healthwatch

Second Public Meeting of Healthwatch England Committee-Feb 2013

A.B - So first thing I'd like to do is welcome everyone and particularly I'd like to welcome our guests here today. Thank you very much for coming to join us on this second of our public committee meetings. So, still quite new for us and we hope you enjoy it and we hope you'll give us feedback on how you think we're doing in our approach to these meetings. I'd also very much like to welcome those people who are watching us at home. When we come to the question session at the end of this meeting, which we also did on our last meeting, we are inviting members of our web audience also to take the opportunity to send questions into us. Whereas last time it was people present in the room, this time we're extending that invitation more broadly to try to give everyone the opportunity to be involved. I want to remind everyone of the hash tag, if you're tweeting - of course, another way of including people outside of room. So it's hash tag Healthwatch for anyone who wants to tweet. And aside from that, I think the only other bit of introduction I'd like to do is to invite members around the table to introduce themselves and just say a brief word about their primary area of interest or expertise. And I'm just going to start with Dag.

D.S - Hi, My name is Dag Saunders. I'm chair of a LINk in the West Midlands and particularly interested in services for people with dementia and learning disabilities.

D.R - David Rogers, I chair the Community Well-Being board of the Local Government Association, which is an interest I should declare under item three. That means that I'm principally interested in the social care aspects, but increasingly the local health dimension as well.

C.V - Hello, I'm Christine Vigers and I'm Chair of Kensington and Chelsea LINk and I have a special interest in older people and dignity and care.

J.C - My name's John Carville. My background is in the media. I was with the Guardian paper for years. Laterly I was social affairs editor and so I bring that skill-set.

K.R - I'm Katherine Rake. This is my second committee meeting, but my first as Chief Executive. I was newly appointed. The last time I was just observing.

J.M - Hello, I am Jane Mordue and my background is in the ten years, twelve years now with the citizen advice service and I'm deputy Chairman of the Citizen's Advice.

D.S - Good afternoon, I'm Dave Shields from Southampton and have had long involvement in health and well-being from a local government perspective.

M.H - Hello, My name's Michael Hughes and I come to the committee with 30 years experience of research in public policy.

P.V - Hi, I'm Patrick Vernon and my background is health and social care and I have an interest in issues around equality, mental health and public health and the London people.

S.R - Good afternoon, I'm Susan Robinson, I'm the development manager for Healthwatch England and I'm responsible for coordinating our offer of support for local Healthwatch.

G.T - Hello, I'm Graham Tinsley, the Planning Performance Manager for Healthwatch England and I'm looking at the business plan which will be discussed later on the agenda.

A.B - Thanks very much, so we have three members of the committee
who are sending their apologies today. Jane McFarlane, Alan Davis
and for this afternoon's meeting, Christine Lenehan. Christine had to leave to go to an urgent meeting in the Department of Health and would otherwise have hoped to have been with us. But she was with us this morning and I should just say we did this morning what we have done before at these meetings, which is to take the opportunity of being in a particular place to hear from some of the local Healthwatch in that area. So we had two absolutely fascinating and completely contrasting presentations from the very recently announced Bexley Healthwatch and the Lambeth Healthwatch, one, the latter
transforming from a LINk, the other a newly commissioned service to
two of the bigger voluntary sector organisations active in the
borough. So very different models. Very interesting for us to hear
how these things are developing. I'm going to go to the minutes of the last meeting please and I hope there are no surprises in here.
They have been circulated to members earlier, closer to the meeting date. Is there any matters of accuracy anyone wants to raise? No, so we can take those as read. Are there any matters arising which
aren't otherwise on the agenda? No? Everyone happy, okay great.
Declarations of interest.

D.R - My LGA
connections as indicated just now.

A.B - Thanks very much David. Anyone else? No, there is, of course, a register of interest on our website for standing purposes. Okay, so item four then, the Chair's Report. This has been tabled and everyone
should have had the opportunity to read it, I hope. I really wanted to just mention a couple of things, one of which has happened subsequent to this original report, and that is that Catherine and
I had our first, what I'll formally call our accountability meeting with the Department of Health. We'll be having those on a quarterly
basis and this is an opportunity for us to talk with them about what
we're doing and how we're fulfilling our statutory remit and, of course, to raise any issues that we have which we would like their help or support with, or issues we feel that they should be addressing. And at this first meeting we took the opportunity to ask the Department of Health to think very carefully about its sponsorship role for the Healthwatch network generally, and the
implications for them in terms of how they monitor, manage and keep us abreast of the increasingly large number of demands from both
elsewhere in the department and across the rest of government to,
for local Healthwatch or Healthwatch England to perform a range of
functions. So I mean, I think one of the things that has emerged in the regional events, which I've mentioned in
my report, is that local Healthwatch have been finding themselves rather inundated with additional requests to go to this meeting, that meeting, this network, that network and just keeping a handle on this, and ensuring that we are not overwhelmed. Nice to be popular but it needs to be in a managed way that we are not overwhelmed by demands - it's important and we think it's part of the function that the Department of Health should be fulfilling but is there anything else we want to say about that meeting Katherine?

K.R - The only thing to add I think is an awareness from the
Department of Health to get things right for local Healthwatch and
making sure that the communications about the regulations and other setup issues are very clearly handled, so I think seeing a very clear need for that in terms of how we move forward.

A.B - I wonder since the regulations are mentioned in my report here, whether you might just say something about the work we're doing with the Department of Health on this.

K.R - Absolutely, I think there's been a lot of concern about the regulations in general and specifically a clause on some readings could look as though it was limiting the ability of local Healthwatch to campaign. I think we've had a very helpful statement from Earl Howe in the House of Lords which has set the record straight, and is literally on the record because it's registered in Hansard. But as we were reminded earlier, and have been reminded through all of our regional events with local Healthwatch, regardless of what's said in the House of Lords, what matters is what people understand about the use of their statutory powers, and we're very keen to make sure that local Healthwatch understand all of their statutory powers and, in particular, their ability to campaign on core issues, which has been reaffirmed by Earl Howe and where we are working very closely with the Department of Health to make is sure that guidance is issued as soon as possible to local Healthwatch to set the record straight.

A.B - Thanks very much. So the other issue I wanted to refer to, and invite some of the members to comment on, was the fact that when this report was written we had only done three regional events, of course we've done two more since. One in Manchester and on Monday, this week, in London, and I just wondered whether there were any observations members of the committee wanted to make about those events.

D.S - Yes, I think first of all we were overwhelmed by the positive nature of the meetings. Vast numbers of people. What it has done is firstly recognise that there is this growing Healthwatch family, and we're delighted to be part of that, but also this role as leaders and champions, and there are now quite clearly expectations on Healthwatch England to be seen to be beginning to deliver some of the work. A number of issues, every meeting we go to, something is added to the list. Things like guidance and support on membership of Health and Well-Being boards, on governance, recently on sign-posting. On the skills of chairing a Healthwatch board, all of these things and people are looking towards us to begin to be seen to be producing work, and maybe producing some timetables of when we're going to be do that, but on the whole very positive and something we have ample opportunity to build on and we need to build on.

A.B - Thank you very much. Anybody else? John.

J.C - Yes, I think before the regional events we were being very cautious, not wanting at the start to be telling people in the local area what to do, and I think we did have a proper idea of subsidiary and letting work happen at the bottom, but what we've been hearing at regional events, time after time, is yes, but we don't need to re-invent the wheels, so please can we help with this and that. I think that has influenced our view and our workload.

A.B - I think that's absolutely right and the challenge for Katherine and the team, and we'll come to this in the business plan, will be to maintain a sense of what can be achieved, in what kind of timetable, in relation to everything that people would like us to do. But really helpful to hear it and so clearly from local Healthwatch up and down the country. Are there any other questions or are comments on the report from me. Michael?

M.H - Just to add to our discussions with an off-field trust about the ratings, a new ratings system for the providers of health and social care. It was quite an interesting session and I think we made very strong points to them that social care and health may all have providers but they're quite different beasts, and when they're thinking about the ratings, when they're advising the Departments of Health, they should be asking constantly what use are these ratings going to be to the users of services, and what use will they be

to people like local Healthwatch, who can aggregate different information in order to identify any problems.

A.B - Thank you very much. If there aren't any other comments,
I'll move onto the chief executive's report, Katherine.

K.R Thank you very much and, as I said, this is my first meeting as Chief Executive so first of all I would like to say how delighted I am to be here, and what a wonderful opportunity to shape something from its very beginning. So it's a really wonderful kind of gift as a Chief Executive. I come with ten years of voluntary sector Chief Executive experience in the Family Parenting Institute. Before that I was at the Fawsett society, and before that I was an academic with
the London School of Economics and spent a short spell in central government. So hopefully I can bring some of the skills I have learned over that career to bear at Healthwatch, although it's a first time that I've setup an organisation from fresh, so I'm very much learning as I'm going along and also learning a lot about the health and social care system. So that leads me to my first point,
which is that we are building this particular boat and sailing it at the same time. We are very much still in setup mode ourselves still.
We haven't recruited yet a full staff, but we're moving on that fast and, just to update a couple of things that are new since this report. An advert has gone out for our senior team, our two directors and thank you very much to panel members who are helping with the recruitment process. So for our communication and engagements post Alan Davis is going to be on the panel. From the committee, John has
very kindly agreed to look over the applications as well. We have Simon Blake from Brooke as an external member of that panel. So we've got a great panel being brought together to look at the communications and engagement post, and for the policy and
intelligence post Michael has agreed to be on the panel, with me along with Neil Churchill, who is the Chief Executive of Asthma UK.
Wonderful to have colleagues from the voluntary sector to help us with these critical recruitments and Anna, I know, you have very kindly agreed to look over all of our shortlisted candidates to make sure we get the right people in place. That's where we are with the recruitment. The recruitment is still live. I think, before it closes, I'm going to use every opportunity to encourage as many applicants as possible. I think it closes on the 8th of March and I think we interview on the 22nd and 25th of April. So looking forward to being able to make those critical appointments. Another couple of things just to update that are new since the report. First of all in terms of the support package. We were already pleased by the
amount of uptake of our support package but it's actually grown
since this report was written. So we said that 60 organisations
had requested ‘website in a box’ and I understand that's now 100,
and we have 150 voluntary sector organisations that have signalled that they would like to work with us in future. So a fantastic basis both of uptake, of the support package and also our building of our broader support. And then I am taking mostly the report as read.
Just one final update and then I'll come to the budget, the management accounts for the current year. One final update, and we've had some very interesting thinking about how we can take this locally
and nationally, but I've been asked to sit on the advisory group
on mortality outlines that Sir Bruce Keogh is chairing, and I believe the first meeting of that is going to be on the 11th of March and we will be thinking now because this gives us a very concrete vehicle to make sure that we are communicating with local Healthwatch and picking any concerns from those local Healthwatch groups in those particular areas, but also that we use our new communications tools to make sure people are aware of the work we're doing nationally with Sir Bruce Keogh and colleagues. So the final bit, in terms of the report, just to update on where we are on the budget and management accounts. They're on the final page of this agenda item. One thing that we've been exercised about as a staff and a committee has
been quite a considerable under-spend through this year. Just to give this some context, we were obviously in set-up this year and I think it would be fair to say that the ambitions

about how quickly we were set-up were quite high and we've been, we have set-up but the kind
of, the time-line wasn't quite what was originally anticipated. So, for example, my post, it was anticipated that that would be filled
in July and I arrived January and I guess this is part of the reality
when you get into set-up mode. So part of the variance is that a
full year's budget was earmarked for what is actually not a full year's operation. So I think that variance is normal and while we will make sure that we are using any under-spend wisely for the rest of the year I think it's also important, because it's public money, that we don't just spend because we want to reduce our under-spend, but that we spend strategically so we're making sure that our spend to the end of the year is driven by our strategic needs and set-up for the next year. And also the other issue that we've had is the procurement requirements which apply to us as they do with any other arms length body. It means that our ability to move fast on some of these procurements is limited by government requirements so that's just something to flag.

A.B - Thank you very much. Dag?

D.S - Having spent many years wrestling with the Department of
Health financial rules, what is the situation in relation to under-spending carry forward? Is it a whole budget or does that money go back to the Treasury?

K.R - It goes back to the Treasury so there is no roll forward. But having said that, yes, I think that the Department of Health have been kept well informed about our spend and we are not anticipating any impact in terms of next year's spend.

A.B - Any other questions? I wonder if you could just mention
perhaps also the work being done on escalation policies.

K.R - Yeah so, thank you for the reminder. There are a number
of things in this set-up mode we need to get onto the table quickly so people are clear about what our policies and procedures are, and top of the list has been how local Healthwatch escalate concerns to us, to the CQC and making sure local Healthwatch are clear where there are safeguarding issues, or where they've got areas where they would wish us to investigate, we need to be very clear as to what our policy is and how that gets escalated. So those policies have been in
preparations and will be published imminently.

A.B - Okay, thanks very much.
If there aren't any other comments? So we will move onto member's updates please. Any reports of work that they've been doing that members would like to give, and I'm mindful of the fact that most members have been very wrapped up indeed with the regional events. We've a very good showing at each and every one of those. So that in itself has been quite a work, but I know there have been some
other things going on too.

D.S - Yes Chair, I attended a legacy event yesterday. It was a LINks legacy event and they've been taking place around the country.
I think the last one is today and that's in Leeds. Reasonable success and very well run and very helpful for those who attended, possibly because they have a LINks, and some Links are not continuing and not as well attended as one would hope, but very well run events and very useful for the people who were there.

A.B - Thanks very much and I think you were saying Katherine, would you like to talk about the LINks database?

K.R - Just to let everybody know that we're exploring the possibility of inheriting the Links data onto our Healthwatch hub and making
sure that that's kept, the database value reports is kept as part of our Healthwatch hub. So that's under exploration at the

moment because I think that people recognise that while Healthwatch
is going to be a new and different organisation, there is a real
keenness to make sure that the legacy and learning of good and bad
practice is carried forward and we're working on the Healthwatch hub to make sure that's reflected there as well.

A.B - That's helpful. Yeah, Christine.

C.V - Just to say that Christine Lenehan, who had to go this afternoon, gave a very interesting talk to the committee at a workshop about working with children and young people, in particular looking at the inequalities and health outcomes, and then that was followed up by another speaker from the National Children's Bureau looking at the ways that we could engage with children and young people and this, I believe, is being carried forward in guidance to local Healthwatch.

A.B - Thank you very much Christine, and that gives me the
opportunity to say that so successful was this that we felt we ought to share it more widely in addition to the guidance. So a quick advertorial. We have our national conference on March the 13th, which is explicitly an event for the Chairs, Chief Execs or equivalents of all the local Healthwatch. So the first time that Healthwatch network will be brought together and we're asking Christine and her colleagues to do some work on children at that event, precisely
because it's one of the new areas of responsibility which Healthwatch
will be taking on which is not as well developed therefore, perhaps,
as other areas of responsibility. So useful dry run for the committee
as something we will use more widely. Any other updates?
No, okay. So I'm going to move onto audit and risk please Jane.

J.M - Thank you very much indeed. Well the audit risk sub-committee of Healthwatch England met for the first time on the 21st of February. I'm joined on that, I am very please to say, by John Carville, David Rogers and Michael Hughes, who bring all sorts of different experience. Some steeped in audit and some less so. But they proved a feisty bunch and you'll be pleased to know Dag, they did ask a question about what was going to happen about the under-spend. The job of the audit committee is to look after probity.
To look after and make sure the money that we've been given indirectly by the taxpayer is used efficiently
and effectively, and to make sure the management has suitably stress-tested what our plans are and what we're doing. So what have we done so far? We've had our first look at the management accounts and an initial look at the discussion about the budget going forward for the year, and, and we did a piece of work on the risk register because it's important for us to know very early on what are the key risks we're facing. We have identified the ones that are on the paper here.
And I think that will then go onto inform our internal audit. It sounds sometimes rather technical, but it is very much for real because if we're saying, for example, that the effective monitoring of data collection and the way we use data is a risk for us. We need to be sure we're doing it in the right way, and we have a slightly
different take on information, in that we're wanting to use it and give it out. Most of the time people are worried about ministers walking into Downing Street with their data on full show to the world's media. We're about, well, how can we share data, safely and properly? So that's to give you a flavour of some of the early work of the audit and risk subcommittee.

A.B - Thanks very much, and as you say this was the first meeting
of our audit and risk committee. Part of whose role then is to exception report to the audit and risk committee of the CQC as the kind of parent of our committee arrangement. Does anyone have any questions or any of the members who went to that meeting have anything to add? No. Everyone content? Great. We're moving through this at an excellent pace, which is great because I want us to focus on the most important business which I think really is around
our business plan, and the items that follow. So we've got more time

for those, which is tremendous. So I'm going to invite you Katherine
to talk about our business plan please.

K.R - Okay. Thank you very much and just to clarify, sorry there's been a bit of wishful thinking crept into the agenda. We're asking members to approve the draft business plan. We're not quite at final business plan at this stage, but I will be talking about the final steps in this process in a little while, but in terms of the status to date, this remains a draft. So it's for comment and for further feed through. This, I'm just going to give a quick recap on activities, business planning activities to date. Clearly at the last committee meeting there was discussion of business planning process and time frame. We've since had a number of events to progress the business plan. A full team workshop, which was the first time we were able to bring the Healthwatch England team together to look at the business plan on the 31st of January, and then the committee
reviewed the output of that at a workshop on the 11th of February,
and I think what came out very clearly from that workshop is the need in this current year to prioritise very keenly. I think the scale of expectation which is a point that members have raised already.
The scale of expectation not only from local Healthwatch but also from providers. The health system and the social care system, and when we get out into the public domain, from the public as well, is no doubt very, very high. But we have only finite resources and what we want to do is make sure we don't spread ourselves too thin and we use these in a very focused fashion. So I think it would be fair to say that was the spirit of the committee's discussion on the 11th of February and since that point, and this is a very much a live process, because one of the references is to a meeting that only happened two days ago, since that point the management team have been meeting to further develop the business plan priorities, look at the budget, activity plan and underlying interdependences, and how we're actually going to deliver this. So what I wanted to do is present a spirit of the thinking we've had to date and obviously then take this as a further round of input before we finally pin down our activities and plans for the coming year. We are also very conscious in terms
of that pinning down process that even this time next year the world will be moving around us. So we need to have some flexibility within the business plan to respond to what comes up anew as the year develops and as we hear new needs from local Healthwatch. So very helpfully we have been pointed by my esteemed chair in the
direction of a number of principles for consumer rights, which have been long established and, I believe, trace their origins back to John F Kennedy, so have some pretty good origins. And are well tested within the consumer rights field although we recognise that the term consumer can be controversial in health and social care so often we use, user or patient or public or person, people instead. Actually one of the very big advantages of using the term consumer is that they come with a series of rights associated with them and a well established framework, and there are eight principles of consumer rights. The right to be heard. The right to redress.
The right to satisfaction of basic needs. Safety. To be informed.
To choose. To be educated and to live in a healthy environment.
Which we think have a lot of read across into the health and social care arena. We need to be testing this through the year and making sure we make that read across transparent to everybody, but we think that the first two are very, very basic rights and where we've been given clear a signal that it would be useful to have Healthwatch England to be a strong consumer champion to make sure that the right to be heard and the right to redress is actually properly embedded
in the health and social care system. So that has led us to a set of
priorities, around our national work as a national consumer champion, as well as around the work we will do to support local Healthwatch.
So we have boiled down all of the expectation and anticipation into
four key priorities. The first is a strand of work around ensuring consumers have the right to be heard. The second is that ensuring consumers can exercise their right to redress, which is obviously the right to be able to complain when services go wrong and have their voices heard and have a proper response, but also have the right to have concerns flagged and have a responsive service. So those are the first two priorities. The third priority is around

supporting local Healthwatch at what is a very key stage of development. And the fourth, which is in recognition that we too are in set-up
mode, is making sure that we establish Healthwatch as an effective
organisation that quickly delivers a real difference in the health and social care landscape. So that is a summary of where our
conversations have got to in shaping our priorities. What I'm going to do now, if it's okay, is give a bit more flavour of what we mean by these priorities. In terms of the right to be heard, I think, there are a number of things that I think we want to do around this area. One is speak in our own voice on behalf of consumers as new and
emerging issues arise in the health and social care sphere.
So that's about exercising our own voice as the national champion.
And the second is about the influence we may have across the whole system. And I was very heartened actually, I was at a round table earlier this week where Robert Francis was talking about his report and he spontaneously actually made reference to the fact that Healthwatch alone cannot deliver an engagement of services with the public. What we need to do is be working to influence across the system to make sure the other players, some of whom are substantially larger than us, and with much bigger budgets, are taking the notion that consumers need to be heard very seriously. So in order to deliver that function what we want to do is a number of pieces of work which really demonstrate what good consumer involvement looks like and ensure that others develop that practice so we would be both spot-lighting good practice that already exists and encouraging and exalting other system players to take that on board. And a critical part of that relationship will be with the NHS commissioning board.
The other piece of work that we will be doing as a national body to
exercise our own voice on behalf of consumers, is publishing our first annual report and we will be laying that in front of Parliament in the autumn and that will really be a benchmark for us where we will bring together a kind of state of the nation report on consumer views and experience of health and social care, and we're particularly conscious of our duty to voice the concerns of the most vulnerable and those that are seldom heard and we will be looking in particular in that report, doing some deep dive work on voice for those that are seldom heard around children in particular and other vulnerable groups and we are working on what those groups look
like at the moment and that will be a point where it will be very useful to get the committee views today but also for the team to have a bit more time to refine that what deep dive work will look like
within the annual report. So that's about the right to be heard.
The second right that I've referred to before is about the right to
redress and that's about as I said, the ability of users of health and social care to raise complaints, but also concerns and actually to work upstream to stop things escalating to a point where they're so serious that you have to raise a complaint and again what we're trying to do is do our independent national advocacy work here, but also work with others around good practice. So critical for us in this is actually establishing what works and what needs improving in order for concerns and complaints to be heard and dealt with. And we will be working in partnership with local Healthwatch, so we will be going out to collect evidence on what local Healthwatch are hearing about what works and what needs to be fixed in the concerns and complaints system and then a second stream in terms of vulnerability.
So vulnerable groups. Groups seldom heard and vulnerable groups and children, what is their experience of making complaints and raising concerns and I'm always conscious that there are many, many
more concerns that never get voiced than there are ever get voiced.
So making sure we work with those groups that have never complained or raised concerns to hear what their experiences are and what would make it easier for them to do that, and then I think in terms of us,
we talked already about local Healthwatch statutory powers but in
terms of us using our statutory powers, I think we are keen over this year to use our statutory powers which is to provide advice to other players right across health and social care system and including to the Secretary of State to provide advice as to what needs to be put right in order for consumers to have the right to redress. And in terms of that sort of push to make sure we get systems improvements, we're wanting to use this work around

complaints and concerns with local Healthwatch as well to support them to act similarly at local level. So we've heard a lot from the regional events about the desire for local Healthwatch to use their place on the health and wellbeing board effectively. To influence policy locally and we think complaints and concerns is a very good topic area for us to work on as a national body but also supporting local Healthwatch
to do similarly at a local level. And then the final piece of work
around this will be tracking progress on key recommendations that flow from the Francis report regarding a good complaints system with redress to make sure that others in the system are taking their duties and recommendations that Francis makes on them seriously. Shall I keep going to the end? So just to then talk through our remaining two priorities. The third around making sure we offer appropriate support to local Healthwatch at what is a very critical
stage in their development and there are a number of ways that we will be doing this. I think the first is about developing a really vibrant Healthwatch network and one that grows and grows its own support as well as one which we support, and again I think we've
had some fantastic examples of where already there are groups,
communities of interest emerging. Regional groups emerging and
we clearly see a need for us to support that process and let it
flourish, lead and let it flourish. So we have already started work on the local Healthwatch network but we will be continuing
that through 2013/14. We have also heard from the regional events some very clear priorities from local Healthwatch in terms of what they need and we list a few here, but the list gets longer everytime we go out but we clearly need to deliver on this as a minimum and we need to have a conversation about what else we maybe able to deliver on.
There's a set of work around setup and governance is a very strong theme there. Making sure that people get it right from the start in terms of their own governance arrangements. We clearly need to do a piece of work around how local Healthwatch influence commissioning and there've been a number of points raised about how they can best work with clinical commissioning groups and so we need to build good practice around how local Healthwatch can influence commissioning and then, of course, a new role, very important one, but a new tool in the box of local Healthwatch, which is their place on the health and wellbeing board, we will be working to train and support local
Healthwatch to be active members and influential members of the Health and Wellbeing Board. And I think it's already been referred to, but support around what is a new responsibility, which is for children. So, training, we're looking at exactly what the mix of that training and support looks like. How much face to face? How many virtually, and again that's a matter of debate, and it would be really useful to get committee views at this stage, but clearly we would need to be delivering that as a minimum package of support and then picking up on the point that John Carville raised earlier about the need for leadership - I think we've taken very clearly from
our regional events the need for our leadership of the Healthwatch
network in terms of establishing basic standards and good practice amongst local Healthwatch and enabling local Healthwatch to exercise their full range of statutory functions and there has been a lot of focus on the campaigning regulations but behind that, in a broader set of regulations, we need to make sure that an easy to use guide in terms of statutory functions, both for us as a national body, but also for local Healthwatch because we want to make sure that local
Healthwatch are using the full range of their statutory functions at a local level. We need to also make sure that local Healthwatch are clear what they do when they want to escalate concerns, something I referred to earlier. And then the final point, but a very critical one, is making sure that we gather data and intelligence from
local Healthwatch so that we can spot emerging issues, but that also we enable them to understand how their local experience fits within a national picture, and Michael and I had another very useful conversation about how we might do that this morning to make sure that when people are sitting within their local Healthwatch groups they know whether they sit high, low, average, so that they can be empowered to act in the most appropriate way locally. And then finally there is a group of work around how we build ourselves as

an effective organisation. This business planning process, I think it would be fair to say, has been done in a short time-line where we haven't had the time to do the full consultation and full public
engagement that we'd like to do in the future. So one of the things that we need to do is develop a strategy and lead by example in terms
of how we engage with beneficiaries. So we will be doing a major
piece of strategic work during the year. We will also make sure that we are effective by adding value and that is by always asking the question, are there others better suited to deliver this work where we could work in partnership? So we will be making sure we develop
good partnerships with providers, with professional bodies, with the
voluntary sector and there have been some very positive steps in all
of those directions and we just need to build on that during this year so that we always add value to what is a very big and complex arena and we also need to make sure that our own policies and
processes are correct, transparent and open to public scrutiny.
So we will be publishing our complaints policy and our whistle
blowing policy on our website very shortly so that everybody is aware
of how we operate in an open and transparent way.

A.B - Okay and I know you've the next steps but I suggest that we
do that as next steps when we finish the conversation.
I wonder, Katherine, if you could take us back to slide five and while I just say, thanks very much for that, in terms of, it has come on in terms of its coherence considerably since we talked about it and since we talked about it last as a committee, but I would like to ask committee members particularly about these four key headings on this slide. And whether you feel content that these kind of encompass what we would want to focus on this year.

D.R - Well, the short answer to that is yes, I do. I like the words that are here. But I want to just add to that by saying that I think we need to, as a committee, we need to keep a pretty rigorous grip on what our priorities are and not allow ourselves to be, to go into all the areas that would be possible to go into, because if we do that we won't be effective as an organisation either in supporting local Healthwatch organisations because they, like us, have limited
resources and that's the real reason why we need to have priorities in the first place. We can't do everything, otherwise we won't do any bit effectively. And I just, with this list that we heard that keeps being added to at the regional events, that's fine and it's understandable that the people are thinking of ways in which we could add value to what is happening locally, but I really think we're going to have to take a long hard look at those and decide what
really is possible and what we can do effectively and what perhaps will at least not be achievable in the first few months and that's sort of internal as to how we operate but I think there's another aspect to this, because in a way, the most important part of what we do is to be effective in making a difference for the people that use health and social care services and again, if we're bogged down or at risk of being bogged down with too many relationships with others and too much structural stuff, if I can put it that way, then I think we're not going to be as effective as we might do in
supporting the real purpose, which is to reflect that consumer voice that you spoke about earlier on. I'm sorry, that sounds almost like
a council of despair before we start. It's not intended to. I think it's quite right that all these ideas are coming forward and it's good that they are, but we will have to tread carefully in order to
not end up disappointing people in the medium term.

A.B - I think it's a terribly important point, David, and don't
apologise for making it at all. I think it's one that we're going to
have to be very disciplined about making for ourselves as the year progresses. There is going to have to be a kind of "one in one out" rule at the very least and maybe more if we have some big additional demands that crop up during the course of the year. So we really

need to be careful not to overburden the staff and to keep our focus clear. I completely agree. Patrick.

P.V - In terms of the four priorities. I think they're all important
and even though there's lots of expectations and demands in terms
of what we should be doing, all the things that people want, the question for us is which one do we prioritise in terms of deliverables which people expect and what we can do and obviously that boils down to resources and timescales. I think if we can remember chair, at the very first meeting we had in Leeds, we started to articulate what it really meant on the ground in terms of priorities and for me in terms of particularly the first priority which is about those consumers, those service users and carers who are not heard, to me that's very important. So we have to demonstrate working and supporting local Healthwatch groups, the work that we do at a national and regional level, that particularly my kind of area of interest is around mental health being in communities, that they feel that they are heard. They feel that Healthwatch is for them. So, as long as we demonstrate in terms of the work local Healthwatch, what they do. I mean we've already heard some good examples of some local Healthwatch, of what they intend to do, which is fantastic, so our job is to support them and at the same time, the work that we do at a national level. And I'm sure if Alan was here, he would be talking about stuff around people with disabilities and sight loss, as well in terms of what we do to make sure that people feel that Healthwatch is for them. So I think the priorities are right and it's about how we deliver those priorities and the perception of how people feel about those priorities and what we do.

A. B - Thanks very much Patrick. All important points and I think speak to particularly the detail around the right to be heard area. Dag.

D.S - Isn't it good that there's more to than we're able to do? Be awful if it was the other way around. Obviously in terms of the four priorities. I strongly support them. Particularly like to stress the
support local Healthwatch at this stage, key development stage and
you've mentioned already ways of doing this, whether it's through
supporting regional groups or interest in special areas but I think at this particular point in time that's really a high priority which may well change as people get bedded in.

A.B - John.

J.C - Yeah, I think we should expect these priorities to change.
In the end we'll be wanting to find things out that are going wrong and put them right. To find things going right and to spread them but at this stage what's going to make us special is that
we're a statutory body at the centre of a network of local Healthwatch groups and those local Healthwatch groups have to be
setup and they have to work well and for them times to reinvent the
same wheel and they have asked for help and we can help them do it, at this stage it's appropriate for us to do it. So that might be less exciting than what we might be doing in a year's time, which is finding out something terrible and hammering it and whatever our style will turn out to be, but it's right to be doing the preparation at the moment.

A.B - Okay. Thanks very much. So I'm hearing general support for these four categories and people saying it will all boil down
to the balance that we attach, the importance that we attach to
these and also for the things that we do under each of them. So I'm wondering if we can move onto the next slide. This is the right to be heard. And I think your point there John about identifying new and emerging issues, that's really in the first bullet here which we may not have so much of to start with but we want to be very alert to and it is clearly a core part of our role. Do these three things feel to you to be the right territory, because what the staff will need to do is go away and put flesh on this and clarity about what they're going to do and deliver for us and for the network generally, following this conversation? So do these feel broadly right? Yeah, Dave.

Dave S – Yes, they do. And I know you've alluded once or perhaps twice about the concept of a consumer, as opposed to some of the
previous patient and public involvement with the emphasis being very much on the patient or the service user. I do think it's really important that we explain that wider concept of consumer voice as part of this work because there will be consumers of health service that aren't necessarily patients, people accessing GP services or
people who aren't ill at the moment but want to make sure that
when they are there will be a minor injuries unit or an emergency
department available for them at the time that they want, as these people do have a strong interest in the future of their health and social care services. So I really want to emphasise the difference about this approach that Healthwatch is doing in terms of widening the public voice in determining how their health and social care services are going to be shaped.

A.B - I think that's a really helpful point David and perhaps
speaks to the kind of introductory commentary for the business plan when we do it, and also the piece that I know you have in your sights which I have seen previously appear under the effective organisation heading which is about kind of giving some life to what these consumer principles might mean for health and social care. Any other?

M.H - The previous slide referred to the new health service and the changing health service and obviously after April the 1st, there will be a lot of change. And I think the second bullet point's about what good consumer involvement, demonstrating what good consumer involvement looks like is going to be very important because there will be lots of agencies, commissioners, providers, et cetera. We've all got to involve consumers. Only Healthwatch is there to maintain some sort of overview of that involvement and I think during the earlier years that's going to be vital.

A.B - Thank you very much and I think this is the space in which,
you've mentioned particularly the NHS commissioning board, but I think this is the space in which thinking about particularly the
commissioning of specialised services and patient and public involvement in respect of those. That's where this would fall. I know some people are keen to know how we'll be engaging with those issues.
Okay, so can I move onto the next slide. So the right to redress.
I think of all the things that we're proposing to do, it's probably the one that the staff have got their heads most wrapped around in terms of what would need to be done. Kind of more advanced plans.
Anyone want to add anything here? Jane.

J.M - Yes I think this is one we can all get our brains around
and I think this would really be a good one for us to make sure that, by the end of the year, we've actually, we've got some progress to show. Wouldn't it be wonderful if, in the next year, we could effect some change in the culture? So that the word complaint isn't used so much. So there is much more the idea of feedback and learning about how things have gone wrong and, in the medical and social care professionals actually wanting to learn how things could be done better. So although I think it's a really good one for us to do there is also a big, big cultural issue underlying this that we don't want to underestimate.

A.B - And of course that's a major theme of Francis.
I think the cultural things that always horrifies me with complaints
is that, that service providers think their target should be to reduce the number, whereas actually in a more commercial context what one would want to do is maximise the information you get from
consumers so that you learn about the service and are able better to improve it. I mean, that's a really deep, cultural thing, I mean, let's get the numbers down because you've got less complaints, it's less of a problem. They're not actually the best indicator.
Yes, Christine.

C.V - Reading this, it just seems to me that this is a vast

field and really in order to be effective one's going to have to drill down and pick out one or two things and for myself, I think I would go with supporting local Healthwatch because we could really get some good examples at ground floor level then that could be disseminated and built on.

A.B - Okay, and Patrick.

P.V - Yeah I think one of the things at local level in terms of
local Healthwatch is about signposting so we can support local
Healthwatch and signpost so consumers feel that they are now aware
that they have redress, because obviously it's a change in landscape as we all know, around reorganisation of health and social care.
So people need to be updated where they can go and I think for us also because of our statutory powers, we need to articulate that clearly, what does that mean for the public and for the local Healthwatch and stake holders, so that we understand what we can do and what we can influence and escalate upwards, downwards as well.

Dave S - I wonder whether, I know it's not part of the core
Healthwatch remit but the complaints advocacy service, which is going through change, where it moves from a national system of being commissioned through to a localised one and obviously it's going to have a lot of cross-over with Healthwatch and I think the information that that generates will be very important and provide perhaps, as it moves into a change, some challenges but I think also it provides some great opportunity for the intelligence that brings out and to inform, across the whole system, a better use of the complaints data.
So I just want to make sure we have that referenced in.

A.B - Thanks and indeed we heard this morning from Lambeth,
I believe it was, the local authority were making it part of the consumer complaints advocacy service, a requirement that they share that data with the local Healthwatch which must be a helpful way forward. Dag.

D.S - Just picking up on Dave's point. The nationally commissioned
NHS advocacy system wasn't terribly effective at bringing up good
information on complaints and how to learn from them. It'll of course now be up to local authorities in their individual commissionings.
So I hope that that message is being learned and there will be better
information so that people can learn from complaints in that system but history hasn't been too good.
A.B - So I think we've probably talked about this one quite a lot more than others. It's been on the list for a while. I think what you're actually hearing from the committee is that this is a big landscape and we need to be quite clear about perhaps what we are going to try to achieve in the first year and thinking that perhaps something in this space might take us more than a year to achieve, I think is a reasonable proposition. So not just one year's worth of work. So let's not try to do it all in the first year. We might signpost what it is we want to do beyond the first year, but focus
really clearly on a few things in the first period. So moving on.
This is local Healthwatch. One area where we don't need more great ideas. We have an awful lot but is there anything obviously missing in this or anything in here which committee members think we ought to give a lower priority to? Dave.

Dave S - Sadly not a lower priority to. I just want to draw your attention to, particularly, on the second bullet point, where you refer to the leadership and support to local Healthwatch on some of the priorities and their role in health and wellbeing boards I think is quite important and some clarification and support to understand the guidance, following the regulations that's come out, would be something that we need to pay some early attention to.

A.B - Okay and I think of several, I think that's one of the ones that we have better in our sights already. That's right Susan.

Okay. I'm going to move us on again, if that's okay, to setting up our own organisation. Any comments here? Dag.

D.S - Again coming back and I'll link this with a previous point.
It's when other people give us our priorities. Refer to recent publications, two publications this week from the national commissioning board in relation to place. That's the Patient Led Assessment of the Care Environment which is going to start in April and will be in every hospital in the country and will involve, if they wish to be, local Healthwatch and the publications that the commissioning boards produced this week, I think it's Monday and Tuesday, refer to the role that Healthwatch will have in training assessors. I just wonder whether that's another priority or another thing being added to our list, whether there was actually any previous discussion with the National Commissioning Board that they were going to do that?

A.B - Katherine.

K.R - Well, I'm not aware. That's not to say there hasn't been.
I have to say that there are a number of colleagues from across the
field that are very generously giving us responsibilities.
Not necessarily always citing us in advance and I do think this refers to the point made earlier about the scale of expectation.
I think part of it is because we are the newest game in town and people would quite like us to solve problems that nobody else has been able to solve before and, I think, we need to be careful about how we manage that expectation and ask them about why those problems haven't been solved before and what was going on there. But it also refers to the point that Anna was making earlier and we will be looking to our sponsor department, Department of Health, but others across government to help with some of this because we can't constantly monitor, I mean we are monitoring as much as possible the environment, but it's a very big environment so we need to ask colleagues across government as well to help us to make sure that when a new responsibility for Healthwatch are being discussed that we get involved at an early stage and I have to say that because it
was our first sponsorship meeting, the Department of Health seemed very live to that as an issue and I'm sure will take that away and make sure that across the arms length bodies, but also we've had mentions in other parts of government that there is some coordinated process of involving and engaging us.

A.B - Thanks very much, any other observations on this? So Katherine, I wonder if you could take us to the last slide and next
step so we can see what is going to happen over the next period.

K.R - Sorry, I haven't got my microphone. Sorry, I'll start again.
One of the things I've heard from committee members is about a real
concern about making sure we add value at all points because we work
in a very big environment and where lots of people are active already and one of the things we need to do in developing these plans further
is make sure we are aware of the existing work and making sure we are
adding value at all times. I think the other thing that I've heard is some, even having refined these priorities some of them will take a long timescale to deliver, so it's about clarity and what we can deliver within the current year and where our long-term horizons might sit, which the committee will come back around when we discuss our strategy. And the final thing I've taken from the reflection is David's reminder that, and something that I say repeatedly but forgot to say this time, which is we need to define success in terms of the difference that we make for consumers and a strong reminder to us to make sure that that's clear in all of our documentation and indeed in the way we work. So in terms of the next steps we will be refining the priorities further on the basis of the conversation today. We are taking the budget through a further stage of development and we will be doing the activity planning and further budget planning and peer
challenge on both of those to make sure that our time lines are realistic and achievable, and we will be bringing that back to the committee workshop for a further round of

consideration towards the end of March. We will also be doing some tests out with key partners.
This is not a full consultation, or full engagement clearly, but within the timescale test out with key partners, clearly with the Department of Health, with the CQC, with the commissioning board monitor as some of the named key partners in our statutory powers, but also with some of our key partners in the voluntary sector and indeed local Healthwatch. So a round of critical discussions, really as our business planning, is being finalised to make sure it feels right from their point of view as well. So we will be presenting a finalised business plan and budget in late March and then we will make sure that we put our business plan on our website and circulate it amongst our key stakeholders, because ultimately it's the document by which members of the public, local Healthwatch, any other stakeholders, will be able to hold us to account and make sure that they're holding our feet to the fire for delivery as well and that's a very critical part of this work.
A.B - Thanks very much, I think an important phase beyond this and you referred to it, it's the communications around the business plan because this is going to be one of the only ways in which we can begin to manage those expectations. So being really clear what we're going to do and what we're not going to do actually is going to be the first occasion on which we're going to be able to talk about that to all those who have high expectations of us and I think local Healthwatch will find themselves in the same position, having to be equally clear about what they're going to do and what they're not going to do. So I think the communications dimension also needs to be considered very carefully and maybe ask when you bring it back to us in March, bring a communications plan for it too so we are clear we're doing that alongside. But then the other thing, having just added to the task is just to say thank you very much to you and the team because you didn't start until January the 14th, six weeks in, I think we've got something that really is shaping up and the test of the business plan priorities for me is when you can remember what they are and if you can repeat them regularly and often to people and the day after they first emerged in this short form I found myself using them. So that's a good sign. So thanks very much for doing the shaping work and I know that the team have generally had to jump to and fill in the detail and there is more to do over the next six weeks. So no small task, so thanks very much to everyone for that because it's coming together really well. I am going to move us on. If everyone is content. To Strategic Partnerships. I'm afraid you again Katherine.

K.R - Yeah, sorry, so, just to remind everybody, we have a range of key strategic partnerships obviously with the Care Quality Commission, with the Department of Health, with Monitor, with the Commissioning Board and the one that I'm going to talk through today which is our strategic partnership with the local government association because this is the one which we feel is ready for sign off effectively. So since I've been in post we've been doing some work with the local government association to clarify our joint responsibilities for the success of local Healthwatch as well as our independent roles, and I just wanted to reflect back where the conversations had come to and you should expect the other key strategic partnerships to be presented in similar form at future meetings, as we work through those, so there is a clarity about how we're going to work with all of these complex system players as we go forward. So I think what has been very heartening about coming in fresh to the working relationship with the Local Government Association has been that we've been able to go back to first principles and thinking about what we hold in common and I think that I have listed them out here really and they are many actually. So not only about a vibrant Healthwatch but also about making sure we get the best possible health and social outcomes for all users and a shared concern with meeting the needs of the most vulnerable, and like us, the LGA believe that if we meet the needs of the most vulnerable we also will get a system that's well designed for everyone else. So there's obviously a joint commitment to not only support local Healthwatch but be led by their needs and we have a common belief that peer and sector led improvement is the most likely thing to deliver change in practice. So a sort of top down approach is unlikely to deliver changes in practice. What we want to do is make sure we empower others to lead the improvement at a grass roots level as much as possible and I think that we have that very much in common. Combined with that we also recognise

that whilst we will have lots of beacons of good and best practice, there will be other situations in which local Healthwatch is struggling for a whole variety of reasons and we'll need to deliver tailored additional
support in those circumstances. So that's, I think, our joint starting point. What that means is we have a common purpose which is ensuring that local Healthwatch is an effective, independent consumer champion that makes a demonstrable difference to consumers of health and social care. And I have to say, that although there is often scepticism in the system, I think we have a fresh opportunity here that the LGA absolutely share that notion of a fresh opportunity to make a real demonstrable difference through local Healthwatch. So just to run through in a bit more detail what that means in practice. So we have a common interest in making sure we have capacity. We build the capacity of local Healthwatch. We disseminate good practice. That we definitely shared expertise and communities of interest. And that we develop an understanding, a common understanding of how ready Healthwatch are to deliver and that not only means them being commissioned but them also being fit for purpose in delivery and where there are areas of concern. Having said all of that about our commonality we also had a very grown up conversation about how distinct our roles were as well and where we
had different sets of interests and different roles. So there are two sides to this chain if you like. The first is that the Local
Government Association holds the ring on supporting commissioners to make sure that they commission in the best possible way and also drive good practice and continuous improvement in local Healthwatch and at the risk of embarrassing colleagues in the room we had a good example of that from Bexley earlier on when actually the commissioning relationship is not seen as, we have signed your cheque
and off you go. It's seen as a continuous support and lots of shared resources there. So I think that that, getting commissioning right is going to be absolutely critical to an effective local Healthwatch.
So that's the LGA side of the equation, and our side of the equation
is about supporting the development of the capacity of local Healthwatch to act as a consumer champion. But also to raising awareness of its role, so in making sure the engagement happens correctly with local people and communities. So what that means is that we are exploring a number of areas of direct partnership working together. So, we will be continuing to deliver independent programmes which are complimentary to one other according to those roles, but that we're also looking at how we can deliver together as partners.
Just to make reference, we've not made any final decision on any of these yet. And we are still at the planning stage but the kind of things we've been discussing have been around joint troubleshooting.
Around explaining the local health and social care landscape. About making clear the role of Healthwatch in terms of overview and
scrutiny around complaints, again we have a long list. Working with
clinical commissioning groups. The development of health and wellbeing boards. So both sides of the equation to present a really rounded picture. Around supporting Healthwatch providers and commissioners where areas are new or otherwise neglected. And we've identified a couple as a sort of starter for ten. Children being one.
Social care being another, and this is where LGA comes with a long history of experience but the conversation sometimes can be heavily weighted towards health and it's really important that we get a rebalancing, so we take both our roles seriously. And then some specific kind of staged areas of concern that I think are arising from the ground and from the LGA's long experience which is
around the transition to adulthood. So those are just some flavours,
this is not a precommitment. It's just some flavour of the joint
work that we've been talking about. So we'll continue to deliver
independently our own programmes of support. LGA to the commissioners and us to local Healthwatch but I think very critical that also we develop these joint products and that gives some flavour of what that might look like.

A.B - Okay, this is obviously mission critical, this relationship in
terms of local Healthwatch and I really like the fact that this is

starting at the top from principle rather than at the bottom with kind of a process and detail. But we will nevertheless need to put
all this into some form which has the substance of a more
comprehensive agreement. So what is the timetable for that process now Katherine?

K.R - So we have a framework kind of agreement between us which is
developed on these principles. Sorry, I should have said at the
beginning that we developed all of this slide pack jointly in true partnership fashion. The LGA weren't able to co-present to the committee today but it is a jointly developed presentation. And so the spirit of this will be reflected in a partnership agreement
with the LGA and we hope to sign that off before the 1st of April.
So before the end of the financial year. So that we've got that one in the bag and we have then, we have also kickstarted the work in terms of developing the actual business delivery that will sit alongside that commitment to joint partnership which will feed into
our own business plan. So you'll see the elements of joint delivery with the LGA reflected in our business plan as well.

A.B - So questions? Michael.

M.H - Mine is more a comment really because I think this, the joint working with the LGA has got to be welcomed. I think one of the things that came from selling my experience to the regional workshops was the number of commissioners who want to keep a relationship with the local Healthwatch after commissioning has taken place and don't want to forget about them until two years later. So I think if we have the LGA working with us that will really help.

A.B - I have Dave and then Dag.

Dave S - It was on the list of areas for direct partnership working
and perhaps it's a little concern of mine but on the bulletpoint where they want to look at complaints, I wonder what scope there was for building into that about relationships with the quality
surveillance groups and the input to them because it strikes me that local Healthwatch and local authorities are being expected to put into that and it strikes me that we could look at how we could encourage people to share resources and inputs and reduce duplications there.

K.R - I just wonder whether it's worth me coming back on that specifically because it's worded quite loosely, it's one word actually on the page but actually it makes reference to the point that was being made earlier about the complaints advocacy service and the recommissioning of that because clearly our understanding of the landscape needs to be informed by what's happening on the new commissioning of complaints advocacy and both the data sharing point but also what the provision looks like at a grassroots level and again I think that's where we could, with them, develop a map of the
changing environment on complaints as well as on local Healthwatch.
D.S - So to echo Dave's point on quality surveillance groups and the link with quality, it would be interesting to do some work on that
in a few months time and see how, how that's worked but obviously you
can't have all the detail in this but I presume that developing work will take place on the joint needs, assessment, health and wellbeing
strategies and that is, that will be part and parcel of the relationship.

A.B - Patrick and then Jane.

P.V - I'm not sure if it's implied in the areas of work but I
think one area for which some of us who are elected representatives is actually, which didn't happen with LINks, is engaging with councillors around the broader leadership of peace. So what would be quite important is, as we have to engage with all stakeholders, I think councillors, because they'll have a key role and because obviously the whole stuff around devolution and the relationship

between local government and local Healthwatch, I think local councillors need to be updated on what's happening and the progress and also to advise them, so they can support their local Healthwatch.
Because that didn't really happen. There was some examples where some councillors did support but the majority weren't aware of Links and we don't want to make those same mistakes and I think it's very important that elected representatives and potential and future elected representatives support their local Healthwatch. It should be their manifesto, I don't know.

A.B - Thanks Patrick. Jane and then John.

J.M - I think my point follows on from Patrick's. In that we have heard a lot about health and wellbeing board and they are obviously a crucial place for the local Healthwatch person to be involved. There is, we've had a lot of different models about how many politicians and sub committees, and I am just wondering here, Katherine, where it says here rather sweetly, supporting the development of health and wellbeing boards, might as well beef that up a little bit. Getting a grip on. And making sure the health and wellbeing boards really do what it says on their particular tin.

J.C - I was just a little bit nervous that it looked as if everything was going to be managed. When actually there ought to be some trouble. This is the old journalist speaking, I'm sorry, local authorities are the providers of services as well as the commissioners of Healthwatch which are going to keep a watch on it all. And I won't be at all surprised if there weren't difficulties and tensions at local level. Clearly, having a feisty independent local Healthwatch is important and that's very different to having an oppositionist, perpetually negative one. But those are relationships that are going to have to be worked out locally. So we're not trying to sort of manage everything so all the passion goes away, are we?

K.R – Absolutely not John, I mean, I think the part the work that needs to be done as next stage in this, is about working through some scenarios where we will have some tensions at a national level, between potential tensions and exploring what we, how we will behave at a national level where we will have to speak with an independent voice for, independent and different voice from the LGA. We've had some of those conversations already but there may well be an opportunity for us to work jointly at a committee level and the equivalent representatives from the LGA to actually explore how we would manage scenarios and develop those because I think actually by doing that at a national level we begin to role model some of the practices we would expect to see at a local level. One of the things I'd say is, and this is my voluntary sector background. One of the things I'm absolutely assured by is local Healthwatch ability to bite the hand that feeds it in an effective way, in other words, speak truth to power when it's necessary and I have to say that given that a lot of these contracts are commissioned from the voluntary sector, the voluntary sector has hundreds of years of experience of biting the hand that feeds it and doing that effectively in a way that manages ongoing relationship but is challenging. So I think that we need to have a further exploration at a national level of, actually we will need to be making separate sorts of statements and saying things differently from the local government association without losing sight of this ongoing programme of work and I think that that hopefully will role model what needs to happen locally.

A.B - I think one of the important things about this level of agreement, and I think you're absolutely right John, and very important to raise the question of tension, but one of the points about this agreement is to make sure that we have tension around the right things rather than the wrong things, because where we really ought to be working together because we've common interest we should know how we're doing that and get on with it so that we can argue about the important stuff when we need to seems to me to be the opportunity here. David.

D.R - I was grateful to John for providing me with opportunities to present a more balanced view which is a requirement of a broadcast journalist maybe not so much in the print world. That was a very selective description of the situation because in the field of adult social care local authorities are largely not providers. They are commissioners and therefore we would expect, as Healthwatch England, to have a similar relationship with them as with clinical commissioning groups, with the National Commissioning Board, and various other commissioners. So I'm sure you would recognise this John as being important to have a balanced view of the whole situation.

J.C - When asked to choose between right and wrong you always try to streak a balance.

D.R - Indeed and the important thing and again I acknowledge your point about journalists, you are interested in points of difference and seeking to emphasise them and where agreement can be reached and where real progress can be made that's not perhaps such a good story.

A.B - I'm going to intervene between my colleagues on my left. I don't think this is a matter of opposition. We need to have both and strong working relationships and that requires us to have some important mutual understanding and what is important about this document is it lays out the basis for those mutual understandings in a way which we of course haven't previously had and which help us to, in a harmonious way, provide support to local Healthwatch and that's the primary focus of this document as it stands. It's providing support to local Healthwatch such that they don't get inundated from two separate bodies but get a kind of coherent set of support from both us and the local authority side. But I think john's point is well made that there will be points of difference and we also need to have a little bit of thought about how we handle those and that's what you're really saying will be the next phase of work which we will look forward to seeing in due course. Am I safe to move on? Yes? So I'm going to move this on then to local Healthwatch, a progress update and I think that's you Susan.

S.R - The report this afternoon on a piece of work that we've been undertaking and working with local authorities and local Healthwatches for two reasons. One is to make sure that they understood the full extent of our support offer and how that is developing and secondly to find out where they are in the stage of commissioning so that we are aware of the progress in that area and able to provide support as required. So firstly just talking about our support offer. We were speaking to local authorities and some local Healthwatches because they're all in a different state of development at the moment and what we wanted to talk to them about was our support offer, including the brand which we know a hundred percent of local authorities have taken up. The branding guidelines, but we also wanted to talk to them about the branding centre which will be available from mid March which will enable them to produce really high quality branded products, particularly for use after April launching. We wanted also to talk to them about the website in a box and we are very pleased to report that over a hundred organisations have expressed interest in this now. And we wanted to point them to the comprehensive guidance that we have on it this and the development of a short film to help them to download this successively. We also talked to them about the communications toolkit that is also available on our website. And that's there to help them with their messaging and in use alongside the branding to enable them to really start embedding a really good general recognition of this very pretty brand that we're very proud of and we're seeing around us today and that has been extremely well received. We are also aware that there is a great interest in the Healthwatch hub. Consisting of a data bank and an extranet which is going to be really important for the use of local Healthwatch so they can store information and not only store information but to share it and they will also be able to use the hub to develop communities of interest. To store guidance and policies and facilitate

some of the networking at a virtual level that we've been talking about today. We also wanted to bring to their
attention the enter and view training that we are developing, and this is an extremely important thing for them to know about because some of them have been expressing a great deal of interest in that, and we're piloting that on the 20th of March with five local Healthwatch groups. So I'm pleased to report that our calls were well received. There is a huge appetite for engagement of the network with
Healthwatch England and if any of you have not seen the full offer document it is on our website, but as we presented it at all of our events I think you're probably all aware of it. So that was the first part. And the second part was really to establish the situation in terms of the commissioning of the network. Now, it's very important to say that this is work in progress and this was the position as of last Thursday and this is a just a one dimensional mapping.
Because it's just showing the position of commissioning. It's not really giving you any further detail and we are hoping to produce a number of maps which will then outline in the future the types of organisations that have been commissioned and in the fullness of
time some of the issues they're facing. So we can use this pictorial reference to give us a flavour of what is going on across the network. And I hope that you feel that this is a very useful graphic and something that we can use positively in the future. So at this particular point what we see here is we have commissioned local
Healthwatch groups and on track. There were delays on and there are
some we have not yet got feedback from. So what I would really like to draw your attention to is the large amount of green which is a very encouraging sign on this map and also to tell you that within the week the numbers have changed. It's a very fast changing situation at the moment because we're in a state of commissioning and there is what is called the cooling-off period and sometimes when we spoke to the locality authorities they couldn't give us a definitive outcome because they were in that cooling-off period when they had offered a tender but there was a period where people could contest
that. So the numbers have slightly changed now. So what I can tell you now is there is which are commissioned. So as I say, a very fast changing picture but one that's looking very positive and I think as we heard this morning from Bexley, although the tender was only awarded on Monday they're feeling quite confident about the future.
So I hope you feel this is a very good place that we are at the moment. Thank you.

A.B - Thanks very much Susan. Do you have a sense of when this exercise of calling around and collecting the information will be completed by? I know it's not entirely in our hands. But when do you think we might have the full picture?

S.R - Well, it is ever changing. There are only three that we haven't made any contact with and we are waiting for calls back from a number
of organisations who are going through this cooling-off period. What we would like to do is produce a new map for the conference on the 13th of March to give an updated position.

A.B - Thanks very much. Any questions or comments from colleagues?
Dave.

Dave S - Nothing like a map to get the attention. I'm pretty sure from some conversations I've had with people I know in the south of England that some of the blue bits down here are probably red and some of the red bits are probably green by now. But I am chasing that up but I do think that by the time we get to the 13th conference that it'll be overwhelmingly green, even if they are two different shades.

A.B - I think one of the things we will have as a result of this exercise is the first, actually only picture across the country of
the way local Healthwatch is shaping up and I mean, it is absolutely
our intention to share that, but also to use it to give us information as the year passes, as you say, about the things that are emerging for these local Healthwatches, and the way they are using their funds and the priorities they are attaching and so on. So this is very, very, a great visual, but in due course we will have a great deal more substance behind this which will give us a much richer

picture of who they are and what they're up to, won't we?

S.R - Yeah as I said, this is very much a starting point and what we would like to do is develop a map that we can click into so we can
see various elements of the Healthwatch. Maybe their priorities, some of the issues they are facing and some of the problems that they're having so we can encourage networking and the communities of interest that we've discussed and certainly the feedback we are getting is that that's one of the most important things that we can help them with. The sharing of good practice, the sharing of dealing with issues. So yeah that's something we'll be moving on with as soon as we can.

A.B - I think I'm right in saying is that, what this is allowing us to do is build a contact list of Chairs and Chief Execs, or their equivalents, in each of the local Healthwatch, and our intention is to share that with everyone on the list so they can begin to talk to each other is that right?

S.R - Absolutely, behind this is a data base where we're collecting that information. And since the events we've been getting a lot more proactive communication, which has been really helpful and that is something we can send out in our newsletters and inviting people to events, but we will be able to share it so the network can get in touch with each other and we are already finding that people are contacting us and we're able to start putting them together and we are able to start sharing common interests already.

A.B - Okay. Thanks very much. Dag?

D.S - One of the interesting things we picked up over the regional meetings, and particularly where the light greens and maybe some of the reds, is where local authorities have gone down a particular
track and that wasn't really producing what they thought, so they've gone down another track. And that's often been a more co-operative track locally. So if they've taken a bit of time but they end up with something more fit for purpose than if they had been driven by the timetable solely and they will be a good thing for local Healthwatch.

D.R - Just a little, passing by the yellow and blue. So it would be helpful if Susan could say a little more about that. When it's listed as not contacted does that mean that we, as Healthwatch England, didn't have the capacity to do that or because there was nobody
to contact and with blue, is there any sort of timescale by which you might expect a reply from those you've contacted but are not yet in a position to reply.

S.R - The yellow, that's purely where we were in the programme
of work and how it was distributed and how people were getting on with the phone calls. So that's yellow. So there are only three
that we haven't contacted now. And the blue, we've contacted and we just waiting for some further information to come back, and that's
usually within the cooling-off period.

A.B - I think we have news off the press
from Jane about one of the yellows.

J.M - Yes my county, Northhamptonshire, at our last regional meeting I was able to find somebody in Milton Keynes who knew what was happening in Northamptonsire. They've given me a name and I've given
it to Susan. So this is moving stuff. It's amazing how a good
picture concentrates the mind. Northhamptonshire is no longer yellow.

A.B - I have Patrick and Dave.

P.V - Just two points. I think that's one of the reasons why we've been setup as Healthwatch England now to make sure we've an overview of what's happening at a local level. Because just imagine if Healthwatch local and national setup at the same time, it would just be a

complete chaos. I think that's the reason why some of us in the room were lobbying at the time, so that's really good. So I think the second point is going back to the previous presentation. It would be quite good to have a post-mortem with the LGA to see how did the commission process worked and how it could be improved in the
future because I'm sure there was some key challenges in these areas
and even though we might have greens we want to make sure we have a smooth process and what lessons can be learned for the future.
Because we have different models which will be explored a little bit
later, but I think it would be quite good to get a post-mortem.
A.B - I'm getting big nods from Katherine, I think that's an idea to take away and thanks very much for that. And Dave.

Dave S - Yeah, just to answer David's point on some of the blues. Often people working on the commissioning, it's work in progress and sometimes hasn't been concluded and made some quite good progress but
don't feel able to communicate that to anyone outside of their immediate local government family. So that's what has to happen and
particularly in parts of the country that I'm familiar with that those blue ones are going to be turning green sooner rather than later.

A.B - I can see it's going to be become a matter of pride for committee members that you A, know and B ensure that your local areas are dark green and I am looking forward to the consequence of that.
Speaks to the benefit of having members from all around the country.
Have I got any other contributions? So just to say thanks very much Susan to you and your team for doing that, because I think it's invaluable, obviously very timely as people are being properly commissioned. So we look forward to seeing the next phases and kept in touch with its development. So I'm delighted to say that we
are running early and this is what I wanted to achieve because the next item on the agenda is an open discussion on the Francis report and I felt we didn't have enough time available to do that report justice. So to have a bit more time I think is hugely helpful.
And I want to start with a couple of general observations about the
Francis report. And the first thing to say is that that what happened at Mid Staffs, it's worth stopping for a second to note that only this afternoon Mid Staffs has gone into administration and what
happened in Mid Staffs was completely unacceptable, but perhaps what is more unacceptable for us, as a body focussed on consumers, is that if it had not been for the very dogged and incredibly brave persistence of the family and friends of those who had suffered at Mid Staffs persisting with their case, this would not have been picked up in the way that it was. So I think we all owe them a debt of gratitude. And I think it was something that we need to bear very much in mind in terms of the way we behave if we feel we're not getting the sort of traction that we need to get, both at national and local level. Having said that, it's been a long journey from the point that it became a public issue to the point where
we received the final version of the Francis report. Probably only two weeks ago now, maybe slightly longer. But it is a very important report and it's a very important report for us because it so clearly puts the patient at the centre of the system, and he says over and over again through that report how important it is that the system, health and social care, really takes people to its heart and starts with their needs and responds to their experiences, their concerns and their complaints and he talks about both and, of course, it goes without saying, that we share that priority and it means above all else we welcome the Francis report. It puts our concern centre
stage and that's hugely important. But perhaps in a way, going a
bit further than that, we feel that the very existence of Healthwatch, national and local, is in part an early response to what happened at Mid Staffs and the importance therefore of us doing our job really, really well and being very focussed on what consumers needs in health and social care experiences is like and ensuring that their concerns and complaints are properly taken account of. Having said that, it's an extremely long report, as anyone who has tried
to pick it up, leave alone read it, with a very large number of

recommendations. So what I would like us to do today is two things.
The first is, that as the committee members know, we had a quick run
through of the specific issues which the Francis report raises in relation to local Healthwatch and Healthwatch so I just want to play back to the committee where we landed on those and check before the staff go off to draft a response to the Francis report, as we will be doing to unsure that we've landed in a place that you are comfortable with. So the first thing I am going to do is run through those key recommendations and what I think are the emerging thoughts that the committee has had. And the second thing is do a tour de table of the committee members and invite everyone to give us their first thoughts about the Francis Report, again as early guidance to the staff
in thinking how we might respond to it. And obviously this will
come back to us in due course. There maybe a timetable, although
Katherine might want to say something about timetable before we close this item. So, there are a handful of recommendations, which particularly refer to either Healthwatch England or local Healthwatch or both and the first is something around the consistent basic structure of Healthwatch and I think when we talked about this before, our feeling was that there absolutely needs to be a level of consistency in terms of basic structure and this is clearly shared by local Healthwatch who, as we reported earlier on in the meeting, have been saying to us that they are keen to establish some basic standards for local Healthwatch. There's a beginning of an outline
in the regulations in terms of the way Healthwatch should be setup, but there needs to be more and there is an appetite for more from local Healthwatch, we're wanting to accept that challenge.
Having said that, I think we also are all really clear that there are some important benefits to having local Healthwatch emerge in local
environments and be responsive to local environments, we felt the
substance of that in the presentations this morning. We want to try and find some balance between consistency and appropriate difference and experiments and pilots to try and see what works best and
ultimately when we talked about this before we thought one of the
most important things to focus on, we recognise the need for consistency and the value of some basic standards but in the end what will count is whether or not local Healthwatch is delivering really good outcomes for consumers of local services and that's why we see a really important role for us in helping local Healthwatch to share good practice and build this picture of what good looks like. So that's my kind of summary of where we got to in our last conversation
and I just want to see whether that's a reasonable summary. Any observations? Christine.

C.V - I think from the last two regional events that I've been
to, that there was more demand from local Healthwatch than we had expected for basic quality standards and I think in the light of that that this is something that we should be looking at and if we did develop such a framework that would answer to a large extent, this point.

A.B - Okay. I think you're absolutely right. Far more demand than we
had imagined that there would be. So giving us some courage to go a bit further on this path.

J.M - Just following on from that. I mean this is something that the CAB service has done over a number of years. All the CABs are independent entities around the country but the most useful thing that the central body has found it can do is exactly that, is to set quality standards and to monitor them. So there are other models out there that we could hopefully copy or work with.

A.B - Okay. But so far so good? Moving onto a second area.
There's a proposal that local authorities should be required to
pass over the centrally provided funds allocated to its local Healthwatch. And we all know it's been a highly controversial issue throughout the passage or throughout the discussion around the Act and then the regulations. Quite clear to us, as it must be to everyone, that currently the legislation puts budgets for local

Healthwatch and decisions around those in the hands of local authorities. I think where we got to in our most recent conversations is where we absolutely wanted to see both consistency and I think transparency around the funding for local Healthwatch and importantly and perhaps not featured so strongly in Francis, we want to see continuity of funding for local Healthwatch and I think there is a real sense around the network, national and local, that we need to see a longer term life which everyone is committed to for the Healthwatch network. It's quite an investment that all the individuals involved are make to setting up these new arrangements. Having said that, we were also clear that we were saying again you could have lots of money and not do a very good job and you could have not very much money and do an excellent job, and of course the reverse applies and that's one of the things that we were keen to see was a really strong focus on outcomes, again, for consumers. And that if we could illustrate a relationship between outcomes and appropriate levels of funding that would be something that we and local Healthwatch could use in the future as part of an argument for ensuring the appropriate level of funding was being made available to do a really good job, if you like, providing the evidence to support any case for additional funding. So I think that's where we landed in relation to this one but I'm sure there will be contributions. David.

D.R - You've summed it up extremely well and I for one, certainly support the concept or principle that outcomes are more important than inputs, and I think an emphasis on that and on continuity is very important. I don't want to delay the meeting this afternoon by rehearsing all the intricate details of local authority finances. I don't think that would be very helpful or productive at all. But save to say that it is often misunderstood, it is sometimes misrepresented and the difference between, let's say an indicative table of figures and the reality when that money is finally available for a local authority to commission a service is sometimes more obscure than untutored observers might imagine.

A.B - Can I just interpret that and say on your behalf that you're suggesting that what government say is available and what local authorities actually get are not necessarily the same.

D.R - What I would say in answer to that is that there are many different parts of government.

A.B - Okay thank you very much. I've got Dag and John.

D.S I understand. I don't understand the complexities of local government finance. Notwithstanding that, however, the Department of Health has published figures of the allocations it's making in relation to local Healthwatch and I understand the principle behind what Francis is saying is that that should be respected by local authorities. This is, of course, is a tiny percentage of the settlement that local authorities get. Let's not forget that, so that as the leader and champion of the Healthwatch world, it is a recommendation that we should fully support and be seen to support it.

J.C - I very much support what Dag has said. I think it would be strange if Healthwatch England was any less fulsome in its support for the adequate funding of local Healthwatch than Francis, so I think in anything we say, we should support its intention. Of course, it's not the job of Healthwatch England or any national body to set the local budget of local authorities and the point of having local government is they ought to be able to make local choices. However is would be a problem for an individual local authority to explain to its council tax payers why it, as the provider of some of these services, is not funding the body that's meant to keep an eye on whether those services are adequately provided. So while we should be respecting the local authority's right to make up their own budgets, we should be supporting what Francis is saying.

A.B - Okay, it seems to me - sorry, Christine.

C.V - I just wanted to add support to that because I think that one of the key issues is transparency. And that local council taxpayers and local residents do deserve to know what is happening to their money and indicative figures have been given and they will be expecting that the amount of money will come forward and also I would say that outcomes are also related to resources and a very poorly resourced small organisation cannot be expected to deliver on this
extremely important agenda.

A.B - Yeah I think that's undeniably the case but a surplus of
money don't necessarily mean that people do a good job either.
So an eye on what people are expected to achieve is going to be
important for us going forward and I think actually it's also going to be an important tool to argue about funds. But I think there is a way of squaring this circle and, correct me if I am wrong David, but the debate here for you, is about what the funding for local Healthwatch is. So there's an assumption here in the recommendation that the funding for local Healthwatch is what government have given as a indicative figure. What you're saying is that it isn't necessarily what is available to local authorities when it comes
to the final point in their budgets. I think what we want to do is fully support this recommendation but be clear that it's the sum of money that's available to local authorities which might not be the indicative figure but because of wrinkles around the way that local authority funding is delivered. Is that right?

D.R - Given the complexity of the situation, that's a pretty good summary, yes.

A.B - I must remember that. Local authority funding, I hope someone wrote it down. So I think we need to pass back to the staff the task of finding a way of strongly supporting the recommendation but being clear about these practical considerations in terms of local authority funding mechanisms. Patrick did you want to add?

P.V - Yes just briefly. I think what Francis was alluding to was that given the investment that's required to have an effective patient
involvement system at a local level. So anything we can do to add value to that debate or argument would be helpful, and I think that's what people would be looking for at regional events. That's one of the top ten things people raise is do we have sufficient resources to deliver what we need. Which is actually different to what Links were doing beforehand so we need to recognise that. And I think that one of the things we can do is obviously, and it's subject to all the evidence from local Healthwatch with what they are delivering.
We can make the case, no different to back in the day with social services to investor save. We can make those kinds of arguments
that this is the investment required and I think that's part of our role to be the advocate of that as well. Whether that translates into more money, that would be fantastic but we have to recognise that we are in difficult financial situation, but I think what Francis was alluding to is you get what you pay for and we want to make sure we have a decent local Healthwatch and what we do nationally as well.

A.B - So one of the things that we heard certainly this morning and that we've heard in other places is that actually some local
authorities are finding more funds than the sum of money identified by central government and I think we need to be careful again in terms of the drafting that we don't do is establish that there is a sum of money which must be made available and no more, no less.
And this is about a minimum and bearing in mind that people are
recognising the potential of the value added from local Healthwatch in many places and arguing for more funding. Any other takers on this?

D.R - Can I say something that isn't specifically about the money, but sort of relates to it and that's that the intention of the legislation always was that there should be a form of synergy between

local Healthwatch and other forms of engagement that the local authority is responsible for within its local area and that's why the approach that as you rightly said, we've heard about from some areas is likely to be more effective in delivering better outcomes than if you just start with a purse or a pot or a wallet and say that's your lot, go away and do it.

A.B - I think that's a very important point. So this is a very subtle piece of drafting that we need to do but we must welcome the intent of his recommendation and then talk about some of the specifics.
Okay. I'm going to move onto the next area which I think is easier because we have not yet, I think, agreed how we want to take this forward but that is about Healthwatch England and LGA as the recommendation reads, to be able to intervene in local Healthwatch when appropriate and I think where we have got to on this is this clearly something we need to discuss with the LGA in terms of how,
when we might want such powers. Or indeed to take such powers.
So if everyone is happy with that for now, clearly there's another discussion we need to have about this. The next one on my list is about guidance being given to promote coordination and corporation between local Healthwatch, health and wellbeing boards and scrutiny committees and I believe where we've landed on this is we would indeed be developing such guidance where appropriate with the
LGA and that's particularly in relation to health and wellbeing boards and scrutiny committees. So it's on that list, you saw earlier on this afternoon. So yes indeed. The next one is around proper
training and expert advice and I think again you've heard and we've already identified the priorities for this and our commitment to unsure that local Healthwatch does have access to the best training and advice to deliver its function and we've talked about some particular areas where we think that's going to be mission critical in the early days but this list is going to grow and change as time passes. So governance is one particular area that's a very high priority for now and a number of others hotly pursuing. The next recommendation that bears on us was about local scrutiny committees having the power to inspect providers rather than relying on local
patient involvement structures. And I think the issue here is really
about the role of local Healthwatch in terms of enter and view and
the relationship that there might be between that activity and scrutiny committees doing something similar. So again something for us to discuss in our relationship with the LGA, Christine.

C.V - On this one, part of this recommendation said that rather than relying on patient involvement structures and accepting reports which didn't have any recommendations in them. And I think that that's the point we need to pick up in the drafting of our guidance on enter and view, that there should be very specific recommendations and provision for following up on those.

A.B - That's really helpful Christine. Any other observations or comments there? Dave.

Dave S - I suppose this is one of the recommendations that caused me most concern, not concern, I was wondering where this was going and wondered about the emphasis on this. There's a lot of emphasis on
this in this whole report on more regulation, more inspection, as if
somehow that's going to right the wrongs, when I think what's really needed is a change in culture. It's a general concern I have about
that balance and I think it's great that we discuss this with the LGA. I didn't really, and most people hadn't really seen council's health overview and scrutiny committees really having a role in terms of inspection and the way that we've understood it. It actually came as quite a surprise for many people in local government and I think it's adding to an already confused picture. So I just wonder if that could be borne in mind with the conversations that you have with the LGA.

A.B - Thanks very much Dave, Dag.

D.S - I've been a member of the scrutiny committee for a number of years. I'm not now. But I can't see that they have the capacity or in fact that's what they want to do. They want to focus on the issues,
I wouldn't imagine that local authority scrutiny committees want to look to themselves as inspectors.

A.B - Do you have a view?

D.R - Well, there is no formal position yet, because the LGA
would want to discuss this with Healthwatch England of course. But I don't disagree with the two comments that have just been made.

A.B - Okay. So I think perhaps that gives sense of direction to the way the conversation might go but let's make sure that we have that sooner rather than later. Everyone content? Okay. And the last area is around the statutory duty of candour. We haven't discussed this in much detail at committee level. So I'm really keen to have whatever
comments people might have in this space but we have had quite a lot of discussion with the staff team and we have kind ended in this sort of place and I want to test the water on this with the committee.
So one has to start in a place where it is quite scandalous that it's
necessary to require people to be honest. It can't be the right place for us to be. However, we are where we are and there's no question that consumers have a right to expect that their concerns will be acted on. Their complaints will be dealt with and as we said earlier on this afternoon, redress is one of the consumer fundamental rights and no accidents, it's one that we propose to focus some energy on over the next period. That we would like to see a world where health and social care embraces the needs for complaints and concerns, as I said earlier we shouldn't be looking for fewer, we should be looking for more and doing something with them and learning from them in a way that allows us to improve the quality of service. Actually, and I think this goes to your point in a way Dave about the emphasis on regulatory solutions to achieve results in the face of what happened at Mid Staffs. That regulation can't really be the right way to insist that people are honest. But I say again, we are where we
are and I think then the question is if we go down this path, should
we be looking at a contractual duty of candour or a statutory duty of
candour and I think there is a very important consumer case for going
for a statutory duty of candour and the reason for that is if it's a
contractual duty of candour it allows managers to do something
about honesty but it doesn't allow consumers to do anything about it.
If there's a statutory duty of candour it means it empowers consumers
ultimately and if they are minded and willing to take cases to the courts, then this, as a statutory duty, empowers them to do so whereas a contractual duty wouldn't. So a slightly circuitous route ending with a welcome for a statutory duty of candour but a regret that this is the place that we find ourselves in. Just comments?

J.M - Yes I think we're approaching this from slightly the wrong angle. Because this is not about people and the professionals and individuals out there who are necessarily lying. It's about protecting people that want to tell the truth. And it is a sad thing that we have to say it but one of the reasons that it's being said that we should have a statutory duty of candour is so that people are now able to say what actually is happening. Without that we are starting to bite into that culture of fear that stops people because of the power plays that go on out there, stopping people from saying what they really think.

A.B - You mean not consumers perhaps particularly but other
professionals in the system.

J.M - Yeah, at all levels.

A.B - I think that's a fair comment. We should put that thought in.
Any other comments, Dag?

D.S - Yes I fully support what Anna and what Jane have said. But I do as a magistrate have to point out to you that there's a difference
between the truth, the whole truth and nothing but the truth.

A.B - Any other observations? Patrick.

P.V - Yeah the key thing about the whole argument of having a
statutory duty, yes there might be a lot of regulations out there but it's actually given confidence to people, whether they are staff working in social care, because the question we have to ask ourselves is, if this happened again, how many years would it take for patients and loved ones to advocate on behalf of their rights? We shouldn't be going through, I mean, talking about several years to be heard. And if our job is for people to be heard we need to look at what is the
best mechanism in the system to prevent that happening again and if
it means that we have to consider having a statutory duty then so be it.

A.B - Okay. I think it's where we are coming to yeah. Just a bit narrative to get there and it's a shame and a scandal but there
we are. So if everyone is content with those things which most particularly affect us, what I would like to do now is move to the main part of the Francis Report and going around the table,
invite members of the committee to gives us their kind of first
thoughts and reflections on reading it. As I say, as a sense of direction for the staff as we think about how we want to proceed.
Is it alright if I start at the end of the table Dag or do people want to volunteer to go first? All right, go on Dave.

D.R - Okay. Well the starting point really is about what happened in an acute provider trust. However, some of the recommendations and certainly the spirit of the report to me is about a lot more than
what happens in acute provider trusts and we need to have that pretty much upfront in whatever we say because of our responsibilities across the whole of health and social care and certainly a lot of the cultural aspects that others have commented on already and is reflected in the recommendations, they definitely apply across the system as a whole and not just in any particular type of provider.
So my fear is that others will concentrate on the acute hospital
aspects of this and therefore it's up to us and anyone else we can persuade or work in partnership to take that broader view about the cultural aspects and about how it does apply, whether we're talking about social care, whether we are talking about mental health trusts or anything else. That must be the way forward. Whether we're talking about the candour we were discussing a few minutes ago or almost anything else that it's a general point coming out of the report.

A.B - I think that's a hugely well made point and speaks to in a
way how we might use some of the Francis Report recommendations when
focusing on the CQC and others, that we encourage them to ensure that the Francis recommendations and their implications are thought about across the piece, not just in relation to hospital trusts. Very important point. Next one. Michael.

M.H - One of the things I noticed about the Francis Report is a paradox. In the way in which volunteers, unpaid people in the system are dealt with. So it was very positive about the friends and families and patients who raised issues and campaigned about those issues, very negative also about volunteers. People involved in Links. And one, we talk about the recommendation about training for
Healthwatch but the recommendation is for the leadership of Healthwatch and I think we should be thinking in the longer term about what sorts of training offer we might be able to suggest for the volunteers, the others who might get involved in working with Healthwatch because we know from organisations like CAB and trade unions that it's possible to develop training for local activists,

which aren't about governance and sitting on committees, about collecting evidence, about being able to observe and record what is
happening and perhaps to be able to advocate and negotiate on behalf of people. So from that paradox we can do more than train leadership.

A.B - Another excellent point. Dag.

D.S - Very ungraciously declined to go first really. Lots and lots of thought about Francis but you certainly won't get them all. The first one is, read the first Francis report. That's where all the content is, that's where the meat is. That's where the tragedies are.
The second Francis report, the one we're talking about, is over legalistic. It's tremendously good on branches and twigs and leaves.
It's not quite as good on the forest. Big thing about culture but it has two hundred plus recommendations. How on earth are we going to cope are two hundred plus recommendations? The big thing is the big picture. It's that the patients, their families and friends that were not properly listened to. Unfortunately some of the proposals
are about shifting the chairs around within the same sort of environment. So I think Healthwatch has got to keep its eyes firmly fixed on the patients and public and whatever comes out of any changes and we have yet to hear the government's response.
I think that's about the 8th of March or the end of March, maybe but the end of March. If we're talking about cultural change, it's really something that takes time and people need to be on their toes looking at what's happening. So I have mixed feelings about the second Francis report.

A.B - Okay, thanks very much. Christine.

C.V - Can I just follow on that. I think for local Healthwatch, the
message and the difficulty is about how you actually garner that grass roots opinion. I mean when he says, every concern should be treated as a complaint. Now local Healthwatch will hear many,
many concerns and it's about how do they document them and how do they filter them and how do they respond to them and feed them upwards? And also in talking about enter and view he says this is only a snapshot but there are ways of doing enter and view which allow local people to have a much more sustained presence in a hospital, for example or a care home over time and to get a more
rounded picture of what is happening. So all those sources of information need to be fed back and that's a key job for local Healthwatch and there is a danger of us getting lost in the systems and structures up here and forgetting that.

A.B - Very helpful. So I have Dave and Patrick and Jane.

Dave S - I just feel that this report and following on what David was saying, it's not just about one acute hospital. It resonates with observations that are being picked up elsewhere in other sectors, private, public and local services and it reflects that this growing climate of fear that exists in so many public services and a defensiveness and an inability to get to grips with something for fear that there might be a punishment or a punitive environment and this is perhaps because a certain type of performance management which emphasises too much the very base unit cost as opposed to looking at some of the quality outcomes and perhaps an accountability that seems to be very much upwards to a system rather than outwards to a population. My anxiety is that we have had our attention drawn to this and there will be all sorts of things responding to that, where might we be in a few year's time and particularly as the financial pressures on public services let alone care, will not let up and will accentuate some of these problems in relation to driving units cost savings in the current financial year rather than over the long term. But also about the potential fragmentation of provision
that we've got a situation where the likelihood is that the provision of a range of social healthcare services will become more
diverse and the ability of the commissioners to effectively hold to
account those who are providing services and to make sure they are

meeting the highest quality standards. And I think that's something we need to bear in mind as the system goes through this next era of change.

P.V - I think the Francis Report has serious and major implications.
The only way I can equate the Francis Report is by what Dag talked about, twigs and trees which is a bit deeper than that, is I have to compare it to the Hillsborough report, the Victoria Climbie inquiry and the Stephen Lawrence inquiry, because if you look at what happened in Hillsborough, that fundamentally changed the culture of football in terms of spectators and safety in many ways. The Victoria Climbie raised fundamental issues around safeguarding and the role of
children's services and obviously that led to a clear outcome where every child matters and the Stephen Lawrence inquiry, the MacPhearson Report, looked at the fundamental issues around policing and issues around racism, and all of these, I think the Francis Report is on that level. Even though the Francis Report looked at a number of deaths in one particular hospital, it raises implications around a half dozen other hospitals around the country. I think the Francis Report, one of the key things he was trying to find was why is there this culture of secrecy, of bullying, of denial, to the extent that people were, patients were denied their fundamental human rights.
So I think it's quite a fundamental report. The question is how do everyone in the sector respond to that and there is clear things we can respond to and we've already discussed this just a while ago, but I think in terms of looking at the culture of health and social care and particularly in acute hospitals, it raises the fundamental issues of how they are run, how staff are supported or not supported and more fundamentally than that is actually the quality and interaction
and treatment of patients, staff and senior management and clinicians. So it's actually quite a fundamental report. I suppose the question is, what the government will respond? How will we play a
part in that response? And more importantly how does the public feel confident that their local A and E will give them the support and service that they need in a very challenging period. So I think the report is quite fundamental and important and it kind of challenges the cultural shift in the NHS that we all love and that we want to preserve but it does mean that we have to fundamentally look at how we deal with service in the NHS and maybe we have to do some real soul searching.

A.B - Thanks Patrick. Jane.

J.M - Francis one and two. It's like the warp and the weft isn't it?
One was the stories and this then is filtering all that through the
structures and the trust, the community and the general practitioners, the primary care, it's filtering all that through there and just listening to Patrick, I'm just thinking, it's not patient focused, it's institutionally inhumane. And when you look at the stories of happened to people, it is pretty devastating stuff.
So I don't think it's exactly what Mr.Roy Griffiths thought when he brought in management into the NHS all those years ago. It wasn't meant it turn out like this was it guys and girls. Two things for me though that seem to be missing and I stand to be corrected. One is the, I would have thought something about the size of the systems we're talking about. I know they've been more segmented now, I still remember going to listen to Nigel Crisp when he was Chief Executive of the NHS, talking about being the second largest employer in the world, second only to the Indian railways and I guy next to me saying, well that's not much to shout about is it. And there's been this emphasis on size, maybe foundation trusts have broken that down but I didn't hear a lot about the overwhelming size and the imbalance of power between the size of the system and the individual consumer and user. And the other thing that was worrying me was I was expecting to hear about these people that were killed, that died in Mid-Staffordshire, were, tended to be elderly and I just wondered was there a streak of ageism in there. I remember when I was a younger
person, how did I think about people who are the age I am now, which
is a little bit scary and I was just expecting to hear a little bit more in there about ageism and some sort of need for training, again it comes back to culture, how much do we value older people in our community?

A.B - Sanguine thought Jane. John?

J.C - I think the story of Stafford was the tragedy of the number of
people who didn't spot the problem over so long. So the performance managers, the regulators at least towards the end. As journalists we weren't involved there, the local MPs weren't spotting it. There was a collective failure, except for a doubting group of patient campaigners, the Cure, The NHS people who put it on the map which is why when earlier in the meeting, I was worrying about troubleshooting, I was wanting to make absolutely sure, that by calm
relations between one set part of the system and the other, we weren't in anyway, contributing to a silencing of a legitimate voice of complaint which we need to be empowering and supporting. And I suppose for me, I spotted on HSJ, early in the day, some remarks
from Kieran Devane, the cancer charity boss, who is on the NHS.
A non-exec on the NHS commissioning board and he was saying the goal should be priority of esteem between the patient voice, the clinical voice and the manager. And it's a huge ask to get that but that's what we ought to be trying to achieve and what we in Healthwatch
England ought to be able to try and foster in local Healthwatch.

A.B - So, we need to draw this to a close because I want to take
questions from the audience but I'll try to point to a couple of
thoughts that come from that. I mean, I think the point you
started with David, the fact that where possible we should be focusing on the lessons learned from Francis but their application across the whole spectrum is enormously important. I think this question about the lack of joined-upness and but the massive data is something that we really have to prod the system about in a big way.
There's a lack of balance between the kind of scale of the system and
the people in it and lack of respect and huge culture change and very
fundamental lessons in a fractured environment and I think we have to
recognise that actually shifting cultures in these institutions is a
major task and I say again, it isn't just a task for us, it is a task for the whole system but it does speak to one of our priorities which is a right to be heard in the system. Then I hear something about a bit of rebalancing actually, as you rightly said Michael between those people who Francis recognises and recommends and those whom he doesn't because of the Mid Staff's example and actually that would be a travesty if that's the way this played out, that the volunteers
were not thoroughly recognised for the excellent work they do in many places. So in that respect this was just one example. And also some rebalancing in terms of the variety of ways in which information is gathered, which you were saying Christine and not overemphasising one way of doing this as against other ways of gathering information.
So I pick up those things from what people are saying. I mean, there's two things which I think we also need to reflect on in
the Francis Report which is part of the solution, rather than part of the analysis and one is this emphasis he puts on fundamental standards and I think, if those new fundamental standards, and I'm going to make the assumption that there is some newness about them. That they aren't the same old old, same old standards that we have at
the moment. If those fundamental standards are going to do their job they have to be absolutely focused on consumers of service in a really meaningful way and there's a job for us to encourage the system and challenge the system to do that because I think that's one of the tools that we will need going forward, and the other emphasis in this report is on the centrality of the NHS constitution
and he doesn't talk about rights but I think he ought to actually. And you know, this is me going out on a limb and not Healthwatch policy, but it's my view that the NHS constitution needs an absolutely radical overhaul in order to ensure that the patient consumer user dimension of it is really clearly identified and is
at the very top of the NHS constitution with all other things supporting rather than leaving and if we had those two tools, some of the culture change might be easier to achieve, but I think we certainly need to take a view, not necessarily my view, about
fundamental standards and the NHS constitution. So it's something for

us to talk about soon. So I've certainly found that really helpful and I hope gives some food for thought. What timetable Katherine?

K.R - Well it seems to me, it's been an incredibly helpful conversation from my point of view and it seems to me that we have some immediate deliverables here, which are the capturing of the spirit of the conversation on those areas that we discussed earlier about the consistency and the basic structure about the funding and others where we need to put out a signal to government, as its
critical friend, as to our views on that and also as a method of
leading their Healthwatch network. So I think we need to do that sooner rather than later. I'd like to get that in the bag and delivered before the national conference because I think that would be a very good time to launch it, but I don't want to lose sight of
the very big issues that people have flagged because in a sense, I think we will probably always work around the framework that Francis has developed for us and I think that there are both some longer term
responses that we're going to need because where we will need to have
conversations with the LGA, with the Department of Health, just to check in what it really will mean in terms of our own statutory functions to have the power to intervene. What it's going to mean
in terms of our resources. So there are a couple of kind of practical, almost recommendations to us, that we would need sometime
to think about and I think that's going to take a little bit longer and is dependent on partners as well. So I'm not going to commit to an immediate time-line on that, but we will develop one and come back to the committee and then I suppose the third part of it is not to lose sight of that broader challenge back to the system and I alluded earlier to our role in auditing progress on Francis and I do think one of the key bits of work that we will be doing is holding the system to account on behalf of consumers, so I would expect us to be coming back to various providers, both in health and social care to hold the mirror back up to them in a year, post Francis. So we need to start that research process now in order, in February, next year for us to provide a report on what progress has been made on
Francis overall. So I think there are three chunks of work, one immediate and hopefully will be out in the next couple of weeks, one which is medium term, which is what does the power to intervene look like? How do we actually exercise that and we need time to do that and the second, which is an ongoing audit process on progress on Francis.

A.B - Okay, that's very helpful, everyone content? So we're going to move to questions from the audience. So we have invited people who are coming to submit questions ahead of the meeting. We've also invited people who are watching us to submit their questions.
And I've got a number of those already in front of me and if we have
time we'll take more. So the first question we have is from Michael Vidal who I believe is in the audience. But was asking if we could put his question. If fact, two, three different questions. The first was about finance and oversight of local Healthwatch in relation to particularly Francis I think, and I think we have probably addressed that. So I'm going to move to the second which is about public scrutiny bodies and this is about guidance being given to promote the coordination and corporation between local Healthwatch, health and wellbeing boards and local government scrutiny committees, but I think we may have been covered this too but David if you would like to reiterate.

D.R - I think you are right in a general sense that we have
indicated that supporting local Healthwatch to be involved in all of
this is something that we see as a priority and also partnership
arrangements with the local government association will help to
facilitate that as well. Just for the benefit, not for Mr. Vidal
because I'm sure he knows all this but for anyone else that might be
watching, local government scrutiny is the longest standing part of the three organisations that are mentioned here. Certainly health scrutiny has been in existence are for just over a decade now.
And although the legislative framework has changed a little, the fundamental purpose hasn't changed and that's continuing. Health and wellbeing boards, whilst not being

statutorily in effect for another month, have been existing in shadow form in most places for well
over a year. So the relationships there have been established and ways of working have been talked through as have assessment of the needs of the local area and the strategy that should derive from that for all the providers to meet those needs and that leaves local Healthwatch and again as part of our conversation today it's very obvious that some of those are now established, but newly, and others are not quite there and I think that raises the biggest issue
about coordination in the role for us to help whoever is going to represent local Healthwatch on a health and wellbeing board will really need quite a lot of support to make-up for the time that the others have been there and already talking to each other. So, if that was perhaps the intention. If I'm reading that intention into Mr. Vidal's question, we understand it and we intend to do something about it.

A.B - Thanks very much and there was a third part to the question which was about the complexity of the health service and the need for
proper training for the leadership of local Healthwatch. I think we've made it clear that we do see that as a priority and it will
be part of our early offer particularly around governance to
start with but also around representation at the health and
wellbeing board. I'm going to ask is Mike Duckett in the room?
Not in the room. So Mike Duckett had a question about improving hospital food and asked what involvement will Healthwatch have in influencing and improving the food available to patients. I 'm going to ask Christine to address this one.

C.V - Yes this is a very good example of how local Healthwatch
can get itself involved in. There are, there is a lot of work
that has already been done by Links and is part of the Links legacy on hospital food and the other national charity, who has done a lot of work on this of course is Age UK. So there has been a lot of work
already but I would encourage anybody who is concerned about this to
contact their local Healthwatch and as part of the enter and view and the work on quality, a lot can be done to improve hospital food and I would say it's not only the food, it's the way it's delivered and the way in which it is served which is a crucial issue.

A.B - Thanks very much and then we had a question from C. Philips about the Francis report and its critique of Links involvement.
I think unless C. Philips is in the room and has got any additional question to ask, we've probably covered that off. So I'm going to go to Kelston Chorley from the British Osteopathic Association. Can I ask you to take the mic so we can get this on the webcam as well?

K.C - My question is that the government wants to engage patients
and involve them in decisions about their health care and enable patients to have choices as well local access to services.
I'm the representative from the British Osteopathic Association and
professionally UK wide we provide million treatments a year largely for muscular skeletal conditions. The bulk of which are back and neck
pain which appears to be a service which is not well represented by consumer's voices. And we'd like to know how Healthwatch could engage with those consumer voices better and how we as an organisation might be able to engage better both locally and nationally with your body to ensure that more consumers have access to that health care which at the moment is largely driven by fee paying patients, but the large bulk of the population is missing out on the level of care that others can have?

A.B - Thanks very much and if you don't mind I'm going to ask
Catherine Smith, from the Chartered Society of Physiotherapists to ask her question and then we'll address them both.

C.S - Provision of many important service such as community based

physiotherapy for stroke survivors is variable across the country.
How will Healthwatch England look to ensure that service provision is
equitable across England and what are Healthwatch's plans to address this issue?

A.B - Thanks very much. I'm going to ask Michael to start on this and then I'll be looking for a volunteer to talk about the signposting function of local Healthwatch in a second.

M.H - Okay I think this is fascinating varied questions because
the first question in my head was what is the consumer issue in this?
What is the consumer of health services issue? Clearly, as the first questioner said, maybe the consumer don't even know there's a service available and clearly in the second question, it maybe an issue, for both questions it's a issue about the extent to which consumer choice is a reality. So what can Healthwatch do about this and this is where we need to think about what local Healthwatch might be doing as opposed to what Healthwatch England might do. Clearly, as the local voice of consumers, one of the important things for local Healthwatch will be collecting evidence and information about service availability, the extent to which people have choice and the extent to which there are voices from consumers and potentially from providers about the way in which choice is made available or not made
available. In terms of Healthwatch England the Chief Executive Katherine has already commented that we are in the process of recruiting our policy and intelligence director and one of the
things that we will be thinking about is developing our own systems to be able to collect the information about disparities in service and disparities in health outcomes, disparities in the involvement of
users and consumers in decision making about healthcare and
then working with local Healthwatches, probably definitely through the hub in order to identify issues which local Healthwatches want to take up. It may well be as an aggregating organisation, we will be able to make a bigger picture in terms of users and consumer's views about where the gaps are in terms of choice, in terms of being able to make decisions.
A.B - Thanks very much. Dag?

D.S - I just want to pick up on the stroke issue.
There is a lot of good practice around about stokes. The National Institute for Clinical Excellence has produced a lot of work
on stroke and the National Stroke Strategy, which I'm sure the
questioner will be very familiar with, published some years ago, it's
clearly up to local Healthwatch to take a view on how their local
commissioners and providers are adhering to the standards in terms of
stroke services and the stroke strategy. That strategy came about because they were perceived failings nationally in stroke services in Britain and we didn't compare very well with other parts of the world. I guess it's one of those priority things that every local Healthwatch will have to look at what is the, what is happening locally and what are the priorities it wants to put its work in.
Maybe there is a role at some stage for Healthwatch England to make
available information where there are such things as the national strategy. I think there is all sorts of regional stroke initiatives going on at the moment but there is work done on stroke but I am sure there is quite a long way to go. Maybe one of other roles is to
make available information to signpost local Healthwatch to where they pick that up and to pick up Michael's point, where they find the
information locally in terms of prescribing treatment regimes.
Access to the right sort of treatment within two hours.
There is all sorts of information out there. Perhaps we can signpost local Healthwatch to where they can find that information if they
find it's a local priority.

A.B - So I think probably two very particular and quite different
things there in a way. One being helping to identify our
differences in practice through our own data collection and giving a

picture and therefore the tools to local Healthwatch to pursue things. I think the other thing of course is there is a role for local Healthwatch in signposting to services. So if there are services available but not widely known about, one of the things that osteopaths for instance can do is to approach local Healthwatch to
ensure that you are properly included in their sign posting function
for those that have those particular issues which are dealt with by
osteopathy which is a kind of a different thing. It's much more about information than it is about a service being widely available. Okay, thanks very much, can we go on then to the next question which is
about the role of local Healthwatch in relation to campaigning and regulations. I think again we've probably covered quite a lot of this earlier on today but in response to the specific question, we were very active around the time that the regulations were being discussed in the House of Lords specifically because we felt there was a clear
need for clarification which we were very pleased to see Earl Howe gave in the House of Lords and I think it's worth pausing for a second, because one of the reasons for having these debates, indeed one of the reasons that the Lords who tabled this debate gave for asking for it in the first place when we spoke to them, was that they wanted to have this discussion on the floor of the house, so that
there could be clarification issued by a minister which then actually
becomes substantive if you like, that's the basis on which the
regulations can be interpreted. So he was very clear in the debate.
We don't think that's enough. We asked that there should be clear
guidance and we asked to be involved in drafting that guidance and that's where I'm going to pass over to Katherine because she's been involved in working with the Department of Health so far.

K.R - So that guidance, as I understand it, is in preparation in
order to get around the problem which we wish we never had which was around the unclear drafting and what it will do is reiterate and as I said, there is freedom to undertake campaigning and policy work in the areas of core activity but just as we have with all of the charitable sector, political campaigning is excluded and I have
to say, having had long experience of working with the charity commission, guidance on political campaigning, that felt very familiar to me which is you weren't allowed to do party political campaigning but campaigning to promote your core activities and on
the basis of a clear evidence base was permissible. And so I think that we will be seeking to issue that guidance or to work with the Department of Health to issue that guidance in the next couple of weeks so there is clarity right across the local Healthwatch network so people feel able to use their statutory powers and that this
point of confusion, this very unfortunate point of confusion is
cleared up as soon as possible.

A.B - Thanks very much. I think Charlotte Patterson is in the room.
If we can get the microphone over here.

C.P - Thanks very much for the opportunity to ask a question. So my question comes about because I work at the University of Cambridge
as a senior researcher and I am involved in measuring quality of care
from a patient's point of view for about a million people in primary
care in England. And I'm very interested and keen to support the work of Healthwatch but unclear as to how I might do this. My question for the committee is, is Healthwatch England interested in engaging with members of the academic and research community, whom I collect data on user and patient experiences of care both on a local and
national level. If so, how would Healthwatch like researchers to engage with the organisation? Thanks.

A.B - Thanks very much and I'm going to ask Michael, our resident
academic to answer that for us.

M.H - The answer is yes. And the slight problem we have

is obviously working out all of our different priorities. When we will be working on developing our information strategy. I had a meeting with Katherine about that this morning and at the moment I
am sort of acting as an unofficial contact for academics and quite a few have already been in touch but I think we will be trying to formalise that and also to get a sense of the range of academics that might be interested. So I was thinking of social policy and health people and this morning somebody who's involved in community
development popped up and said they might be interested in Healthwatch activity. So I think the answer is a very positive yes and we will create mechanisms to make sure we can learn from people doing research and help the rest of the network and learn from that.

A.B - Thanks very much Michael
and Graham, I think we have some
other questions from...

G.T - Yes a few live questions that have come in. Firstly from Anita Hyam which is can the committee clarify the nature of the authority relationship between health overview and scrutiny committees and
health and wellbeing boards? Which of the two will call the shots
and within that some requests for guidance. The local Healthwatch representatives both on the health and wellbeing board and on the health overview and scrutiny committees would like some.

A.B - So I'm going to take money on which committee member I'm
going to ask to take this question and it will be David.

D.R - Your wish is my command. And what I would say about that
is this was one of the fundamental issues that was discuss in the
earlier stages off the health and social care bill, quite what
the nature of the new creature, the health and wellbeing boards would
be as opposed to the existing creature, health scrutiny, and it became clear and this is reflected in the Act, that the health and wellbeing board, whilst not being a normal committee of a local authority, is much more closely related to the executive functions of a local authority and this is again something, I'm sorry if I am using terms which are not familiar to some of those watching or
even here today, but for the last years or so, the way local government has worked is quite clearly been divided between the cabinet or the executive which is responsible for the decision making procedures and the scrutiny function which is everybody else and they have the opportunity to call in those decisions or they have the
opportunity to suggest ways in which various practices or procedures might be improved for the future. So it will be executive members
of local authorities who will be joining their local clinical colleagues from the local clinical commissioning groups. The professional advice of directors of adult services, children's services and public health, and of course, very importantly, the local Healthwatch representative on the health and wellbeing board to devise strategies and inform commissioning across all of those organisations, and it will remain the role of scrutiny to either
ask questions about what decisions they have made or, indeed, to identify areas they might wish to investigate in more detail and make
recommendations for improvement.

A.B - Thanks very much, another question.

G.T - Second question from Cyril Scott. What are the committee's views on whether local Healthwatch should have a standard operating model?

A.B - And I'm going to ask Dag to respond to this one.

D.S - Well, I think we have referred to this on a number of occasions. Francis talked about some consistency and I think we would want to see consistency in terms of the legal powers

that local Healthwatches have but they're bound to find different ways of operating those depending on what they see their local needs are and what the members of the local Healthwatch are. I suspect this question is aimed at whether Healthwatch England has a role in it and we have talked about we need to have some sort of leadership role in terms of standards but I don't think we should be talking about
detailed operating of individual local Healthwatch. What we want to see is they're all performing their statutory duties. The interim view. The consultation with members of the public, the focus on the hard to reach groups, all those areas. Whether that falls into a standard operating model, I'm not entirely sure. Standard operating model sounds to me a bit restrictive where as we really want flexibility that addresses all the key issues but is flexible enough
to deal with the local issues are as seen by a local Healthwatch.

K.R - I just thought to give an illustration about what standards might look like and in a sense, it was reflected in the
presentation we heard earlier today where the outcome was good
engagement with the community but how different Healthwatches get
there depends on the local variability. So we what we wanted as standard in terms of excellent engagement with the community, specific engagement with otherwise unheard groups but I think it is right that the way you get there is locally determined and that's all dependent on the local history of the voluntary sector, of Links, because you know, then the local authority will be able to and
has been in power to choose which organisation has the best connections with the local community but the standard we would want is good engagement, how you get there I don't think is an issue for us to judge on and actually I think what we've heard is lots of different ways of getting there which are very different but equally effective.

A.B - Okay. Thanks very much. Have you got any more for us Graham?

G.T - There are a couple. This is one is slightly longer but it's a question embedded in two statements but this is from Jeffrey Smith. Today there are 32 days before local Healthwatch start working. As they emerge they need a source of information, good practice and advice if they do not want to waste time and scarce money in setting up different forms of governments. How soon will Healthwatch England make it available? This goes onto say, together we need to show that the lessons of the transitions from CHC, the Community Home Councils to patient and public involvement forums and from patient and public involvement forums to local involvement networks have been understood and acted on.

A.B - Thanks very much so I think we have partly dealt with this
in terms of our discussion earlier about the offer which is available on the website but I just wonder if you want to add anything on the legacy question perhaps.

S.R - I was actually going to add something on the government's question if that's okay. Just to say that we're very aware that people are asking for governance support very quickly and we are in
negotiation with a couple of national organisations to see if they will share the work they have done for local Healthwatch groups with us so that we can sign post people to that as soon as possible.
And I've also received, this week, a suite of governance papers from
Leicestershire Link and from Dorset Healthwatch so those are things that we can sign post people to. We're also going to have a break out
session at our conference on the 13th of March on governance where our local Healthwatch will be sharing some of their ideas and actions to date. And I know Jane, you and I have had a conversation and this is your particular area of expertise and you're very happy to help prepare any guidance and support that we can provide so hopefully we will be able to get something out very quickly.

A.B - And I've got another one here which relates to public
understanding and awareness of the Healthwatch network's existence

asking what additional publicity we propose to do at a national and local level to promote awareness? And I'm going to ask Karen our
communication lead to take this.

Karen Riches - Again, the short answer is lots, but if I focus on two big areas. The brand that you see around you has been adopted by every single local Healthwatch already which we're really, really delighted about. A big area of our work at the moment is giving them support to make that brand fly at a local level. So we've produced a whole lot of stuff recently which means when we launch on the 1st of April, it's going to look good at a local level and that will mean
something to local people. So we've produced a common website that they can use. We've produced some key messaging that they can use.
We've produced a communications toolkit to give them some kind of easy steps how to get knowledge and awareness of how Healthwatch out to a local level because that's really where it makes a difference.
It's very tempting sometimes to think that you've got an advert on telly that that's going to result in anything. Usually that results in quite a big invoice and not much impact. So we're looking very much at focusing at a very local level. What we're doing at Healthwatch England is very much focusing on stakeholder communication so we're talking to the big systems players,
the NHS commissioning board, to Monitor, to CQC, talking to the
big third sector organisations, CAB, Mind, and we're talking to all of those people that have already got Links with the communities that we need to be talking to, to raise awareness about Healthwatch and the particular focus for that is our network launch which
is on the 11th of April and what we're trying to do is get all of those organisations to cascade through their own networks and their
own communication channels about Healthwatch. What we stand for, what we're seeking to achieve and importantly how they can get involved with us. So there's a lot of activity going on. I would describe other approaches as a snowball rather than a big bang and I think it's appropriate at this stage that we're talking to the people that already talk to the punters that we need to talk to and I think as the Healthwatch network grows and as Healthwatch becomes more mature then the kind of communications we do with the general public will probably up in frequency.

A.B - Thank you very much. Links legacy. Sorry, would you like to do that Susan.

S.R - Yes, just to answer the question about Link legacy, there's
a number of work streams going on and Dag already has alluded to five
workshops that were organised in partnership between the local government association, ourselves and regional voices, CQC and the Department of Health and at those workshops we've been talking about
the legacy of Link and celebrating the role of volunteers and
our particular role in that was to present the outcome of a piece of research that we have had undertaken for us looking at Link
reports and pulling out themes of issues that have really mattered to
the public over the last year or so. So that's something that's been happening. Also regional voices and other voluntary organisations have been putting out a call for Link legacy work and that's going to be collected and put on a portal which will be on the Regional Voices website. So there will be a collation of information there. So there's a number of pieces of work that are going on and the local
government association have produced a very useful checklist that Link are using to capture legacy. So there is a lot of work going on to make sure that that very important work doesn't get lost.

A.B - Thank you very much Susan. So we are drawing very close to
five o'clock which is our appointed finishing time so I'm going to draw our meeting to a close and say thank you very much to all those who came and to all those who stayed. I hope you found it useful.

A special thanks to all those I cannot see but who can see me. Again, I hope that you found it an interesting meeting. We would be very pleased to have feedback from people in either location about what we could do to make your viewing, watching of our activities more productive from your point of view. So any changes or tweets please do let us know. We'll have time to do something about those because the next public meeting of the Healthwatch committee is the
12th of June, it will be in Newcastle. We will as we did here be taking the opportunity to meet with local organisations, in private session in the morning and then a public meeting in the afternoon and look forward to seeing some of those who perhaps are only watching on
this occasion way up north. So by that time of course local Healthwatch will have been up and running for two months so I think inevitably part of our discussion will be about how that's going and what support we've delivered in the interim. So left only really to say, thanks to everyone for your contributions and your setting up of the meeting and your attendance and look forward to seeing you all soon, thanks very much.

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