To: Healthwatch Surrey Board

From: Kate Scribbins, CEO

Date: 11th July 2016

Progress on "What we've heard" meetings with commissioners

1. Introduction

One of the key elements of our 2016/17 work plan is to develop "What We've Heard" (WWH) meetings. This is a significant development for the team. It is also a key part of our obligation as a local Healthwatch to make the views and experiences of local people known. It is closely allied to our ability to collect sufficient "useable experiences", and to analyse our database in order to generate meaningful reports for the meetings. Therefore it is felt desirable that the Board is kept up to date on our progress.

The purpose of this paper is to update the Board on progress. The Board is asked to note that progress and to endorse next steps.

2. Purpose of activity

"Providing challenge through the amplification of a selection of local voices, leading to outcomes for local people and increased credibility of their voice."

WWH meetings with commissioners provide important decision makers (senior executives) with the opportunity to hear unique insight into the views and experiences of those that are seldom heard in Surrey ("2 out of 3 people do not make complaints when things go wrong in the NHS", Healthwatch England).

One of the key requirements of local HW is that they obtain the views and experiences of local people and "make these views known". Healthwatch Surrey's WWH meetings are a key plank of our strategy for meeting this requirement alongside other forms of escalation.

This activity will also be key to achieving a number of key performance indicators in our work plan, namely:

> ***1.1 We will receive positive feedback from stakeholders around perceptions of respect, trust and credibility***
>
> ***1.3 We will achieve agreement from all CCGs and large service providers to engage with us at executive level on a regular basis…***
>
> ***3.6 We will produce bespoke, evidence-based reports summarising what we've heard from the public to feed into meetings we have with CCGs, Acute and large providers***

3. Nature of the activity

Commitments have been secured from each Clinical Commissioning Group (CCG) and the newly formed Adult Social Care Quality Surveillance Group to meet with Healthwatch Surrey at least 6-monthly to exchange information, plans and to provide opportunity to hear about what we've heard.

The agenda for each meeting is tailored with and for each CCG before each meeting. However an item on what we've heard is included in each on a 6-monthly basis. An example agenda is in Figure 1 below.

Figure 1

What we've heard meeting – Agenda
1. Working together a. Summary of HWSy activity, plans and priorities b. Update on recent reports and projects c. Summary of CCG activity, plans and priorities
2. What we've heard in Guildford & Waverley CCG localities; a. Summary report (written and attached) b. Insight (verbal)
3. AoB

A senior executive and member of the Healthwatch Surrey staff team are required to attend. We also have a volunteer allocated to each CCG who will attend. The participation

of local volunteers and Board Members significantly enhances the value of the meeting and the ability to secure outcomes. Participants are provided with a briefing ahead of the meeting (see Appendix 1: Briefing for "What we've heard meetings").

A summary report is provided to meeting participants in advance of the meeting. An example can be seen in Appendix 2: *Surrey Heath CCG - WWH Q4 2016*. In addition to this report, the Healthwatch Surrey participants will conduct a secondary and more in-depth analysis of the last 6 months of data that has been gathered within the CCG's locality. In doing so, they will aim to:

- Identify additional themes that may not be picked up by the systematic coding structure
- Identify individual experiences or collections of experiences which provide insight into the themes identified
- Identify any other individual experiences that;
    - may be of particular interest to the CCG
    - provide insight into one of our thematic priority areas;
    - or otherwise be considered to have high potential in securing outcomes for local people

The meetings have so far taken place at the CCG offices and have been chaired by Healthwatch Surrey. Following each meeting Healthwatch Surrey drafts the minutes and we are using a standard format for these to ensure that we capture the commitments made at each meeting so that we can be tenacious in following these up.

4. Update on progress

A meeting schedule has been created which identifies key opportunities to engage, including meeting commitments with CCGs (see Appendix 3). A "What we've heard" meeting series has now been established with all of the CCGs in Surrey and the Adult Social Care Quality Surveillance Group.

Since the 1st April meetings have been held with:

- 9th May: Elaine Jackson (Chief Officer) & Elango (Vijay) Vijaykumar (Chair), East Surrey CCG
- 10th May: Andrew Whitfield (Chair), North East Hampshire & Farnham CCG
- 23rd May: Alison Hugget (Director of Quality and Nursing), Surrey Heath CCG
- 21st June: Chris Hastings (Quality Assurance Team Manage), Surrey County Council and nursing quality leads from each CCG
- 29th June: Karen McDowell (Chief Finance Officer and Deputy Chief Executive), Guildford & Waverley CCG
- 6th July: Claire Stone (Chief Nurse), North West Surrey CCG

5. Outcomes

There are limited outcomes to report from these meetings at this stage. The experience during the piloting of this activity in Surrey Downs CCG and Surrey Heath CCG indicates that creating the right relationship and tone through the initial meetings is crucial to future success. Whilst we feel the groundwork has been laid in the new CCGs we are meeting with, it is too early to meaningfully report on outcomes.

The following outcomes were achieved from recent meetings with Surrey Heath CCG and Guildford and Waverley CCG:

- Healthwatch Surrey became aware of and committed to promoting an upcoming consultation opportunity for people to become involved in decision making

Specific cases

XXXX has a problem with anxiety and depression. He is registered with the [GP practice] and has seen two GPs at that surgery. He was not very impressed with the first who just gave him medication to take which did not help. He felt the second GP was more sympathetic and more helpful in terms of offering counselling.

- There was **acknowledgement** from the CCG that more investigation was required in relation to an experience of difficulties accessing IAPT services (below)
- The CCG committed to **act** by triangulating this experience with their own data on referrals to IAPT service from different GP practices in their area to explore whether there are unusual patterns i.e. lack of referrals from some GP's

Client's husband is suffering from vascular dementia; he needs constant care and attendance as his behaviour is erratic, he is incontinent and has bad memory lapses such as leaving the hob on. Client is approaching 80 and can no longer cope. She approached her GP who gave her a referral form for the rapid response team which was largely completed but not signed by the GP as required. Client was told to go to the CAB to deal with the form. It was not clear what her GP wanted the CAB to do. A CAB advisor called the response team at xxxxxxx Hospital and spoke to a member of the team who was perplexed as to why the client had been referred to the CAB when it was the GP's responsibility to deal with the referral. The client was advised to take the form back to the GP and have it signed by him and faxed to the rapid response team.

- HW discussed the referral process with the CCG and was assured that this is not normal practice.
- Outcome: CCG will notify CCG members doing quarterly checks on GPs in Guildford and Waverley to remind/ advise practices what their responsibilities are with regards to referrals and learn from this experience

Client contacted us because he is the full time carer of his 88 year old mother who suffers from dementia. The client would like some help with the care of his mother as he is her only carer and is in need of a break. The client stayed with his mother for 8 hours in accident and emergency because he thought his mother was seriously ill. However, there was nothing they could do so the client's mother was sent home. While in hospital the client was told that they would contact social services for him. No referral was made and the client had to make contact with adult social services himself.

- Discussion involved the role of the social care team at RSCH whose sole purpose is to refer patients to the relevant social care professionals.
- Outcome: CCG will check that the social care workers are still employed within RSCH and that adequate provision is in place for the referral of patients to social care services.

6. Learning / reflections

- All senior executives in these forums have been very receptive to HWSy engagement and the information shared
- In the case of Guildford & Waverley CCG a lay member of their Board was present and this really helped as he was very supportive
- Some CCGs have commented that top level "sentiment" info is not that useful in the meeting, they are more interested in specifics
- Reporting insight has, on occasion, been problematic; we provide a summary of 12 months of data to identify themes, however it is not always possible to provide a recent – and therefore more relevant – individual experience on that theme i.e. a cluster of experiences may have been gathered around that theme at the beginning of the year
- Whilst we would like to provide more balance in the report by naming the top 10 positive service areas (as well as top 10 negatives) there is not currently a high enough volume of data to be able to do this
- Each CCG has different requirements that need to be catered to; concerns with GP practices are very important in North West Surrey CCG where they have co-commissioning, less so in other CCGs
- This is a time consuming activity, particularly the preparation, and will require involvement of volunteers to be sustainable once the model is embedded
- It has provided a great opportunity to share priorities and to find out where CCGs are doing their work and find opportunities for greater joint working
- Commissioners have seemed happy to take cases at face value rather than asking for more detail, which is unlikely to be the case if the same activity was undertaken with providers

7. Next steps

- Roll this out to acute hospitals and mental health trust
- Provide another report to the Board on this activity in 9 months

Appendix 1: Briefing for "What we've heard" meetings

What we've heard meetings - Briefing for HWSy participants

Purpose

Providing challenge through the amplification of a selection of local voices, which leads to outcomes for local people and increased credibility of their voice.

Objectives

1. Secure outcomes for local people (three A's; assurance, acknowledgement, action)
    a. **Assurance** that issues identified by individuals are being actively addresses
    b. **Acknowledgement** that an issue requires further investigation or triangulation with other evidence
    c. **Action** that seek to improve services
2. Encourage more listening to the voices of local people
3. Provide an insight into what local people are saying about services
4. Gain an understanding of the commissioner view of the detail around specific issues (AKA intelligence), which can be used for future challenge and other HWSy activity

How – important values

To achieve our purpose and objectives we will need to be ***tenacious*** and:

- Personal
- Inquisitive
- Realistic

How – important principles

To achieve our purpose and objectives we will need to work in alignment with these principles:

- It is highly unlikely that conclusions can be drawn from individual experiences captured by HWSy
- Individual experiences are evidence of a lived experience and are a valid platform from which to seek understanding and provide challenge
- Whilst tenaciously seeking outcomes for local people, we should not lose sight of the necessity of relationships to our influence and the less tangible benefits of this activity (e.g. attitudes, culture, and 'accumulated knowledge')
- We do not have the resources to share (i.e. process and anonymise) with the commissioner individual experiences in writing, but can do so for a smaller selection of experiences after each meeting
- Whilst we may be able to put the commissioner in touch with some individuals, this is not the primary objective of the meeting and should not be accepted as a pre-requisite for action in all cases
- The current position of the health and care system, combined with our piloting of this work, leads us to conclude that securing three immediate outcomes for local people from each meeting should be considered a success

- This activity requires participants to engage in dialogue rather than debate: (http://capstone.unst.pdx.edu/sites/default/files/Dialogue%20and%20Debate_0.pdf)

Appendix Two: see attached 'Surrey Heath - What We've Heard'

Appendix Three: see attached CCG MEETING SCHEDULE 11 07 16