East Midlands Healthwatch transition programme

Resource Pack

Multi Stakeholder Learning Events

How Healthy is your Healthwatch workshop 1: Building A Credible Healthwatch Workshop East Midlands – 8th October 2013

Introductions – hopes and fears!

We aspire for LHW to….

- be recognisable but different
- mean something to everyone
- seen as a helping hand,
- be for everyone not just the few
- be balanced and realistic
- be a HW for all seasons
- involve all orgs together working together
- branch out and reach out
- be memorable and recognisable
- encourage different people going on their own journeys come to HW
- continue to develop, but also be a constant.

Our fears – we don't want a Healthwatch that….

- Is continually searching, trying to get somewhere, never sure where!
- Is part of the community but outside, not listened to
- A like a traincrash
- Is tripped up by hidden dangers
- Is complacent
- The public perceive as a tank, an enforcer
- Is told we don't belong, and to get out of town as not relevant
- Is of and for one single demographic.

Shapes & Structures

Please see the separate presentations from James Moore, Healthwatch Derby and Rosie Newbigging, Healthwatch Northamptonshire (attached).

Building a Credible Healthwatch

Key features of a credible Healthwatch drawn out of the models created by mixed sector groups included: strong but flexible foundations; an honest broker of information; working in appropriate partnerships effectively and making a difference using available resources.

Strong but flexible foundations

If you get the Board right from the start, the structure will stand up to future knocks. This includes having a Board that is representative of the local community

Values are a key part of the strong foundations running through the whole structure – including values of honesty, transparency.

Interdependence of key players – and flexibility between them. In an area where other partners' work on PPI is very strong, for example, LHW may divert some of its energy into other aspects of its work, trusting those partners to work together and share information on PPI.

In order to contribute to change, and respond to change, the base needs to be strong but flexible, to enable HW to be open to doing things differently. And LHW can enable providers to make changes in their practice to make things better.

Broker of information

A continual circle of credibility, when looked at from outside or inside.

LWH playing the role of honest broker – ensuring that not only do providers say they are providing the best possible service but that they prove it!

LHW was an important role in ensuring the closing of loops of information – ensuring appropriate feedback and response to information between partners and most importantly to local residents and patients.

It is a place where information from different sources comes together, and people want to and need to communicate with HW – local residents and people of power (not that they are necessarily different!)

Appropriate partnerships

Different stakeholders meet physically together, and work together appropriately.

There are a myriad of potential partners to it is really important to be strategic to be credible, rather than running around trying to work with every potential partner individually.

If one pillar of HW doesn't work effectively, it will have a negative impact on patients.

LHW has relationships not just with health and social care partners, but also the wider community – schools and Universities for example.

Makes a difference and uses resources wisely

Where commissioning decisions take into account the conclusions of HW – HW feeds into the decision making processes of other stakeholders (CCG, Commissioners, others)

The style is participative not just consultative, and LHW uses appropriate resources that are available – not reinventing the wheel.

A credible HW is a place for honest conversations – where expectations are managed and realistic, and where we ask "what should we do with what we've got" not "what do you want us to do?"

Panel discussion – key points: What makes a Credible Healthwatch?

Dag Saunders – Healthwatch England Board Member

1. For any local issue relating to Health & Social Care the press contact you first
2. Don't have to remind providers and commissioners of the four week rule
3. Your Health & Wellbeing Board seat name badge is not the one by the door!

Darren Bailey – Derbyshire Healthwatch Chair

1. Good two way communication channels with stakeholders; one way of ensuring this is via the Health and Well Being Board.
2. Stakeholders and public contact us re information and sharing issues
3. Partnership working – We have Enter & View trained people and work with Derbyshire Community Health Service to sample the Enter and View work with different organisations

Cathy Harvey – LA Commissioner

1. Strong governance, strong Board and robust group
2. Good use of resources – money and resources
3. Visible presence – being known, bricks and mortar and people knowing where to go

Eddy McDowall – LGA

1. Local Healthwatch has a flexible and sustainable organisational model that is capable of learning and adapting to meet further policy changes around the citizen voice in the NHS and social care.
2. Local Healthwatch draws upon knowledge and experience that already exists to maximise its reach across the diversity of the local community, with a particular focus on understanding the views and experiences of seldom heard groups
3. Local Healthwatch has an open and transparent structure for making decisions and enabling local people to influence what it does and acts in accordance with the Nolan principles of standards in public life.

Alison Kirk – NHS England, Area Team

1. Bringing representative patient voice to the table (whether at CCG or QSG) and will help to develop patient focussed solutions to issues facing communities.
2. Ensure that organisations being supported in listening to the public as well as holding them to account
3. Bringing patient voice into discussions, being part of the solution and feeding back to the community – closing the loop

Pam Purdue – Head of Patient Experience, North Derbyshire CCG

1. Fine line balance – an organisation having credibility because of its knowledge re Health & Social Care and not gone native
2. Network and liaise with commissioners and providers of Health & Social Care – having regular communications that are ongoing. Not formal but ongoing which will lead to organisations using Healthwatch.

3. Ensuring closing the loop on achieving outcomes but feeding back generally or to individuals

It was acknowledged that Social Care and Patients views were missing from the input!

Evaluation

Today was good because…

- Group work and creativity
- …of the interactive format
- Enjoyed workshops and chance to have conversations
- There was a lot of outside-the-box thinking which was prompted by the work of the facilitators
- It was extremely well planned, focussed and pacey
- It provided the opportunity to hear lots of different viewpoints from different people
- Good representation
- Found out about what is happening in other HW
- Opportunity to play and explore in a different way
- Networking

Today would have been better if….

- We had had more time (even half an hour would have made a difference)
- More time perhaps, but the workshop was focused and full
- It had been longer, it felt rushed.
- Social care and providers had been better represented
- If we had the public perspective, and the social care perspective, and more CCG reps
- Handouts of slide shows
- If we had more of a focus on specific areas eg:
    - Board development, campaigning, promotion, marketing
    - Expectations
    - Reporting
    - Developing projects
    - Basically we needed more time – session felt rushed.

Suggestions for the next workshop on data

- Sharing of systems that already exist in provider and commissioning organisations so that HW info can easily be included
- What is valid data

How Healthy is your Healthwatch 2:
Data Collection and Capturing Evidence

19th November 2013

Travel Data Analysis Exercise:

Using the examples of people's individual journeys, we looked at how to build a picture of a whole system, or parts of a system, from different information collected. The following observations about use of information and collection of data were made:

Comfort

- Planning your journey (patient journey or transport!) can help but not always ensure comfort
- Public transport – overcrowded or comfortable, depending on individual experience and expectation

Efficiency

- Different definitions of efficiency – some about cost, some included safety –pool info on something undefined is difficult
- Walking was self-reported as efficient – does that make it efficient?
- What is efficient personally might not be efficient for the whole system

Value for Money

- Mixed news on VFM for train journeys depending on trains – some delayed, some full of football fans, some comfortable. VFM depends on ability to plan, and on expectations
- Walking in had huge VFM- self determined, most in control and predictable
- Often the VFM options are not appropriate

Connections

- potential for it to go wrong, lack of integration so reliability can be questionable
- If you are physically able, and know how to use the bus timetables, and they happen to be located suitably for your journey, connections are better.

Specific issues

- Inadequate directions and diversions creating issues
- Delays and cancellations
- Additional benefits of some choices – eg Locals walking in the sunshine or car sharers chatting

Overall experience

- Lovely weather made a difference
- Self determination directs overall experience

Reflection on the exercise:

- Data samples very small
- Negotiations for the meaning of the data – large amount of data not entirely reflective but was negotiated. Subjectivity creeps into analysis.
- What is the criteria – most frequent, the thing that had the most impact on the user?

- Definitions and starting points
- If you know you are going to be asked, you can be more prepared to observe and feed back

Alison Kirk –NHE Area Team presented the NHS England Insight Dashboard:
Information for patients, staff and the public regarding the quality and value of the NHS. You can go on and look at England as a whole and then go onto your area. www.insights.england.nhs.uk Alison's slides attached.

Questions:

- Any data, interpretation and trends with it? No
- Any info on complaints? Information very generic
- Driven by community needs – is there a discussion around different needs? Intentional public facing tool to hold the NHS to account

Presentation on Robust Data – input and discussion Peter Bates and Jim Hatton: (also see slides)
Initial input on using data to create a predictor model for example around patient readmissions. Bad data presentation can be costly and combining data and analysing can lead to a predictor model that can enable planning around lots of issues. For example can you predict when a patient hits A&E how long they might be in hospital for.

Three key questions:

- **Find the questions** –Definition of the measure is crucial e.g. readmissions – patient discharged and readmitted, whether emergency or planned, are very different. So define the measure and break it down.
- **Find the conclusion** – why are some things research and others evaluation. Some things have to go through ethics committees and some not? It's a grey area and getting clear advice is tricky. You need to define why are you collecting the data and what comparisons are you using?
- **Find the help** – When looking to commission support around data or research check out if people are curious and helpful, check the extent to which people are curious about the issues you are interested in. It is worth checking around speed and service as well.

- ***Crucial issues***

1. Quantitative and qualitative – how do you prioritise what you focus on? How do you marry issues and make decisions about where to focus your data gathering – one person at a care home compared with 30 people in a hospital?
2. Don't take one issue and prioritise, look at in a suite of things – CQC has the same issue, and has developed a methodology that weights certain things. Again use a wide range of indicators.
3. Just reporting one case study or human story doesn't show how big the sample or how representative. Challenge – triangulate data across a team. Narrative helps you determine impact – but in Health and Care, risk trumps all. Categorise risk – qualifiers minor, moderate and major.
4. Most questions need a combination of qualitative and quantitative data; Look carefully at ways of using qualitative data – numbers are accurate,– we have to look at qualitative data

with the same robustness as you would quantitative information. Context is important. Apply social research rigour.

5. HWE need to be an integration of data sets – case studies are important to formulate hypothesis – test them further with extended usage projects.
6. The East Midlands Academic Health Science Network are building a core team to look at data; they want to rotate analysts where people are involved for a period of time. Jim wants to offer out the opportunity to build a pool of regionally based analysts – if interested contact Jim and Peter directly *Peter.Bates@ndti.org.uk*

Sharing information: principles, protocols and practice

We worked in groups, each taking the perspective of a different stakeholder, and drew up some key principles to propose to the whole group.

Then the groups proposed a scenario to test out the principles, based on their experience. These were shared then each group tool a scenario, worked with other groups to identify how data/information is gathered, shared and presented in that scenario, and who with. The principles were then revised:

Principles that emerged, were tested out and refined:

1: Appropriate contact/ relationship between service users and data.

Inform the source of the information about what happens to that information and what happens as a result of that information – closing the loop

Use structures that are there if appropriate

2 Data must be…

….. robust, accurate, clear, balanced, representative, referenced in terms of source, and timely (esp. where risk is an issue).

3 – clear roles and boundaries

Eg re LHW and HWE: LHW should share information through the Hub; LHW should escalate specific info through HWE; HWE should share the whole picture

4 Communications pathway

Named posts (not individuals) in each LHW to be responsible for the communications pathway

5 Cross Boundary issues

Have and share protocols for cross-boundary issues

6 Information sharing

Agree appropriate levels of transparency, confidentiality, data protection etc. And be clear what can be shared, when, and where it can be found.

7 Timescales

Appropriate and clear timescales for requesting and receiving information

The scenarios developed to test out these principles were as follows:

1: A care home has a high hospital admission rate – how do we get to the causes/ issues to focus our resources on?

2: At HWB, Adult Care presents a questionnaire re satisfaction: how do you get to the bottom of what it means?

3) There are more deaths due to acute mental health issues in BME communities, coupled with lower uptake of services. What do we do?

4) EMAS risk summit: how do we look more widely at cross-boundary issues?

5) LHW report to HWE re GP access – how does HWE respond?

6) CCG seek input from LHW (in three days) on views of the population regarding CCG priorities

7) Commissioners get data from LHW indicating poor performance of a provider. Further research shows a different picture.

8) Independent review of a patient journey into to continuing care. LHW is asked to work with VCS on the most concerning bit of the journey. How do we use and collect relevant information?

Evaluation of the session

There was an extra session at the end of the workshop, and not many people filled in the evaluation questions. It would be really helpful for us to have more feedback, so we would appreciate you responding if you did not on the day. Here is what we have so far! Please send comments to Helen@just-ideas.co.uk

One thing learnt or taking away

- How to glean intelligence from disparate data

What was good and Why?

- The exercises were very helpful. Really defined how insight is gathered from individual pieces of data.

What could have been better?

- More time
- Would have liked the opportunity to discuss issues with peers i.e. would have liked the CCG table to have been CCGs at the event to discuss joint issues

How Healthy is your Healthwatch 3:
Effective influence and challenge to improve services
12.30 – 3.30, 14th January 2013
Notes

Welcome, introductions and updates

Eddy announced that LGA and HWE are organising four multi stakeholder workshops to bring together commissioners, HW and key strategic partners around developing relationship. Dates are: 17th march Birmingham, 18th March Leeds, 24th March Taunton and 25th March London. More information from Eddy.

The language of influence, improvement and challenge

A brief exploration of the language of 'challenge,' and the effect this has on partnerships and relationships. How do we encourage a mind-set of constructive collaboration and partnership to improve services. Participants were each given a selection of synonyms for the words Challenge Influence and Improve. They were asked in groups to select those words they found helpful in talking about LHW's role ineffective challenge to improve services, and those they found unhelpful:

Helpful words (most helpful in bold)	**Unhelpful words**
Revamp, leadership, change, question, transform, increase, **cultivate, boost,** promote, effect, sharpen, **help,** progress, raise, regard, direction, update, **act on, advance,** reputation, consequence, objection, better, move,hold, importance, acess, reputation, significance, credit, alter, interest, turn the corner, **improve, involve,** revise, enhance, clarify, refine, pick up, **straighten out,** shape up, test, induce, persistence, **influence.**	Modify, upgrade, agency, polish, threat, control, domination, **dominion, protest, rectify, summons,** money, trial, prestige, grease, force, **stir,** provoke, pressure, defy, **accost,** civilise, rally, to contest, **mend, sway,** claim, erturb, clout, common, **ultimatum**

What MUST and what CAN LHW and HWE do in terms of challenging services?

Michael Hughes, Expert Researcher on HWE Committee, and Director of Healthwatch Birmingham, introduced the legalities of what LHW and HWE are required to do in relation to challenging to improve services, and the process for escalating and acting on concerns raised.

Please see attached slides - these notes capture additional points and the discussion:

Escalation is a key issue being discussed at HW Board meeting tomorrow – it's a tricky issue and they aim to produce a report later this month to help LHW think about whether an

immediate safeguarding issue needing immediate escalation or is something that can be moved through a staged process.

The term 'Challenge' is used by HWE in its values:

- Independent – we challenge those in power to design and deliver better health care services.
- Credible – we seek out data and intelligence to challenge assumptions with facts.

Challenge is based on:

- Failure to meet a standard
- Value to engage public and not delivered in interpretation
- Comparisons – data crunching, using intelligence to show comparisons around learning

Example from West Midlands: comparison around renal care for Kidney failure – in some areas the ambulance phone ahead to the renal unit so the patient can go straight in. In other parts they have to go through A&E which on average adds 17 minutes – so even if the ambulance meets its' targets there is further delay. This has led to other aeas being challenges as to why they can't improve their processes.

Don't get angry – get change!

Values of HW overlap with those of Health and Social Care commissioners and providers – the Helathwatch role is extremely helpful, being part of the system but independent and outside of the system.

Case studies – experience of 'challenge'

Two case studies/ scenarios were presented from LHW of different approaches to influence and challenge. Followed by discussion of other examples from all participants

Please see slides from presentations. Points noted from discussion:

In the scenario where a Hospital questions the validity and robustness of a LHW challenge. Questions arise such as Do patients know how to complain about services? – are there signs and leaflets? Do patients have welcome pack and knowing you have the right to challenge?

One suggestion was to publish reports and the response from the provider simultaneously, being clear from the outset that this will happen. This has resulted in one LHW never having any challenge pushed back to them, as the providers know they will be publishing the response to the report/ challenge.

The escalation process should deal with this – but the question is where to take it? The CCG? The CQC? The issue is that there are lots of ways to take it up and it is hard to be clear on each occasion which is the best route for LHW.

Commissioners raised a question: the threshold for care/ interventions may be changed in various ways by clinicians – a case of "trust me I'm a Doctor" rather than "Trust me I'm a patient". There are specific issues around surgical thresholds which are hard to understand. We may feel the public won't find information on these thresholds accessible but commissioner need to save cash, and it's on the public health and it is going to happen. We would be interested to know where HW can take that?

One LHW made a challenge last year - a referral to Overview and Scrutiny panel where the CCG decided to close a service and there was a perceived lack of engagement and patient involvement. LHW made a referral, the overview and scrutiny committee didn't refer it on – their recourse is to Secretary of State. LHW continued to monitor the impact on service users and alternative respite arrangements, but the service closed at very short notice.

Here the Health and Wellbeing Board could have a key role to play. This example triggered a discussion at H&WB around meaningful engagement.

HW sit on every Board at East Leicestershire and Rutland CCG and this works well in terms of provide ongoing challenge and influence right from the design stage.

Sharing ideas and learning:
In mixed groups, participants discussed the case studies and other examples og effective challenge, using the following questions:

1. What tools or methods for challenging to improve have you tried in your LHWs or other organisations?
2. What are the benefits of each tool or approach? What impact has it had?
3. What are the partnership challenges in each of these?
4. What role can each partner play in facilitating effective improvement of services?
5. What tools/ methods/ ideas could you take from today and try in your own organisation

Group 1: Recognise that effective challenge about the longer game, not just the short term

Approach: It is all about building relationships, and being proactive. Developing information sharing protocols is important, as is being clear between partners as to what we expect of each other.

Benefits

- Groundrules in place
- Named contacts
- Step process informal -> formal
- Collaboration is a benefit to everyone

Impact

- Better buy-in
- Triangulate information
- Richer info/intelligence
- Better outcomes

Challenges

There are so many relationships to build, this continuously needs work. Often there is a lack of understanding of the healthwatch role. There is also a fear of misrepresentation

Different partner roles

Looking at roles to identify and express areas of mutual benefit, looking for the quick wins and remember that two heads are better than one.

Group 2: Don't reinvent the wheel

- Youth parliament
- Condition-specific partnership boards
- Forums etc.

Benefits

- Sharing of channels/routes can benefit both LHW and councils
- To some providers, LHW may be less threatening than an approach by the Council.

Impact

- Enables councils in service planning and priority setting
- Demonstrates LHW has added value to the system

Challenges

Funding, potential duplication of areas is an issue, as is the challenge of working across a diverse system.
Timing is crucial – planning ahead is important

Group 3 also focused on relationship building and clarity, the main benefit of which was seen as credibility, which can enable change or improvement. Resourcing the development of these relationships is a challenge, and it can mean hearing from the same voices rather than individual direct experiences. Roles should be developed through partners having an open dialogue.

Group 4: focused on the way that Healthwatch bring ideas (communication, engagement – widest range) to the table. Particular methods included listening events,

surveys, market/shopping place, phone calls – ensuring a richness of information coming into the HW office

Benefits of shared working

- Better outcomes
- Shared resources
- Skills and knowledge increased for all

Impacts include Reputation and credibility, and a grown-up relationship, adult to adult, an equal partnership.

Challenges

Fragmented ways of working – i.e. advice; signposting, advocacy needs to be based on facts and patient feedback

Cultural challenges and barriers include

- Sharing info
- Sharing tools and processes
- Sharing financial resource
- Sharing professional resource

These are maturing organisations and will take time for the relationships to develop.

Reflection and next steps

Evaluation

One thing I have learned/will take away and try from today….

- Keep going! Keep talking!
- Evidence, evidence, evidence is the key
- Development work and consultation on rights and responsibilities
- More about what Healthwatch is actually for (x2) and relationships with LAs
- Would have liked more time to discuss the scenarios and challenging presentation
- Relationship building; clarity of role/purpose; evidence
- The scope of HW's challenging role
- Find out more about my local Healthwatch
- Reinforce process and methods
- Understand the barriers to challenge other service providers.

Today's workshop was useful/good/enjoyable because….

- Multi agency event
- Case studies – particularly 2nd one which made you think
- Good opportunity to share across agencies

- Networking and conversations (x4)
- Cements some developing relationships
- Sharing experiences
- Everyone in the same position
- It's always useful to take time out in a partnership environment to reflect and share
- Content of the workshop
- Listen to other people's experience – focused
- Well facilitated, good timing, close to station car park
- Opportunity to meet colleagues in multiagency organisations. Everyone is treading own path without national framework – 'divergent opinions' helpful – but need to get 'convergent'
- Workshop was useful – hearing from other HWs and CCGs their views and points.
- Meeting people from other HW

Today's workshop would have been better if….

- We had more direction from HW England about their views on how we escalate challenge and how they support it.
- Better if more commissioners had attended
- More time allowed to finish discussion
- Assigned groups with a mix of organisations
- 'Challenging services' presentation should have been more tailored to audience – felt quite high level principles re: challenging
- Balanced focus on health and social care. Easy to always focus on health. When we look at relationships in March, the balance/connection with councils and (commissioners of) social care/LHW.

Plan for the next workshop – teleconference at 2pm, Friday 7th Feb If you want to join, email Helen@just-ideas.co.uk for the joining instructions

How Healthy is your Healthwatch 4
Partnerships with CCGs and other Stakeholders
6th March 2013

Learning outcomes: Participants will…

- gain practical tools, based on shared examples, that will support them in developing partnerships with other organisations
- have a greater understanding of the role of LHW and CCGs in sharing information and joint initiatives

Welcome, introductions and updates

LHW and CCGs – common aims and shared responsibilities?

We showed brief video clips exploring the roles of LHW and CCGs and other organisations and how these interact. Including

- The Kings Fund: Alternative Guide to the new NHS www.kingsfund.org.uk/newnhs
- Healthwatch England video about Complaints: http://www.healthwatch.co.uk/complaints
- http://www.youtube.com/channel/UCBhfcoc8JJvKQMGUqSsJbCw

This was followed by plenary/ table-top discussion around the questions:

- How does this reflect what really happens on the ground?
- What is the key purpose of LHW and CCGs working together?

Key points from that discussion included:

General Feedback on Films:

- The Kings Fund film is still useful, and participants use it with a range of groups to explain system – however it does become out of date as the system is moving and evolving. For example it doesn't mention the Trust Development Authority at all – the TDA looks after Trusts that are not Foundation Trusts.
- It would be useful to have an overlay of where patient public involvement sits as well.
- Healthwatch seems like an afterthought in the film, with no explanation of where HW fits in across the various structures.
- Kings Fund talks about the CSUs (Commissioning Support Units) being there and this is not widely felt to be the experience on the ground.
- It was felt that the HW video did HW a dis-service by focussing on complaints rather than role in shaping services, however it was explained that this was one of many, and we chose the film on complaints as it had been the subject of trhe previous workshop – there did not seem to be a complete overview of HW on film.

Key Purpose of LHW and CCGs Working Together – reflections:

- Systems generally let people down but the quality of care is good – e.g. "I couldn't get an appointment but when I did the care was great etc"
- The situation really varies – for example there is a single HW in Lincolnshire and three in Leicestershire – key point of working together is to ensure patients' voice is heard by CCG.
- We need to collaborate on activity around involving the public in CCG to avoid duplication and so people to see there is a joined up approach
- The objective of working together is to improve outcomes – what we need to work on is how to have the conversation with the person at the centre.
- There was a degree of lost knowledge after being restructured. How do we retain and manage knowledge to influence other areas, crossing the boundaries?
- There are many different ideas of what working together is about – often the principles are there but there are different ways of achieving those ideals. There is a lot of talk but not a lot of real examples of how CCGs, LHW and other stakeholders are working together. We need messages around **how** they should work together rather than key purpose of it.

Local examples of LHW CCG collaboration: two case studies were presented

1) HW Rutland and East Leicestershire and Rutland CCG *"We are Listening"*

David Henson –Volunteer & Steering Group member, Healthwatch Rutland
Fiona Fretter – Quality Lead, East Leicestershire and Rutland CCG
(see presentation attached)

Followed by Q&A:
Are you open to other organisations coming to HW about what you are hearing on specific issues? Yes, for example one of the emerging themes is around dementia. Would invite and welcome people to come with and receive information.

What is your approach to the project work? The 'Listening Booth' is going out with three very simple questions:

- Have you had a recent experience of H&SC?
- Tell us what went well?
- Tell us what didn't go well?

The CCG will analyse data but it is clearly shared data between HW and CCG. HW are integral in accessing community groups in small places that the CCG would never have reached.

In terms of other work there are many good examples of how the relationship is working. One example is the Urgent Care Services review the CCG re currently undertaking where both HW Rutland and Leicestershire are key members of the board and provide real challenge. Importantly they work together on the consultation side of it to the point where the GGC has pre meetings with HW around consultation strategy

How are you going to pass information on to the Area Teams and other partners about things like dentistry and other directly commissioned services that you are not responsible for? All partners have made a commitment at the beginning that anything not our responsibility we pass on to providers – once we start doing more analysis and information regarding themes and trends is clearer it will be passed on to other providers. There is a strong commitment to feedback anything to relevant providers. We are currently reviewing the impact of information receiving. We're using information to inform other areas of involvement for HW like Enter and View. The Area Team stressed the power of joined up working, using knowledge from 4 LHW's to build a bigger picture and triangulate data.

2) **HW Derbyshire and North Derbyshire CCG– "*Local Healthwatch information in action for CCGs"***

Helen Hart – Healthwatch Derbyshire
Amanda Brikmanis, North Derbyshire CCG
(see presentation and protocol attached)

Followed by Q&A:

In terms of your protocol and feeding back to providers first – did you have any response from them about what they have done in response? Initially we couldn't plan meetings with commissioners and providers in the right order so we gave the information to commissioners first with a health warning that it might change. Now it is in the right order and the system ensures providers always have 28 days to respond and an opportunity to respond first. If they do respond that is what goes forward to the provider.

Power of triangulation of how intelligence has informed that visit from patient experience perspective – joint information. It's about understanding that personnel are changing and roles developing – and thinking about what does it mean to monitoring specific contracts. The project is helping frame some of those conversations.

What systems are in place to gather intelligence in HW? Four community engagement officers in the county, split across the area, are out and about gathering information. One main way through these engagement workers – when they bring experience back, we're recording experiences on a bespoke database compatible to the information bank. The work programme is defined by looking at comments - do we have comments that need picking up or gaps in what information we have?. From the gaps we have identified a focus this year on domiciliary care to look at what we know and don't know and design work programme.

What have you done regarding residential care homes, which is a key issue in Lincolnshire? HW Derbyshire has trained some enter and view volunteers and started to look at what good looks like to set as a benchmark. Also doing some research supported by

Derby University and comparing residents' experiences of care with CQC inspection reviews.

Followed by plenary discussion – further examples of collaboration:

- Lincolnshire CCG has a HW member on Governing Body – given a specific 'patients' voices' slot. Proactive role, and strategic – involved in the strategic review and on programme group. It's hard for LHW to balance role.
- Strategic Clinical Networks – fundamental to link in with HW across the counties. Want to be involved in the thinking about information sharing.
- Lincolnshire – challenges reaching migrant work population who are hard to reach and there is limited understanding as to how to reach them as vulnerable group. CCG and HW Lincs planning to do some work together and HW good at linking with harder to reach groups.
- Another CCG in south of Lincs – looking at how to avoid duplication around a locality. Work in progress and become something new.

Small group discussions: mixed groups discussed the following questions:

6. Each describe a relationship between your LHW and another stakeholder
7. What are the challenges, opportunities and successes you have experienced?
8. Select one example of collaboration which you think other areas could learn from

Some of the feedback included:

1)…an example of cuts to beds at a local cottage hospital. The provider was invited to brief LHW and other stakeholders at a meeting involving both the public and organisations. They were given information, and myth busting, and it was seen that LHW can be very useful for providers and commissioners at times of service change and crisis. The challenges include engaging stakeholders, getting strength in the network in the first place, and fitting in with PPI structures. The opportunities are around partnership, benchmarking and the power of triangulation, and processes that can be inclusive.

2)..an example of GP surgeries and PPGs looking at attendance (DNAs) across all clinical practitioners. There is a role for LHW to educate the public, particularly in relation to their expectations. This work identified issues about transport, fuel poverty and increase in unemployment affecting attendance at appointments. The challenges are that some PPGs don't want HW to get involved with them, perhaps because they have been seen as aggressive and challenging. Also PPGs may be unhappy that HW have a seat on the Governing Body and not them. Opportunities – once over the above, there are communication opportunities which they are starting to recognise. It is important to explain that HW role is to facilitate each patient having the best possible experience.

3)…LHW involvement in an Urgent Care Network: This helped put the patient story at the beginning, focusing on patients. It changed the group dynamics of provider/ commissioner – HW playing the role of a critical friend, and involved on the Health and Wellbeing Board.

Challenges included: the fit with the planning cycle and commissioning cycle; budgets and boundary issues (specifically that there is one Healthwatch but multiple CCGs and even more providers in an area). Successes include information sharing in North Derbyshire, and the opportunity for provider and commissioner feedback on issues raised by LHW.

Plenary feedback and panel discussion
Questions arising from the group discussions were put to a panel including the presenters from earlier, and also representatives from HWE (Faye) and NHS Area Team (Alison)

Do you agree there is too much patient and public involvement? (Dag Sanders – Healthwatch England)

Alison - Keep asking questions about what is important and what we know, but that means nothing if we don't do something about it – service improvement needs to be what's happening.

Fiona – it's about making sure we're engaging with enough people and not just a tick box exercise, listening to the first people to answer questions. It's about going out there.

Amanda – the 'so what' is important – telling the people who we engage with what has been done as a result of their information or experience

David – echo what has been said, and in addition we need to think about looking at population make-up and targeting specific groups in that area. To do that we need to engage with as many as possible and not be exclusive.

Mary – it's not just about listening but joint decision-making and working together. There are dangers of different stakeholders asking the same questions to same people – lots of people doing it but the important thing is sharing information and what you do with it.

I know HWE reports national trends to D of H, and we've also got Area Teams in NHS England – how will all the information join up? Worried that we've all got our own patient engagement going on, but how does it gel together and get fed back? (Darren Bailey – Healthwatch Derbyshire)

Faye – An example is Care data, that was brought up by a couple of HW to the attention of HWE, so we asked is everyone finding similar things, and if so what is the issue? We went to DofH and created change.

Alison – hard question to answer. What we have is a lot of systems sitting behind all the intelligence, insights board, friends and families etc. Don't talk to each other. So we need to look at what NHS England is doing to link it all together. One new function/ initiative to look out for is NHS Citizen – HW are shouting about needing to be part of that conversation – banging on open door but not a quick win. Insights dashboard is starting to pull some of that together. ATs are working with HWs to look at how triangulate data to inform policy and practice.

Have GPs become the innovators or gate keepers? (Martin Gawith – Healthwatch Nottingham)

Alison – a lot of GPs are innovators and a lot are very protective and don't want to change. We are having some challenging conversations when implementing plans but also looking at savings in services.

Fiona – there are some really passionate GPs

Reflection and next steps

Evaluation of the day: comments

- I found the workshop helpful and informative.
- I have more clarity on Healthwatch and how it supports the CCG
- I've only been to this one – it was a great networking opportunity. It made a difference – made me think of other ways to deliver patient engagement and involvement

Discussion of potential for future multi-agency East Midlands –wide workshops:

Is there a place for regional multistakeholder workshops?

- Yes it is important for information exchange and learning opportunities
- Useful forums to exchange ideas and best practice. Need to keep some forum in the future around specific issues/ agendas. Need to keep focus
- Stimulate collaboration and shared learning
- An annual 'checkpoint' may be useful
- Regional network events are useful to share best practice between CCGs and Healthwatches
- Yes – working with the commissioners/ service providers informally is well worth while in building understanding of the joint goals we all need to achieve
- Would like a forum to continue

How do you see them going forward?

- Make space for sharing of ideas such as the listening booth, drop-in feedback and information
- Have a focused agenda
- Support regional working
- This was my first meeting – it was very essential for me to meet others and learn from good practice and case studies from relationships between the two. More Please!
- Sharing of information and different ways of working
- Different ideas of engaging and reaching the public too
- Planning group – HW and AT and a CCG rep is a good model. We can use teleconference for this. Need a central venue though.
- Suggestion – Local area action planning at end of each workshop

Close

Local Healthwatch Providers

Terms of Reference of East Midlands Providers Forum

Membership	Chairs **and** CEO's (all with deputising ability) of all EM LHWs Healthwatch England rep (s) Local Government Association rep
Purpose	• To identify issues shared in common, solve problems and offer collective experience and mutual support • To identify and plan workshops and learning across the East Midlands • To develop a mandates for a collective approach to working with CCG's and other partners such as EMAS. To ensure a common approach to individual relationships, to give the confidence and backing, and greater voice, of a network. • To discuss key topics and encourage active learning plus share information to equip LHW providers with confidence • To agree protocols for working together and addressing cross border issues • To address regional and sub regional services that are commissioned and agree LHW leads regionally or sub regionally where appropriate and helpful • To support two way dialogue between LHW and HWE
Roles / Principles / Key Functions	• Lead by Chair, Undertake agenda planning based on identified issues • Have the authority to delegate leadership roles on behalf of the regional LHW providers where appropriate and in dealing with regional and sub-regional issues
Communication / Administration	• CDF can provide this support to March 2014 • Further clarity from HWE and regional HW Steering Group around options beyond that
Chairing	To rotate across the LHW Chairs in alphabetical order

Protocol for Neighbouring Healthwatch

1. Introduction

Local Healthwatch have been established to provide a voice for local people in the planning and delivery of health and social care services. Healthwatch have been set up in each upper tier local authority area, but many health and social care services work across local authority boundaries and people may not use services in the areas in which they live.

It is the aim of Healthwatch …….. and Healthwatch …… that there should be 'no wrong door' for members of the public who wish to make contact and that relationships with commissioners and providers should be as constructive as possible. This protocol details how the two Healthwatch will work together to provide services in the most effective and efficient way and for the benefit of the people of the areas they serve.

2. Members of the Public signing up to Healthwatch

Members of the public may sign up to Healthwatch in a number of ways. When members of the public sign up to one Healthwatch, but live in the area of the other Healthwatch, their full details will be taken and they will be asked if they agree to their details being passed on to the other Healthwatch.

3. Members of the Public making information and signposting requests

If a member of the public makes an information or signposting request to a Healthwatch, by phone, in writing or in person at a drop in or event, and they live in the area of the other Healthwatch, the receiving Healthwatch will:

- Collect information from the person in line with their own protocols
- Ask the person if their information can be shared with the other Healthwatch
- Resolve the query if it can be done confidently and quickly or if not, inform the person that their query will be passed to the appropriate Healthwatch
- Pass the information about the query and any action taken to the other Healthwatch

The other Healthwatch will report back to the receiving Healthwatch about the outcome of the query

4. Members of the Public reporting issues

If a member of the public reports an issue to one Healthwatch, by phone, in writing or in person at a drop in or event, and they live in the area of the other Healthwatch, the receiving Healthwatch will:

- Collect information from the person in line with their own protocols
- Ask the person if their information can be shared with the other Healthwatch
- Pass the information to the other Healthwatch and agree which Healthwatch will take any further action, if needed
- Both Healthwatch will record the issue in accordance with their own monitoring arrangements
- To avoid double counting of issues nationally, the Healthwatch whose area the person lives in will report the issue to Healthwatch England.

5. Cross boundary issues

If a member of the public reports an issue that relates to providers or commissioners in the areas covered by both Healthwatch, agreement will be reached about whether one Healthwatch will lead on the issue or if it will be a joint piece of work.

6. Shared service providers

The following services are the main services used by people from both Healthwatch areas:

- Provider
- Provider
- Provider

Wherever possible, the two Healthwatch will work together to ensure that Healthwatch is easy to access and responsive to issues as they arise both for members of the public and for staff in the provider organisations. This will involve:

- Use of joint promotional materials
- Shared stands, stalls etc. at relevant drop ins and events
- Joint meetings with key staff at provider organisations, particularly at a strategic level
- Sharing information about issues, contacts and meetings
- Shared pieces of work e.g. Enter and View visits

In some instances, it will be appropriate for one Healthwatch to act as the lead for certain providers. It is agreed that the following Healthwatch will act as lead contact for the following providers:

Provider	Healthwatch ……..
Provider	Healthwatch ……..

7. Enter and View/Mystery Shopper etc.

The two Healthwatch will work together on Enter and View and other activities where services are used by people from both areas as follows:

- Planning activities
- Agreeing who will lead activities
- Recruitment and training of volunteers (where needed)
- Reporting, recommendations and action planning

8. Research and Reports

The two Healthwatch will share data about shared providers and overlapping services in an agreed format and will agree collective actions, where appropriate. This will include any information to be presented to the Quality Surveillance Group.

Where appropriate, the two Healthwatch will produce joint reports relating to information and data collected about services that are used by people from both areas, which will be presented to

commissioners, providers, Health and Wellbeing Boards, Overview and Scrutiny Committees, as appropriate.

The two Healthwatch will share relevant information and data produced as a result of links with academic or research organisations.

9. Quality Surveillance Group

The two Healthwatch will share attendance at Quality Surveillance Group meetings (QSG), as appropriate. If the representative from one Healthwatch is not able to attend the QSG, the other will present issues on their behalf, if requested to do so. Where information is to be presented to the QSG about a shared provider, this will be presented as a joint report.

10. Operational issues

The two Healthwatch will make best use of limited resources by looking for opportunities to:

- Share good practice examples, resources and materials
- Share staff and volunteer training
- Make bulk purchases or take advantage of economies of scale
- Produce joint promotional materials, where appropriate

11. Liaison

The two Healthwatch will meet quarterly to review the operation of this protocol.

Signed	Signed
Name	Name
Date	Date
For Healthwatch …….	For Healthwatch ……..

East Midlands Local Healthwatch Principles for working together

12. Introduction

Local Healthwatch have been established to provide a voice for local people in the planning and delivery of health and social care services. Healthwatch have been set up in each upper tier local authority area, but many health and social care services work across local authority boundaries and people may not use services in the areas in which they live.

There are nine local Healthwatch in the East Midlands, each of which is set up and delivers its services locally. This document outlines the principles that have been agreed by the nine Healthwatch about how they will work together to ensure the best possible outcomes for the people of the East Midlands.

It is the aim of East Midlands local Healthwatch that there should be 'no wrong door' for members of the public who wish to make contact and that relationships with commissioners and providers should be as constructive as possible. In addition to agreeing these principles, East Midlands Healthwatch will agree detailed protocols with neighbouring Healthwatch about how they will work together to deliver services in the most effective and efficient way.

13. Members of the Public signing up to Healthwatch

When members of the public sign up to one Healthwatch, but live in the area of another Healthwatch, their full details will be taken and they will be asked if they agree to their details being passed on to the other Healthwatch.

14. Members of the Public making information and signposting requests

If a member of the public makes an information or signposting request to a Healthwatch, by phone, in writing or in person at a drop in or event, and they live in the area of another Healthwatch, the receiving Healthwatch will collect the information, resolve the issue if appropriate and then pass on the information to the other Healthwatch.

15. Members of the Public reporting issues

If a member of the public reports an issue to one Healthwatch, by phone, in writing or in person at a drop in or event, and they live in the area of another Healthwatch, the receiving Healthwatch will collect the information and pass the issue on to the appropriate Healthwatch. Both Healthwatch will record the issue in accordance with their own monitoring arrangements. To avoid double counting of issues nationally, the Healthwatch whose area the person lives in will report the issue to Healthwatch England.

16. Cross boundary issues

If a member of the public reports an issue that relates to providers or commissioners in the areas covered by more than one Healthwatch, agreement will be reached about whether one Healthwatch will lead on the issue or if it will be a joint piece of work.

17. Shared service providers

Where a service is used by people from more than one area, the local Healthwatch covering those areas will work together to ensure that Healthwatch is easy to access and responsive to issues as they arise, both for members of the public and staff in the provider organisations.

In some instances, it will be appropriate for one Healthwatch to act as the lead contact for a particular provider.

18. Enter and View etc.

Where appropriate, East Midlands local Healthwatch will work together on Enter and View and other activities where services are used by people from more than one area.

19. Research and Reports

East Midlands local Healthwatch will share data about shared providers and overlapping services in an agreed format and will agree collective actions, where appropriate. This will include any information to be presented to Quality Surveillance Groups.

Where appropriate, joint reports will be produced relating to information and data collected about services that are used by people from more than one area, which will be presented to commissioners, providers, Health and Wellbeing Boards, Overview and Scrutiny Committees, as appropriate.

East Midlands local Healthwatch will share relevant information and data produced as a result of links with academic or research organisations.

20. Quality Surveillance Group

East Midlands local Healthwatch will share attendance at Quality Surveillance Group meetings (QSG), as appropriate. If the representative from one Healthwatch is not able to attend the relevant QSG, another may present issues on their behalf, if requested to do so. Where information is to be presented to the QSG about a shared provider, this will be presented as a joint report.

21. Operational issues

East Midlands local Healthwatch will make best use of limited resources by looking for opportunities to:

- Share good practice examples, resources and materials
- Share staff and volunteer training
- Make bulk purchases or take advantage of economies of scale
- Produce joint promotional materials, where appropriate

22. Working at a Regional Level

East Midlands local Healthwatch will meet regularly to discuss common issues and to liaise with Regional and National bodies, including Healthwatch England and the Local Government Association.

Where appropriate, one Healthwatch will take the lead on behalf of the others at Regional Meetings or with a Regional provider.

East Midlands Regional Healthwatch will review these principles and the protocol for neighbouring Healthwatch annually at one of their regional meetings.

Draft 1
September 2013

Local Healthwatch Board Members Workshop and Networking Event Report

Aims:
By the end of the workshop participants will:

- Have the opportunity to reflect on their role as Board members
- Understand further the relationship between HWE Board and LHW Board
- Look at potential for strengthening the regional network
- Network and share with colleagues from other areas and make regional links

Present:

Healthwath	Representative
Derby	Steve Studham
	Olwen Wilson
Derbyshire	Pam Gill
Northamptonshire	Des Savage
Nottingham	Martin Gawith
Nottinghamshire	Joe Pidgeon
	Dr Juliet Woodin
Healthwatch England	Dag Saunders
	Faye Williams
CDF	Wendy Sugarman

Key roles of Local Healthwatch Board
Working in pairs the group were asked to identify the three key roles of the Local Healthwatch Board. The priority areas identified were:

1. Business skills
2. Board Experience – from private sector or social enterprise
3. Communications, engagement and website
4. Independence
5. Challenging
6. Conciliatory
7. Strategy
8. Accountability (to who – being able to be credible)
9. Sustainability
10. Champion for the customer on Board

11. Challenge and critical friend to CE and staff
12. Exploiting member networks

Discussion:

- Hard to be strategic when on short contract timescales and NHS England have to put more pressure on around this to support LHW to think strategically
- Issue of income generation from potential providers could undermine independence
- You can easily end up fire fighting day to day as very stretched rather than fire prevention and planning for the future
- Paid staff need to be able to get on with their job and clear structures for liasing with staff and feedback need to be in place
- There is a risk around retaining staff based on the length of the overall HW contracts – this affects stability and planning.
- Challenge to HW in terms of the depth and breadth of evidence that HW needs to collect across Health and Social Care from birth to death. No other part of the system has to grasp this to such a diverse extent and this presents challenges to CEOs and Board members
- The interests of the Board need to be strategic not operational. The CEO should be the main link between staff and board members – other methods of connection include joint meetings occasionally and staff members presenting key issues to board members

Open Space

Topic One: Tensions between working collaboratively and holding to account

Convener: Joe Pidgeon – Healthwatch Nottinghamshire

Key themes / Topics:

- Negative reaction from critical reports from Healthwatch from local politicians. Over engagement of councillors.
- Health providers better to responding to critical reports than possibly LA commissioners and providers particularly where had politicians influence
- LA Commissioners not properly using co-production and partnership working.
- Establishing cultural patterns of behaviour amongst LA commissioners stands in the way of the relationship with Healthwatch

Key actions / proposals

- Good example of relationship between Rutland CCG and Healthwatch Rutland.
- Model good practice examples of where local HW has successfully challenged a particular service to good effect without undermining partnership thinking
- Clarity of where HW sits, its relationship to LA and NHS complaints.

Topic Two: To what extent should Healthwatch Boards 'sign off' substantial critiques of services?

Convener: Olwen Wilson – Healthwatch Derby

Key themes / topics:

- Share with organisation visits before going public
- Not making an enemy of provider opportunities to respond / amend for providers
- Chair / chief executive sign off
- Draft report through board

- Depends on how public / media would react
- Board can help see wood for trees
- Extra layer of security
- Where publish and evidence not as it was, reputational damage /risk / financial risk
- Difficult to undo negative publicity
- Board meeting in public? Priorities panel
- County boards moving round / liaise with parish councils
- Relationship with press, help to achieve visibility

Key actions / proposals:

- Report with implication for providers, should have sight and approve to do a public document. Could be chair and chief executive / sub board
- Good practice to share draft for accuracy with provider
- Find out if we're subject to the 'Public Bodies Admissions to Meetings Act'

Topic Three: Sustainability, funding and income generation

Convener: Pam Gill – Healthwatch Derbyshire

Key themes / Topics:

- Problem due to commitment to localism will not easily be changed by any party
- HWE doe raise it with the minister
- Business plan – how can you develop one, especially long term, when our services and products are under question. Can only realistically do a two year business plan.

Key actions / proposals:

- Political lobby nationally
- Two year business plan to approximately six outcomes
- Awareness needs raising nationally about Healthwatch (at election and lobbying)
- Local Healthwatch needs to build links which are appropriate – local awareness raising
- Adopt a plan to make links with key regional offices of all key parties (they are key signposters too). Healthwatch Nottinghamshire has sent information to all elected members around the services Healthwatch offers – good profile raising and they welcome it as somewhere to take any health issues raised

Topic Four: Health and Social Care; two management systems

Convener: Martin Gawith – Healthwatch Nottingham

Key themes / Topics:

- Two cultures with inevitable clashes
- 'Social Care' do people see it in Healthwatch
- Goes back to bed blocking debate
- Healthwatch may be biting hand that feeds them
- Why do we have two organisations – many other countries have one
- Growing elderly population will test / kill the system (no affordability)

Key actions / proposals:

- How does Healthwatch fit in the middle? Healthwatch has to ensure coherent patient / public voice to debate

- How do we enable elderly citizens to access health and care? Hold partners to account, have a strong voice and question consultation

Moving Forward & Next Steps

The report from today will be sent to all the EM LHWs. The key recommendations and actions from the open space session can be taken forward both at local and regional levels and need some time and reflection by the regional group as well as each LHW.

All agreed it would be good to meet again. Martin suggested one HW host and Joe agreed that Healthwatch Nottinghamshire would host the next one, deal with bookings and provide a light sandwich lunch.

Date of next East Midlands Board Members Networking Event - Wednesday 4th June2-14, 11am to 2pm.

Protocol developed between Healthwatch Derbyshire and CCGs other partners

Information Sharing Protocol

NAME OF ORGANISATION: DATE:

The allocated person of contact for Healthwatch Derbyshire is:

Name: …… Job Title: ……

Email address: ……..

Telephone number: ……

Postal address: ……..

……

Post Code: ……..

Signed: …….. Print Name: ……

The main liaison at Healthwatch Derbyshire is:

Name: …… Job Title: ……

Email address: ……..

Telephone number: ……

Postal address: ……..

……
……

Post Code: …….

Signed: …….. Print Name: ……

FREQUENCY

When relevant information has been received, information sharing will take place (*delete as applicable) ***monthly** **bi-monthly** **quarterly**

REVIEW:

We will monitor and review this protocol on a continuous basis, with a formal review after six months.

Review date:

Indicators of the effectiveness of this protocol will be:

Background

Healthwatch Derbyshire believes that when the public and consumers are involved in decisions affecting the commissioning and delivery of health and social care services, it has resounding benefits. Individuals feel empowered, which results in increased quality and higher levels of satisfaction. Services that are shaped around the needs of individuals can increase the efficiency and effectiveness of care pathways.

Healthwatch Derbyshire recognises that we cannot achieve this without effective information sharing and being part of a positive and constructive partnership with commissioner and provider organisations. This is why we have developed, and are firmly committed to the principles of this information sharing protocol.

Collaboration will help to develop solutions to the current issues of the public and consumers, highlight risks and develop creative and innovative ideas that can shape future service improvements.

Introduction

Healthwatch Derbyshire conforms to strict information sharing protocols, a copy of which can be provided on request.

An agreement is in place between the local Healthwatch network and Healthwatch England to guide the information sharing process, and support Healthwatch England in its statutory functions.

Information is also shared between local Healthwatch organisations for the purpose of identifying common themes or issues relating to the provision of health and social care and for joint working on

issues which cross boundaries between multiple local Healthwatch organisations. This information sharing is also guided by an appropriate protocol.

The purpose of this document is to facilitate the lawful, appropriate and effective sharing of information with our partner organisations.

How information will be shared - from Healthwatch Derbyshire to partner organisations

Information is received by Healthwatch Derbyshire from patients and the general public in regards to health and social care services. This feedback, in the first instance is received as comments, or patient stories. Healthwatch Derbyshire may also undertake targeted work to explore priority topics and, as part of this, additional information may be produced, such as a report or recommendations. This information will be held on an internal IT system, prior to upload on to the secure Healthwatch England Hub. This Hub has been created to facilitate appropriate data sharing between Healthwatch England and other local Healthwatch organisations.

This data can be manipulated to show information received for each individual service provider, by commissioner, by district, by age or by topic. Information can, therefore, be extracted that meets the specific requirements of each partner organisations.

In the first instance, anonymised comments information will be collated according to the requirements of the recipient, and will be sent to each individual organisation on a monthly, bi monthly or quarterly basis by agreement, to the nominated information recipient who has signed this information sharing protocol. Any associated patient stories available on request will be flagged on the report provided. For security reasons this will be sent as a password protected attachment to an email. Additional information to support further investigation, if available, can then be requested and will be provided if appropriate and in line with our information sharing protocols.

As part of this protocol, Healthwatch Derbyshire will submit to the recipient (delete as appropriate)

- *Information relating to all services provided by the named provider organisation (provider).*
- *Information of interest to a commissioning organisation on account of commissioning responsibility and/or geographical area (commissioner).*

  Further details _____

- *Information relating to registered services (contract holder, CQC).*

A condition of receiving this information is that the organisation responds to Healthwatch Derbyshire within 28 days, providing feedback on how the information has been used to inform, shape or influence service delivery.

After 28 days, the Healthwatch information together with the provider response will be forwarded as appropriate to service commissioners, other relevant decision makers and regulators. In turn, these recipients will also be invited to respond within a 28 day time scale, so Healthwatch Derbyshire can begin to build a

picture of how effective we are at ensuring the voice of patients and the public is impacting on the delivery and commissioning of health and social care services.

This feedback may also be used by Healthwatch Derbyshire to report back to public and patients as appropriate through written publications and the Healthwatch Derbyshire website.

Each subsequent information bulletin from Healthwatch Derbyshire will build on the previous information exchanged to give an on-going mechanism for the recipient to update Healthwatch Derbyshire on any further actions.

Whilst Healthwatch Derbyshire is committed to the principal of regular information sharing with a provider first, there may be occasions when information is requested from Healthwatch Derbyshire by other bodies for a specific purpose, such as commissioners, regulators and the Quality Surveillance Group (QSG) without information having yet been sent to the provider. In this instance, information will be submitted simultaneously to the provider and the organisation requesting information.

Reciprocating information sharing - from partner organisations to Healthwatch Derbyshire

It is requested that partner organisations share their own relevant information, related to patient and service user experience, with Healthwatch Derbyshire so that we can act as a 'hub', with the aim of assisting Healthwatch Derbyshire to:-

- Become instrumental in creating a 'network of networks' so that information and intelligence can be shared across the whole system of patient experience and engagement teams working across Derbyshire, both in the Statutory and Voluntary sector.
- Draw together a strong evidence base for service improvement, so that we can speak up on behalf of the consumer with evidence based opinions and recommendations.
- Fulfil our mandate from the Government, to put *'patients at the heart of the NHS and social care'*, by *'strengthening the collective voice of patients and the public.'*
- Take an active role in the strategic decision making within health and social care by having a strong evidence base to take to strategic forums such as the Health and Wellbeing Board, Quality Surveillance Groups and Improvement and Scrutiny Committees.

This reciprocation will be applied in the case of this agreement as follows:

Principles of Information Sharing

- **Personal data and consent**

In most cases, it is anticipated that the information sharing protocols outlined above will be met by sharing information that is not personal data (i.e. from which individuals cannot be identified).

Healthwatch Derbyshire will only disclose identifiable personal data to other parties to this agreement with the consent of the person who provided that information to them (unless there is a legal obligation to disclose, or, in extreme and exceptional circumstances, where failure to disclose the information is likely to result in very serious harm to any person). Where non-personal or anonymised data can be used practicably to achieve the same purpose, the personal data will not be shared or used.

- **Safeguarding**

Where Healthwatch Derbyshire receives information or allegations regarding abuse (including neglect, physical abuse, emotional abuse, sexual abuse or institutional abuse) or other information which suggests that the welfare of vulnerable people may be at risk, this will be reported directly in accordance with local safeguarding procedures.

- **Information quality**

Healthwatch Derbyshire will take all reasonable steps to ensure that the information provided to the recipient will be of sufficient quality, namely:

- Adequate
- Relevant
- Not excessive in relation to the purposes for which it is required
- Accurate

- **Prohibition on further use**

The recipient shall ensure that the information provided by Healthwatch Derbyshire is used exclusively for the specified purposes set out in this protocol, and shall not further use the information in any manner incompatible with that purpose.

- **General Responsibilities**

Each partner organisation is responsible for ensuring that the requirements of this protocol are appropriate and adequately communicated to their staff, and for ensuring compliance with the protocol. Staff must only be given access to personal data provided by Healthwatch Derbyshire where that access is necessary in order for them to perform their duties.

Each partner's organisation must ensure that any of its employees accessing personal data is fully aware of their responsibilities to maintain the security and confidentiality of personal data.

Each partner organisation remains responsible for ensuring their own compliance with applicable legislation and common law. If they consider that any part of this protocol is incompatible with that requirement, then compliance with the law takes precedence. In such circumstances, they must notify all parties as soon as possible.