Healthwatch England 8th December 2021

Meeting #37 Committee Meeting held in Public

Location: Teams Meeting & Westbourne Room, 2nd Floor, Redman Place, Stratford, London E20 1JQ

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 by Healthwatch Wakefield on ICS Collaboration	Gary Jevon - CEO	For NOTING
11:50	1.4	Minutes of meeting held in September, 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	CM	For NOTING
12:30	1.7	Committee Members Update	ALL	VERBAL
12:35	Lunch			
13:00	1.8	Demonstrating Impact through the Network's Annual Reports	JT	For NOTING
13:15	1.9	Elective Waiting Times	JL	For Noting
13:35	2.0	Business Items a) Equalities Diversity and Inclusion Action Plan 21/22 b) Summary - Delivery and Performance Report.	 CM CM	For DISCUSSION Verbal
14:00	2.1	Audit, Finance and Risk Sub Committee Meeting Minutes & Risk report	AM	For NOTING
14:10	2.2	Forward Plan	Chair - RF	For NOTING

14:15	AOB		
14:20	Questions from the public		
	Date of Next Meeting 9th March 2022		

Healthwatch England Committee Meeting
Held in PUBLIC

Online & Room Thames 35/36, 2nd Floor, 2 Redman Place, Stratford London E20 1JG

Minutes and Actions from the Meeting No. 36 – 13th October 2021

Attendees

- Sir Robert Francis – Chair (SRF)
- 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)
- Phil Huggon – Vice Chair and Committee Member (PH)
- Amy Kroviak – Committee Member (AK)

In Attendance

- Imelda Redmond – National Director (IR)
- Chris McCann – Director of Communications, Insight and Campaigns (CM)
- Jacob Lant – Head of Policy and Partnerships (JL)
- Gavin MacGregor – Head of Network Development (GM)
- Joanne Crossley – Head of Operations (JC)
- Jenny Clarke - Deputy Head of Engagement and Sustainability (JCL)
- Felicia Hodge – Committee Administrator (minute taker) (FH)

Apologies

- Danielle Oum – Committee Member and Chair of Healthwatch Birmingham (DO)

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. Apologies for absence from Danielle Oum was noted.	
1.2	**Agenda Item 1.2 – Declaration of Interests** There were no declarations of interest.	
1.3	**Agenda Item 1.3 – Presentation on Collecting Demographic Data by Dianne Barham- CEO Healthwatch Tower Hamlets (HWTH)** Dianne Barham (DB) and GM gave a presentation to the committee on collecting demographic data in the Tower Hamlets area, which has been shared with the network and could be adopted by other HW. The committee were asked to note the contents. DB explained to the committee that people's experiences of services and institutions differed according to the demographics, life circumstances and equalities. Differences in needs, attitudes and capabilities led to differences in access to services and barriers for some health inequalities. HW Tower Hamlets had carried out a study of people with disabilities in the borough experiences of being informed about the Covid-19 vaccine. The study found that email contact was the most popular option and face to face the least popular. However, when broken down further it was found that only 18% of neurodivergent respondents wanted to be contacted by email and only	

	19% of blind or sight impaired respondents preferred email contact. A slightly higher proportion of 22% and 23% respectively, wanted face to face contact. 25% of Bangladeshi respondents with a disability wanted face to face contact. From their survey, HW Tower Hamlets were able to provide recommendations on the vaccine's rollout early on. As a result of their insight, HW Tower Hamlets were able to establish the channels where different members of communities obtained information from and were able to provide recommendations on vaccine communication. The insight HWTH provided to GP surgeries helped them to understand the community needs and shape the changes to GP bookings in the area. They were able to identify the people most likely to successfully access medical services online, and those likely to struggle with online services. The strengths and pitfalls of total triage were highlighted which helped GPs respond more rapidly to virtual consultations at the outbreak of Covid, which helped to save lives. DB informed the committee that by asking the same questions across multiple projects, they were able to construct a knowledge base and design engagement tools that built upon each other. She gave examples of where questions were based around digital inclusion, general health and financial circumstances and found that since their previous survey in 2019 where 38% of participants were digitally excluded, of the 2020 Covid-19 survey respondents, 14% had no internet access or device to access the internet or were IT literate. These were more likely to be people of black ethnicity, older people, people in poor health or with a disability or people who are not in work and were financially insecure. HWTH has shared their learning with the network and have delivered workshops on why it matters to collect demographic data consistently. They have also produced a guidance paper on demographic data collection and an interactive online training resource that is accessible to local Healthwatch. The committee wanted to know how the information was gathered and which were the most difficult groups to reach. DB responded that pre-pandemic, respondents approached the LHW, but during the pandemic surveys were conducted online and community insight workers were employed from across different sections of the communities who used their networks, family and friends. No group was difficult to reach, it was a matter of figuring out where they were and using different approaches to go there. The committee also wanted to know the size of the surveys and how did HWTH get staff and volunteers to participate. DB responded that it was hoped to get at least 300 people per survey. They also used data from social media and community insight systems, including joint surveys funded by ICS. Staff and volunteers were trained up and took part in role plays to cover all situations. **The Chair and committee thanked DB and GM the work they had done and noted the presentation**	
1.4	**Agenda Item 1.4 – Minutes and actions from 9th March 2021 Committee Meeting** The minutes from the meeting held 9th June 2021 were accepted without amendment. action log **20191113 1.4 -** *IR to bring back comments regarding how local Healthwatch deal with people treated far from their home and in closed environments* Covered on the agenda by Deborah Ivanova – Deputy Chief Inspector at CQC **20210609 1.8** - *JC to prepare briefing for committee to discuss risk appetite at the next committee workshop.* This action was completed at the Committee workshop on 12th October 2021 20210609 2.1 *FH to include an agenda item on the January workshop agenda*	

	IR requested the committee members to consider what they would like to include on the committee workshop agenda in January. There were no other actions **Matter Arising** There were no matters arising.	
1.5	**Agenda Item 1.5 – Chair's Report** The Chair gave a verbal update on activities since the last meeting. He informed the Committee that he had met with nine Chairs and CEOs of the new ICSs and found their enthusiasm for engaging with Healthwatch very encouraging. He had attended meetings with the Patient's Association and ADASS and had met with Amanda Pritchard, the new CEO at NHSE. He mentioned that he had spoken at a Trust Mediation and NHS Resolution conference and that he has given evidence in the House of Commons on the Health and Social Care Bill. Other activities included attending the quarterly Healthwatch CEO and Board meetings and is encouraged to learn how positive Chairs are about Healthwatch. He praised the Healthwatch England staff, who despite still mainly working from home have produced fabulous and vital work. **The Committee noted the report.**	
1.6	**Agenda item 1.6 – 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 June 2021 and asked the committee to note the report. IR told the committee that Healthwatch England was in a good place but is stretched because the work plan agreed has been very challenging. Good quality work is being produced with great outputs. IR mentioned that ICS engagement with local Healthwatch needs work in some areas and that the DHSC submitted a bid to the Spending Review to provide an infra structure to support the network to engage. JL updated the committee on work being done in close collaboration with NHSE. Having got the data of what LHW and ICS needs for support, phase 2 is being moved on to. This includes providing LHW with a range of tools to assist in the creation of Memorandums of Understanding and data sharing agreements to help formalise relationships. LHW are being encouraged to develop and present strong, clear, evidence-based offers to ICS leaders and to cement relationships with voluntary organisations. ICSs have advanced at different rates and HWE will be providing 1:1 support programmes for local Healthwatch where there are challenges. HWE are also working with NHS and DHSC on providing guidance for the ICS rollout. PH stated that whatever the result of the DHSC spending review, ICS will take priority over some of the projects. IR informed the committee that Joy Beishon has been focusing on a work plan to help the network in moving forward with Equalities, Diversity and Inclusion (EDI) programme. This will be a main theme of the conference this year. She praised the work that Joy has done and highlighted what a bonus she has been to Healthwatch. IR informed the committee that during Q3 of the current year HWE will be campaigning about the issues around accessible information. HWE wanted to find an issue that was tangible and had parameters that tied into EDI. New ways of working will be trialled, and the network will be included. An agency has been appointed to assist. Feedback has so far been encouraging. IR mentioned that the agenda for the online four-days conference 9-12 November is finalised and that there is a strong line up of speakers. The opening speech will be from Ben Page, CEO, Ipsos	

	MORI and the conference features two sessions with patient advocates of which one will be around air quality. She thanked committee members for their help in judging the network awards **The Committee noted the report and commented that HWE were using expertise in the network very well.**	
1.7	**Agenda Item 1.7 – Committee Members Update** The Committee members had nothing to report.	
1.8	**Agenda Item 1.8 – Evaluation of "Because We All Care Campaign"** BK and Flora Deshmukh (FD) gave the committee feedback on the joint campaign with CQC to encourage people using services to give feedback on care which ran July 2020 -March 2021. The committee were asked to note the outcome. BK gave a recap of what the campaign had set out to achieve, which was to increase real-time feedback by 10% as no face-to-face engagement was possible. The campaign focused on 3 specific audiences.1. People with long-term conditions; 2. Unpaid Carers; 3. Older people. BK presented the campaign's timelines and spikes covering hospital discharge, NHS 111 and Covid-19 vaccines and FD gave a breakdown of the top line statistics. These included: • 10.8m Social hashtag reach • 16.8m Social reach (Paid) • 781 Media mentions • 500 partners' support • 544.7k social media organic Engagement • 58.1k Website visits • 54.3k views shared (online forms) • 6.3K Partner Toolkit views. BK informed the committee that the pooled resources and expertise between HWE and CQC helped to improve the campaign's performance and that the campaign message resonated with the target audience and outperformed past campaigns. Whilst partnership support was strongest amongst charities and the NHS, more focus was needed on local government and social care. Although social media played a key part in increasing audience reach and engagement, particularly Facebook, the risk of relying on one main channel was recognised. Consumer media coverage did not achieve the results that was expected. Greater feedback from the target audience was achieved, but men and people from black and Asian communities were under-represented. The committee wanted to know the reason for the under-represented groups. BK responded that men do not usually look after their health and there is a need to look at how the questions were framed. **The Committee Noted the report**	
1.9	**Agenda Item 1.9 -Feedback on Closed Environments by Deborah Ivanova Deputy Chief Inspector – CQC** DI introduced herself to the committee as Deputy Chief Inspector for services to people with learning disabilities and autistic people. She informed the committee that she is trying to introduce a programme across all CQC's work that focuses on making sure that they use their influence to make changes happen through their work on improvements and regulation. They have been given good grounding for the changes through CQC's "Out of Sight - Who Cares" Report and the two Glynis Murphy responses to Whorlton Hall. DI talked about 3 workstreams that are being taken forward: 1. **Registration** – To ensure that only the right services are registered that meet the fundamental model they agreed was for people with learning difficulties and autistic people under the mantra "I use services that support me in the I want to live and where I want to live". The focus was on independence, the right care, the right support, choice, culture and control and they are working to ensure that it is understood by providers,	

planners and commissioners. This includes pre-engagement with providers before they start the planning process and using the model of care in their inspections. They are concerned with supported living and at the point of registration CQC can check where people are going to provide that service and once registered, the care can be provided anywhere. Longer term, there may be changes in the regulation needed to regulate supported living in a different way and they are looking at if supported living regulation cover the right people. There will be some people coming out of long-term hospital stays who don't fit into the model and do not require personal care, where CQC have no authority to investigate services provided to them, but they are working on it.

2. **Taking the Right Action** – Making sure that services are supported to improve and taking the right action if they don't. The two principles are "I will not move into a service that isn't safe" and "I won't be expected to continue to live in a service that doesn't meet my needs". CQC are piloting a new approach to inspections by using a specialist team of staff from the hospital directorate and adult social care, alongside pharmacists and other services that are needed. The team would do ad-hoc and some out of hours visits to ensure a holistic view of what is happening in the services. The team will observe and focus on people's experience of care and how their humanities are recognised and respected. The new approach is proving successful and CQC are focusing on high risks and have used their regulatory powers at quite a few inspections. As a result, three hospitals have been closed, and a fourth is in the process of being closed. They have stopped admissions to four others. CQC have recognised the need to work with commissioners in supporting this to stop people being placed in services that are inadequate. It has been noted that where they act at services not running safe and effective care, there is an absence of enough community services to support people and to stop them going into hospital in the first place. Added to that many services suffered during Covid-19 and have had to close. CQC are working with the Ministerial Delivery Board who are trying to tackle the issues of budgeting and commissioning responsibilities which underlines the services problems.

3. **Pathways** – around influencing health and social care. This is for people to be able to say, "I can access local services that meet my needs and get the right healthcare when I need it". This is about people living in a place that they call home and living the life they choose with the right support available in the community. CQC are probing into acute hospitals looking at the journey of autistic people and those with learning difficulties. They are also looking at primary care services and the support that can be given to primary care doctors, dentists and others and adjustments that are needed to care for autistic people and those with learning difficulties.

The committee thanked CQC for the work they are doing on what seems like a step change to the right strategy. IR questioned if there were opportunities for CQC to have a role to see if commissioners were commissioning the right services. DI responded that with changes in the legislation this may be possible in the future. Presently, it is about influence, but she is involved with NHSE and is regularly involved in discussions with them. CQC are concerned about commissioning as they have devolved responsibility across the country for services that fall under the local authority, and it is hard to get a good grasp of the plan. It will be the ICSs in the future and their knowledge of the people in their area and how they plan to meet their needs.

IR also wanted to know if new targets had been set by the ministerial boards for the reduction of people in assessment. DI responded that they were still working with the old targets that have been set but conceded that there is a need to revisit them. Information is being gathered through CQC's "Out of Sight" report.

The Chair asked if there was anything that Healthwatch can do to contribute. DI responded that Healthwatch should keep asking the questions about how often people have face to face consultations about their care and how are services meeting their needs, so that CQC can get to know the problems early. She asked that when in a hospital or primary care setting, HW think with a learning disabilities lens.

The committee noted the report and thanked DI.

2.0	**Agenda Item 2.0 – Audit, Finance and Risk Sub Committee Meeting Minutes** AM (Member of HWE Audit, Finance & Risk Sub-committee (AFRSC)) thanked PH who has recently stepped down as vice chair of the AFRSC for his contribution to the sub-committee and welcomed JO as PH's replacement on the committee. Referring to the minutes of the AFRSC meeting held on 8th September 2021, AM asked the committee to note the minutes and the following: • The results of the staff survey which commenced on 4th October will be reported at the next meeting • Finance is on track, but the sub-committee will look at the results of the grants structure showing grant allocation and RAG rating in November and assess the risks. • The sub-committee asked for a few risks to be reviewed in the risk register, mainly SR01, SR24 and SR20 and for SR36 post mitigation rating to be re-classified to amber. **The committee noted the minutes, and the Chair thanked the sub-committee for their work**	
2.1	**<u>Agenda Item 2.1 (a) – Update Equalities Diversity and Inclusion (EDI) Action Plan 2021/22</u>** CM presented the report and explained to the committee that the report is a snapshot of the work that is being done across the organisation. CM informed the committee that HWE has started a campaign about the Accessible Information Standard (AIS) with Mencap and SignHealth to gather insight from users with learning difficulties and sensory impairments. HWE will be focusing on non-English speaking participants and will be partnering with Doctors of the World and six local Healthwatch. The campaign is expected to go live in Q4, and the resulting insight will be factored into NHSE's review of AIS. CM reported that there has been media coverage of the work HW partnered with Kings Fund exploring the impact of extended waiting times through an equalities' lens. The findings are supporting broader calls to not only focus on the waiting lists, but to also focus on the support given to people whilst they are waiting. CM mentioned that the work being carried out on data collection has highlighted the need to improve the information the network is collecting, and the lack of demographic data being shared. The demographics for the Healthwatch taxonomy have been updated and is currently being rolled out and this should improve the data capture infrastructure and facilitate more consistent recording across the network. CM reported that promotional material is being updated and will be available in easy read, BSL and a range of languages. There will also be two campaigns running to reach sections of the community that are seldom heard from. One includes targeting people from ethnic minority backgrounds and people with higher deprivation levels to understand their experiences of waiting for hospital treatment and the other will focus on understanding people's experiences of getting accessible health and care information. CM stated the National Development Team will continue to work with the network. A local Healthwatch EDI peer group has been set up which includes LHW staff and Board members, who meet quarterly to support each other and share experiences, successes and challenges regarding equality, diversity and inclusion and to offer practical examples and discuss solutions. Following the work done by Joy Beishon, a 3-year plan to improve performance across the network is being created and is intended to be published in time for Healthwatch Week, 9th-12th November 2021. CM reported that HWE strives to provide a happy working environment for their staff and the annual staff survey will be launched on 4th October, which should identify any areas of unfairness or inequalities that need to be addressed. There is also the Staff Engagement Group and the Speak-Up Guardian who represent staff and escalate any issues that staff feel does not align with HWE equalities aims. Referring to recruitment, CM mentioned that EDI is at the forefront of HWE recruitment campaigns. The committee wanted to know if David Bryant's observation of Healthwatch lack of vision had been addressed. GM confirmed that it had, and the results should be seen in Healthwatch Week. **The committee thanked CM and noted the report**	

	Agenda Item 2.1 (b) – Delivery and performance Report Update JC presented the delivery and performance report for Q1/Q2 (2021/22) summarising the delivery and performance against the business plan and KPIs to date. The committee were asked to note the report. JC explained that most of the projects were on track and highlighted the ones that were delayed: 1. **Equality Impact Assessments** due to new systems being introduced 2. **% Of Board Members, CEOs and Staff rating HWE support as good or above** survey postponed until January 2022 3. **Establish Benchmark to expand understanding of engagement approaches** due to resources being re-distributed 4. **Bi-annual report showcasing impact made against strategy.** Report being revisited and now due in Q3 IR told the committee that she had no concerns about the KPIs as resources had been re-distributed to cover time-sensitive ICS work. The committee wanted to know which projects and how projects have been reprioritised. JC responded that projects are currently being reviewed. A heatmap has been created highlighting the pressure points for discussion by the Leadership team on 14th October. **The committee noted the report.**	
2.2	**Agenda Item 2.1 – Forward Plan** The Chair presented the Forward Plan for the next 12 months containing the standard agenda items and asked members if there was anything they would like to include on future agendas. The committee responded that they would like to include: • Annual Report • Health Inequalities and Levelling Up • Children's Services **The committee noted the plan**	
	AOB The Chair mentioned that this was the last committee meeting that IR would be attending before stepping down as National Director for HWE. He thanked her for being a great servant and applauded her for taking the organisation from local to national level. The Chair commended IR and gave her credit for the way services are changing as a result of her leadership. On behalf of the committee the Chair wished her well and the other members endorsed his sentiments.	
	Comments from the public There were no comments from the public.	
	The Chair thanked everyone for attending The chair closed the meeting at 14:18 pm	
	The next meeting will be held on 8th December 2021 at 2nd Floor, Redman Place, Stratford E20. Guests can join online via Teams. Details to follow.	

HEALTHWATCH ENGLAND PUBLIC COMMITTEE MEETING – ACTION LOG

9th June 2021

Agenda Item	Lead	Reference	Comment	DEADLINE	STATUS
20210609 2.1	Felicia Hodge	FH to include an agenda item on the January workshop agenda on bids for ICS		Jan 2022	Complete

AGENDA ITEM: 1.6

AGENDA ITEM: National Director's Report

PRESENTING: Chris McCann

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 October.

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

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

1 Healthwatch week

Healthwatch Week 2021 took place from Tuesday 9th November to Friday 11th November and was our most successful annual conference to date. We delivered 39 sessions across the four days, with over 750 attendees participating, an increase of 200 on last year's event. There were 137 Local Healthwatch areas represented.

We delivered themed days dedicated to tackling health inequalities and ICS preparedness. A highlight of the week was when we heard from historian and broadcaster Professor David Olusoga about the role of Black and Asian communities in the development of the NHS and why it's crucial to have often hidden voices in leadership roles. We also heard from NHS England chief executive Amanda Pritchard and Minister of State for Health Edward Argar MP.

The most engaged session of the week was the mainstage 'ICS and Healthwatch: Collaborating for people and communities' event. Over 200 people attended the session which was led by Healthwatch England Deputy Head of Network Development Jennifer Clark.

1.1 Healthwatch Awards

As ever a highlight of the week was the annual Healthwatch Awards. Work to prevent the abuse of people with sensory impairments, help reunite care home residents with their families and train people to access their care online are just some of the projects were recognised.

The five award categories and their winners were:

- Engagement - Healthwatch Reading

- COVID-19 response - Healthwatch Essex
- Celebrating our volunteer team - Healthwatch Islington
- Tackling inequalities - Healthwatch Leeds
- Working with your integrated care system – Healthwatch in North East London: Healthwatch Barking and Dagenham, Healthwatch City of London, Healthwatch Hackney, Healthwatch Havering, Healthwatch Newham, Healthwatch Redbridge, Healthwatch Tower Hamlets and Healthwatch Waltham Forest.

The standard of entries was higher than ever this year and congratulations go to everyone who participated.

2 Influencing updates

2.1 Elective care report

At the last committee meeting in October, we reported on the joint work we did with the King's Fund to highlight how people living in the poorest areas of England are more likely to wait longer for elective treatment than those who live in more affluent areas. In November, we built on this work by publishing a more detailed report on what people have told us about waiting for elective care. Between September and October 2021, we spoke to 2,500 people affected by NHS waiting lists and established the following:

- The amount of information people received during their wait was a key factor in determining their overall experiences. Over three in five (62%) people on a waiting list said they were given no information on how to manage their condition, and a further 17% said they were given some information, but it was insufficient. Just 6% said they were given adequate supporting information to manage their condition, including a clear point of contact in case their condition deteriorated.
- This finding became even more stark when we looked at people's income. Respondents with more disposable income were more likely to report being given information while waiting for their treatment. Only 3% of less financially secure respondents said they received a good amount of information.

- Respondents on lower incomes also reported a more significant impact for all outcomes due to delays when compared to those with higher incomes:
    - Ability to work (89% vs 44%)
    - Ability to carry out daily household tasks (80% vs 56%)
    - Ability to care for someone else (54% vs 24%)
    - Level of pain they had experienced (93% vs 49%)
    - Mental health or wellbeing (89% vs 67%)

- Our report made specific recommendations to ensure the Elective Recovery Plan does not exacerbate health inequalities including:

    - Challenging the NHS, that if they create surgical hubs for fast track treatment, then this must come with support for transport and accommodation for patients and families who may not otherwise be able to afford this.
    - Calling on Government to consider expanding statutory sick pay to provide more support for people on low incomes if they must wait longer for treatment.
- Whilst the number of people from minority ethnic communities who responded to our research was small, there is some indication that people from Black, Asian and ethnic minority backgrounds are experiencing similar issues to those on low incomes. Non-white British respondents were less likely to feel supported by the NHS and less likely to feel they were given clear, accessible and easy to understand information.

We are currently scoping out the possibility of commissioning further research to explore the experiences of individuals from Black, Asian and ethnic minority communities, and help NHSE ensure the recovery plan does not exacerbate the health inequalities experienced by these groups.

We have positive conversations about our findings with the NHSE team behind the Elective Recovery Plan and at time of writing this report we are confident the messages we have shared around the need to improve communications, and for policy solutions to avoid exacerbating health inequalities, have been heard and will be acted on. A copy of the Elective Recovery Plan will be circulated to the committee when published.

2.2 Vaccines update

With Government beginning the mass roll out of its vaccine booster programme we decided to produce a short briefing for DHSC and NHSE counterparts on our early feedback.

As this analysis was carried out at an early stage it looked at views and experiences shared with 18 Local Healthwatch across the country, bringing together insight from over 150 of the first people to get the booster.

Over a third of what we have heard is negative with a further 10% mixed. A further 12% was positive. This is a similar pattern to what we saw with the initial roll out of the first dose.

Key themes included:

- **Access to information about the booster vaccine** including eligibility and variation between different areas in terms of who was being invited. People told us about wanting more information about where they can get the vaccine, as the sites have changed from the initial roll out.

- **Booking a booster vaccine** – Most of the feedback about the booking process has been negative, with significant confusion and mixed messages from GPs and 119/the online booking system about who can book and when.
- **Location of vaccine centres and transport** - Those who struggled to access the vaccine first time around have been put off trying to get a booster, including a number of people who are housebound left frustrated by the challenge to get a home visit.

- **Failed attempts** - Some people reported having turned up to get their booster, only to find the vaccine centres closed, or people being told they hadn't booked the 'correct' location.

- **Bad experiences** - we also heard from people who had been put off getting a booster because of a bad reaction to the first two doses.

In terms of recommendations, based on this early feedback and what we learnt from the first roll out, we suggested:

- Greater clarity in message about who should book a booster vaccine appointment and when people should book.

- 119 call handlers being up to date with the latest messaging to avoid people going around in circles.

- Looking again at extending the home visits from GPs - this feels like it has gone backwards from before.

- Think about how communications can be used to reassure those who had bad reaction to 1st or 2nd doses.

We were pleased to see the Prime Minister make in his announcement about the booster programme, that GPs would be doing more home visits to support the roll out. It is encouraging to see the Department of Health and Social Care, and Government more widely, acting on the issues we have raised.

2.3 Access to GPs

We continue to feed in regular briefings to NHSE on how current issues around access to primary care are being experienced by people.

We have now joined an advisory group with National Voices, Patients Association, NHS Confed and others to shape a major NHS led comms campaign on how access has changed and how people can get the best out of their GP service.

We are stressing the need to focus on ensuring policy is in the right place on access, not just communicating how things should work in theory.

2.4 Accessible Information Campaign Plans

In January 2022, we are planning to launch a campaign to help encourage the provision of more accessible information by health and care services. The campaign is planned to coincide with a review by NHS England of the Accessible Information Standard (AIS). The standard, which was introduced in 2016, gives certain groups rights when it comes to being provided and supported to get information in a way they can understand.

Planning for the launch is already underway. We have completed a review of our existing evidence, as well as evidence provided by our partners. This review will be used to launch the campaign and will set out how well the AIS is being experienced by those covered by the existing standard, such as people with a sensory impairment. We have also commissioned primary research with local Healthwatch to start to understand the experiences of those not covered by the AIS by looking at issues people whose first language is not English. This evidence will be used, in partnership with stakeholders, to help shape our initial recommendations and will then be followed by an engagement drive to understand more fully the experiences of people not currently covered by the standard.

This engagement phase is likely to generate further recommendations that we'll use to inform the review by NHS England of how services can ensure they provide accessible information.

2.5 Media coverage

Our refreshed approach to media continues to generate extensive coverage on the issues that people are telling us about care. Our monthly media reach in the first seven months of this is financial year is 290% higher than our average monthly reach in 2020-21 (21-22 Average media reach by month = 433053944, versus 110856430 for 2020-21)

Highlights of our recent coverage include:

- Our joint call with the British Dental Association for more funding for dental services as part of the comprehensive spending review gain extensive news and broadcast coverage including in the Times, Daily Mail, BBC Breakfast and Daily Express.
- Our work on waiting times has covered by The Times on several occasions and in the Observer.

3 External Updates

3.1 Legislation / ICS reforms

We have continued to monitor the progress of the Health and Care Bill and the associated guidance being developed alongside.

In terms of the bill itself, it has now completed report stage in the House of Commons and is set for second reading in the House of Lords on 7th December.

During the Commons report stage much of the focus was on an amendment tabled by Chair of the Health and Social Care Select Committee, Jeremy Hunt MP, on workforce issues. If passed the amendment would have forced the Government to publish biannual projections for workforce to increase transparency and ensure continual focus on making sure the NHS has the staff it needs in the pipeline to meet future demand. However, despite widespread support, MPs rejected the amendment by 280 votes to 219, with a total of 18 Conservatives rebelling against the Government.

There was also significant debate on whether the bill would enable greater privatisation of the NHS. Speaking in the Commons, Health Minister Edward Argar said it was "never the intention for independent providers to sit on ICBs".
He pointed to an amendment which would bar anyone who would undermine the independence of the NHS "as a result of their interests in the private healthcare sector or otherwise" from sitting on an ICB.

Others have argued that the privatisation debate distracts from holding ministers to account on important aspects of the bill, such as increasing the Secretary of State's powers to influence local decision-making. As the bill enters the Lords, we anticipate renewed focus on governance and the role of communities in decision-making structures.

When it comes to guidance for ICS areas, we have secured a commitment from NHSE that relevant local Healthwatch must be consulted by their ICS during the second phase consultation on their draft ICB constitutions (22 Nov - 30 Nov). Alongside this NHSE have added the following to the FAQ document on the development of ICBs:

> ***"How should the board of the ICB ensure governance and oversight of involving people and communities in decision making?***
> *The ICS Implementation Guidance for involving people and communities sets out considerations that ICSs should give to involvement of people and communities in ICS Governance on pg13. It guides systems to define, adequately resource and support the role of members of the public in*

governance arrangements. Therefore, the ICB governance documents (including its constitution and "governance handbook") should make clear how delivery of the people and community engagement strategy will be assured, including:

- *How the board has strategic oversight and assurance of involvement of people and communities in the exercise of its functions;*
- *Arrangements it has made to work with and alongside local partners such as Healthwatch and VCSE partners;*
- *How the board and its committees will consider the diversity of the population, including those who experience the greatest health inequalities, and how they have been involved making decisions (including delegated decisions), including through formal collaboration with local Healthwatch to ensure that their statutory functions are considered and how peoples' voice and experiences across provider and partners are coordinated and heard;*
- *Set out how decision-making and governance will be transparent for the wider public (e.g. published papers, meetings in public, direct community engagement).*

"In addition, in advance of April 2022 NHSE will update the current statutory guidance on involving people and communities (patient and public participation) (here) to reflect ICBs succeeding CCGs; designate ICB chairs and chief executives will be engaged in particular on how the updated guidance should enable the board to discharge its duties to involve people and communities."

3.2 White papers

Since the last committee meeting, we have been feeding in to two DHSC white papers due to be published in late November / early December 2021.

Social care

On social care we have fed in our position on the Government's plans for reform, mainly how the introduction of the cap and floor for care costs only tackles one part of the problem. There is a still a lack of clarity how this will address concerns about eligibility for care in the first place and improve the quality and range of services on offer to people.

An area of focus for us has been around the need for a much- enhanced information and advice service in social care. We have stressed that:

- People need personalised advice that is focused on their specific needs not just generic information that can be confusing to navigate, particularly for those in crisis or with immediate needs.
- A lot of information and advice services exist but they are fragmented. There is a need to build on what is there, and pull things together, rather than reinvent the wheel.
- This type of advice service is best delivered locally but should be delivered under a national umbrella brand to make it easier and more cost effective to promote. When we have engaged with people in the past, they have talked about having an equivalent service to NHS111 but for social care.
- The independence and impartiality of any future advice service is important. People consistently tell us they want advice they can trust, and this means it needs to be separate from those who are paying for services (e.g. councils) and those delivering care services.
- The Government could play a role in funding and evaluating how local advice is delivered. This could then feed into national level strategy or guidance.
- The Government could also play a role in monitoring and oversight to ensure a high-quality offering across the country.

We were therefore pleased to see many of these points reflected in the White Paper, especially the recognition of the need for personalised advice, not just information. We will now seek to work with the DHSC to support next steps around piloting the approach.

Integration

The Government's white paper on integration of health and social care looks to provide further clarification of policy direction rather than set out any new legislative changes above beyond that which is already set out in the Health and Care Bill. The Department's view is that the current bill is sufficiently permissive to achieve their long term aims around integration.

Our discussions with the department have largely focused on ways in which the system can track if integration is improving care for people. We have therefore continued to stress our position that user experience of how well services are working together has a vital role to play here.

We have shared the work we completed earlier in the year on the Health and Care Experience Profiles and examples of how local Healthwatch are already ensuring insight from people is being brought in to integrated decision making structures.

4 Support to the Network

4.1 Supporting Commissioning of Healthwatch

The first commissioners' newsletter was distributed to commissioners of local Healthwatch. The Local Government Association and Healthwatch England are also

working together to facilitate a round table with local authority commissioners of Healthwatch. Discussions will focus on changes to our commissioning guide, including:

- How local Healthwatch work with Integrated Care Systems is reflected in future contracts, and
- The need for updated guidance on the changing expectations of local Healthwatch resulting from the proposed provisions in the Health and Care Bill.

4.2 Equality diversity and inclusion

We have published our Equality, diversity and Inclusion Roadmap to support our strategy and put equalities at the heart of our work. The plan sets out:

- Our journey so far, including the work supported by Joy Beishon, Chief Officer of Healthwatch Greenwich,
- Opportunities we can build on and the challenges we need to address, and
- What we plan to do over the next three years, such as strengthening the collection of demographic data and running campaigns that increase feedback from those we do not hear from enough.

4.3 Engagement

Healthwatch England is building a collection of Healthwatch approaches to engagement and inclusion. Healthwatch North East Lincolnshire and Healthwatch Essex showcased their approach to involving young people and people with learning disabilities in their work, while Healthwatch Central London and Healthwatch Lincolnshire showcased their approaches to working with the Black African and Gypsy and Traveller communities respectively. For each, we held webinars to share learning with other Healthwatch.

4.4 Learning, development and events

Our Learning and Development Programme seeks to share learning from the Healthwatch network and bring in external expertise. We have recently produced new e-learning course on collecting and analysing demographic data. This builds on our existing e-learning courses, which have been used by 172 learners in just the last two months. Our learners have reported an average of 8.5 satisfaction rating.

In addition, over 351 people have attended 36 webinars in the last two months covering areas such as project planning, brand and communications, tackling health inequalities for volunteer managers and demonstrating impact. Over 90% of attendees report that they are likely or very likely to apply the learning to their work.

4.5 Brokering Partnerships

Healthwatch England helps broker partnerships with local Healthwatch and other organisations. Recently, seven local Healthwatch have been matched to work with

NHE England teams on issues such as carers' recent experience of hospital discharge and another people's views on community pharmacy.

4.6 Strengthening our brand and communications

We have continued to roll out our **updated brand** values and tone of voice, with new resources and training, including several sessions at Healthwatch Week to help local Healthwatch think about how they can embed our brand and values in their work. We have also finalised several changes to strengthen our visual brand and align it with our brand personality. These changes have been tested with local Healthwatch and a representative sample of the population in England. This research indicates that (a) public awareness of the brand is 33%, which reflects previous awareness polling and (b) the key attributes the public value in our brand is our independence, trustworthiness and being on their side (i.e. not part of the system). Again, this reflects the findings from the research we commissioned to develop our brand values and personality with seldom heard communities, the network and stakeholders. Our updated visual guidance will be launched in December and rolled out across the network.

We have continued to develop and update our national **advice and information**, especially in response to COVID-19 and to share this with local Healthwatch. From April to October, our online advice has been accessed by 587,000 people (285,000 using our national website, and 302,000 people using the 72 local Healthwatch website we support). Advice and information continued to be the main action people take via Healthwatch services.

We have also finalised our plans to **upgrade our national and local estate of websites**. This work will start in December. Our 72 local Healthwatch websites have been accessed by 877,000 people so far this year. The upgrade will enable us to continue to provide a secure and accessible website to existing local Healthwatch users, as well as enabling enhancements such as the quicker syndication of advice and information content. In the new year we also plan to start rolling out the website again to new Healthwatch who want to take up our website offer. Based on current expressions of interest, our website offer could be being used by over 100 local Healthwatch by the end of 2022-23.

We are also working with Care Quality Commission to update our joint **Because We All Care Campaign,** which we used to help prompt public feedback during the pandemic. The campaign which has encouraged more than 50,000 people to share views with us and CQC, is being refreshed to ensure the messaging and visuals still work for the public. The campaign resources will be provided to local Healthwatch to help support local engagement activity and the new push is expected to start in February.

5 ICS Support Programme

5.1 Showcasing Promising Practice in the LHW and ICS Landscape

Healthwatch England are currently profiling the promising practice within the network through a series of case studies which can be found here: How are Healthwatch and ICS's working together? | Healthwatch Network website (staff)

These have been distributed through the network and via NHSE to ICS leads.

Supporting relationships between Local Healthwatch and with their ICS:

Traverse - an engagement agency - have been contracted to deliver the following tools to support local Healthwatch:

1. A partnership development tool to support formal agreements to be developed between local Healthwatch to define how they will work together.
2. A tool to develop Memorandum Of Understanding between local Healthwatch and their ICS
3. Briefing for local Healthwatch and VCSE Leads, in partnership with NAVCA and National Voices, to support them to work collaboratively in engaging people and communities and representing their views at ICS level.

Traverse will also be supporting local Healthwatch in 5 ICS Patches more intensively to implement the tools where the complexity of context or relationships means independent support is needed. Patches are in the process of being selected.

Ad-hoc support is being provided by National Development Team and Policy Team to resolve issues that arise and to support feedback on Integrated Care Board Constitutions. The calls on ad hoc support are increasing and there may be future capacity issues unless additional resources are available.

5.2 Summary of where next

- Publication of tools set out above
- Delivery of intense support offer.
- Integrating a longer-term support offer into business planning for the new year.

6 Equalities Diversity and Inclusion

6.1 Accessible Information Campaign

As referenced at item **1.4** our campaign will launch next month to coincide with a review by NHS England of the Accessible Information Standard (AIS).

6.2 Work on elective care waiting times

As per item **1.1** we published our latest research on elective care which was accompanied by recommendations to ensure the Elective recovery plan does not exacerbate health inequalities.

6.3 Reaching people from more diverse backgrounds

We have continued our work to reach different sections of the community via our communications. More detail is included in our quarterly EDI update.

6.4 Making our information more accessible

We have continued to deliver our work programme to make our communications as accessible as possible. In the new year we plan to roll out our updated accessibility policy to the network. More detail is included in the quarterly EDI update.

6.5 Healthwatch Week

As referenced at item **1.0** of this report equality, diversity and inclusion was a theme that ran throughout Healthwatch Week this year. We also had a whole day dedicated to tackling health inequalities.

6.6 Network Three-Year Plan

As per item **3.2**, as part of Healthwatch Week we published our three-year road map to support our strategy and put equalities at the heart of our work. The plan sets out our journey so far, opportunities we can build on, the challenges we need to address.

7. Key Meetings Attended since the last Committee meeting

October	
Lord Phillip Hunt	House of Lords
ICS Cheshire & Merseyside	Sarah O'Brien- Director of Strategy & System Development; Christine Hughes-Director of Communications and Engagement
Mark Cubbon	NHSE
CQC Board	
Professor Karen Middleton	The Chartered Society of Physiotherapy
VCHA	
Tyson Hepple	CQC
Equalities Ambassadors	Bola Owolabi
State of Care Launch	CQC
Hannah Kearsey	Traverse Ltd
Local Authority & ICS Advisory Group	Kate Terroni -CQC
Policy Exchange Ministerial round table	Edward Argar
November	
Chris Day	CQC
HW Salford AGM	
Integrated Care Delivery Partners' Group	
Baroness Finlay	
ADASS	Stephen Chandler; Cathie Williams
Local Government Health and Care Sounding Board	
Core20PLUS5 Connectors Meeting	Bola Owolabi
Policy Exchange – Ministerial Roundtable	Association of the British Pharmaceutical Industry
Delivery Coordination Committee	CQC
Tyson Hepple	CQC
Reform Event: Integrated Care Systems	Mark Cubbon, Interim COO, NHS England and NHS Improvement
Ruth May, Chief Nursing Officer, in conversation with National Voices	National Voices
Quarterly CQC Meeting	
National Pharmacy Association (NPA) Centenary Dinner	
Ian Trenholm	CQC

AGENDA ITEM No: 1.8

AGENDA ITEM: Demonstrating impact through annual reports from the network

PRESENTING: Jon Turner, Impact Programme and Regional Network (North West) Manager

PREVIOUS DECISION: N/A

EXECUTIVE SUMMARY:

The HWE Impact Programme was established as a response to the network asking for more support to demonstrate the difference Healthwatch makes for service users. From last year to this year, we have seen an increase in the level of outcomes and impact reported. From a review of Healthwatch 2020/21 annual reports a selection of these outcomes is presented to demonstrate the range of achievements of the service and great value Healthwatch bring for their local communities. This enables HWE in turn to better promote what our network delivers.

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

Demonstrating impact through the network's annual reports

Jon Turner, Impact Programme and Regional Network (North West) Manager

Healthwatch England

December 2021

Showing how Healthwatch makes a difference is important

It builds trust with local people, including those whose voices are not being listened to, by showing that sharing their experiences with us is worthwhile.

It increases credibility of the service with local partners, increases trust, and makes it more likely they will act on what the public has told us.

It demonstrates to our funders that we provide value for money, in an environment where there is always more competition for public money.

Why we are seeing more outcomes and impact reported by Healthwatch

- Carefully selecting priorities is becoming the norm
- Including a Theory of Change at the start of planning a new piece of work brings real benefits
- There's a growing understanding of the importance of building in time to follow-up on what's changed
- Our Annual Report template headlines outcomes and training emphasises telling impactful stories.
- Healthwatch are getting braver at claiming their contributions to changes and improvements
- Impact is now central to our brand values and behaviours – with the value of 'acting' increasing the focus on making positive change

Examples from Annual Reports 2020/21: improving accessibility and safety of services

‘From April 2020 to March 2021 St Mary’s hospital have held 28 X-ray Clinics, attended by 237 patients across all five islands … since the day was changed, at £100 for a return boat fare, that will be a significant saving to patients.’

healthwatch Isles of Scilly

‘A patient brought to our attention the use of a ‘defective’ batch of cannulas that were being used within United Lincolnshire Hospitals. The hospital along with the cannula manufacturer quickly resolved the issues making sure defected cannulas were disposed of and no longer in use.’

healthwatch Lincolnshire

Examples from Annual Reports 2020/21: tackling health inequalities

‘- The establishment of a Reference Group for Turkish and Kurdish communities so Haringey Council can hear directly from these communities;
- Funding … for Turkish and Kurdish voluntary and community sector organisations to provide public health information about COVID-19;
- Routine translation of information about COVID-19 and public health messages …
- Provision of two community Link Workers, working within Turkish and Kurdish communities
- Provision of a Turkish-speaking Social Prescriber, based within primary care settings.’

healthwatch Haringey

‘As a direct result of our work on health inequalities, service users from the Somali community and other ethnic minority groups in Birmingham will benefit from … greater involvement in decision-making and better quality of care.’

healthwatch Birmingham

Examples from Annual Reports 2020/21: improving mental health

‘Following our continued engagement … we have been pleased to see a 24/7 mental health line created to improve emergency access to those needing mental health services.’

healthwatch Cornwall

‘We also worked collaboratively with the CCG to successfully secure funding which will establish new mental health support teams within schools providing more early intervention and low-level support for young people. A new parent peer support group is being implemented in the coming months.’

healthwatch Darlington

Examples from Annual Reports 2020/21: working through COVID

"The results of this report helped to direct the CCG's approach to addressing the temporary drop in childhood immunisation rates seen during the first wave of the COVID pandemic … "

Dr Kirsty King – Associate Clinical Director Braford CCG

healthwatch Bradford and District

'Helping Boaters register for GP services and get their COVID-19 vaccine.'

healthwatch Cheshire East

healthwatch Cheshire West

'Following feedback shared by us from residents' families, Solihull Council assured us that care homes would all provide equipment so that safe outdoor visits could continue.'

healthwatch Solihull

Examples from Annual Reports 2020/21: influencing strategies

‘The recommendations from our 2019 report on young people’s oral health have been reflected in the 2021 Oral Health Strategy. This includes …

- Integration of oral health into targeted home visits by health/social care workers
- Supervised tooth brushing in targeted childhood settings
- Targeted peer support groups/peer oral health workers
- Healthy food and drink policies in childhood settings’

healthwatch Blackburn with Darwen

‘As a result of our recommendations the Local Pharmaceutical Committee worked with Durham County Council, the Clinical Commissioning Groups and Healthwatch County Durham to plan and deliver the publicity campaign for pharmacy that focused on 'self-care.'

healthwatch County Durham

Examples from Annual Reports 2020/21: improving health and wellbeing of young people

‘Thanks to feedback from social workers about the challenges they faced that contributed to low completion of Initial Health Assessment (IHA) for looked after children … our recommendations have led to almost 50% increase from 37% to 70.32% in the proportion of children receiving their IHA on time …’

healthwatch Lambeth

‘**Young People's experience over lock-down facilitated through young influencers:** Local Council are working with young people to develop an offer that teaches young people how to maintain their health and wellbeing.
A £70,000 donation was made to buy books and as well as a donation from the National Grid of 70 laptops that are being distributed to a selection of schools.

healthwatch Tower Hamlets

This was just a selection

From our review of this year's reports Healthwatch England has a greater than ever number of examples that we can use in turn to promote what our network delivers for the public.

There's a real appetite among national stakeholders to hear more of this. No doubt this appetite is replicated with local stakeholders across the country.

We're excited already to see what next year's reports bring!

AGENDA ITEM No: 1.9

AGENDA ITEM: NHS Elective Care Recovery Plan and what people are telling us about waiting for treatment

PRESENTING: Jacob Lant

PREVIOUS DECISION: N/A

EXECUTIVE SUMMARY:

- We published an insight briefing in November, highlighting inequalities in waiting
- We made several recommendations to improve the experience of waiting
- NHSE/DHSE published their recovery plan, acting on our recommendations

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

- 'What are people telling us about delays to hospital care and treatment' report attached.

healthwatch

What are people telling us about delays to hospital care and treatment?

Key messages from our evidence

November 2021

Contents

About

This briefing provides an update for national health and social care stakeholders about those who have been or are still waiting for NHS hospital care and treatment, including:

- How long people are waiting to receive treatment
- What type of treatment people are waiting to receive
- What communications people are receiving during their waiting time
- The quality of communication and support people are receiving
- How delays have impacted people's quality of life

This briefing is informed by:

- The views of 1441 people in national polling commissioned by us and carried out by YouGov between 19 – 23 August 2021. YouGov screened the total sample size of 6248 adults for those either waiting for treatment or with a family member waiting for treatment. Healthwatch England then filtered the sample again to capture data from England only. Of the resulting sample size of 1675 respondents, 1441 completed the survey. Throughout this briefing, we describe these views as from the **YouGov poll**, with all figures referenced from YouGov Plc.
- The views of 1075 people either waiting for treatment or who have received treatment in the past 18 months in our national survey, which was live between 6 September and 11 October 2021. Throughout this briefing, we describe these views as from the **Healthwatch survey**.

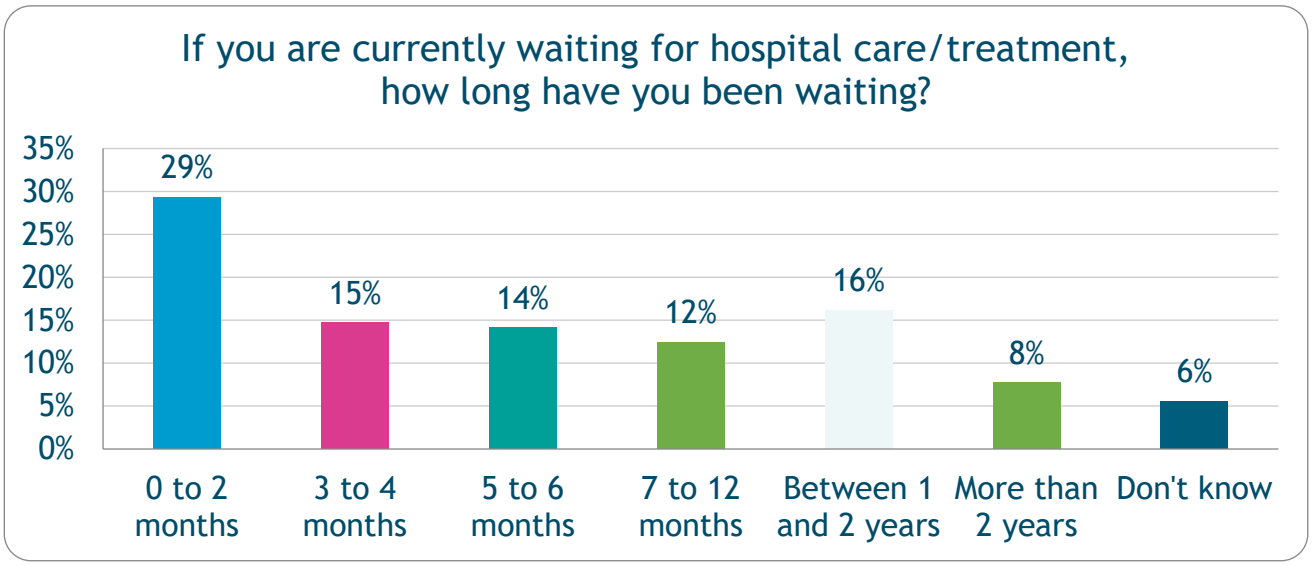
Key Messages

Length of wait

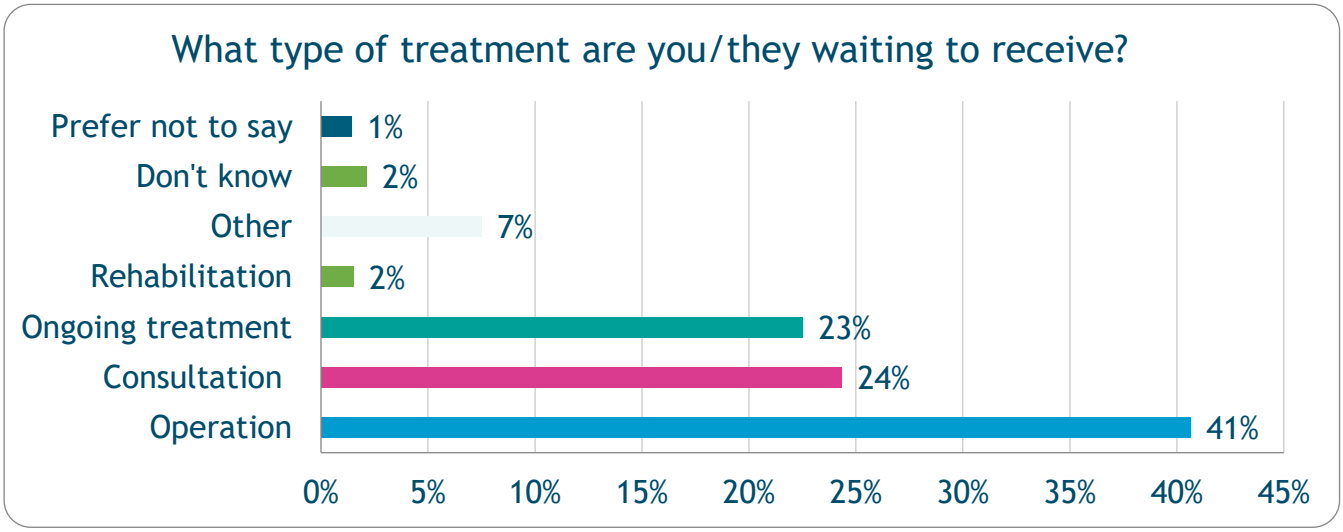
In both the poll we commissioned through YouGov and the online survey we conducted, we found:

- There is variation in how long individuals are waiting to receive care/treatment
- The greatest proportion of patients are waiting for operations
- Nearly a third of patients have received an appointment cancellation
- Of those who have had an appointment cancelled, many received very short notice

The YouGov poll clarified that, of the 1,441 respondents, 60% of people waited a year or less for care or treatment, with 8% waiting more than two years. Nearly three-quarters of people waited a year or less in the Healthwatch survey, with 4% waiting over two years.

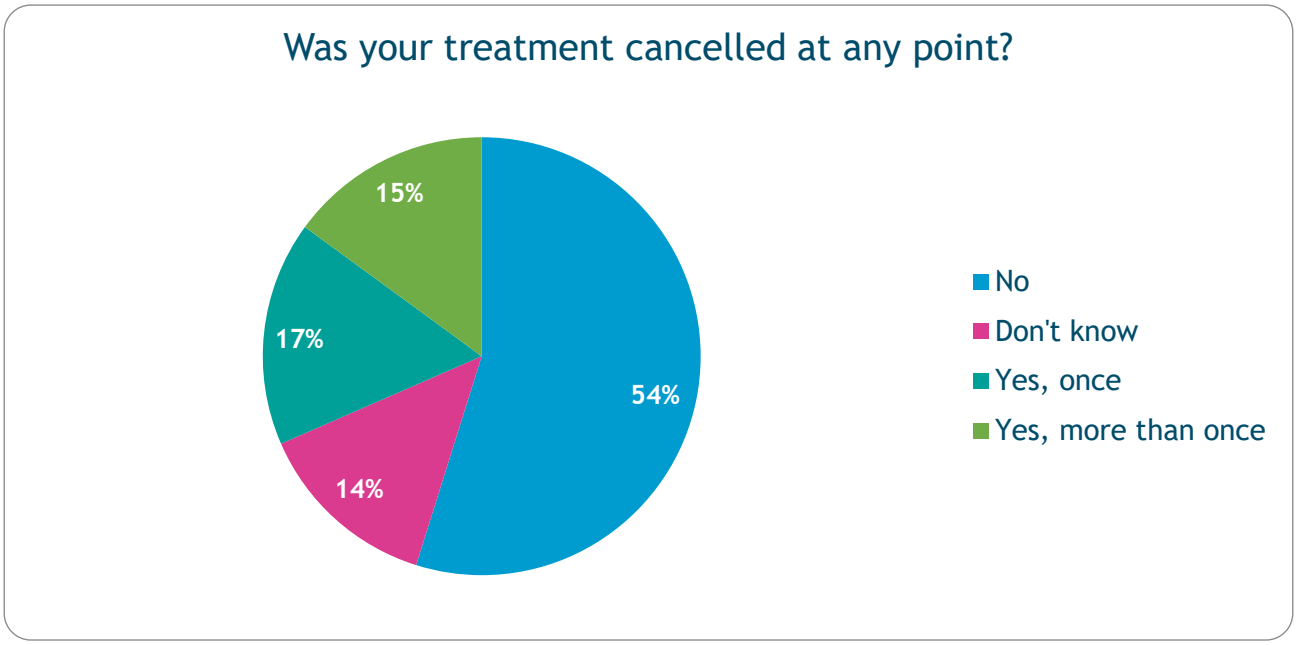


The YouGov Poll also showed the types of treatment people were most commonly waiting to have. Of the 1,421 people who responded on this topic, 41% said they are waiting for an operation (for example, surgery, biopsy or other procedure). Nearly a quarter said they are waiting for a consultation (for example, an outpatients appointment without an intervention or procedure). Finally, 23% said they are waiting for ongoing treatment (for instance, a pre-planned review of a long-term condition.)

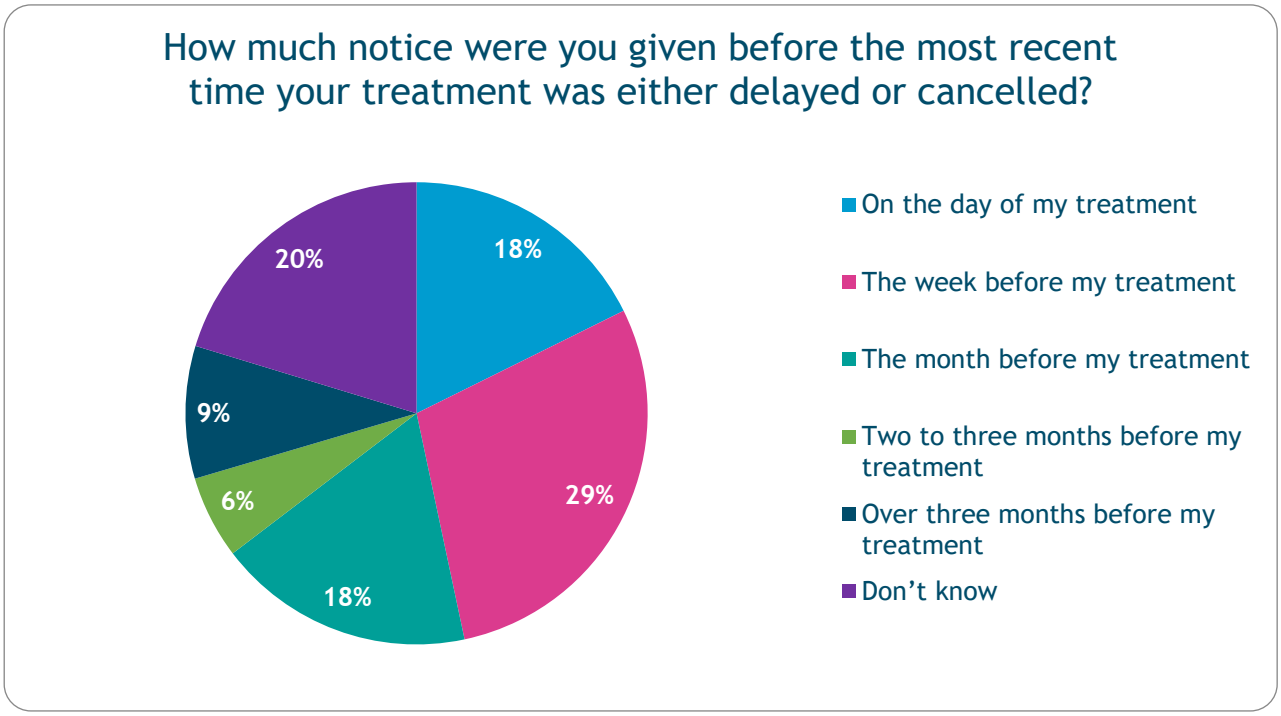


Our national survey corroborated these findings. While these long waiting times, especially for operations, are understandable due to the restrictions and limited resources throughout COVID-19, there have been issues with the frequency and short notice of cancellations.

The Healthwatch survey asked patients whether their care/treatment was cancelled at any point, 1,043 people answered:



People having treatment cancelled were often given very short notice, with only 15% given notice longer than a month before the care/treatment was to take place.



Compounding these issues is a feeling among patients that communication of cancellations is poor. Many individuals reported feeling forgotten.

"The first cancellation in July 2021, I was being wheeled down to surgery when they turned me around and took me back to the ward as no ICU bed available.

They promised to do the surgery on 26 July 2021 and would make sure no one took my bed. I started a week in isolation at home prior to surgery, only to receive a phone call three days before the procedure that it was cancelled and couldn't give me another date. I have heard nothing since about another date."

People reflected this sentiment in the Healthwatch survey, which asked those with last-minute cancellations (on or after the day of admission) whether they were given a new date within 28 days of their original appointment date at the same or a different hospital. Nearly three quarters (72%) of people who answered this question said they did not.

Nearly three-quarters of people reporting this suggests that the elective waiting times policy is not being followed. Patients that are told of last-minute cancellations often face uncertainty over how promptly they would receive their delayed care.

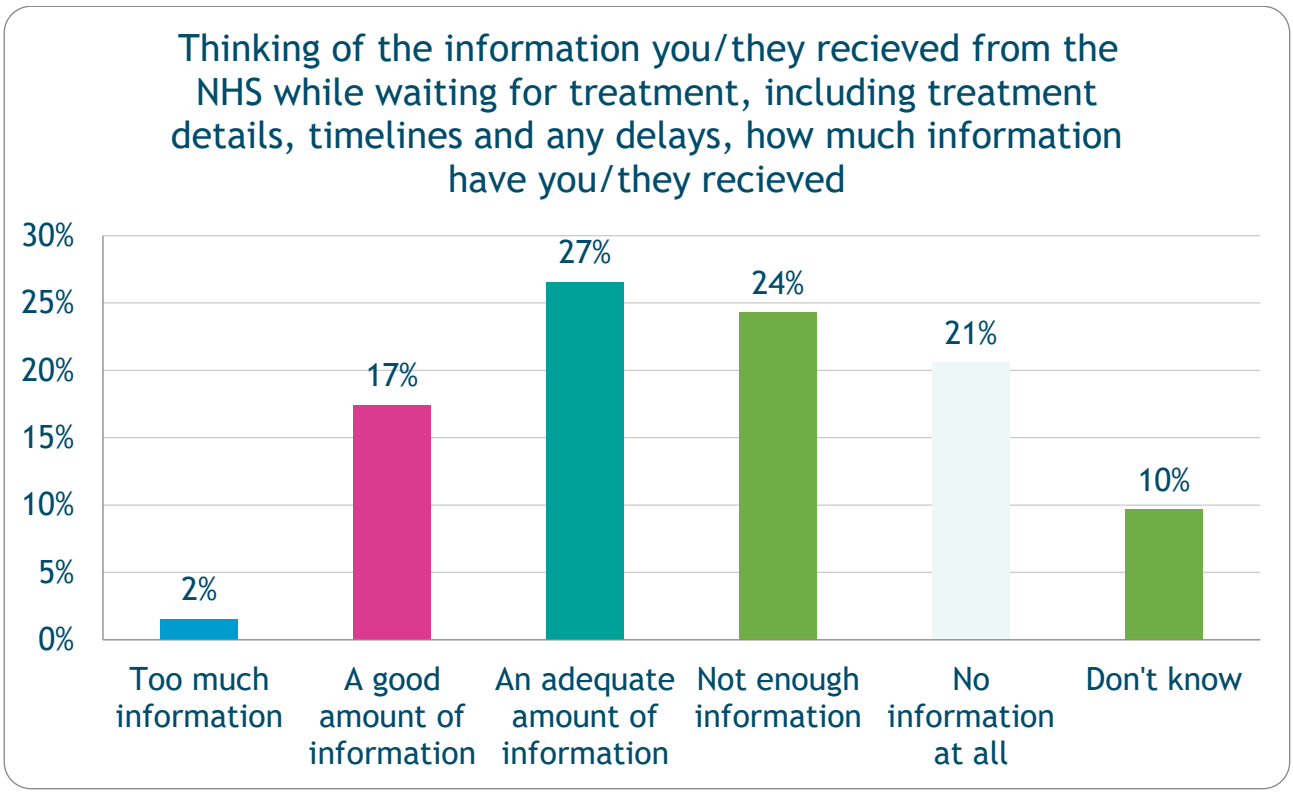
We also asked individuals whether they thought the statement “I have the right to have treatment at another hospital of my choice if my local hospital cannot treat me within 26 weeks” was true or false. 70% answered that they did not know, while only 23% correctly identified the statement as true. This finding indicates that not only are patients facing uncertainty following cancellations, but there is a serious information gap relating to patients' rights to accessing care.

Quality of wait

The uncertainty surrounding appointment cancellations is just one element of the quality of wait. We also wanted to understand the impacts that waiting has on people's quality of life. We ensured that questions about communication, information provision and condition management were the focus of the YouGov poll and Healthwatch survey. We found that:

- The majority of patients report that the amount of supporting information provided during their waiting period was inadequate, especially in helping them manage their condition.
- Of those who received support, they reported the most valuable interventions to be information about conditions and treatment, and pain relief.
- Most patients do not think that communications from the NHS have been accessible and easy to understand.

The YouGov poll found that 45% of people said they received no information or not enough information whilst waiting for their treatment.



These findings were even starker in the Healthwatch survey, where 58% of people said they were given no information at all, and a further 21% said they received not enough information whilst waiting for care/treatment.

Lack of information was especially apparent for supporting people in managing their condition while waiting for care. Over three in five (62%) people said they were given no information on how to manage their condition in the meantime, and a further 17% said they were given some information. Still, it wasn't sufficient to manage their condition in the meantime. Just 6% said they were given adequate supporting information to manage their condition, including a clear point of contact in case their condition deteriorated.

Respondents with more disposable income were more likely to report being given information while waiting for their treatment. Only 3% of less financially secure respondents said they received a good amount of information.

The lack of supporting information for condition management can seriously affect an individual's quality of life.

"From being referred for a total hip replacement on 11 February 2020, I finally had my operation on 31 August 2021. That was a wait of over 18 months, during which time my condition and the excruciating pain accompanying it deteriorated significantly so that I became virtually housebound. At no time was I ever contacted by anyone with updates of any kind but was left to suffer in silence. Primary care was catastrophic, and trying to see a GP was nigh on impossible. It has been such a difficult time because I have no

family in the UK, let alone the Isle of Wight. I felt completely abandoned and alone, and there were times when I lost all hope and seriously felt I'd be better off dead."

Most pointedly, the Healthwatch survey asked, "Have you received support from the NHS whilst waiting for treatment?" Just 15% of people said yes, whereas 82% of people said no.

"I had to access the crisis team as the effect on my mental health due to the severe pain caused me to be suicidal. I am under the crisis team at a different hospital to the one I receive my spinal care from."

Of the number that did receive support, 32% said they found information about their condition useful, and 33% said they found information about the treatment itself useful. Over a quarter (27%) said they found support with pain relief helpful. The YouGov poll reflected this, where information about treatment and condition were the most commonly selected options at 17%, closely followed by support with pain relief at 14%.

"[I've had] two steroid injections in two months - was put on waiting list when consultant saw my x-ray during that procedure. Six months later, I requested a 2nd steroid injection as the pain had become unbearable. I got a month of my choice to allow me to be comfortable enough to enjoy a short break away. Through rest, it remains bearable."

Supporting people with personalised information is crucial to their physical and mental wellbeing. Quality of communication is also pivotal. The Healthwatch survey asked 'To what extent do you agree with the statement "The communications I received from the NHS about my treatment were clear, accessible and easy to understand"':

- 21% said they strongly or somewhat agree with the statement
- 59% said they strongly or somewhat disagree with the statement

Many patients felt let down, either with how often information was provided or via the methods of communication.

"I understand the service is so stretched, and I hate complaining knowing how busy they are. However, I feel that I have been left on my own to manage my condition. My double [vision] is getting worse, and I cannot learn to drive meaning I risk losing my job. The delays are understandable, but I just wish I could have some communication on even a rough estimate on how long it will be until I can be seen. My mental health is impacted as I am embarrassed to go out socially due to my squint."

Impacts on quality of life

Both the length and quality of wait have impacted the quality of people's lives. We wanted to understand how delays had impacted different areas of daily life. The Healthwatch survey found:

- 55% agreed that delays had impacted their ability to work
- 68% agreed that it had impacted their ability to carry out daily household tasks
- 40% agreed that it impacted their ability to care for someone else
- 73% agreed that it had increased the level of pain they had experienced
- 80% agreed that it had impacted their mental health or wellbeing

Disabled people (80%), carers (76%), or those with a long-term condition (76%) were more likely to agree that delays had an impact on the level of pain they had experienced than those who do not fall into those categories (60%).

Similarly, disabled people (69%), carers (63%) or those with a long-term condition (57%) were more likely to agree that delays had an impact on their ability to work than those who do not fall into those categories (46%).

Disabled people (80%) were also more likely to report an impact on their ability to carry out household tasks.

When looking at people's mental health, 90% of respondents under the age of 35 agreed that treatment delays had an impact, with the trend steadily decreasing up the age groups (72% of over-75s reported an impact).

And the least financially secure respondents reported a more significant impact for all outcomes due to delays when compared to those with large disposable incomes:

- Ability to work (89% vs 44%)
- Ability to carry out daily household tasks (80% vs 56%)
- Ability to care for someone else (54% vs 24%)
- Level of pain they had experienced (93% vs 49%)
- Mental health or wellbeing (89% vs 67%)

The highlighted effect on people's physical and mental wellbeing was also reflected in the comments provided to our national survey:

"My health and mobility is decreasing with every month that goes past. Without intervention, I will be wheelchair bound instead of me walking the dog every day. I will soon need help with personal care cleaning etc., because my conditions have not been adequately monitored and treated for 18 months."

"During heavy loss of blood, I have to take time off work. I do not receive sick pay. Financially I am suffering along with my mental health due to worry and lack of support from the NHS."

Health inequalities

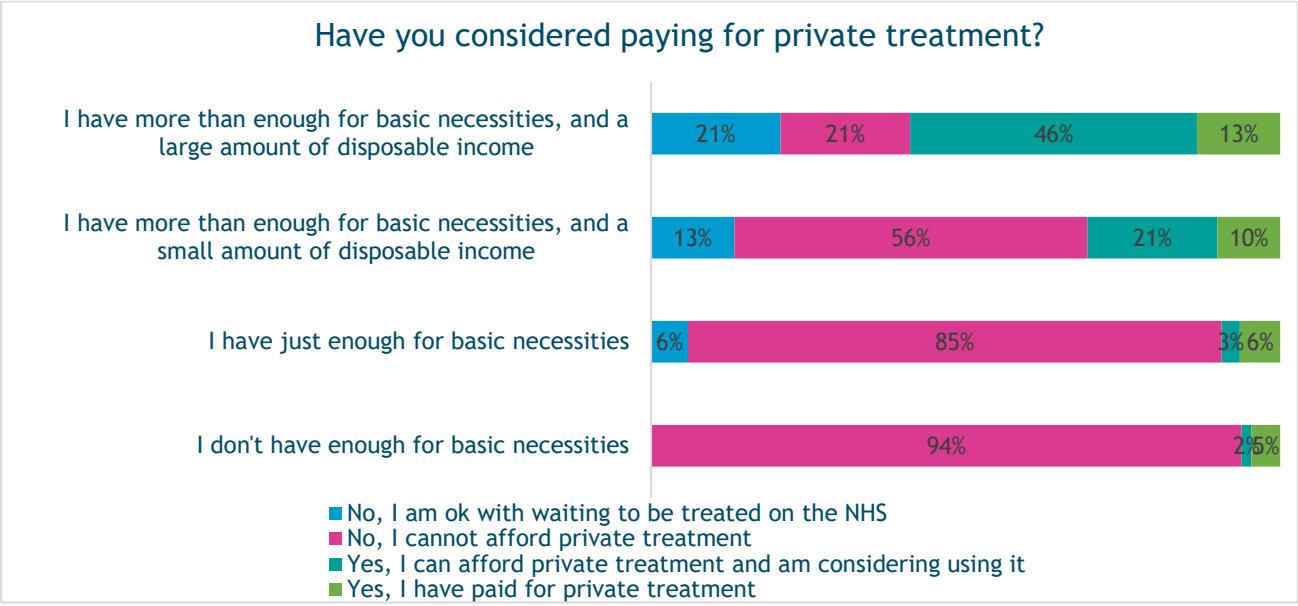
The above quality of wait and quality of life insights highlight several health inequalities in waiting for planned treatment.

While the number of people from minority ethnic communities who responded to our research was small, there is some indication that people from Black, Asian and ethnic minority backgrounds are experiencing similar issues to those on low incomes. Non-white British respondents were less likely to feel supported by the NHS and less likely to feel they were given clear, accessible and easy to understand information.

These indicative findings came through in the YouGov poll and Healthwatch survey and now require further research to understand the impacts of and solutions to waiting for care.

Our data also highlights inequalities in terms of people's access to private treatment. The Healthwatch survey found that 8% of people had paid for private treatment, whilst 14% said they are currently considering it and could afford it. Nearly two thirds (65%) said that they would not go private as they could not to, and only 10% said they were not considering going private and were ok with waiting to be treated on the NHS.

The more financially secure the respondent, the more likely they were to say they can afford treatment and are considering it; however, those who are most well off appear to potentially be ok with waiting to be treated on the NHS.



Some also described borrowing money and using up savings to get care/treatment.

" I was advised if I did not have cardiac ablation as soon as possible, my paroxysmal atrial fibrillation could become chronic. So I took out a loan for £10k plus £7k savings to pay for the ablation."

This is also true of how people have dealt with the quality of life impacts, such as mental wellbeing.

" I have actually found hospital treatment has been brilliant throughout the pandemic - I am not an emergency case, and the hospital (Colchester, Essex) kept me updated and informed. However, for mental health issues, I pay privately - I wouldn't even consider trying the NHS. It takes years."

One way to address this inequality moving forward is to create more spatially diverse access points for patients who urgently need treatment. We asked people if they would be willing to travel to receive treatment to reduce their waiting time. The YouGov poll highlighted that 29% of people would under and circumstances, while many others said they would if they had various provisions. Only 14% said no, and 14% did not know.

The Healthwatch survey also reflected this:

- 29% of people said they are happy to receive treatment at any hospital in England
- 45% said they are happy to receive treatment at a local hospital
- 13% said they would travel to another hospital if the NHS provided help with travel
- 6% said yes if the NHS helped them and friends/family with other support, such as accommodation

- 2% said yes if they got help to look after the person/children they are caring for
- 4% said yes if their family were able to visit them
- 10% said no
- 6% said don't know

These findings show an overwhelming willingness to travel if it means that waiting times reduced, though there were differences in response depending on age. 41% of respondents under the age of 35 would be happy to receive treatment at any hospital in England, compared with just 17% of over-75s.

Financial stability also had a bearing on responses, with the least financially secure twice as likely to require travel support for themselves or their family (35%) compared to those with large disposable incomes (17%).

Recommendations

Communication recommendations		
Recommendation	**Why**	**Who**
Implement the good patient communications guidance to provide people with regular information and advice about their treatment. This information should include how to access support services, how to manage their pain and how to access benefits such as Statutory Sick Pay (SSP). Where appropriate, this might include signposting to social care and welfare teams or link workers in primary care. Communications should be clear, accessible, easy to understand and personalised to each individual's condition and preferences.	Good communication would reduce health inequalities and the potential for health anxieties. It would also help prevent people from feeling forgotten while supporting them to ensure they are not waiting in pain or struggling to pay household bills.	NHS England (NHSE), NHS trusts, local authorities and Primary Care Networks (PCNs).
Put systems in place to allow regular updates to patients on their position on the waiting list. Where the NHS cannot give treatment dates with certainty, services should provide	To reassure patients by providing information on other people's experiences and	NHSE and NHS trusts.

other updates to patients and their carers to provide context. Updates could include national and local data such as waiting times for other patients with relevant conditions or interventions, or information on when they should next expect to hear about their treatment date. Updates could take the form of a monthly statement from the NHS to help avoid patients feeling lost and forgotten.	potentially reduce no-shows or 'did not attends' (DNAs) through improved expectations management.	
Use all possible communication channels to allow patients to regularly feedback on their condition and how they are feeling while waiting. This could be over the phone, via newly procured digital solutions, or through adaptations to the current NHS App, whereby patients could submit symptoms or changes in their condition on a daily basis. Doing this would also provide patients with an easy process to provide updates when they no longer need care and wish to cancel an appointment. Communication channels in these instances must then follow up to understand why patients are cancelling and provide appropriate support where necessary.	Doing this would improve remote monitoring systems and potentially reduce the need for as many follow-up appointments for patients. It could also minimise DNAs, allow patients an easier route to cancel, and provide opportunities for trusts to provide the support some patients need to attend an appointment they otherwise couldn't make (e.g. transport costs).	NHSE, NHS trusts and PCNs.
Acknowledge that we don't just need more doctors and nurses to tackle the backlog, but more well trained and compassionate admin staff to manage waiting lists better. These teams should be supported to implement and manage the above patient communication recommendations. This includes serving as a single point of contact for patients to access information on their	Doing this would provide hospital trusts and/or PCNs with an administrative hub for patient communications, relieve pressure on GP services, and help in managing waiting lists and communicating with those waiting for planned care.	Government, Department of Health and Social Care (DHSC), NHSE, NHS trusts and PCNs.

planned care proactively, so that they don't need to contact general practices for updates. There should be greater investment in the recruitment and retention of administrative staff to manage these new support services.	It would also help reduce variation across the country in the number and utilisation of administrative staff.	

Support recommendations		
Recommendation	**Why**	**Who**
Support patients while they wait by making physiotherapy, pain management and mental health services more widely available. This could be done by investing funds allocated to tackling the backlog into these services that support people while they wait. To ensure support is as accessible as possible, particularly while COVID-19 remains a threat, services should explore ways of delivering help both as physical services and remotely. Consideration should also be given to how the NHS and social care services could provide more care via home visits.	Our insights highlight the impact waiting has on people's ability to carry out household tasks, the level of pain they're experiencing and their mental health. Greater access to support would allow people to wait in more comfort for their planned care and help ensure they are in the best possible shape to receive treatment when the time comes.	NHSE, NHS trusts, local authorities, Integrated Care Systems (ICSs) and PCNs.
Commission voluntary sector organisations and local Healthwatch who can support signposting and access to local support services.	As well as helping local people access the interim care they need, these organisations can also bring insights into where there are gaps in support.	NHSE and local authorities.
Provide financial and organisational support with travel and accommodation for patients asked to travel to a regional surgical hub for diagnostics or treatment. This support should	Our insights highlight that some people would require additional support to travel for care. Implementing this recommendation would	Government, DHSC, NHSE and ICSs.

include support for carers, chaperones or other loved ones where appropriate.	prevent health inequalities, in particular for people living on low incomes.	

Medium-term recommendations		
Recommendation	**Why**	**Who**
Consider widening Statutory Sick Pay (SSP) eligibility thresholds.	To support the increasing number of people struggling to work due to growing waiting lists and longer treatment delays.	Government, local authorities and Department of Work and Pensions.
Continue to provide additional dedicated funding to support hospital discharge to assess arrangements. Previous Healthwatch work has shown how important this funding has been to facilitating good patient flow and getting people home from hospital quickly and safely.	To support consistent implementation of current guidance and increase the likelihood of hospitals freeing up bed space where appropriate.	Government, DHSC and the Treasury
Restart the clinically led review of access standards. As part of this review, consider: a. How to limit the anxiety of waiting in silence for patients. This could involve splitting the 18-week referral-to-treatment (RTT) pathway into separate measures for diagnosis and treatment. b. How to improve data and demand management processes that prioritise the sickest patients on elective waiting lists while not exacerbating health inequalities faced by those facing long waits. c. How to prevent long waits occurring, for example, via the introduction of a more publicly understood backstop to ensure	To develop longer-term solutions for managing the elective care backlog, considering factors across all health and social care.	NHSE

there is a limit to the length of time someone can wait for elective care.		

AGENDA ITEM: Update on HWE Plans to fulfil our commitments of Equalities Diversity and Inclusion
PRESENTING: Chris McCann
PREVIOUS DECISION: Approval of the 21/22 Healthwatch England Equalities Diversity and Inclusion action plan
EXECUTIVE SUMMARY: This paper sets out an update on our progress in delivering our Equalities Diversity and Inclusion Plan for 2021-22.
RECOMMENDATIONS: Committee Members are asked to note this report.

Background

In May 2021, we published alongside our refreshed strategy an action plan on how we would deliver our commitment to Equalities Diversity and Inclusion in 2021-22. This plan aims to support the delivery of our strategic objective to: *seek the views of those who are seldom heard and reduce the barriers they face.*

This paper outlines the work we have undertaken since our last update, which covered Q1 and Q2 of 2021.

New roadmap published

In October we published our Equality, diversity and Inclusion Roadmap to support our strategy and put equalities at the heart of our work. The roadmap sets out our journey so far, including the work supported by Joy Beishon, Chief Officer of Healthwatch Greenwich, as well as the challenges we face and opportunities we can build on. The document also sets out how we will support local Healthwatch over the next three years to:

- Think about equalities, diversity and inclusion in every aspect of our work.
- Continually ask what more we can do to listen to those the system overlooks and address any barriers to participation,
- Make sure our evidence is heard and acted upon.

Supporting local Healthwatch

We have continued to deliver our existing plan to support local Healthwatch to improve our approach to equalities. Highlights include:

- **Healthwatch Week (9-12 November):** Equality, diversity and inclusion was a theme that ran throughout Healthwatch Week this year. We also had a whole day dedicated to tackling health inequalities. We heard from historian and broadcaster Professor David Olusoga about the role of Black and Asian communities in the development of the NHS and why it's crucial to have often hidden voices in leadership roles. A panel comprising the heads of the NHS's main equalities programmes, set out their plans to tackle health inequalities and the role that Healthwatch can play. Delegates also heard about the different approaches that can help improve our approach, including the importance of collecting demographics and accessible communications. We also discussed the role of volunteers in tackling health inequalities and how Healthwatch Worcestershire had used the Quality Framework to strengthen equality, diversity and inclusion across their work.

- **National Healthwatch Awards:** Equality, diversion and inclusion ran across all the categories of our National Awards. For example, Healthwatch Essex won the Covid-19 Award for their campaign to bring attention to the challenges faced by people living with sensory impairments adhering to COVID-19 restrictions, such as communicating effectively when people have masks on. The campaign generated great media coverage and reached an estimated 170,000 people.

- **Learning and Development:** Equality, diversity and inclusion features prominently in our Learning and Development programme which seeks to share learning from Healthwatch as well as bring in external expertise. We are currently evaluating the programme. However, we have:

    - Launched a new e-learning module to support the collection and analysis of demographic data.
    - Provided training:
        - 12 people attended equality, diversity and inclusion training with the Diversity Trust. Of those who provided feedback, all said it had increased their confidence and are likely to apply learning to their work.
        - 20 people attended a learning & sharing event on Healthwatch case studies of engaging particular communities.
        - 6 Healthwatch Board members attended action learning sets to explore how they can improve equality diversity and inclusion in their local Healthwatch.
    - Raised awareness of different approaches by expanding our collection of approaches to engagement and inclusion and supporting this via webinar training. New resources include Healthwatch North East Lincolnshire and Healthwatch Essex approaches to involving young people and people with learning disabilities in their work, as well as Healthwatch Central London and Healthwatch Lincolnshire approaches to working with the Black African and Gypsy and Traveller communities.

Communications, policy and research

We have continued our work to engage people from diverse backgrounds, understand their experiences and to make sure policy makers hear and act on this evidence. Highlights include:

- **Waiting times for hospital care:** In partnership with the King's Fund, earlier this year we highlighted how people living in the poorest areas of England are significantly more likely to wait longer for elective treatment than those who live in more affluent areas. In November we built on this with a more detailed report on our work around elective care. Using the views of over 2,500 people who told us in September and October how they have been affected by NHS waiting lists, we were able to highlight that:

    - The amount of information people received during their wait was a key factor in determining their overall experiences. Over three in five (62%) people said they were given no information on how to manage their condition in the meantime, and a further 17% said they were given some information, but it is was insufficient. Just 6% said they were given adequate supporting information to manage their condition, including a clear point of contact in case their condition deteriorated.
    - This became even more stark when we looked at people's income. Respondents with more disposable income were more likely to report being given information while waiting for their treatment. Only 3% of less financially secure respondents said they received a good amount of information.
    - Respondents on lower incomes also reported a more significant impact for all outcomes due to delays when compared to those with larger incomes:
        - Ability to work (89% vs 44%)
        - Ability to carry out daily household tasks (80% vs 56%)
        - Ability to care for someone else (54% vs 24%)
        - Level of pain they had experienced (93% vs 49%)
        - Mental health or wellbeing (89% vs 67%)
- We were also able to make specific recommendations to ensure the Elective recovery plan does not exacerbate health inequalities including:
    - Challenging the NHS, that if they create surgical hubs for fast track treatment, then this must come with support for transport and accommodation for patients and families who may not otherwise be able to afford this.
    - Calling on Government to consider expanding statutory sick pay to provide more support for people on low incomes if they have to wait longer for treatment.

    - Whilst the number of people from minority ethnic communities who responded to our research was small, there is some indication that people from Black, Asian and ethnic minority backgrounds are experiencing similar issues to those on low incomes. Non-white British respondents were less likely to feel supported by the NHS and less likely to feel they were given clear, accessible and easy to understand information.
    - We are currently scoping out the possibility of commissioning further research to explore the experiences of individuals from Black, Asian and ethnic minority communities, and help NHSE ensure the recovery plan does not exacerbate the health inequalities experienced by these groups.

- **NHS Dentistry:** As the committee is aware, we have been reporting throughout the pandemic the impact on dentistry and we have another report planned for mid-December which will share analysis of the feedback we have received during Q1 and Q2 of 2021/21. During this time, we have

received 1.5 times the amount of feedback about children and dental services that we received in the entirety of 2020/21. The report will:

  - Pull out the experiences of children and families as a key theme, including analysis of national performance data and an assessment of which parts of the country have been worst affected.
  - Highlight that among adults, one of the groups who has been worst affected has been care home residents, with restrictions around visits to care homes, and issues with residents having to isolate for two weeks if they went to see a high street dentist, causing significant access issues. This is important to note, as care home residents were already a group badly affected by the limitations of the existing dental service pre-pandemic, and it is clear the current restrictions have made things much worse with limited mitigations put in place.

- **Improving our research systems:** We remain on track to complete the roll out of changes to the Healthwatch CRM by the end of Q3. This will bring our demographic categories in line with best practice and help us start to create the wider data standards that will ensure we are able to use our insights to address health inequalities. Alongside this we are now discussing with NHS England, NHS Digital and CQC on how we make sure our demographic reporting aligns with their systems. This is to help ensure our insights land in a way that our partners can use to easily compare with their own data and make informed decisions about future policy.

- **Making our information more accessible:** We have continued to deliver our work programme to make our communications as accessible as possible. In the new year we plan to roll out our updated accessibility policy to the network. Other highlights since our last report include:
  - Rolling out our new brand tone of voice and language guide with training on how to make our communications clear, understandable and accessible in terms of language. To date we have delivered five training sessions to more than 100 staff and volunteers.
  - Making changes to our visual brand to ensure that the colours and fonts we use in our communications are more accessible. A new guide to support this will be launched in December 2021.
  - Updating our accessibility guidance for the network and providing training.
  - Developing an updated Drupal nine website which will be accessibility tested and rolled out to up to 100 local Healthwatch services.
  - Introducing a new tool to replace our existing website accessibility checker. This tool will better enable us to scan pages for accessibility problems that can then be quickly addressed.

- **Reaching people from more diverse backgrounds**: We have continued our work to reach different sections of the community via our communications. Highlights include:
  - Using postcode targeting on social media to help increase feedback from people living in deprived areas to help inform our waiting times

report in November. Our campaign resulted in over 2,500 people sharing their views.

- Applying our new brand language guide and always on marketing to help increase engagement. Via our general feedback form we have seen the proportion of people from non-white backgrounds sharing their experiences increase.
- Preparing for our Accessible Information Campaign, which will launch in January. Evidence for the first phase of the campaign is being supported by 1-2-1 interviews with 100 people whose first language is not English to understand the barriers they face to accessible health information. The campaign platform is also being developed using audience testing with a range of audiences including those who have sensory impairments, people with a learning disability, individuals whose first language is not English, as well as carers.

AGENDA ITEM 2.1

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 NOVEMBER 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. 16
Meeting Reference: AFRSC202116

Minutes of the Audit, Finance and Risk Sub-Committee (AFRSC) 18 November 2021
10:00 am-12:00 pm
Teams Meeting

Attendees:
Andrew McCulloch (AM) – Acting Chair and Sub-Committee Member
Helen Parker (HP) - Sub-Committee Member
Sir John Oldham (JO) – Sub-Committee Member

In Attendances:
Chris McCann (CM) – Acting National Director & Director of Communications, Insight and Campaigns
Joanne Crossley (JC) – Head of Operations
Gavin MacGregor (GM) - Head of Network Development
Sandra Abraham (SA) – Strategy, Planning and Performance Manager
Phil Huggon (PH) – Committee Member
Felicia Hodge (FH) – Committee Administrator (minute taker)

Apologies
Danielle Oum (DO) – Chair

No.	Agenda Item	Action and Deadline
1.1	Andrew McCulloch (AM) welcomed everyone to the Audit, Finance and Risk Sub-Committee meeting (AFRSC). Apologies from DO were noted	

1.2 1.3	**Draft Minutes of Meeting of September 2021:** Minutes of the last meeting were AGREED without amendment **Action Log** Please see Appendix Action Log. All actions completed **Matters Arising** No Matters arising	
2. 0	**Finance and Procurement** JC Presented a summary of the budget spend as at the end of September 2021, plans to utilise the underspend, a summary of procurements to date, grants allocated to local Healthwatch and the outstanding balance on the Norfolk Fund. The sub-committee were asked to note the reports. **2.1 Financial Position as at end September 2021** **2.2 Plan for Underspend** **2.3 HWE Recharges** JC explained that as at end of Q2 just under half of the budget had been spent. On pay, an underspend is being carried due to staff movements. On non-pay just under a fifth of budget has been spent, with the main expenditure lines beingdigital, social media, web hosting and maintenance, learning and development, support to LHW, branding and the annual conference. Less has been spent on travel and meetings and projected spend in this area is not expected to increase greatly by year end. The digital inequalities work which was planned will not materialise this financial year and the budget set aside for this activity will be re-allocated to cover work on accessible publications and feedback campaigns. JC referred the sub-committee to the summary of the movement of monies between budget lines. JC advised the sub-committee that staff workload had been reviewed to ensure that work with the greatest impact could be delivered and the Non-Pay budget was reprofiled and funds re-allocated to research, stakeholder perception work, digital transformation and the quality framework. JC said that that although the Non-Pay budget has been re-profiled, there is a likelihood that the total budget may not be spent in time by year end but grant funding around ICS work would be considered in order to reduce the potential underspend. The sub-committee wanted to know how grant allocations are measured for value for money (VfM). JC responded that there is a process in place and GM confirmed that grant recipients report back on outcomes. However, he said that more work needs to be done and from December more structured formal reports will happen, as robust scrutiny is required for ICS work. Currently, grants are awarded against criteria, but this has not yet been integrated into VfM. The sub-committee requested a work-in-progress report sufficient for them to understand and reassure themselves that work is being done in this area.	

	ACTION – GM to provide a report of work-in-progress on the measurement of VfM for grant funding to the network to assure the sub-committee that work is being done in this area, by the next sub-committee meeting. The sub-committee wanted clarification of the timings for grant funding and to establish why it seemed that some grant allocations were backloaded to the end of the year, mainly Board support, engagement and managing contracts. The committee also wanted to know what would happen to the underspend and if it would be used for grant funding in time. GM responded that HWE wanted to ensure that they had the right Board governance support and had worked with a Board Advisory Group which took time before rolling this programme out. There were two aspects to this, one around Board governance and the other around EDI and Board diversity. GM believed that the timing is right as HWE needed to have a clear understanding of what they were trying to achieve. They are now ready to proceed with advertising for the grants process. GM advised that the engagement grant allocations are straightforward and are ready to roll-out, but inclusion advice needs more work before rolling out. The Deputy Head of Engagement and Sustainability had been working on ICS projects, but has now been released to concentrate on these areas. GM stated that although there is some risk, it is manageable. JC confirmed that grants are expected to have been allocated and processed by mid-March. CM and JC confirmed that the Leadership team are constantly reviewing the underspend and the next review will be 23rd November, although they are already clear on the areas that need additional support. PH expressed concerns about the underspend and suggested that it is allocated earlier and in readiness for ICS. He highlighted that recharges could be quite substantial, but this will not be known until March. He would like to have seen 25%-30% spent in Q1. JC responded that discussions with CQC are still ongoing in relation to allocation of desks and she does not foresee a rebate being achieved in year. CM mentioned that CQC are themselves running with an over-capacity of desks, which could influence their decision regarding recharges. **2.4 Income Update** JC informed the committee that £10k had been received from ADASS to support safeguarding work being done by HW Kingston and £160k is due to be received in two instalments from NHSE to support work around research and a number of projects including collaborative work with the King's Fund. An immediate payment is due, with the balance due in January. JC mentioned that HWE has provided a business case for funds around ICS work and await the bid outcome from DHSC. **2.5 Procurement Update** JC explained that a lot of the spend had been on digital, social media and Facebook. During Q2 spend had been on research activities and polling and	**GM**

	preparation for ICS. During Q3, there will be spend on staff learning and development for middle managers, digital upgrades and research activities. JC confirmed that there are no concerns with procurement, and all is going well. **2.6 Grants allocated to date** There was nothing further to add that wasn't covered in 2.1 – 2.3 above. **2.7 Norfolk Grant Funding** JC informed the sub-committee that Norfolk are currently holding £185.7K of funds of which some will be used to support the LHW website upgrade and this will leave a balance of around £98k. **The sub-committee noted the reports**	
3.0	**<u>Digital Funding</u>** **3.1 Local Digital Fund** GM informed the sub-committee that a series of interviews were taking place with LHW who do not use HWE systems in order to understand the pros and cons, strengths and weaknesses of the systems they use and whether the LHW would recommend their system to others in the network. Some LHW use systems that serve functions not associated with HW work, such as case management systems for advocacy work. GM mentioned that HWE would be looking at several systems to connect to the central data store which could be mapped across and are keen to hear about low-cost systems that can do this and are replicable. This would be the base and it needs to be right. In addition to this, the challenge will be to build in other systems around it. He suggested that after the audit, the findings are brought to the sub-committee at the next meeting to discuss the pros and cons, with the intention of sharing the results with the network. The sub-committee welcomed the report and asked that it include HWE's preferred route and details of software choice (including consideration of current HWE software), so that the sub-committee can make a judgement and be assured that the needs assessment looks to achieve what it set out to do and will meet the needs of the network. GM agreed that lessons had been learnt from the failure of the two previous pilots and that HWE didn't have the skills and knowledge then that they do now. **<u>ACTION</u>** – GM to provide a report of HWE's preferred route of travel and software choice (including consideration of what is already in use by HWE) following LHW digital/data audit and needs assessment review. **3.2 Digital Transformation Spend to Date** CM presented an update on the digital transformation spend and asked the sub-committee to note the report.	**GM**

	He explained that the spend on the HWE digital transformation fund will be completed by year end. The spend has been backloaded because key decisions weren't made until November as it was important to spend on the right projects and in the right manner. The sub-committee wanted to know if the Smartsurvey tool uploads data into other apps such as Excel and other Microsoft applications. CM responded that the reason for going with Smartsurvey is because it is a platform that interacts with other apps. He feels sure that the platform can easily transfer data to other platforms but offered to check and confirm. **ACTION** – CM to investigate if SmartSurvey can easily transfer data to other platforms. The sub-committee suggested that HWE consider looking at their current systems to see if it already has the capability to deliver what is required. JO mentioned that ICS would be very interested if HWE could demonstrate that they had the mechanisms to produce the sort of data they wanted, and this would enhance their offer. The sub-committee wanted to know the timeframe for doing the work and whether the impact on next year's budget had been considered. CM confirmed that sustainability over the next 5 - 10 years had been considered with the removal of CiviCRM freeing up funds that can be used on other platforms. There is capacity if needed to fund Smartsurvey out of the Norfolk fund. Future spend predictions over the next 5 years are being looked at in addition to year 2022/23. The sub-committee mentioned that only half of the data is easily acceptable throughout the network and wanted to know if HWE was viewing data collection through that lens and driving to increase the amount of data received. CM responded that critical mass data is the driver for HWE actions. It is referred to as "data transformation automation". SmartSurvey is an example of this as it allows HWE to shape data transformation from the network to HWE and templates can be used to provide HWE with the data and demographics that they require. The sub-committee asked for a multi-year view report and a roadmap of the direction of travel. **ACTION** – GM and CM to provide multi-year report of predicted digital spend and roadmap for direction of travel of data transformation automation. **The committee noted the reports**	CM **GM/CM**
4.0	**Staff Relations** **4.1 Staff Movements** JC provided details of staff movements informing the sub-committee that during the past financial year there had been a restructure within the Network Development Team (NDT) and some adjustments in other teams. Although there had been some redundancies in 2019/20, new roles had been created within the NDT to support HWE work on impact, quality assurance, campaigns, engagement	

and sustainability. This allowed skills gaps to be filled which aligned with HWE strategy in demonstrating impact.

JC reported that issues with line management at the beginning of the year have been resolved.

JC provided a comparison of staff turnover against peer organisations which indicated that HWE turnover at 11% was higher than CQC (9.6%) and other NHS and public bodies (10%). The previous year CQC average turnover was 15%.

JC mentioned that in one HWE team, staff tenure was 1.4 years compared to the HWE average of 2.7 years, but this figure is now improving. She expects that by year end, HWE staff turnover will be in line with similar directorates.

4.2 Staff Survey Results

JC provided the sub-committee with a quick reminder of the results of the full survey carried out in March 2020 and the follow up mini survey in September 2020 to evaluate staff perceptions and updated them with the progress on actions taken following the surveys.

JC informed the sub-committee that a further survey was carried out in October 2021 and provided them with the results and highlights which reflected the progress made in staff relations, which the committee found encouraging.

- There was an increase in staff being proud to work for HWE
- Good results around leadership decisions
- Staff morale improved – staff are aware of their objectives
- However, there were lower scores around support to staff through organisational changes. The Leadership Team (LT) are already addressing this issue through cross team planning meetings and increased communications with staff when changes are made.

JC mentioned that LT are currently digesting the results of the survey and will compile an action plan based on the results.

The sub-committee suggested that the next action plan should include a rolling programme of actions and their impact. HP noted that only 23% staff found staff meetings useful and effective, and sought reflections on actions so far and what could be done.

JC responded that staff can include items on the staff meeting agenda. Key messages are fed back to staff at briefings, all staff meetings and individual team meetings. CM added that although individual teams were getting information from their team leaders, coherence across the leadership group was needed and clarity on work priorities.

Regarding usefulness of meetings, CM agreed that this needs to be investigated and to come back to sub-committee with an action plan. Due to staff working remotely, meetings have become more formal and the ability to have impromptu discussions has been lost. CM assured the sub-committee that LT are committed to improving staff morale, which has been remarkable considering the environment staff have been working under to the pandemic. Staff are allowed

	flexible working and are encouraged to avoid back-to-back meetings. GM advised the sub-committee that that there had been a lot more matrix working and change management programmes. Middle managers are being provided with training to take control of the working groups and to give staff responsibility for their role within the group, with LT providing the framework. The sub-committee discussed the CQC e-voucher scheme and concluded that whilst it would be a motivational driver for a large organisation like CQC, it would not have the same effect for a small organisation like HWE. JC advised the sub-committee that although the scheme was open to all CQC directorates, HWE were in talks with CQC to see how the e-voucher scheme could be adapted for HWE staff, so that the rewards align with our values. The committee concluded that the survey had been a good one overall, even with the few lower scores on some responses. **4.3 Equality & Diversity** The Chair stated that the results from the survey on EDI reporting was unusual in that 62% of respondents did not wish to disclose their religious beliefs and 33% did not disclose their sexual orientation. This raises concerns because if people are not disclosing, EDI cannot be monitored effectively. He suggested that the reasons why people are not disclosing is investigated and HWE look at the questions being asked to see if the right data is being collected as we need to understand what is really happening. JC said she will speak to CQC regarding the structure of the questions and report back to the sub-committee. AM asked if he could have a look at the questions to see why it isn't capturing key EDI information. **ACTION** – JC to liaise with CQC to investigate the structure of EDI questions and to share the questions with AM. **4.4 Staff Turnover/Benchmarking results** Covered under 4.1 above. **4.5 HR Policies update** The sub-committee offered no comments. **4.6 Staff Learning and Development** JC informed the sub-committee that during the objectives setting process, several staff training needs were identified. These included individual courses to help upskill staff in their roles, and the middle management development programme which started mid-November and will run until mid-2022. The committee noted the report and were impressed by the depth of information and actions contained within.	JC

5.0	**<u>Risk Review</u>** **5.1 Strategic Risk Register** SA presented an update on changes made to the strategic risk register for 2021-22 since it was approved by the full committee on 13th October 2021. The register 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 risks presented in the register and recommend the changes made to the full committee on the 8th December 2021. The sub-committee made suggestions and comments on the following: **<u>SR25</u>** *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.* The sub-committee requested that this risk is rephrased with less political and more neutral wording. **<u>ACTION</u>** – CM to rephrase language with a less political content **<u>SR33</u>** *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* The sub-committee felt that the low rating for this risk was incorrect. It is a new risk which is strategically critical to HWE. The external context and environment are fast changing and fundamentally controversial. They suggested that the risk should have a higher rating. Although they recognised that HWE have good mitigations and couldn't be doing any more than they already are, they cautioned that not all good mitigations should have a low rating. The sub-committee asked for this risk to be reviewed and the rating reclassified. **<u>ACTION</u>** – CM and SA to review and re-categorise the risk. **T**he sub-committee agreed with the recommendations subject to the changes requested above. They considered the register a good moving document of mitigations and narratives. **5.2 Risk Appetite** JC presented a paper outlining risk appetite statements, and the key risk areas grouped by category. The sub-committee were asked to agree the risk appetite statements and levels provided and risk tolerance criteria for each of the areas listed. The sub-committee were also asked to advise if more levels are required. JO mentioned that he had questions about some of the categorisations and asked if he could send his comments in separately, to be considered as part of the	CM CM/SA

	meeting. AM requested the same and to speak to DO about some issues. The sub-committee agreed. The sub-committee agreed that it would be prudent to abandon risk tolerance and focus on risk appetite as this is more useful. They mentioned that the appetite should describe the range, like what has been provided in the narrative and suggested that maybe a heatmap could be considered. The sub-committee stated that the narratives around **Financials** and **Data** needs refinement and should capture the strategic intent and details of where the risks are. They noted that there could be other observations to consider when the written comments are received. The sub-committee requested that consideration is given to how the risk appetite will be used by HWE and that it is kept simple, useful and articulates how it will help in decision making. They recognised that work is needed outside the committee and AM stated that he will be happy to assist. The Chair requested that members take note of the discussion and provide comments to AM, DO or JC within the next week. A meeting will then be held with JC to compile a revised simplified tool with clarity in the narrative that has a shared understanding and will assist executives in their decision making. **ACTION** – Members are asked to provide AM, DO or JC with their comments and feedback about the categorisations and narratives on the risk appetite statement by end November. The sub-committee agreed with the Chair's suggestion.	ALL
6.0	**Forward Plan** The sub-committee reviewed the forward plan and concluded that: • Risk Appetite to be included in Q1 2022/23 **ACTION** - FH to include on appropriate agenda There were no other amendments or comments on the forward plan.	FH
5.0	**AOB** JC advised the sub-committee that work has commenced on next year's business plan to obtain budget approval in March. CM mentioned that timelines for business planning will be shared with the committee within the next week. The committee noted the comments and asked to be advised if there are any problems to be discussed in February. CM informed the sub-committee that there would be a public announcement on the new National Director appointment later that day. **The Chair thanked everyone for their attendance.** **Meeting concluded**	

AGENDA ITEM:2.2

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 2022/23

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
Jun 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 • Digital Transformation Progress • Delivery and Performance Update • Diversity and Equalities Update • AFRSC Minutes • Questions from the Public
Sep 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 • Digital Transformation Progress • Delivery and Performance Update • Diversity and Equalities Update • AFRSC Minutes • Questions from the Public
Dec 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 • Digital Transformation Progress • Delivery and Performance Update • Diversity and Equalities Update • AFRSC Minutes • Questions from the Public

Healthwatch England Committee Workshop Forward Agenda 2022/23

January 2022	Stakeholder Mapping Accessibility Update on Business Plan Trademark Licence
April 2022 or later	Working with Children