developing the necessary guidance that will go alongside the bill.

In April, we hosted a network webinar with NHSE/I which gave the network an opportunity to hear about the proposals being put forward by DHSC and NHSE. It

also provided a good opportunity for the network to raise their concerns directly around public participation in ICSs.

It was encouraging that in their report in mid-May, the Health and Social Care Select Committee fully backed our call for Integrated Care System boards to include representatives with experience and expertise in the views and needs of patients and directly referenced our evidence suggesting that Healthwatch, as the existing statutory vehicle for user voice, is well placed to deliver this.

To read the report, click here.

2.3 Quarterly meeting with the Department of Health and Social Care

At the end of May we met with our sponsor team and the Director of NHS Quality, Safety and Investigations (standing in for our Director General who has recently stepped down).

At the meeting we updated on the position around local Healthwatch funding:

- Local Healthwatch are reporting **total funding of £25,220,917 in 20/21** which is **a 1.7% reduction** on the £25,650,174[1] received in 19/20.
- When we dig beneath the headline figures, over the last year:
    - Funding for the vast majority of local Healthwatch remained the same. Sixteen actually received increases in 20/21.
    - Twenty-nine local Healthwatch reported less funding in 20/21, with an average reduction of 10%.
    - Ten of those who received reductions were the result of new contracts starting in 20/21 following a tender process, with reductions ranging between 1% and 20%.
    - The remaining reductions resulted from either efficiency built into existing contracts or reductions agreed on extending contracts.

- Changes in funding over time:
    - Whilst total funding has continued to fall over the last year, the rate of reduction has fallen again from that in 2019/20. This continues a trend we have now seen over a number of years. This is evidence that hard pressed local authorities and individual commissioners are committed to protecting funding for local Healthwatch, particularly

[1] £25,650,174 is the adjusted figure for 19/20 which represents the actual budget received, replacing the projected figure of £25,536,039 that was reported in the State of Support 19/20 report

in 20/21 where public services have all been affected by the added financial pressures resulting from the pandemic.

- Reductions over the last three years are as follows:
  18/19 - 3.4% (actual)
  19/20 - 2.6% (actual)
  20/21 - 1.7% (projected)
- However, it is important to note the cumulative impacts of cuts over the last eight years which mean the funding reaching local Healthwatch in 20/21 is now 37.4% less than the original allocation of £40.3 million set out by DHSC in 2013. In real terms the impact is even greater, reducing Healthwatch resources by 53%[2].

- View for the current financial year –
  There are concerns the lower reductions last year may be a temporary reprieve. With a number of contracts extended last year during the height of the pandemic, we understand 57 local Healthwatch, a third of the network, are potentially up for tender this year. This could result in significant instability precisely as we embark on larger changes in health and care.

In response to the findings, officials agreed to speed up the work on joint commissioning guidance from DHSC and MHCLG to remind local councils of the need to commission an effective local Healthwatch.

2.4 NHS 111 First and Clinical Review of Standards

In the last report we fed back on the research we carried out in to the new NHS 111 First campaign which encourages people to call NHS 111 before attending A&E with a view to improving signposting to other services and providing pre-booked appointments for people who do need emergency care enabling them to wait at home.

Since April this service offer has become part of the NHS standard contract for all areas. This should improve the coverage and consistency of the offer and make it easier to communicate patients.

Through the NHS Mandate process, we have also managed to secure a commitment for NHSE to run a full evaluation of the programme to be conducted in the next few months. NHSE have said they will be drawing on our research to support the

[2] Based on average increase in inflation of 2.5% (as used by the Bank of England) the original Healthwatch allocation would be now worth in today's spending terms £47,231,000. The effect of inflation on the network's collective spending power was highlighted in the NAO's report on Healthwatch finances published in 2020.

evaluation and have asked us to review data from sites that have been offering a larger number of pre-booked appointments already so we can analyse for improvements in user experience. We have also agreed to get them some additional data on 111 in Manchester by re-running our survey as part of a trial of a new survey tool.

On the wider Clinical Review of Standards, at the end of May NHSE published their report on the consultation exercise conducted between December and February. It was positive to see that the respondents were overwhelmingly in favour of the proposals, reflecting what patients have been telling us throughout the review process.

In total we have now brought insights from over 12k people into these discussions and we are pleased to see the final performance management proposals put patient experience front and centre. Our efforts have seen the review re-focus performance around key areas including speedy and meaningful assessments upon arrival, prioritising of urgent cases and preventing very long waits.

There is still a lack of clarity around the creation of a composite metric to simplify reports, but like the majority of respondents, we have argued that using a single measure like the current 4hr target is not helpful. It oversimplifies what is a complex picture and no one measure can satisfy all uses. A new proposal for a six or eight-hour metric has also been floated as part of the response which we remain to be convinced by. This will be useful if it reduces long stays but not if this is interpreted as a simple replacement for 4 hours. We will be watching this issue closely as it develops.

The key now will be in the implementation, and it is clear everyone wants to see this result in meaningful change in the way emergency departments, and wider health systems, deliver care to those in need.

Read the consultation response document here.

2.5 **Access to Dentistry**

Following the publication of the dentistry report back in December, and our analysis of Q3 data in February, at the end of May we launched our Q4 NHS dentistry findings. You can read the long read and a briefing document for more information.

As a reminder to the committee, prior to the pandemic dentistry accounted for 5% of the feedback we hear, but since June last year it has jumped to 20%. And in Q4

we saw the biggest ever split in terms of sentiment with just 3% of the feedback we receive being positive.

This is being driven by a twin crisis of access and affordability, with 4 in 5 people now saying they struggle to access care in a timely way and 3 in 5 saying they find NHS dental charges expensive. Through our research we also identified that the worst affected groups are those from the North East, people living on low incomes and people from ethnic minorities highlighting that this is a serious equality issue.

To support the work, we produced a communications pack for the network including the press release and social media assets etc. and supported the network to raise the issues in their area with their MPs.

Media coverage:
The Q4 report generated significant media attention with the findings being mentioned on Radio 4 and ITV's Good Morning Britain and reaching the front pages of Daily Mail and Daily Express. All national newspapers featured our story, and ITV News covered it in its news bulletins throughout the day, including interviews with the British Dental Association, our own spokesperson, Jacob Lant, and our media case study.

Most articles featured our call to action and key messages, including people on low incomes and those from ethnic minorities being most affected by the lack of access to NHS dental care and high charges.

The following day saw commentaries on our findings in national and trade media, including the Guardian, Daily Mail, Dentistry, and the Daily Telegraph.

Overall, the launch has generated 527 pieces of coverage across national and regional broadcast, print, trade and digital media, achieving an estimated circulation of 535.7 m people.

Examples of media coverage:
BBC News: Dentistry: Rising numbers struggling to access NHS care - BBC News
The Guardian: People in England 'face three-year waits for dentist appointments' | Dentists | The Guardian
The Times: Patients wait three years for NHS dentist | News | The Times
Dentistry: Patients asked 'to wait three years' for dental care in England - Dentistry
LBC: Nick Ferrari | Global Player an interview with Jacob Lant at 1hr 35 mins into the programme
The Guardian: Why am I so furious about teeth? They are deeply socially divisive | Emma Beddington | The Guardian

Daily Mail: Don't blame NHS dentists, DR PAUL WOODHOUSE says THIS is the real reason you still can't get help | Daily Mail Online
Dentistry: Profession speaks out following 'frustrating' Healthwatch report - Dentistry

Political engagement:
Prior to the launch on Monday, we sent out key findings to a group of MPs. Many of them showed their support across their social media channels, in the media, and during a debate in Parliament on 25 May – below are quotes we have noted:

Mohammad Yasin MP (Labour, Bedford):

"A report published yesterday by HW found 80% of people struggled to access timely dentistry care during lockdown. Even before pandemic, current system saw only enough NHS dentistry commissioned to cover just over half of the population in England. Over a quarter of people struggle or can't pay and so avoid dental treatment altogether."

"HW found those living in the NE, people on low incomes and ethnic minority groups were hardest hit by the twin crisis of access and affordability."

Clive Lewis MP (Labour, Norwich South):

"Just yesterday HWE said that people are now faced with up to a 3 year wait for a dentist appt. 4 in 5 people are struggling to access timely care and even when they get an appt a staggering 61% find treatment too expensive. And who is bearing the burden of this chronic govt failure to provide healthcare for all? Surprise surprise its ever those on low incomes and those from ethnic minority groups who are affected the most by the lack of appts and soaring costs."

"HWE revealed that almost twice as many of those people on lower socioeconomic groups struggle or can't afford to pay NHS dental charges than those from higher socioeconomic groups. The cause of this is no secret – NHS dental services … is chronically underfunded by the Govt."

Bob Seely MP (Conservative, IoW):

"The HWE report – 7 in 10 people are finding it difficult to access an NHS dentist. In 2019 the same body published data which showed that 85% of dental practices across the country were closed to new patients. This is definitely reflected in my constituency."

Judith Cummins MP (Labour, Bradford South):

"Yesterday's report by HWE stressed that the dental crisis shows no sign of slowing and they rightly call for a radical rethink of NHS dentistry and a rapid and radical reform of the way that dentistry is commissioned and provided."

Navendu Mishra MP (Labour, Stockport):

"HWE reported that they've seen a significant rise in calls and complaints at the start of this year – we know the pandemic has been an unprecedented challenge but it still cannot be acceptable that in one of the richest countries in the world, some people have been informed that they'll have to wait up to 3 years to see a dentist."

Fleur Anderson MP (Labour, Putney, Roehampton and Southfields):

Referred to figures in our report but no direct mentions of HW.

Minister for Prevention, Public Health and Primary Care - Jo Churchill MP (Conservative, Bury St Edmunds):

"The HW report published yesterday shows that demand for dental access remains high and there are many patients experiencing difficulties. I am not shying away from the fact that there is a problem there and we need to work hard to fix it. However, there was an access problem prior to the pandemic. I very much welcome the HW report and I look forward to meeting the Chair tomorrow actually."

"I acknowledge the HW report also highlights info on NHS dentist availability is not always easy to access and again, I have tasked others with going away and making sure that patient info is more readily available"

Link below if you want to watch:

https://www.parliamentlive.tv/Event/Index/65517cf9-7ae5-4103-86a5-a87e43bba3ea

Ministerial meeting:
In the days following the launch, Sir Robert held a very positive meeting with Jo Churchill MP, the Minister responsible for dentistry. The minister is keen to continue working with us on issues of better information, transparency around cost and understanding of capacity needs. The minister also seemed on board with our ideas about expanding the role of dentists to address wider prevention issues. Speed of reforms has also been heard, with clear commitments that proposals

being worked up at the moment and will be in place by April next year. These are now being led by NHSE and we have been invited on to the advisory group.

2.6 Access to GPs

In March we published 'GP access during COVID-19', which highlighted the experiences of 200,000 people trying to access GP services between April 2019 and December 2020. The key driver for this work was Healthwatch's thematic data on GP access hitting 75% for negative sentiments. Our report highlighted, despite the huge efforts of the NHS and GP practices to keep services running, changes and barriers to access have affected some of the most vulnerable during the pandemic. We have recommended that NHS England commission a full review of GP access arrangements as part of the COVID-19 recovery plans. This will help establish the changes that are working well and should be maintained and identify where GPs need additional support to address access barriers. We understand both NHSE and the DHSE are considering this recommendation thoroughly.

Throughout the report we highlighted that for some patients, remote consultations were not meeting clinical or communication needs. We therefore recently welcomed principles communicated by NHS England to GP practices recently, encouraging the offer of face-to-face appointments once again as the default model of delivery. NHSE directly referenced that this was in response to evidence provided by Healthwatch and others. In a formal response we, in partnership with National Voices and the Patients Association - noted that giving people the agency to say what is the right appointment for themselves is a vital way for the system to manage people's varying needs more effectively, while still monitoring the safety of staff and patients alike.

2.7 NHS Mandate

In our advice to Government on the objectives for the NHS for 2021/22, we supported the need to continue focusing on tackling the COVID-19 virus and praised the efforts to keep health and care services at near normal-levels during the 'quieter' summer months of last year.

We also stressed the importance of several areas relating to the response to COVID-19 which have been picked up in the Mandate. These include:

COVID-19 Vaccinations
With the vaccination programme underway, the Department for Health and Social Care must ensure the NHS is properly resourced to manage the short and medium-

term pandemic response, including delivering the vaccination programme and engaging harder to reach groups, such as those who are housebound.

Dealing with the backlog of care
Alongside this, NHS England and NHS Improvement need to put plans in place to:

- eliminate the backlog of care that built up over the last year in areas ranging from cancer screening and diagnostics to dental treatments;
- ensure health inequalities won't be allowed to widen;
- explain to those awaiting care how the NHS will manage their cases.

Ensuring communications are accessible
COVID-19 brought about the need to provide care while physically distanced. While this worked for some, for many patients, particularly for people with learning disabilities and the deaf community, communication hasn't been compliant with the Accessible Information Standard (AIS). In our advice, we emphasised the need for the Government to set clear expectations around how the NHS should communicate with those seeking care and the importance of meeting the AIS.

Encouragingly we now understand the AIS is due to be reviewed formally in 2021/22 and we will be feeding in to this review the evidence we have gathered.

You can read our advice here and the Minister's response here.

2.8 Parliamentary Engagement

March

- 3/3/21 Meeting with Shadow Health Secretary, Jon Ashworth MP on ICS proposals (follow up meeting scheduled for 15 June)
- 5/3/21 HW mentioned in House of Lords (HoL) debate on NHS Dentistry, referring to our report from Feb
- 10/3/21 HW mentioned in House of Commons (HoC) debate on Teignmouth Hospital
- 15/3/2021 HW/SRF gave oral evidence to HSCSC inquiry into the Department's White Paper on Health and Social Care.
- 15/3/21 HW mentioned in written answer for PQ tabled on access to vaccination for those unregistered with GP
- 18/3/21 Met with Feryal Clark MP who has a keen interest in health inequalities and primary care access
- 19/3/21 HW mentioned in written answer for Prime Minster Questions tabled on access to vaccination for those unregistered with GP

- 22/3/21 Wrote to 5 key MPs with a keen interest in GP/primary care about our GP Access report
- 22/3/21 Met with Laura Trott MP who is a member of HSCSC to discuss our annual report
- 30/3/21 Written Prime Minster Question tabled on our dentistry report from Feb

April

- 13/4/21 HW mentioned during DHSC Oral Questions (public engagement)
- 14/4/21 Meeting with Chair of the HSCSC Jeremy Hunt MP on ICS proposals
- 14/4/21 Meeting with Elliot Colburn MP (former Public Affairs Officer for ICS) to discuss HW ICS proposals
- 26/4/21 HW/IR gave oral evidence to Health Devolution Commission's inquiry on WHAT IS THE PURPOSE OF INTEGRATED CARE SYSTEMS - INTEGRATION OF SOCIAL CARE, HEALTH IN ALL POLICIES, TACKLING HEALTH INEQUALITIES AND A VOICE FOR PATIENTS?

May

- 18/5/21 Organising follow-up HoL Public Services Committee's oral evidence session on Public services: lessons from coronavirus with members of the public sourced by LHW. Session taking place 10 June.
- 25/5/21 x6 mentions of HW in HoC debate on NHS Dentistry: Waveney
- 25/5/21 x10 mentions of HW in HoC debate on Oral Health and Dentistry: England
- 25/5/21 Written PQ tabled in HoC about our new dentistry insight publication
- 26/5/21 Ministerial meeting with Jo Churchill MP to discuss publication of our new dentistry insight
- 6 MPs tweeted mentioning Healthwatch

2.9 Work with academic partners

In the last quarter we have started advising on two new projects in partnership with academic organisations.

- Taking up a role on the expert advisory group for a study by LSE looking at '*Understanding the factors that shape care homes' responses to Government COVID-19 guidance on visiting arrangements'* (to run from January 2021 to April 2022)

- A study investigating safety incident reporting in relation to transition between hospital and care homes with the University of Northumbria.

- We continue to support a collaboration between the University of Sheffield and NIHR

- The committee will also be pleased to see the latest output from the Kings College ethnographic study of LHW which we have been supporting over a number of years.

  Chap 6, page 59 - gives some fantastic evidence about how local Healthwatch responded during the early stages of the pandemic. https://library.oapen.org/bitstream/handle/20.500.12657/48755/9781447361763.pdf?sequence=1&isAllowed=y

2.10 Stakeholder perceptions work summary

We completed the second wave of stakeholder perceptions research with Savanta-ComRes. This included engagement with 931 stakeholders at national and local, including representatives from the health and care sector as well, as well as MPs and Cllrs.

Overall, the report has shown good progress for Healthwatch in its interactions with its key stakeholders and we have achieved several of our key performance indicators, including:

- Health and care stakeholder awareness rose from 76% to 87%, a 14% increase.
- And those stating that they valued our work rose from 60% to 71%, an increase of 18%.

However, MP awareness on the other hand has fallen. Awareness fell from 51% to 48%, but this will have been affected by a general election taking place between the first and second wave.

Key highlights from the report include:

- Stakeholders at local and national level see an important role for Healthwatch in ensuing user voice at ICS level in upcoming legislation.
- Stakeholders recognise our contribution to the COVID response.
- One key area where stakeholders are keen to see Healthwatch's emerging work is equalities and diversity. Local stakeholders feel they have already

seen a shift from our focus on engaging more people, to engaging people from different backgrounds and national stakeholders are keen for us to do more on EDI.

3. Support to the Network

3.1 Supporting Commissioning of Healthwatch

Healthwatch England's role includes advising local authorities on commissioning effective Healthwatch. Although the funding position remains very challenging (see 2.3), we are pleased to see local authorities setting longer length contracts which better allow Healthwatch to plan and achieve change. Over 20/21 we saw 12 local authority contract specification reference Healthwatch England's Quality Framework which ensures there is a consistent understanding of Healthwatch effectiveness between local authorities, Healthwatch providers and Healthwatch England.

3.2 Equality diversity and inclusion

Strategy Launch blog
To coincide with the launch of our new strategy

Collecting demographic data
Our work to identify Equality Diversity and Inclusion gaps in our data continues. The technical work to update our taxonomy will be complete this month and we will be carrying out a programme of engagement with Healthwatch before rolling this out across the network. To kick this off, Healthwatch Tower Hamlets are running two sessions on collecting demographics information and understanding the barriers that sometimes make this challenging. We will be using feedback from participants to produce some resources to deliver the rollout.

Vaccine hesitancy
Since January 2021, the Healthwatch network has gathered views and experiences from 15,000 people across England about the Covid-19 vaccine and the roll out and we have feed the insight gathered back into the system via our stakeholder bulletin.
This month we will publish our findings from an in-depth piece of engagement carried out in partnership with Traverse with 95 individuals from Black, Pakistani and Bangladeshi origin who have expressed a hesitant attitudes or low confidence towards Covid 19 Vaccines.

Embedding and supporting best practice in the Network
Last year we initiated a program to better understand Healthwatch approach to Equality Diversity and Inclusion. Healthwatch England seconded Joy Beishon, Chief Executive from Healthwatch Greenwich to lead this work, which has included facilitating a number of events and Action Learning Sets involving a third of Healthwatch. The work is guided by an Equality, Diversity and Inclusion Working Group with representatives from the Network and led to new initiatives including commissioning of training, the setting up of a Black Staff Network and a pilot survey to understand Board diversity. We will continue to build on this work in 2021/22 and have extended that secondment until the end of September to work on embedding the learnings from this work in the Local Healthwatch Network. More detail on this is outlined in the 2021/22 EDI plan which will be discussed later in this meeting.

Digital health services
Data collection for the digital exclusions work finished in early March.
We have coded all the data and conducted a thematic analysis, presenting initial findings at a series of stakeholder meetings in April and May to discuss and develop potential recommendations.
We also worked with National Voices to co-brand a 'know your choices' patient information poster which they have published as part of their digital exclusions work, and we will also promote alongside our report. The team are currently finalising the report which will be designed up and is scheduled for publication next week (commencing June 14th).

3.3 Digital

Our Digital Transformation Programme (DTP) continues to progress at pace. We created a temporary post of Digital Transfer Programme manager in order to ensure that the co-ordination of the project is properly resourced – following an internal recruitment programme that was open to all Healthwatch Staff, Laura Blower was appointed this post.
The various elements of the DTP continue – the piloting of three engagement and surveying platform solutions and the development of a new central data store to run on schedule. We envisage that we will be in a position to make investment decisions on our preferred digital approach, in August or September. As agreed at the last committee meeting in March we will present our findings and recommendation to National Committee in September.

3.4 Quality Framework

Healthwatch England is supporting all Healthwatch to complete the Quality Framework to help demonstrate their effectiveness. Over the past three months, 18 Healthwatch have completed it, with a further eight in the process. Part of its value is in identifying areas for improvement. Examples include strengthening relationships with local stakeholders which resulted in the Healthwatch being asked to lead engagement activities; new commissioned work resulting from improvements in research analysis; strengthening the skills and diversity of a Healthwatch Board and improving the understanding of the culture and values which fed into a refreshed strategy and work programme.

3.5 Impact

Our Impact Programme is designed to help Healthwatch ensure their engagement and research activities lead to positive improvements in people's health and wellbeing, whilst also better communicating to local authority commissioners how they benefits people's lives.

Using a theory of Change model, we have delivered workshops for 69 Healthwatch between September 2020 and March 2021 with 78% of participants reporting an increase in confidence around outcomes and impact. We have developed an impact tracker to help a Healthwatch team log and follow-up on anticipated outcomes; a template for a Theory of Change diagram based on work by Healthwatch Islington; and a form to enable completion of an Equalities Impact Assessment before finalising project outcomes or report recommendations.

> "We've found all the related templates and guidance to be invaluable to our team. They are easy to understand and give us a complete journey from theory, to concept, to delivery, to finished report and influencing. We feel we have a much more professional approach, and this has helped us when collaborating with other stakeholders … as a consequence we are getting more organisations contacting us because of our efficiency. If only we had had these in 2013, we could have conquered the world by now!" Healthwatch participant

3.6 Learning and Resources

Healthwatch England provides opportunities for Healthwatch to learn and share experiences – including drawing on the expertise of Healthwatch themselves. Between January and march we delivered 43 sessions for 731 learners ranging from impact to research skills.

We have developed new resources including e learning on engaging people who are digitally excluded with Healthwatch Islington, Healthwatch Brighton and Hove and the Consultation Institute; induction modules for Chief Officers and Board members and resources to support good governance and decision-making.

3.7 Volunteering

Healthwatch's 4,000 volunteers play a vital role in the work of Healthwatch. We've developed a suite of resources to support staff managing volunteers, including a handbook, template role descriptions and volunteer policy. We've run masterclasses on motivating volunteers and diversity bringing in expertise from the sector. We've set up a new Volunteer Leads Network to provide peer support and inform Healthwatch England's work.

3.8 Brokering Partnerships

Healthwatch England helps broker partnerships between national and regional bodies and local Healthwatch. Healthwatch are helping with a GP-led NHSE funded research project on the impact on vulnerable patients of remote consulting in general practice. We have recruited seven Healthwatch to work with The Healthcare Improvement Studies Institute study of Operational Failures in General Practice.

4. Supporting more people to have their say

4.1 Advice and information

We saw more people than ever access our national advice and information in 2020-21, with our content viewed over 464,000 times, a year on year increase of over 300%. COVID-19 related articles continue to be in high demand, as does advice related to access services such as NHS dentistry. While restrictions remain in place, we continue to review and update our advice as content changes. We have also reviewed all our non-COVID-19 advice and information content to identify information gaps and poor performing contents. Following this, we have started a rolling process of updating content to make it easier to find online, more accessible to read and ensure the public find it useful. We are also planning new content to fill our current gaps and to test a new focus on public health.

4.2 Public feedback campaigns

Our "Because We All Care" campaign has demonstrated our ability to use digital channels to reach and engage our audience. Following the establishment of a media function within the communications team in January 2021, we have also started to ramp up our use of traditional media to extend the reach of our campaigns and findings. Thanks to this investment, we have seen our national and broadcast media coverage steadily climb in 2021. We are now planning an additional focus on trade, consumer and regional media to raise awareness of our role and encourage public and health and social care professionals to take action.

5. Supporting Healthwatch to engage their communities

5.1 Communications support

Healthwatch England has continued to support local Healthwatch to engage their communities and demonstrate their impact. Recent examples include:

- Providing local Healthwatch with the tools and training, they need to report their impact when they publish their annual reports in June 2021.
- Planning a Campaigns and Communications Ambassadors Network, which aims to eventually have a named Campaigns and Communications lead for every service to improve expertise, coordination and our ability to campaign regionally.
- Running training on media skills, campaigning, paid advertising, using websites and writing for impact.

5.2 Digital support

We have continued to roll out and train local Healthwatch how to use our website template. The template is now used by over 70 local Healthwatch services, with more wanting to adopt the template in 2021-22. We have also developed a new 'Digital Dashboard' tool to enable local Healthwatch and us to understand which channels bring the public to their sites and what content are they engaging in. For example, we can see that in Q4 2021, the local Healthwatch websites we support had over 436K users, and our most viewed content was advice and information. The tool also enables a local Healthwatch to compare themselves to an average similar Healthwatch to understand the performance of their website. We are now planning for a significant upgrade required for our estate of websites by Q3 2022 when the Drupal platform moves from Drupal 7 to Drupal 9. This planning includes testing how we can automate as much work as possible and resource this over two financial years.

5.3 Brand support

Following our brand audit last year, we are now ready to launch the first of our products to help strengthen the Healthwatch brand – an updated brand personality, values and proposition. The product was developed with the input of over 100 staff and volunteers at a series of workshops. We then tested it via interviews with seldom heard groups, local and national stakeholders and the Healthwatch network. With an overwhelmingly positive response during testing, the final values have also been approved by the Healthwatch England Committee. We are now starting the process of rolling out the brand product across Healthwatch England and local Healthwatch. Steps include:

- Updating our tone of voice across our communication channels
- Embedding the use of the values in Healthwatch England staff recruitment, objective setting and planning.
- Providing training and tools for our volunteers and staff across the network.

We are also planning to update our visual brand guidance in 2021-22 to make it easier to use and ensure it aligns with our new brand personality. This process will involve engagement with the network and testing with our audiences. Once all the updated brand guidance is in place, we will also update the brand licence to ensure that all local Healthwatch services understand the brand standards and guidelines.

Key Meetings Attended since the last Committee meeting

March	
NHS Standard Contract Consultation	Dr Bola Owolabi
Govconnect Webinar Chair – Reducing Variation in Healthcare	
CQC	
De brief NQB	Anna Severwright, Clenton Farquharson
NHS Blood and Transplant & South West London ICS	Millie Banerjee
NHS Assembly	Ana Gamez
Royal Voluntary service	Catherine Johnson
Social Care (Covid-19) Stakeholder Group	
People need People	David Jones
EHRC	Baroness Kishwer Falkner - Chair
Information and signposting in Social Care	DHSC
Patients Association	Rachel Power
Live Q&A - Personalised care in practice	Kings Fund
Feryal Clark MP	
Speaker – Hospital Design Conference	Policy Exchange – Wolfson Economics Prize 2021
Integrated Care Delivery Partners' Group	
Social Care Stakeholder Group Meeting	DHSC

DHSC	Aiden Fowler
April	
National Quality Board	
NHS Assembly	
Elective Task Force	
Elliot Colburn MP	
Specialised Commissioning Stakeholder Forum	DHSC
Patients Association	
ADASS	
Local Government Health and Care Sounding Boarding	
Social Care Stakeholder Group	DHSC
DHSC	Rebecca Chaloner
NQB Position Statement and Shared commitment	
ICS Development	NHSE/I
HDC Roundtable	
Simon Chapman	NHS
NEPTS	
Knowledge Exchange – Complaint handling	
May	
VacciNation Findings	
Tom Griffiths	DHSC
Social Care Stakeholder Group	
VCHA (Veterans Covenant Healthcare Alliance)	
DHSC	
CQC	
NHS Transformation Unit	
Jill Morrell	CQC
BMA PLG symposium	
Local Government Health and Care Sounding Board	
DHSC	
Tabitha Jay	DHSC
People Business	Chrissie Saunders
STP/NHSE Teleconference	
Peter Cary on Dentistry	Press Association
Integrated Care Roundtable	
Health Devolution Commission Inquiry	
Quarterly Strategic Meeting	DHSC
NHSE	
ITV News re Dentistry	

HEALTHWATCH ENGLAND – PUBLIC COMMITTEE MEETING

Healthwatch England 9th June 2021

AGENDA ITEM No. 1.8

AGENDA ITEM: Draft Strategic Risk Register 2021-22

PRESENTING: Joanne Crossley

PREVIOUS DECISION: AFRSC reviewed and made amendments to the new draft strategic risk register for 2021-22 at their meeting on the 13th May 2021.

EXECUTIVE SUMMARY: The new draft strategic risk register for 2021-22 highlights the potential risks to Healthwatch England's reviewed strategy, the network and the business plan for 2021/22.

RECOMMENDATION: Committee is asked to **REVIEW** and **APPROVE** the risks presented in the register

Background:

Strategic Risk Register 2021-22

Following the approvals of our reviewed strategy in January and our business plan on the 9th March 2021. The new strategic risk register was drafted by the Leadership Team and Committee in April. It includes 10 new risks and 5 risks carried over from 2020/21. New risks created by the Leadership Team have been indicated in blue text and new risks created by the committee are indicated in red text.

The risks are placed in order of their post-mitigation rating with the highest risk first. The highest flagged risks are:

- **SR24** - Due to reduction in funds from local authorities, local Healthwatch are unable to deliver some or all their statutory activities, affecting their; viability/result in gaps in England coverage by Healthwatch, their impact and the wider reputation of the Network.
  Post Mitigation Rating = 25 (very high)

- **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.
  Post Mitigation Rating = 15 (high)

- **SR20 -** Failure to demonstrate the difference we make and to show the broader value of our work and impact, both locally and nationally, risks cuts to the network funding, reputational damage and people having less trust in the brand.
  Post Mitigation Rating = 15 (high)

- **SR25 (NEW RISK)** - Due to reduction in funds from government cuts, Healthwatch England will be unable to deliver some or all of their statutory activities, which will affect the delivery of our strategic goals and cause reputational damage.
  Post Mitigation Rating = 15 (high)

- **SR28 (NEW RISK)** - If the Healthwatch network is given the additional legal responsibility and remit to operate at ICS in the upcoming Health Bill, there is a risk our ability to deliver on this could be compromised if the network does not receive the necessary additional funding.
  Post Mitigation Rating = 15 (high)

AFRSC suggested that the committee consider their appetite for risk in groups of items instead of on an individual basis and Leadership Team set the tolerance for each risk. Appetite for risk will be addressed in the next Committee workshop.

The sub-committee commented on the following risks in the register:

SR33 – Equality, Diversity and Inclusion

The sub-committee felt that the focus on seldom heard voices covered two different points and suggested that these should be separated.

1. If we didn't implement and execute our strategy well, there is a risk that we would sound like a minority voice, rather than the voice of all users of health and social care.
2. Alternatively, a failure to practice what we preach and/or raising expectation in equality, diversity and inclusion, risks damage to our reputation and credibility.

SR33 is now: A failure to clearly articulate the context and rationale behind our focus on Equality Diversity and Inclusion risks Healthwatch England being seen as a voice for minority issues and perceived as not representing the concerns of all users of health and social care.

SR36 risk is now: A failure to effectively implement and communicate our work on Equality Diversity and Inclusion, in line with explicit commitments outlined in our refreshed strategy, risks damage to our reputation and credibility, particularly among the seldom heard groups that we need to reach.

SR28 – Funding

The sub-committee considered the ICS project to be a much bigger risk and a much bigger opportunity than is being presented and that it would have a huge knock-on impact on the network and our reputation. Whilst considering it to be a bigger opportunity than risk, they suggested that the risk rating is increased. The sub-committee agreed that the full committee would probably have the lowest appetite for this risk.

The increasing complexity of the organisation could be a significant upscale, especially in view of the ICS changes and there is a risk that there may not be the input and support that is needed to manage this.

Pre-mitigation rating has been raised from 12 (medium) to 20 (High) and post-mitigation rating raised from 8 (medium) to 15 (high) pending Leadership Team's agreement.

Equality and Diversity Risks

The sub-committee stated that risks around EDI would be the biggest risk and one for which they would have the lowest appetite, and significant effort and resources would be needed to address those issues. They felt that the wording of this risk did not give enough credence to the importance of what HWE does. They asked consideration given to how people experience healthcare, with the need to focus on inequalities and those seldom heard voices who suffer worse outcomes in the system.

Committee is asked to **REVIEW** and approve the risks presented.

Draft

Healthwatch England

Strategic Risk Register 2021-22 (Q1)

CREATED BY: Leadership & Committee April 2021

REVIEW BY: AFRSC 13th May 2021

APPROVED BY: Full Committee 9th June 2021.

No.	Category	Risk	Owner	Link to Strategic Objective (1, 2, 3, 4, 5, 6)	Pre-Mitigation Rating	CURRENT Risk Controls and Risk Actions (mitigations)	PLANNED Risk Controls and Risk Actions (mitigations)	Post-Mitigation Rating	Committee Risk Tolerance
HIGH LEVEL STRATEGIC RISKS									
SR24 **Old Risk**	**FUNDING**	Due to reduction in funds from local authorities, local Healthwatch are unable to deliver some or all their statutory activities, affecting their; viability/result in gaps in England coverage by Healthwatch, their impact and the wider reputation of the Network.	Head of Network Development	2	5 (Imp) 5 (Lh) **25 (V. High)** 	• We completed collecting and analysing Healthwatch funding and contract terms. We will be publishing State of Support in Q4, state of Network for publication in Q3/4 • We have an engagement programme with local authorities, including formally raising concerns about impact of reduction in income and adoption of Quality Framework to support effective commissioning of Healthwatch	• We are engaging with those local authority commissioners who are considering retendering their Healthwatch to protect income • We are preparing an internal briefing drawing on the learning from engagement process to inform DHSC e.g. supporting councils with their case to move to direct award	5 (Imp) 5 (Lh) **25 (V. High)** 	

No.	Category	Risk	Owner	Link to Strategic Objective (1, 2, 3, 4, 5, 6)	Pre-Mitigation Rating	CURRENT Risk Controls and Risk Actions (mitigations)	PLANNED Risk Controls and Risk Actions (mitigations)	Post-Mitigation Rating	Committee Risk Tolerance
SR01 **Old Risk**	**FUNDING**	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.	Head of Network Development	2	5 (Imp) 4 (Lh) **20 (High)** 	• We have an engagement plan for local Healthwatch who are facing potential contract changes • We review the Healthwatch Network Risk Register monthly and put in mitigation plans to protect Healthwatch income and report key risks to Leadership; we are active on mitigation plans to address reputational risk • Our impact and quality programmes support Healthwatch to articulate their effectiveness and the difference they make as part of their case for investment	• Healthwatch England is seeking to generate income for Healthwatch • Phase 3 of the Quality Framework will see the remaining Healthwatch (100 Healthwatch) invited to complete the Quality Framework by March 2022	5 (Imp) 3 (Lh) **15 (High)** 	

No.	Category	Risk	Owner	Link to Strategic Objective (1, 2, 3, 4, 5, 6)	Pre-Mitigation Rating	CURRENT Risk Controls and Risk Actions (mitigations)	PLANNED Risk Controls and Risk Actions (mitigations)	Post-Mitigation Rating	Committee Risk Tolerance
SR20 **Old risk**	**FUNDING/REPUTATION**	Failure to demonstrate the difference we make and to show the broader value of our work and impact, both locally and nationally, risks cuts to the network funding, reputational damage and people having less trust in the brand.	Head of Network Development /Head of Policy, Public Affair and Research & Insight	2	5 (Imp) 3 (Lh) **15 (High)** 	• We have an Impact Programme to support Healthwatch to understand and communicate the difference they make • Our Quality Programme enables Healthwatch to understand and demonstrate their effectiveness and value and support local authority commissioners to commission effective Healthwatch • We have a programme of training, resources and support in place to help the network develop expertise in developing credible research/engagement and in stakeholder influencing	• We will be introducing technological solutions that will enable us and the network to record, collect and report on the difference we have made more easily in 21/22 • We will be using new processes incorporated into our planning and coordination processes to encourage and increase the collection of data about the difference we have made and how our insight has been used	5 (Imp) 3 (Lh) **15 (High)** 	

No.	Category	Risk	Owner	Link to Strategic Objective (1, 2, 3, 4, 5, 6)	Pre-Mitigation Rating	CURRENT Risk Controls and Risk Actions (mitigations)	PLANNED Risk Controls and Risk Actions (mitigations)	Post-Mitigation Rating	Committee Risk Tolerance
SR25 **New Risk**	**FUNDING**	Due to reduction in funds from government cuts, Healthwatch England will be unable to deliver some or all of their statutory activities, which will affect the delivery of our strategic goals and cause reputational damage.	Head of Operations	6	5 (Imp) 4 (Lh) **20 (High)** 	• We monitor funding and adapt plans	• Regular review of expenditures against business plan • Regular review of workplans	5 (Imp) 3 (Lh) **15 (High)** 	
SR28 **New Risk**	**FUNDING**	If the Healthwatch network is given the additional legal responsibility and remit to operate at ICS in the upcoming Health Bill, there is a risk our ability to deliver on this could be compromised if the network does not receive the necessary additional funding.	Head of Policy, Public Affairs and Research and Insight and Head of Network Development	1 & 4	5 (Imp) 4 (Lh) **20 (High)** 	• We have established two working groups of Healthwatch operating at ICS level to understand support requirements and impact on capacity. • We have submitted a business case to DHSC for additional funds to support this activity • We are actively working with DHSC, NHSE and broader stakeholders to inform and influence the development of the legislation.	• We will be piloting support to Healthwatch, funded by NHSE to learn about impact on capacity on Healthwatch operating at ICS level •	5 (Imp) 3 (Lh) **15 (High)** 	

No.	Category	Risk	Owner	Link to Strategic Objective (1, 2, 3, 4, 5, 6)	Pre-Mitigation Rating	CURRENT Risk Controls and Risk Actions (mitigations)	PLANNED Risk Controls and Risk Actions (mitigations)	Post-Mitigation Rating	Committee Risk Tolerance
STRATEGIC RISKS									
SR35 **New Risk**	**DIVERSITY**	Failure to have a diverse committee and staff team, risks a lack of good skill sets and expertise that different people bring.	Head of Operations	6	4 (Imp) 3 (Lh) **12 (Medium)**	• Transparency in the recruitment process • Recruitment panels reflect diversity wherever possible.	• Actively encourage candidates from all the protected characteristics to apply for roles at all levels, and candidates are anonymous when shortlisted. • We will review the diversity of our staff team and committee and we will strive to make sure our staff and committee are diverse to reflect the population served.	4 (Imp) 3 (Lh) **12 (Medium)**	
SR26 **New Risk**	**DIGITAL**	Due to its complexity and scale, we fail to effectively manage the sequencing of the digital programme or that we develop products that are not fit for purpose, leading to a loss of credibility.	Director of Communication, Insight and Campaigns	1, 2, 3, 4, 5 & 6	4 (Imp) 3 (Lh) **12 (Medium)**	• We are piloting any potential new products with the network to ensure suitability • Project Manager appointed to support Digital Programme • We have set aside a Digital Fund to support Healthwatch transitioning to new systems		4 (Imp) 2 (Lh) **8 (Medium)**	

No.	Category	Risk	Owner	Link to Strategic Objective (1, 2, 3, 4, 5, 6)	Pre-Mitigation Rating	CURRENT Risk Controls and Risk Actions (mitigations)	PLANNED Risk Controls and Risk Actions (mitigations)	Post-Mitigation Rating	Committee Risk Tolerance
SR27 **New Risk**	**WORKFORCE**	Due to the Healthwatch England being a small organisation, there is a risk that we don't have the resources to achieve our level of ambition in the strategy leading to a loss of credibility.	Head of Operations	1, 2, 3, 4, 5 & 6	4 (Imp) 3 (Lh) **12 (Medium)**	• We review new work to ensure that it will achieve value for money and impact • We work with others to maximise our resources and impact • We are undertaking a value for money review of all our contracts.	• By taking an agile approach to our work we ensure that our projects remain both ambitious and impactful • We will review workplans to ensure that they while being stretching that they remain realistic • By selecting the right partners for our projects we will ensure that we amplify the impact of our work.	4 (Imp) 2 (Lh) **8 (Medium)**	

No.	Category	Risk	Owner	Link to Strategic Objective (1, 2, 3, 4, 5, 6)	Pre-Mitigation Rating	CURRENT Risk Controls and Risk Actions (mitigations)	PLANNED Risk Controls and Risk Actions (mitigations)	Post-Mitigation Rating	Committee Risk Tolerance
SR29 **New Risk**	**CHANGE MANGEMENT**	Due to the range, scale and complexity of the change management programmes underway (Digital, Diversity & Inclusion, ICS and Engagement), there is a risk that that local Healthwatch may show resistance to participation in these and other Healthwatch England activities e.g. campaigns, data sharing, projects etc. This will impact on the collective value of our work and cause reputational damage.	Head of Network Development	1, 2, 3, 4, 5, 6	4 (Imp) 3 (Lh) **12 (Medium)**	• We have a communications and engagement plan led by Head of Network Development and Director of communications, Campaigns and Insight to support take up of programmes and promoting rationale • We have set aside a Digital Fund to support Healthwatch transitioning to new systems • Project Manager appointed to support Digital Programme • We have commissioned learning and development support for our work on EDI and the network and extended the secondment of Joy Beishon, Healthwatch Greenwich until October 2021 • We work in an agile fashion testing and	• New Deputy role to support Engagement Programme starting in June 2021 • Campaign Programme will be co-developed with Network • We have commissioned Healthwatch to support take up for the data changes	4 (Imp) 2 (Lh) **8 (Medium)**	

No.	Category	Risk	Owner	Link to Strategic Objective (1, 2, 3, 4, 5, 6)	Pre-Mitigation Rating	CURRENT Risk Controls and Risk Actions (mitigations)	PLANNED Risk Controls and Risk Actions (mitigations)	Post-Mitigation Rating	Committee Risk Tolerance
						refining proposals with the network to ensure they are based on evidence of need and are useful to the network.			
SR12 **Old Risk**	**ENQUIRIES**	Due to poor information management processes, there is a risk that we fail to react appropriately to serious incidents or issues (e.g. safeguarding) raised by the public resulting in a failure to take appropriate action and/or loss of trust in the brand and damage to our reputation.	Head of Operations	6	3 (Imp) 4 (Lh) **12 (Medium)**	• Clear safeguarding policy in place • Clear whistleblowing policy in place • Line management arrangements set clear accountability for acting on information • Healthwatch England has strong links with relevant statutory bodies e.g. CQC, GMC & NHSE • The process on how NCSC deals with Healthwatch England enquiries has been reviewed and updated. • We have a crisis/issues management protocol in place	• We will provide further training for Staff on how to handle difficult calls. • We will also provide a refresher information session on what constitutes safeguarding and whistleblowing. • We will review the NCSC offer to consider whether it still fit for purpose.	3 (Imp) 2 (Lh) **6 (Medium)**	

No.	Category	Risk	Owner	Link to Strategic Objective (1, 2, 3, 4, 5, 6)	Pre-Mitigation Rating	CURRENT Risk Controls and Risk Actions (mitigations)	PLANNED Risk Controls and Risk Actions (mitigations)	Post-Mitigation Rating	Committee Risk Tolerance
SR30 **New Risk**	**FUNDING**	Failure to demonstrate value for money and impact from our grants programme given to local Healthwatch, risk damage to our reputation and inability to attract future funding opportunities and partners	Head of Network Development	1, 2, 4	3 (Imp) 3 (Lh) **9 (Medium)**	• We have a robust grants process in place and report on our grants programme to AFRSC • We assess and track the value for money and impact of each grant we make • We have a working group and Collaboration Manager focused on managing Healthwatch projects		3 (Imp) 2 (Lh) **6 (medium)**	
SR31 **New Risk**	**WORKFORCE**	Due to the move to more home working and reduced office space, there is a risk that we see an increase in staff isolation and a fall in innovation and outcomes.	Head of Operations	6	3 (Imp) 3 (Lh) **9 (Medium)**	• We have increased the rate of team and 1-2-1 meetings • We have improved cross team planning and working • We are focussing on empowering managers and staff • We have improved our approach to internal communications • Some staff with particular needs can work from the new office subject to social distancing rules	• Introduce regular face to face meetings when allowed • Continue to monitor the impact of the hybrid working approach. • Continue to support staff in managing workloads	3 (Imp) 2 (Lh) **6 (medium)**	

No.	Category	Risk	Owner	Link to Strategic Objective (1, 2, 3, 4, 5, 6)	Pre-Mitigation Rating	CURRENT Risk Controls and Risk Actions (mitigations)	PLANNED Risk Controls and Risk Actions (mitigations)	Post-Mitigation Rating	Committee Risk Tolerance
SR32 **Old risk**	COVID-19	Due to the Healthwatch network, both locally and nationally, being unable to ensure our services keep staff and public safe when carrying out their work, there is a risk of reputational damage.	Head of Network Development / Director of Communications , Insight and Campaigns	1 & 6	Imp (4) Lh (3) **12 (Medium)**	• We have issued guidance to make it clear of the steps that local Healthwatch needs to take to keep their staff, volunteers, Board and the public safe. • We will continue to communicate government guidance regularly • We review updated advice from PHE, NHSE and DHSE and cascade this via our public channels to the network • Our Covid Response Group makes daily assessments to look at emerging risks, new information and then the actions required	•	Imp (2) Lh (3) **6 (Medium)**	

No.	Category	Risk	Owner	Link to Strategic Objective (1, 2, 3, 4, 5, 6)	Pre-Mitigation Rating	CURRENT Risk Controls and Risk Actions (mitigations)	PLANNED Risk Controls and Risk Actions (mitigations)	Post-Mitigation Rating	Committee Risk Tolerance
SR33 **New Risk**	**EQUALITY, DIVERSITY & INCLUSION**	A failure to clearly articulate the context and rationale behind our focus on Equality Diversity and Inclusion risks Healthwatch England being seen as a voice for minority issues and perceived as not representing the concerns of all users of health and social care.	Director of Communication, Insight and Campaigns	1, 3 & 6	(5)Imp (2) Lh **10 (Medium)**	• We have engaged with key stakeholders to ensure we land our emphasis on equality, diversity & inclusion (EDI) in a positive context. • We will continue to collect insight from across the community and run reactive campaigns to ensure that we articulate the view of a broad section of the population	• We will ensure that through our communications and stakeholder work that we frame our EDI focused projects in a positive context to ensure that the work is positively perceived. • We will continue to raise issues where we receive high volumes of evidence from the general population. Ensuring that we are seen to be addressing issues of broad concern.	(5) Imp (1) Lh **5 (Low)**	

No.	Category	Risk	Owner	Link to Strategic Objective (1, 2, 3, 4, 5, 6)	Pre-Mitigation Rating	CURRENT Risk Controls and Risk Actions (mitigations)	PLANNED Risk Controls and Risk Actions (mitigations)	Post-Mitigation Rating	Committee Risk Tolerance
SR36 **New Risk**	**EQUALITY, DIVERSITY & INCLUSION**	A failure to effectively implement and communicate our work on Equality Diversity and Inclusion, in line with explicit commitments outlined in our refreshed strategy, risks damage to our reputation and credibility, particularly among the seldom heard groups that we need to reach.	Director of Communication, Insight and Campaigns	1, 3 & 6	(5)Imp (2) Lh **10 (Medium)**	• We have undertaken an EDI audit • We have an EDI action plan in place • We are transparent about where we need to improve and how this will be achieved. • We have carried out a range of programmes with a specific focus on EDI.	• We hve updated our organisational EDI plan to reflect the commitments made in our refreshed strategy. • We will implement a plan based on the EDI audit to ensure that Healthwatch understand their duties in this area. • Will seek to address issues raised round areas, such a board make-up, diversity of volunteers and improve Healthwatch ability to engage with diverse communities. • We will engage with key stakeholders to ensure we land our emphasis on equality, diversity & inclusion (EDI) in a positively • We will deliver three programmes of work including a major flagship campaign with an EDI focus	(5) Imp (1) Lh **5 (Low)**	

No.	Category	Risk	Owner	Link to Strategic Objective (1, 2, 3, 4, 5, 6)	Pre-Mitigation Rating	CURRENT Risk Controls and Risk Actions (mitigations)	PLANNED Risk Controls and Risk Actions (mitigations)	Post-Mitigation Rating	Committee Risk Tolerance
SR34 **New Risk**	**STAKEHOLDERS**	Failure to get the right balance when presenting our evidence, risks causing upset with the government or other key stakeholders.	Head of Policy, Public Affairs and Research and Insight	1	4 (Imp) 2 (Lh) **8 (Medium)** 	• We brief key stakeholders on our strategy, business plans and priorities for the year. • We share regular stakeholder insight bulletins with stakeholders to socialise findings early. • We have specific stakeholder engagement plans in place for all publications and recommendations. • We triangulate our qualitative and quantitative data sources with insights from other organisations. • We work in partnership with influential and credible organisations.		3 (Imp) 1(Lh) **3 (Low)** 	

Risk Grid April 2021 - March 2022

1 risk rated very high (rating 25), 4 risks rated high (rating 15), 9 risks rated medium (ratings between 6-12) and 2 risks rated low (rating 3)

	LEGENDS - Risk Ratings				
Impact	Risk Ratings Based on scores				
5 - Very High	**5** SR33 - EDI	**10**	**15** **SR01 - Funding** **SR20 - Funding/Reputation** **SR24 - Funding** **SR28 - Funding**	**20**	**25** SR24 Funding
4 - High	**4**	**8** SR26 - Digital SR27 - Workforce SR29 - Change Management	12 SR35 - Diversity	**16**	**20**
3 - Medium	**3** SR34 - Stakeholders	**6** SR12 - Enquiries SR30 - Funding SR31 - Workforce SR32 - Covid-19	**9**	**12**	**15**
2 - Low	**2**	**4**	**6**	**8**	**10**
1 - Very Low	**1** **SR36 - EDI**	**2**	**3**	**4**	**5**
	1 - Very Low	**2 - Low**	**3 - Medium**	**4 - High**	**5 - Very High**
	Likelihood				

Legends
Very High
High
Medium
Low

AGENDA ITEM 1.9(a)

AGENDA ITEM: Equalities Diversity and Inclusion Workplan setting out our activities in the area for 2021/22
PRESENTING: Chris McCann
PREVIOUS DECISION: We have committed to publish and EDI action plan annually.
EXECUTIVE SUMMARY: We have drafted a refreshed EDI plan outlining our proposed activity in this area in 2021/22.
RECOMMENDATIONS: Committee Members are asked to approve the plan for publication.

Equalities Diversity and Inclusion Work Plan

June 2021

As we begin to emerge from the pandemic it is has become ever clearer that COVID-19 has had on people with protected characteristics under the Equality Act and the most deprived sections of our society. This has shone a stark light on the need to address the continuing impact of inequalities on people's access to and outcomes from Health and Social Care services

This document lays out the steps we will take to apply an Equalities Diversity and Inclusion lens on all our work in 2021/22 and also provides an outline of projects we will be undertaking which have a specific focus on Equalities Diversity and Inclusion.

In 2020 Healthwatch England made an explicit commitment to apply an Equalities Diversity and Inclusion lens across our work and last August, for the first time, we published an organisational action plan setting out our approach in this area.

In May of this year we restated our commitment to putting equalities issues at the heart of our work when we launched our refreshed strategy which saw the addition a new strategic objective - *To seek the views of those who are seldom heard and reduce the barriers they face*.

Also in 2021 we launched new brand values with EDI at their core and in 2021/22 we will build on the work we have carried out over the past 12 months as we design our programmes of work to meet the diverse needs of the population we represent.

As was the case in 20/21 our National Committee will scrutinise our delivery against the objectives contained within this plan to ensure that Healthwatch England lives up to commitments that we have set.

We recognise that some people and communities they face multiple layers of disadvantage and discrimination and we will ensure that our approach to our work reflects the intersectional inequalities that people face

Objective of this plan

The objective is this plan is to ensure our that we meet the commitments to addressing Equality Diversity and Inclusion laid out in our refreshed strategy throughout all workstreams both internally and externally.

We will do this by:

1. Ensuring that every piece of policy work we undertake is designed deliver real world impact that addresses issues relating to Equality Diversity and Inclusion.

2. Ensuring that we continue to develop an evidence base that informs our work more accurately reflects the diversity of the community we represent.

3. Fostering a workforce culture that promotes and embraces Equality Diversity and Inclusion.

4. Involving and consulting with individuals and groups as necessary and develop our work streams through local and national partnerships where appropriate.

5. Providing support to local Healthwatch to challenge local systems to be better on Equality Diversity and Inclusion, and providing them with the tools and skills to carry out engagement that will put Equality Diversity and Inclusion issues on the table of local decision makers.

6. Conducting appropriate and proportionate equality impact assessments when planning our work and assessing how effective these have been in ensuring our work has factored in issues relating to EDI.

We will also carry out a number of programs of work with a specific focus on Equality Diversity and Inclusion. These will be designed with a diverse representation from across the staff team at HWE, diverse input from the network and with external expertise.

Projects with a specific focus on Equalities

1, Qualitative Research Programme on Vaccine hesitancy among individuals of Black, Pakistani and Bangladeshi origin –

- In June of this year we published our findings from an in-depth piece of engagement with 95 individuals from Black, Pakistani and Bangladeshi origin who have expressed a hesitant attitudes or low confidence towards Covid 19 Vaccines.
- Since January 2021, the Healthwatch network has gathered views and experiences from 15,000 people across England about the Covid-19 vaccine and the roll out.
- Overall, feedback has been positive but uptake of the vaccine has been significantly lower among specific communities, and there remain issues of vaccine confidence among groups now being targeted for the vaccine.
- Healthwatch England commissioned Traverse to undertake in-depth conversations and online exercises with the 95 participants from African, Bangladeshi, Caribbean, and Pakistani communities ethnicity over a period of five weeks during March and April.
- The engagement and research was with people who have primarily hesitant attitudes or lack confidence in the vaccines, testing out a number of hypotheses, developed from the original work of the network, as to why people are hesitant and what could be done to give additional assurance.
- It is also worth noting that both the findings from this work and the way in which it was undertaken provide important lessons beyond the Covid-19 vaccines programme and can help as we all work together to tackle health inequalities.
- We will use lesson learned from this piece of work to inform and refine our approach to future projects.

2, Flagship campaign to engage seldom communities

- COVID-19 highlighted the health inequalities faced by some communities, especially individuals from ethnic minority backgrounds.

- To help address the issues that some communities face we plan to run a flagship integrated communications campaign to support specific communities to share their experiences and highlight the barriers they face to health and care leaders.
- This campaign will be insight driven and run in partnership with our network and external partners.

3, Embedding best practice on Equality Diversity and Inclusion in local Healthwatch and supporting the network to understand and deliver on their duty in this area.

Last year we initiated a programme to identify Healthwatch who carry out good work around Equality Diversity and Inclusion, and gain an understanding of best practice looks like across the network. We recruited a secondee to work alongside Healthwatch England's Learning and Development Manager to identify best practice on Equality Diversity and Inclusion and learning approaches for Local Healthwatch approaches to EDI. We will continue to build on that work in 2021/22.

Specific initiatives that we will be delivering this year include.

- **Board diversity -** We are running a pilot to survey Boards in the North East to understand their diversity with a view to rolling this out across England. This will help inform future work we have planned to support Board development.
- **Training opportunities -** We have invested in training for the network on understanding and applying public sector equality duty. This work is being done in partnership with the Consultation Institute and has been tailored to meet local Healthwatch needs. We have also commissioned a bespoke course from the Diversity Trust to help LHW develop their approaches to EDI. We have six courses throughout the year for people who want to learn how to create their own easy read materials
- **Collecting demographic data -** We offered a grant opportunity for a local Healthwatch to facilitate two sessions on collecting demographics information and understanding the barriers that sometimes make this challenging. Healthwatch Tower Hamlets will be running two sessions in June and using feedback from participants to produce some resources to deliver this.
- **Peer support -** We have set up a quarterly peer support network meeting for LHW to share successes, challenges and their approaches to EDI. The first meeting is on 24 June where attendees will shape the agenda for the group and agree what they would like to get out of it.
- **Engaging seldom heard groups -** We have published some new guidance which we hope will be useful on Engaging with seldom heard groups in Healthwatch research | Healthwatch Network website (staff)

- **Communities of interest pilot -** Following a grant opportunity to facilitate this pilot, we hope to be offering places for six LHW to work together between June and September on engaging Gypsy and Traveller communities and for another six to engage Black African communities. The two facilitators will then run sessions in October that will be open to everyone in the Healthwatch Network to hear about the approaches they took and what they learned.

Embedding a focus on Equalities Discrimination and Inclusion in all work

1, Policy and Influencing

General work:

- **Dentistry** – This has been a major theme in the feedback we have received over the last 9 months, with access and affordability issues the principle driving cause. We will be exploring how this breaks down across different demographics and how affordability and continual NHS price charges are increasing inequality.

- **Social care** – Provisional plans are to look at two topics – the level of unmet need and access to social care, particularly among Black, Asian and Minority Ethnic communities, and the information and advice available to people and how current services take account of tailored communications needed for different communities.

- **Digital health services** – We will be sharing the findings our work looking at digital exclusions, picking up on a strong theme around language barriers

In our responsive policy work we will:

- Use our evidence to successfully influence NHSE and Government communications as we enter the recovery phase to ensure it addresses the needs of different seldom heard communities.

- We will continue our work to push the sector to gather better demographic data to support it's understanding of access to and experience of services.
- Secure references to Healthwatch work with seldom heard communities in 2 reviews/investigations into the handling of the covid-19 pandemic.

Building on work carried out in 2021/22 we will continue to seek to eliminate any data bias from our evidence base to ensure that our policy positions and influencing campaigns are drawn from insight that reflects how disadvantage and discrimination affect people's experience of Health and Social Care.

We will continue to identify Equality Diversity and Inclusion gaps in our data and access other data sources or undertake specific engagement to fill them to ensure that we are representing the needs of as many different communities as possible. We will also encourage and support local Healthwatch to take action to identify gaps in their data and take action to address this.

We will continue to help enhance the skills and capabilities of the Healthwatch network through our research support service, ensuring that they can effectively engage different communities.

2, Working with Local Healthwatch

We will continue provide support to local Healthwatch in understanding their duties to under the equalities act and seek to equip the network with the necessary skills and confidence to challenge local systems to be better on Equality Diversity and Inclusion.

In 2021/22 we will

- Ensure local Healthwatch services understand their legal equalities duties and take a consistent approach to champion equalities in their work.
- Encourage local Healthwatch to review the makeup of their boards to ensure a diverse range of perspectives drives their decisions.
- Identify if we are recruiting enough volunteers from the diverse communities we support and, if not, what solutions are needed.
- Improve the skills and confidence of local Healthwatch to engage and support more communities to have their say on care.

- Promote a Healthwatch culture where everyone feels welcome, that their views are valued and that they want to work with and for us to make a difference.
- We will provide support to Healthwatch local in holding local systems to account on meeting their duties around EDI.

3, As an employer

We will foster workforce culture that promotes and embraces Equality Diversity and Inclusion and recognises that each individual adds value to a team. We are committed to supporting our workforce to develop and to commission or deliver a high-quality work that meets the needs of everyone.

Specific initiatives that we will be delivering this year include.

- **Equalities Impact Assessment** - We have updated our Equalities Impact Assessment Template for our project work. In 21/22 we will track how this is being used in the development of projects being undertaken by Healthwatch England.We will also assess how the implementation of the EIA template is improving the impact of our work and also to highlight where there may still be challenges
- **Talent Management, learning and development** - We will ensure that all staff have the opportunity to develop their skills and capabilities in their roles via on-the-job, project management and academic learning. We will extend opportunities for staff through secondments and mentoring. We will ensure all staff undertake the e-learning course that has been developed by CQC Academy on Equality, Human Rights and Diversity – we will review this training and see how we might augment it to ensure that the training offer to staff is effective. We will use agencies which specialise recruiting in diverse talent as part of recruitment processes.
- **Recruitment** - We will demonstrate transparency to ensure all internal and external potential candidates are treated fairly and equal opportunity in the interview process and encourage candidates from all the protected characteristics to apply for roles at all levels. Candidates will be anonymous when shortlisting. We will ensure a diverse make-up for all our recruitment panels.
- **Workforce relations** - We continue to strive for a happy working environment for all staff. We will use staff surveys to identify where there may be unfairness and inequalities, and we seek to address and resolve these issues when they arise. Line Managers will complete unconscious bias virtual courses offered by CQC Academy as part of their mandatory objectives.

Our Staff Engagement Group will continue to represent staff and escalate any issue which they feel does not align with our equalities aims for the organisation. We also have Our Speak Up Guardian representing HWE staff.

4, How We Communicate

We will ensure that all our communications take account of Equality Diversity and Inclusion. We will publicly challenge inequality and discrimination and ensure that we raise awareness of Healthwatch among a broad range of communities.

In 2020-21 we will focus on the following areas

- **Raising awareness of our brand -** We will focus on improving our marketing of the Healthwatch service to seldom heard groups using a mixture improved brand support for local Healthwatch, as well as national social, partnership and PR activity.
- **Marking our advice more accessible** - We will focus on making all our content, including advice and information, more accessible to seldom heard communities by reviewing our accessibility policy and continuing to roll out tools such as the ability to translate our content on national and local websites we support.
- **Increasing feedback from seldom heard groups -** We will run reactive and proactive campaigns to target seldom heard communities including a flagship campaign planned for Q3 referenced as referenced in the 'Projects with a specific focus on Equalities' section of this plan.
- **Evidence use -** We will focus on increasing awareness of our findings that relate to seldom heard communities through PR, social media, partnerships and email marketing.

Communicating with Local Healthwatch - We will focus on championing and promoting the importance of EDI in our communications to the network, as well as the support available to staff and volunteers to better engage their communities.

AGENDA ITEM No: 1.9 (b)

AGENDA ITEM: Delivery and Performance Report – Q4 (March – 2021)

PRESENTING: Imelda Redmond

PREVIOUS DECISION: The Committee NOTED the delivery and performance report for Q3/Q4 (2020/21)

EXECUTIVE SUMMARY: This paper summarises the delivery and performance against our Business Plan and KPIs at the end of year (March 2021)

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

Background

The report below provides a trend on our KPI performance over the past 3 years based on our business plans covering 2018-2021. The business plan during these years were set against our previous strategy, which the committee approved 2017.

Highlights over the past 3 years (2018-2021)

2018–2019 (Year 1 of the previous strategy,2018)

During year 1 (2018) of our previous strategy (2018) we aimed to do more to support people to have their say and ensure their views were heard and have an impact on health and care policy. We also trialled new ways of working while ensuring key deliverables were achieved. In the first year of our business plan the following areas were addressed:

- Initiatives to build a higher profile, both for Healthwatch and the power of the public's voice, so we double our contacts with people to more than one million a year by 2023
- The sharper use of digital systems to capture people's views and provide a more responsive information and advice service
- Research to help health and social care professionals understand the value of listening to their communities in both quality and monetary terms
- Activity to strengthen the impact of the Healthwatch network, the service we provide and improve the skills of our staff and volunteers.
- Establishing a right to give grants to Healthwatch

2019-2020 (Year 2 of the previous strategy, 2018)

In 2019/20 we saw the implementation of the second year of the 2018 strategy. In year one we focused a significant amount of transition from old ways of doing things to new ways. This laid the foundations for us to move into 2019/20 with the platforms in place to help really improve our impact on creating improvements in health and social care, in our relationships with external stakeholders and in our relationship with the network. The 2019/20 business year was a year of real achievement for Healthwatch England and the Network and made a big impact on enabling people's voices to shape policy developments in health and social care. Some of our achievements included:

- Our work on Maternity and Mental Health was crucial in influencing NHSE plans to introduce a new six-week check for mental health of new mums to be rolled out from April. This came with an addition £12 million of funding for GPs to deliver the service and to help 600,000 new mums.
- Our work on dentistry saw CQC carrying out 100 visits to care homes, these visits resulted in a significant change in practice across the care sector.
- The report on Patient Transport Review was a great example of how by leveraging our evidence and combining it with data from external partners we can put an issue on the national policy agenda.
- Our contribution to the NHS Long Term Plan work has helped to change perspectives of what we are capable of in terms of reach and insight we can develop.
- The reach and impact of our communications work continues year on year. We have seen across the board increases in engagement on digital platforms, from social following to website visitors.
- Our work protecting funding has been vital to sustaining the network. 2019/20 saw the lowest overall reduction in Healthwatch funding – just 2% compared to 7% in 2017/18 and 4.3% in 2018/19. The network continues to be affected by reductions in local authority funds, but we have managed to stem that flow and through cooperation and challenge with local government have been ensured that in the region of £600k budget reductions have been avoided.
- The introduction of the Quality Framework required a major effort to secure buy-in from the Network on its development and take up by the early adopters. We have emerged from this phase with every participant happy to be an advocate for the process which will key rolling it out across the network.

2020-2021 (Year 3 of the previous strategy, 2018)

In 2020/21 we saw a significant change in our ways of working due to the pandemic and national lockdown. This also led to a change in our focus as we pivoted to help the system response to Covid-19. Despite the pandemic and the need to do things entirely via digital means, we still had a hugely successful year and some of our achievements include:

- We achieved blanket media coverage on the issues people face accessing NHS Dental Care. We shared the evidence we have gathered on people's poor experiences access in NHS dentistry during the pandemic. This has involved a series of constructive meetings with the Chief Dental Officer, the British Dental Association, NHSE, DHSC and others across the profession laying the groundwork for our campaign next year.
- Visitors to our national website passed the half million mark for the first time. Engagement with all our public facing channels are at an all-time high.
- We have continued to see high engagement with our advice and information content. Our new ratings system indicates that 4 out of five users view our advice as useful or very useful.
- Our "Because We All Care" spike targeting carers was supported by 80 partners and gained over 25 items of media coverage.
- We had engagement with over 30 local authorities and Healthwatch on potential contract changes and to support effective commissioning of Healthwatch.
- We published the early evidence we have gathered through the network on the vaccines programme and successfully petitioned NHSE to start collecting and publishing better demographic data around up uptake of the vaccine.
- **Healthwatch Week 2020 -** Following the move to an online event offer due to the pandemic, our aim for Healthwatch Week was to deliver a week-long online programme for all colleagues in the network. The event was well received by the network with the highest participation of 516 local Healthwatch attendees (373 in 2019), and social media activity than in previous years with
- We secured key mentions in the Government White Paper on legislation and NHSE's consultation on ICSs.
- We completed our research project with Black and Asian communities on the Covid Vaccine
- Mid 2020 we conducted a review of our strategy, which the committee approved in January 2021. With the health and social care services facing big challenges as a result of COVID-19, we have updated our strategy to make sure we are as effective as possible and that our work has the greatest impact.

2021-22, Business Plan Objectives

In our new strategy 2021-2026 many of the programmes of work underway will continue, but we will focus on some strategic difference during this period as stated in our new strategy (2021-2026) . In this first year (2021-22) our objectives are:

- To build a sustainable and high-performing network of local Healthwatch services.
- To find out the experiences of people needing or using health, public health and social care services.
- To seek the views of those who are seldom heard and reduce the barriers they face.
- To act on what we hear to improve health and care policy and practice.
- To build on and share our expertise in engagement.
- To be strong, well-governed and use our resources for the greatest impact.

The committee are asked to **note** this report.

Healthwatch England:

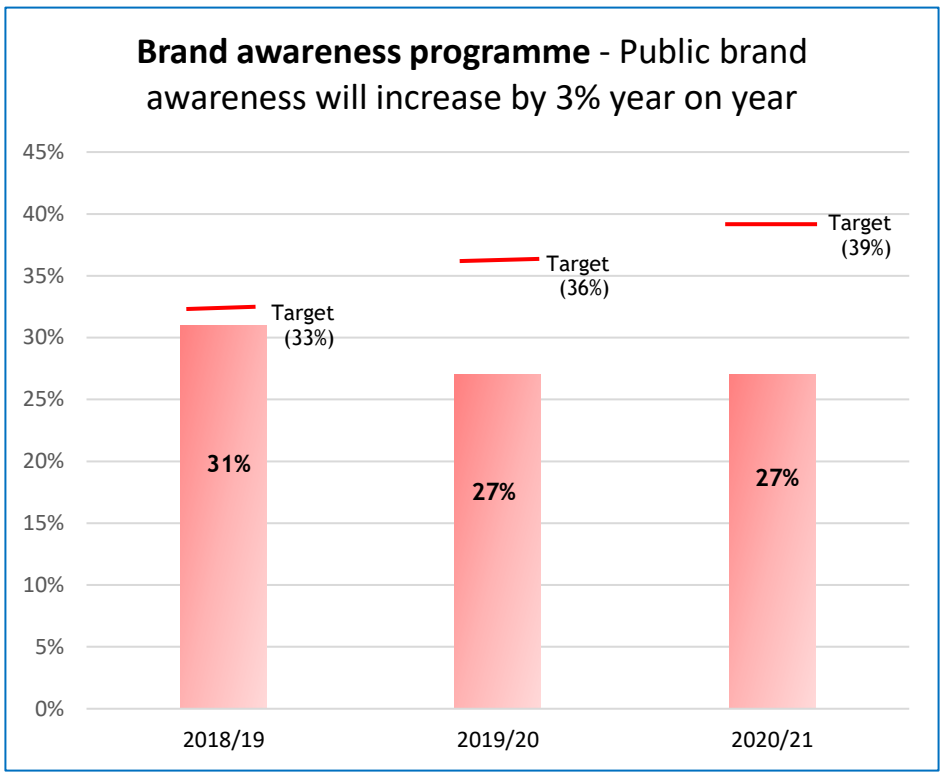
Performance Report against our KPIs (2018-2021)

KPI Trends 2018 - 2021

1- Brand awareness programme

In 2020/21 Public brand awareness of Healthwatch in our 2020 survey was 27%, which was four % less than 2018 but the same as 2019. Like many of the brands we measure against we have not seen a significant shift in brand awareness with the previous year, it is unclear why awareness has not increased given the increase we have seen in public engagement with our service nationally and locally at the same time. The target which was set for this year was based on running a mass participation campaign in 2010-21 which was adapted due to the pandemic.

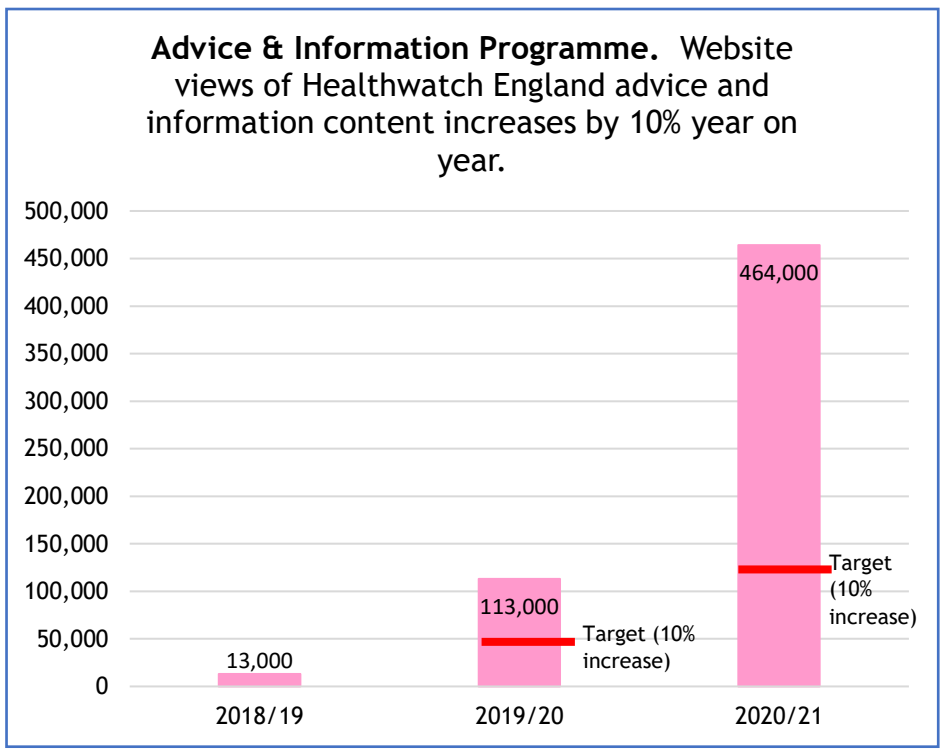
In 2021-22 as well as use of our brand resources increasing year on year, we also want 100% of local Healthwatch signing up to our brand licence. This focus is because we are rolling out the new brand resources to strengthen our brand and want to ensure these are adopted by local Healthwatch services. We will continue to measure engagement and awareness as BAU.



2 - Advice and information Programme

We have seen an increase of 308% year on year when it comes to unique views of Healthwatch England advice and information content. Our advice and information service content seen significant growth since we introduced it in the summer of 2018.

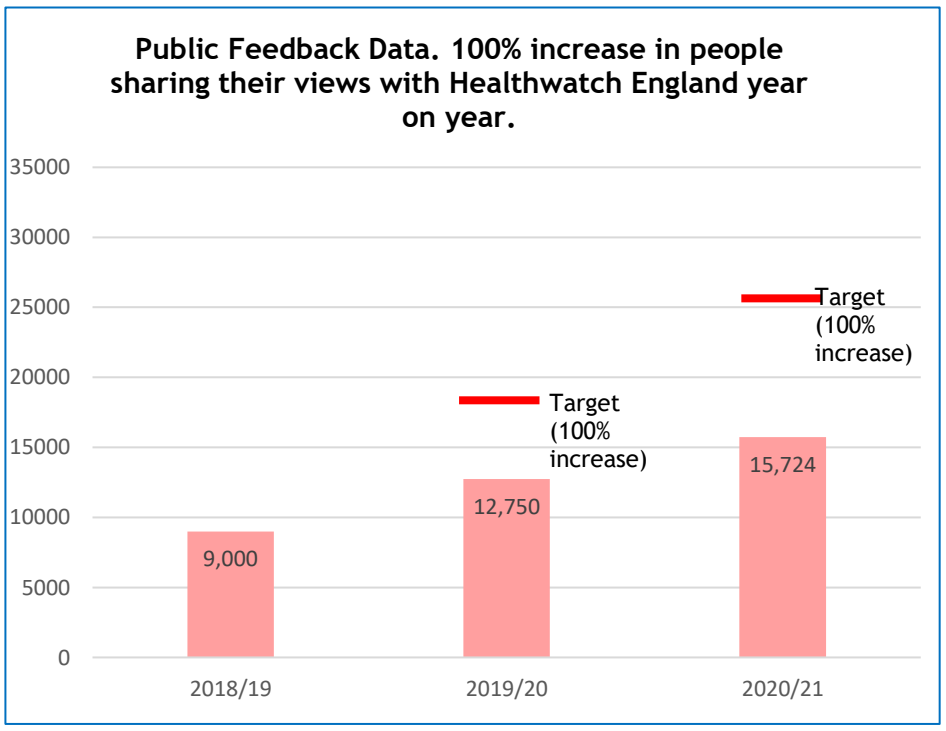
Our focus now will be on improving the quality of our content rather than growth. Given this our future KPI aims to ensure that the average user rating of our content is 4 out of 5 in terms of usefulness.



3 – Public Feedback Data

15.7k views shared with Healthwatch England in 2020/21 compared to 12.7k the previous year. This is an increase of 23% year on year. We did not reach our target of doubling public feedback year on year due to a change of emphasis to focus on COVID-19 feedback.

In 2021/22 rather than scale of response, we will instead focus on increasing the proportion of data we gather from Black, Asian and Minority Ethnic groups through our national feedback form from 4% to 15% (including white Irish). This is so that we can focus on collecting views from communities who are underrepresented in our insight.



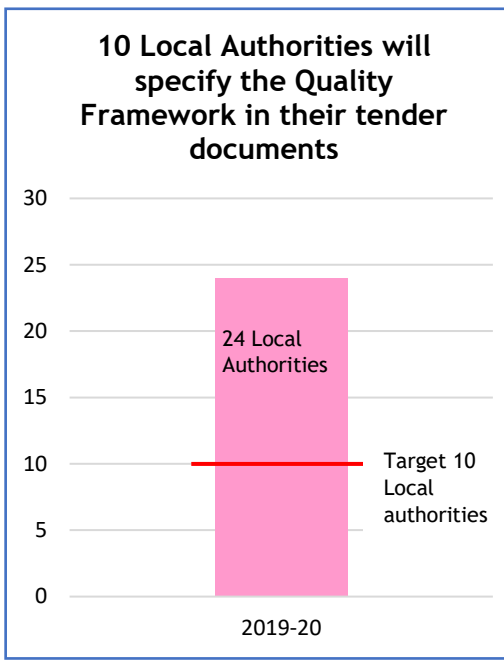
4 – Additional list of socio-economic categories to be used by local Healthwatch in both the Civi-CRM

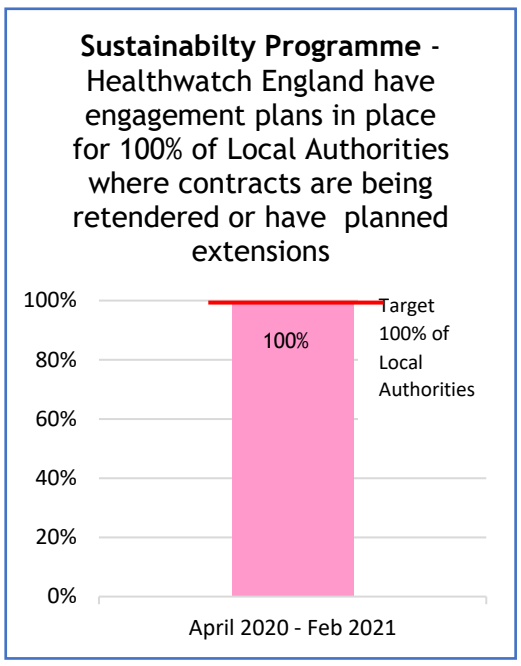
There have been delays on the development side to implementation of the new demographic categories to both the reports library and CRM taxonomies. We anticipate that the technical changes will be complete on both platforms by the end of Q1 and we have commenced a programme of engagement to support the rollout of the changes across the network.

5 – Sustainability Programme:

Many LAs have decided to extend contracts rather than tender. Healthwatch England has had influence: improved contract terms (length); incorporation of Quality Framework; use of Healthwatch England's Commissioners Resource Pack; some increase in budget (balanced against some cuts)

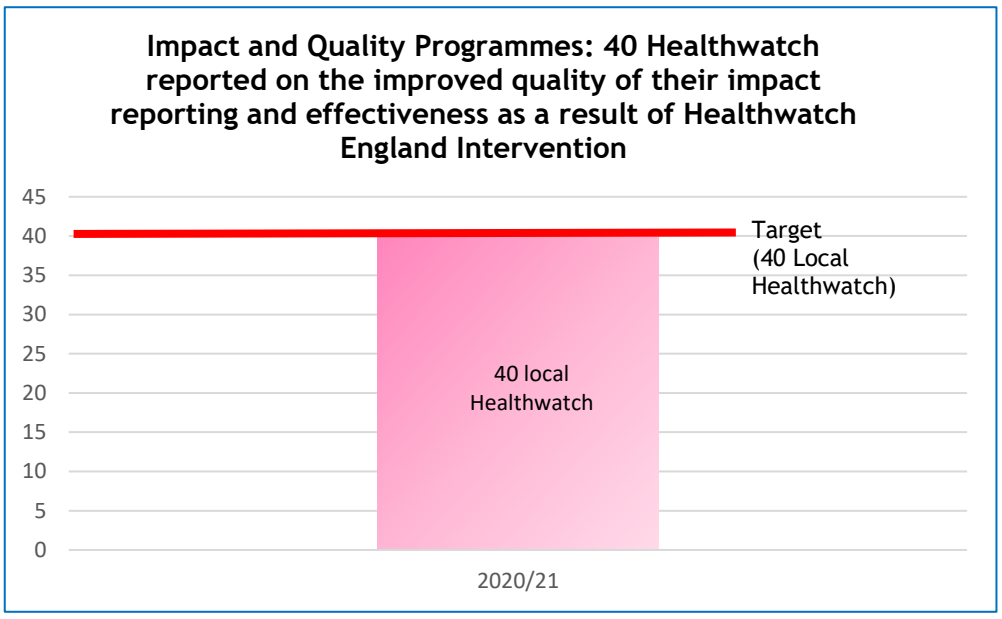
We have an estimate of 46 local authorities (LAs) who are due to confirm contract extensions with only one pursuing tender. We are not fully clear about status with some LAs as vacancy of the Deputy post since February 2021 means less capacity to oversee and manage engagement.





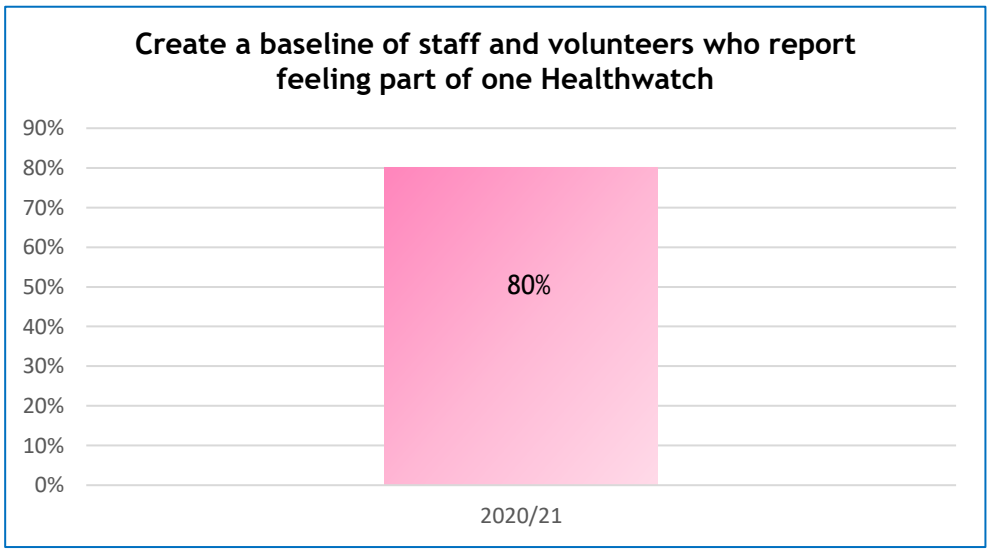
6 – Impact and Quality Programmes

Impact is a key element to ensuring the network have a strong case for investment. Targeted support to individual Healthwatch is proving to lead to better outcomes. A report was done in Feb 2021 on the outcomes achieved during 20/21. Tangible examples where local Healthwatch have strengthened their case for support through demonstrating impact as a result of the intervention by Healthwatch England



7 – Create a baseline of staff and volunteers who report feeling part of one Healthwatch

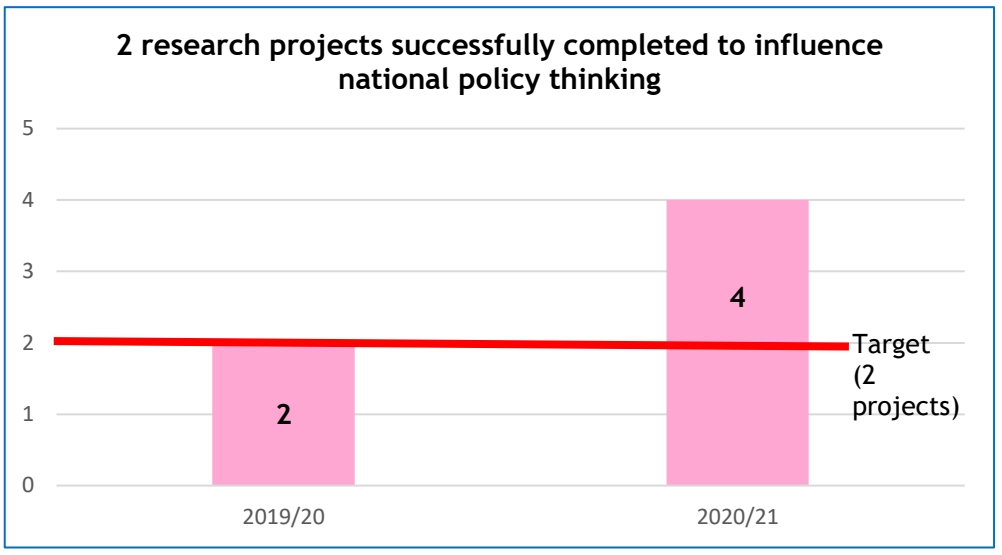
In 2019/20 we conducted first survey asking if respondents felt part of One Healthwatch. We had 246 respondents with just 21 volunteers (total 4,000). For 20/21 we wanted to promote to volunteers and Board members to create a baseline, plus continue to measure among staff. Following the report completed in November 2020, 80% reported strongly agree or agree with feeling part of the network



8 – 2 Research Projects successfully completed to influence national policy thinking

To ensure Healthwatch research is being used to shape emerging national thinking and policy positions of key sector players we set out to complete 2 research projects to influence national policy thinking. This was based on a baseline from 2019/20 where published 2 reports on mental health issues.

In 2020/21 we actually completed 4 research projects on Digital NHS services (Q2), Hospital Discharge (Q3), NHS 111 (Q4) and Access to GPs (Q4).



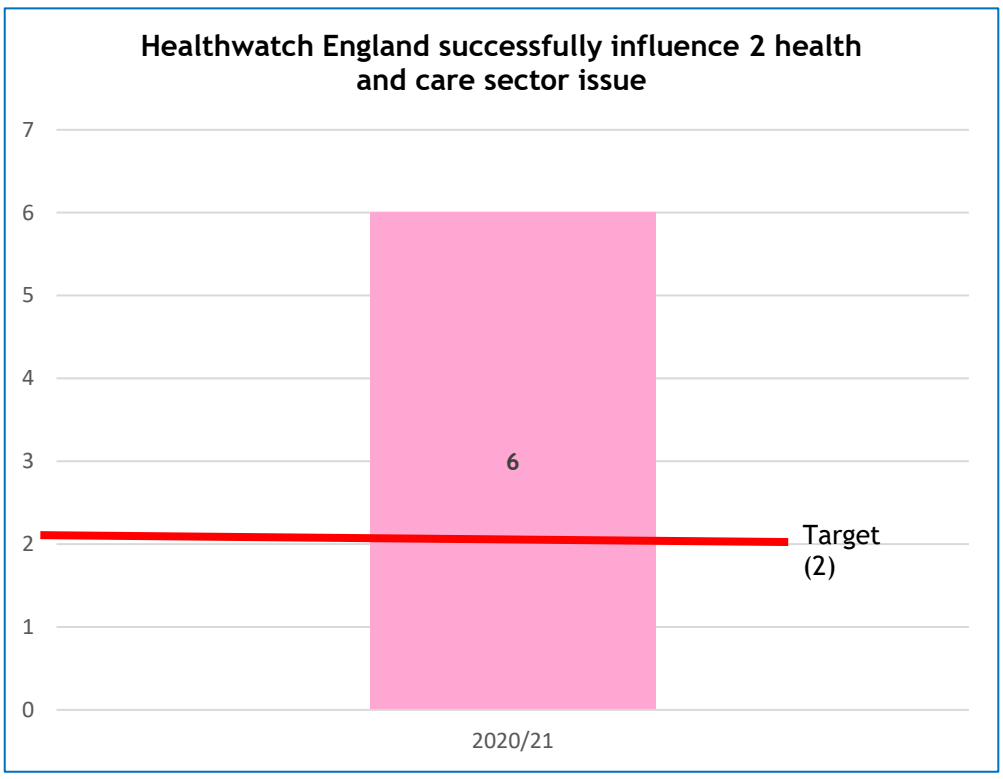
9 – Healthwatch England successfully influence 2 health and care sector issues

In December 2020, we published a report outlining the impact COVID-19 has had on people's dental care and in Q4 followed this up with further analysis showing the growing scale of the crisis.

We have shaped NHSE's equalities priorities through our role on the Equalities taskforce and ensured the Elective recovery taskforce has a primary focus on improving communications.

Through our regular stakeholder briefings and engagement on Covid we have successfully influenced the:

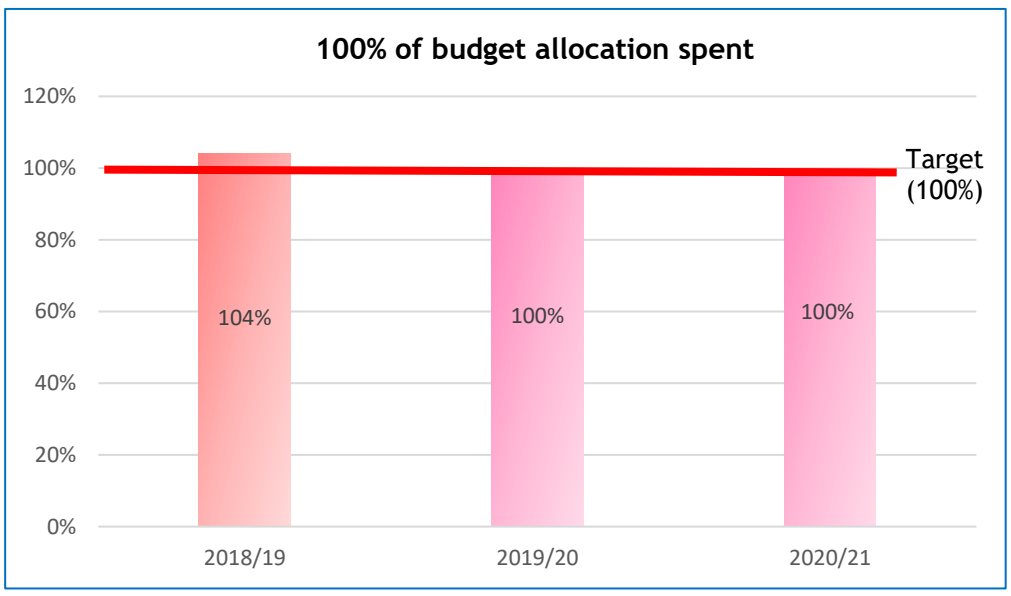
- The development of the test and trace App
- The roll out of the vaccine
- Care home visiting rules



10 – 100% of budget allocation spent

Over the last three years we spent the total budget allocation as planned. During 2020-21 the impact of the pandemic resulted in a significant projected underspend. However, we saw this as an opportunity to reallocate the budget to innovative projects and secondments via grant funding to local Healthwatch.

For 2021-22 the budget is slightly less than last year. Our planned spend is focused on EDI activities and digital engagement, which will support our strategic aim to demonstrate our impact.

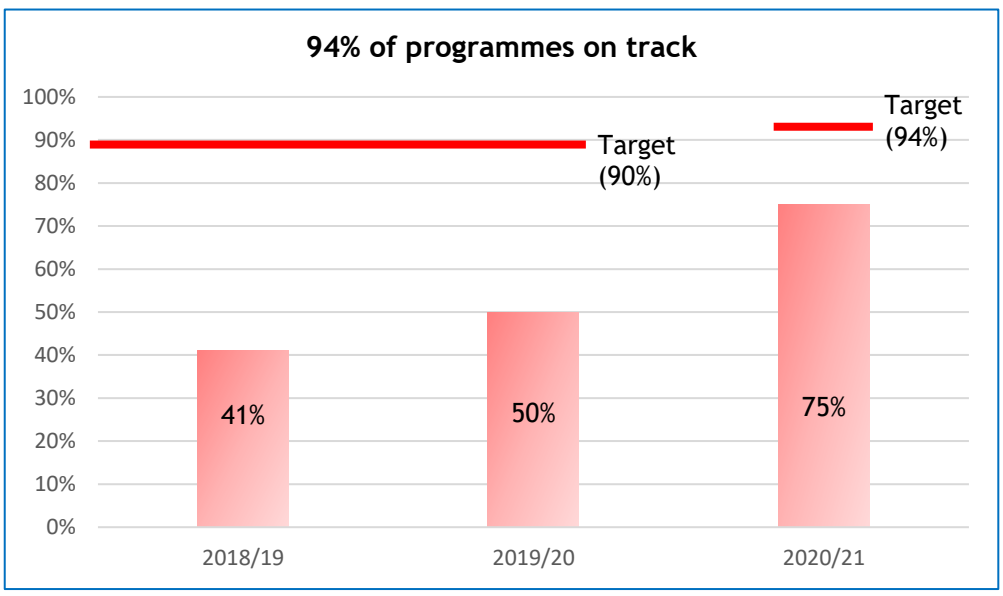


11 – 94% of programmes on track

Over the last 3 years our programmes have been below our targets set.

2018/19 saw some major delays in projects caused by staffing shortage and some procurement issues.

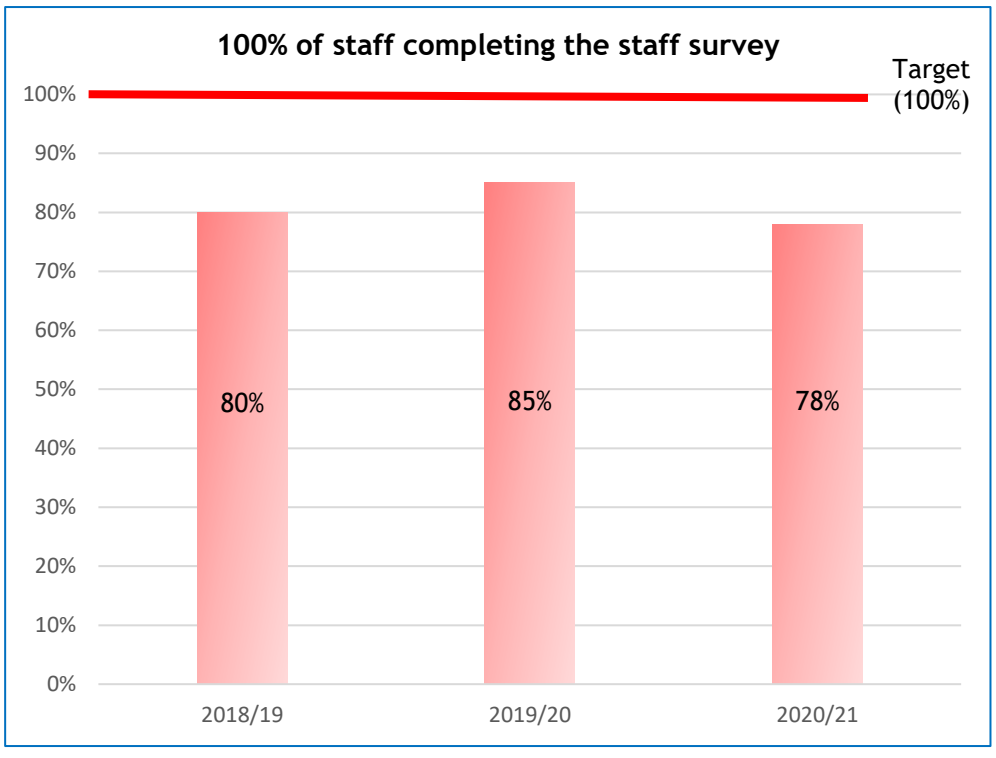
2019/20 major setbacks through to early 2020/21 was largely due to the impact of Covid-19 and the need to focus resources and projects on the pandemic.



12 – 100% of staff completing the staff survey

The responses to our staff surveys over the last have been very good, although there was a dip in 2020-21 with a backdrop of a team restructure and staff redundancies, and questions concerning leadership style and how we operate as an organisation. The issues that came out of the previous survey have been addressed and since the last survey we have made changes which have seen real improvements in our ways of working.

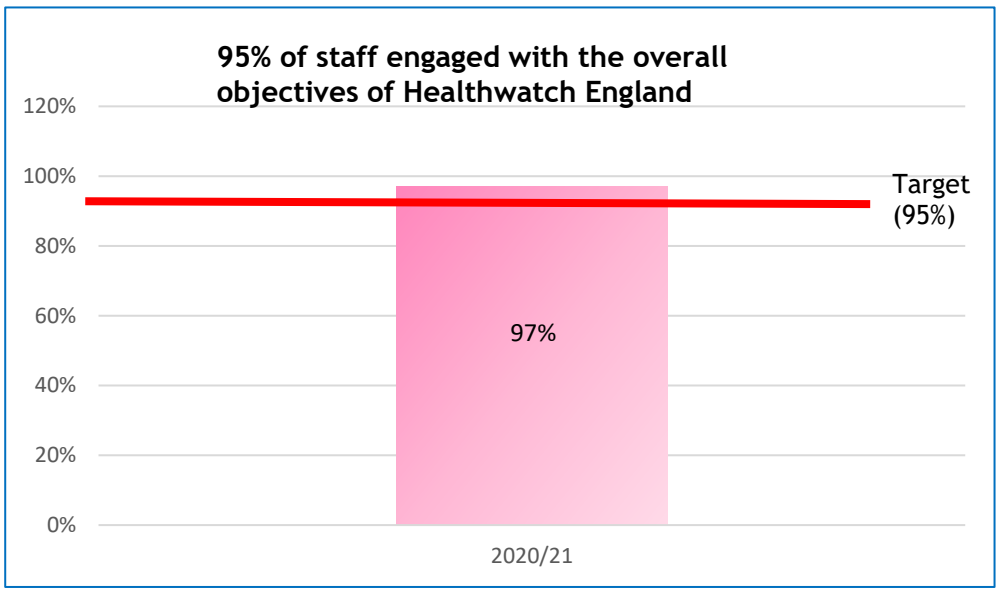
For 2021-22 we will encourage all staff to complete the next survey to ensure that everyone will have the opportunity to shape the culture of the organisation and to make HWE a great place to work.



13 – 95% of staff engaged with the overall objectives of Healthwatch England

We are very pleased that the majority of staff are participative in our organisation's objectives. Our cross-team planning meetings and team meetings have enabled staff to contribute toward our strategic aims.

We will continue to embed our new strategic values for 2021-22 though individual and team objectives.



AGENDA ITEM 2.0

AGENDA ITEM: Audit, Finance and Risk Sub Committee (AFRSC) meeting minutes
PRESENTING: Danielle Oum
PREVIOUS DECISION: N/A
EXECUTIVE SUMMARY: The minutes of the AFRSC meeting held in May 2021 are presented to the Committee
RECOMMENDATIONS: Committee Members are asked to NOTE this report

AUDIT, FINANCE AND RISK SUB-COMMITTEE MEETING

Audit, Finance and Risk Sub-Committee (AFRSC) Meeting
Minutes of meeting No. 14
Meeting Reference: AFRSC202114

Minutes of the Audit, Finance and Risk Sub-Committee (AFRSC) 13 May 2021
10:00 am-12:00 pm
Teams Meeting

Attendees:
Danielle Oum (DO) – Chair
Andrew McCulloch (AM) – Sub-Committee Member
Helen Parker (HP) - Sub-Committee Member
Phil Huggon (PH) – Sub-Committee Member

In Attendances:
Chris McCann (CM) – Director of Communications, Insight and Campaigns
Joanne Crossley (JC) – Head of Operations
Sandra Abraham (SA) – Strategy, Planning and Performance Manager
Felicia Hodge (FH) – Committee Administrator (minute taker)

Apologies
Imelda Redmond (IR) – National Director

No.	Agenda Item	Action and Deadline
1.1	**Welcome & Apologies:** Danielle Oum (DO) welcomed everyone to the Audit, Finance and Risk Sub-Committee meeting (AFRSC). Apologies from IR were noted	

1.2 1.3	**Draft Minutes of Meeting of March 2021:** Minutes of the last meeting were AGREED without amendment **Action Log** All actions completed or held over to next meeting Please see Appendix Action Log. **Matters Arising** No Matters arising	
2. 0	**Finance and Procurement** **2.1 Financial Position YR End 2020/21** JC presented a paper providing an update to the AFRSC and asked the sub-committee to note the following: • A Summary of HWE expenditure as at year end 2020/21 • Key Procurement activities during the year • HWE Grant funding to Local Healthwatch Although the sub-committee had expected a slight overspend at the end of the last financial year, they questioned: • How we ended up with 1% overspend at £34k • What is HWE position in avoiding this going forward • What was CQC's response to the overspend JC responded that the anticipated rebate on recharges from CQC didn't materialise and that decisions made around under-spend had been allocated to grants, which ensured that we spent all of the budget that resulted in an overspend position. IR has had meetings CQC about this and regular meetings have been embedded to ensure this situation does not arise again and CQC tolerance is sought. The sub-committee requested an update from IR on her meeting with CQC and their tolerance for the HWE overspend. **ACTION** – IR to update committee on CQC tolerance of the £34k overspend at the end of last year Whilst the committee recognised that there had been a lack of communication regarding the recharges, due to JC's absence, and that because of the unusual situation caused by the pandemic making it difficult to predict expenditure during the year, they suggested that in order to mitigate this happening again in the current financial year, if there is a likelihood of there being an overspend, any issues are to be flagged up when they arise and if necessary, an extraordinary meeting is called at the end of the year. **The sub-committee noted the report**	**IR**

	2.2 Budget 2021/22 JC presented a summary of our budget spend for 2021-22 and asked the sub-committee to note expenditures. JC explained that the budget allocation had been reduced by 2% from last year's budget. Staff continue to work from home and the conference for this year will be held online. The focus this year is around digital and the budget spend will be roughly the same as last year. The committee asked for clarity on budget movements for last year's activities and asked for a comparison at the end of Q1 between the figures for the two years. **ACTION JC to provide a comparison with last year's figures and budget for 2021/22 at the end of Q1** The sub-committee asked for the rationale behind holding the conference online again this year. CM explained that a lot of planning is involved, and decisions must be made early to secure speakers. Last year, because the conference was held online, a wider audience was reached, and engagement made with a variety of higher-level speakers which was much more attractive. This would not have been achieved if we had had the conference with a physical presence. The sub-committee also wanted an update regarding the recharges and the number of desks allocated to HWE at the new premises. JC explained that the recharges for this year includes the costs of 14 desks allocation, but HWE is negotiating to reduce the number to 10, which could result in cost savings of £60k. The sub-committee suggested that HWE are firm in their negotiations with CQC regarding the number of desks required. The sub-committee sought clarification on the costs for Board development and managing contracts. JC responded that the costs related to support and training for the committee, although she was unsure whether it related to both HWE and LHW training. JC confirmed that the costs included support around managing LHW contracts and engagement. The committee suggested that the contents in the paper be reduced and reformatted before being presented to the full committee and provide clarity on what is being spent on LHW and what is being spent on HWE. They were not supportive of money being spent on Board development for HWE committee but agreed with support for LHW Board development. **The sub-committee noted the paper** **2.3 HWE Workforce Annual Review** JC presented a review of Recruitment and Vacancies 2020- 21; Staff Training Opportunities; Policies update; Mini Survey results and Diversity	**JC**

	and Inclusion reporting. The Sub-committee were asked to note the comments. **Staff Recruitment and Training** The sub-committee acknowledged the fact that they need to add value and to enable them to do this, they sought a more strategic analysis of the information than had been presented to them to include: • What is the level of staff turnover; the reason for turnover; what are the hotspots and what is being done about it • What are the skills gaps and what training is being provided to fill those gaps? • What progress is being made against the training programme • Comparative turnover with other similar organisations • The context on what is trying to be achieved. JC confirmed that a benchmarking exercise had been completed and she would share this with the committee. **<u>ACTION</u> JC – to share results of the benchmarking exercise on staff turnover with committee at next meeting** CM acknowledged that there was a high staff turnover in the research team. He mentioned that as a small organisation, there was not much opportunity for progression, unless those in more senior roles left. Junior members tend to stay for around 2 years and then move on to larger organisations where there is more opportunity to progress. The committee suggested that HWE could consider defining themselves as an organisation that will develop people in their first job and prepare them to move on. This is something that we are already doing. The committee agreed that the paper needed more work and whilst recognising that it was not an audit function, HP agreed to support JC in reviewing the paper and getting more context in what is trying to be achieved. They suggested having a conversation with IR to discuss whether the staff review should be done on an annual or half-yearly basis. **Mini Staff Survey Sept 2020** The sub-committee requested a progress report and more information about the surveys. They sought assurance that there had been movement since the survey conducted six months ago, particularly on leadership values and behaviours. They wanted to know more about what is being done relating to the feedback, including what action has been taken, what is working and what more needs to be done. They also questioned the situation around workloads. JC responded that things had moved on in areas that needed to be addressed and the next survey should reflect this, and leadership have talked about supporting staff around workloads. She mentioned that staff are encouraged to put items on the agenda at the All Staff meetings and	**JC**

	that there is a "Praise wall". Plans for managing workloads are in progress and will be reviewed more regularly. CM confirmed that the changes that have been made will need time to bed in. Clarity around communications has improved by having cross team planning meetings (to which at least one member of each team is invited) and weekly internal communications updates. He is hopeful that how staff feel about working for Healthwatch and how they feel about the leadership team representing the values of the organisation will be reflected more favourably in the next survey. The committee referred to the pros and cons of home working and asked what the impact was and if there were any problems that need mitigation. JC responded that although staff are working remotely, those who need to work from the office can do so, subject to COVID tests. Conversations about hybrid working and face to face staff meetings when it is safe to do so are ongoing. We are guided by CQC. JC also mentioned that the Staff Engagement group picks up any issues that staff may have and feed back to leadership, and they arrange social meetups. CM confirmed that there have been staff social interaction and there is an awayday planned for the autumn. The sub-committee sought clarification on the EDI data relating to religious beliefs as the percentage of those who did not wish to disclose their religion seemed unusually high. JC agreed to seek clarification as to whether the figure related to non-disclosure or have no religion. **Action JC – clarify the responses to the religious beliefs data in EDI reporting** The committee sought assurance that the actions from the last survey had been reviewed and asked for updates to be reflected in the next report presented to them. They also sought re-assurance that consideration is given to actions taken relating to staff wellbeing and that outcomes and impact is also included in the report. The sub-committee suggested that HP and DO meet with IR to discuss this further. **Action – HP and DO to meet with Imelda to discuss outcomes and impact requirement from the staff survey**	**JC** **IR**
3.0	**<u>Risk Review</u>** **3.1 Strategic Risk Register** SA presented the new draft strategic risk register for 2021-22 which highlights the potential risks to HWE's reviewed strategy, the network and the Business Plan for 2021-22. The sub-committee were asked to	

	review the strategic risks and subject to recommended amendments, recommend the draft risk register to the full committee for approval. SA explained that there were 10 new risks and 5 carried over from 2020/21 and sought committee tolerance for each of the risks. The committee responded that they require to see the risk appetite on the register and not the risk tolerance and consideration should be given to defining the appetite from minimal to hungry, instead of low, medium and high. The sub-committee agreed that more structure was needed to the risk appetite exercise. They agreed that the whole committee should have the opportunity to review the risks around the new strategy. The sub-committee commented on the following risks in the register: **SR33 – Equality, Diversity and Inclusion** The sub-committee felt that the focus on seldom heard voices covered two different points and suggested that these should be separated. 1. If we didn't implement and execute our strategy well, there is a risk that we would sound like a minority voice, rather than the voice of all users of health and social care. 2. The increasing complexity of the organisation could be a significant upscale, especially in view of the ICS changes and there is a risk that there may not be the input and support that is needed to manage this. **SR28 – Funding** The sub-committee considered the ICS project to be a much bigger risk and a greater opportunity than is being presented, and that it would have a huge knock on impact on the network and our reputation. Whilst considering it to be a bigger opportunity than risk, they suggested that the risk rating is increased. The sub-committee agreed that the full committee would probably have the lowest appetite for this risk. **Equality and Diversity Risks** The sub-committee stated that risks around EDI would be the biggest risk and one for which they would have the lowest appetite, and significant effort and resources would be needed to address those issues. They felt that the wording of this risk did not give enough credence to the importance of what HWE does. They asked for less corporate wording and consideration given to how people experience healthcare, with the need to focus on inequalities and those seldom heard voices who suffer worse outcomes in the system. CM acknowledged that more can be done about the wording and what it means for people's experience and outcomes in their interactions with social care. He asked for DO and AM to support him in reframing the current version of risks before it is presented to the full committee. DO and AM confirmed that they were happy to assist. **Action – CM to arrange meeting with DO and AM to reframe wording around EDI risks.**	**CM**

	Action – SA to review the Risk register based on the comments above.	**SA**
	3.2 Risk Appetite JC presented a paper outlining risk appetite, risk tolerance and a list of the key areas for consideration and asked the sub-committee to provide their appetite for risk and risk tolerance criteria for each of the areas listed. JC explained that following a conversation with DO, it was suggested that the committee consider their appetite for risk in groups of items rather than on an individual basis. She gave examples such as Finance having no appetite for risk and caution must be exercised. However, work around digital would have a greater appetite for risk because the impact would be greater and more beneficial. She sought the sub-committee's assistance in defining the groups. Please also see comments in **3.1** above. The Chair made a comparison of some of the risks taken last year and suggested that a meeting is arranged with some of the sub-committee members to support JC in preparing the document for full committee approval. DO also suggested that, if possible, it is discussed at the next workshop or less formal meeting and asked JC to liaise with IR on this. **Action – JC to arrange a meeting with DO and AM to discuss structure for risk appetite requirements.** **Action – JC to discuss with IR which is the best less formal committee meeting to have further discussions on this.** PH left the meeting at 11:22 CM left the meeting at 11:27	**JC** **JC**
4.0	**<u>Forward Plan</u>** The committee asked for the Workforce review to be added to the November agenda and the forward plan. **FH – To add workforce Review in November to the forward Plan.** **JC – To Present Workforce Review at November meeting**	**FH** **JC**
5.0	**AOB** **The Chair thanked everyone for their attendance.** **Meeting concluded 11:30 am**	

AGENDA ITEM:2.1

AGENDA ITEM: Forward Plan

PRESENTING: Sir Robert Francis

PREVIOUS DECISION: N/A

EXECUTIVE SUMMARY: This forward plan sets out Committee meeting agenda items for the next 12 months

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

Healthwatch England Public Committee Meeting Forward Agenda 2021/22

Sept 2021 Public Meeting	• LHW Presentation • Welcome and Apologies • Declarations of Interests • Previous Minutes, Actions and Matters Arising • Chair's Report • National Director's Report • Committee Member Update – verbal • Digital Transformation Progress • Delivery and Performance Update • Diversity and Equalities Update • AFRSC Minutes • Questions from the Public
Dec 2021 Public Meeting	• LHW Presentation • Welcome and Apologies • Declarations of Interests • Previous Minutes, Actions and Matters Arising • Chair's Report • National Director's Report • Committee Member Update – verbal • Delivery and Performance Update • Diversity and Equalities Update • AFRSC Minutes • Annual Report • Annual Data Return • Questions from the Public
Mar 2022	• LHW Presentation • Welcome and Apologies • Declarations of Interests • Previous Minutes, Actions and Matters Arising • Chair's Report • National Director's Report • Committee Member Update – verbal • Delivery and Performance Update • Annual Plan & KPIs 2022/23 • Draft Budget 2022/23 • Diversity and Equalities Update • AFRSC Minutes • Questions from the Public

Healthwatch England Committee Workshop Forward Agenda 2021/22

July 2021	Action plan for mitigating commissioning risk Risk Appetite