To: Healthwatch Surrey Board
From: Kate Scribbins
Date: 16th April 2020

Purpose of this paper: To review the Escalations Panel and the purpose it serves within Healthwatch Surrey's process of analysing and sharing our insight.

The Board is asked to: Approve the changes to how we analyse our insight, escalate concerns to NHS and social care partners, and to the remit of the Escalations Panel. Agree to review in one year. This paper has already been approved by the Escalations Panel. The key changes include:

- Remit of EP
- Definition of a CONC
- The way CONCs are identified within the team
- The concept of the Escalations Tracker
- The approach to clusters
- Definition of a "reasonable response"
- The reporting of insight to Panel via Intelligence Report
- The approach to Enter and View

The Escalations Panel update

April 2020

Background

The Escalations Panel (EP) has not been reviewed since October 2018. In that time much has changed in the way the team has developed. Changes in the staffing of our Evidence and Insight functions has created the need to review how we handle our insight, and fresh perspectives have shed new light on how we can work more effectively.

We want to review how we analyse and report on our insight and the place of the Escalations Panel within this for two reasons – one pragmatic in light of staff changes, and one principled in terms of learning more about how to make best use of our data.

We are currently operating without an Evidence and Insight Officer to handle our data output. Sam is due to return from maternity leave in a few months, and Margaret, who was

her maternity cover, resigned and left us at the end of Feb. We are covering the vacancy with various staff members picking up the slack. From a pragmatic point of view, we need to find a way of working that makes the best use of our insight for 6 months, and then have a further review once Sam is back.

In terms of principles, over the last few months we have realised that there are a number of inefficiencies in the ways we are working:

- We are producing too many different reports for different audiences;
- We have been "holding on" to concerning cases for too long before escalating;
- We have not done enough in-depth analysis of our own insight before coming to the EP with recommendations for action;
- We have reacted to negative sentiment analysis without fully understanding the limitations and potential shortcomings of this approach without more sophisticated analysis.

We are now taking action to address all of the above. We would like to do this in a staged manner, making some changes now, with a further review once Sam is back (autumn 2020).

These changes include a change to the way the Escalations Panel (EP) works, and what insight will be taken to the EP.

Changes to EP

There are two key changes we want to make to the EP:

1) The way the EP looks at our concerning cases;
2) The way we use our intelligence and insight to inform what the EP looks at.

Why do we have an Escalations Panel?

What has been the purpose of the EP to date?

1. To help spot emerging issues to guide what HWSy investigates further;
2. To help work out what is going on in these emerging issues – scratch below the surface;
3. To help work out which cases amongst all our insight are the most concerning and how to escalate these.

What will the new purpose of the EP be?

1. To look at all the cases the staff team have escalated, consider the responses we have received from providers/commissioners and determine whether these responses are satisfactory, or whether HWSy needs to take further action using all the powers at our disposal;
2. To receive an update on our insight via an "Intelligence Report" and advise the staff team on context and what issues should be pursued further.

Concerning cases (CONCS)

Since October 2018, the EP has been operating as the filter for all concerning cases (CONCS[1]), deciding which ones to "escalate" and where. This means cases are delayed whilst waiting to go to the EP (with the expectation of safeguarding which is always actioned immediately). It also means that the EP has limited time to look at cases and can only select a sub-set for escalation. This judgement is quite subjective.

Currently we define concerning cases as those experiences which includes issues around *unmet needs; quality of care not acceptable; person exposed to avoidable harm*. We recommend that this definition is adapted to remove unmet needs *except where this relates to harm*. This is because unmet need is quite wide in interpretation and covers issues which are often more suitable to be reported back to commissioners as a theme (e.g. people unable to book GP appointments due to poor booking systems, or people feeling they have been discharged to early from mental health services. Where we have a number of these cases, they will be acted on as a cluster. Therefore, we will define concerning cases as those where the quality of care was not acceptable and/or a person was exposed to avoidable harm. We will keep this definition under review.

As our relationships with providers and commissioners has developed, and staff expertise in spotting concerning cases has developed, we have moved to a system of escalating any CONCS to providers and commissioners straight away. This is due in part to the work we have been doing with the new Surrey Heartlands architecture, where we have been building relationships with Quality team leads and agreeing to escalate more to them.

Our remit as a Healthwatch is to share and escalate as much as possible without applying subjective filters of our own, and this is best served by staff escalating CONCS as business as usual, without needing additional filtering at the EP.

We also need to improve the way CONCS are flagged as they are put onto our database. Currently all stories are read by our Data and Admin officer (Margaret's old post) and it is their job to pick out the CONCS. There are a number of problems with this approach:

1) It is difficult/potentially traumatic for one individual to read such a volume of distressing cases
2) It is too subjective for one person to be making this judgement call for all our stories
3) It is too risky to have only one person in the team reading all our stories.

We are therefore moving to a system whereby:

- The Intelligence Officers have overall responsibility for identifying CONCs and maintaining the Escalations Tracker;
- People who put stories on the database (Helpdesk, CA Champions, IHCA as well as core team) will be trained in how to identify and flag potential CONCS as they input;
- More team members *and volunteers* will be involved in reading all stories and identifying CONCS (coordinated by the Intelligence Officers) thereby spreading the

[1] Current definition is an experience which includes issues around unmet needs; quality of care not acceptable; person exposed to avoidable harm. These are currently under review.

load, reducing the impact on one individual, and reducing the risk of subjective judgement.

By doing this we believe we will be better at identifying CONCS in the first place. These will then be escalated to providers for responses. We will do more to harness volunteer support in helping us work out what's gone on in each case and therefore what questions we need to be asking of providers/commissioners.

We are developing a master Escalations Tracker of all our CONCS. This will include the original issue; the questions asked of the provider/commissioner; the status of the CONC and any response received.

This tracker will be reviewed by the EP and the role of the panel will be to look at the responses received and evaluate whether they are "reasonable/satisfactory" (definition to be developed). On occasion we receive inadequate responses to our escalations, and the role of the EP will then be to decide what further action we need to take, and whether we need to use our powers (e.g. more formal approach; Enter and View; take matters to CQC or Adults and Health Select Committee or elsewhere).

We will also develop our sharing of the tracker with colleagues in quality across SH and Frimley who are interested in knowing what we've escalated and what responses we get.

Clusters

If we are satisfied that the above process is effective at dealing with all individual CONCS which come our way, the question remains about how we identify a **cluster** of experiences which may not in themselves merit classification as a CONC but taken together may indicate a problem. This is particularly the case with unmet need. An example might be many patients from on GP surgery telling us that the appointments system isn't working for them. Or a number of patients trying to book sexual health clinic appointments and finding that the online system isn't offering them any appointments. Or users of mental health services telling us that they feel they are discharged too early without ongoing care.

Our approach to these needs to be viewed in the light of the following:

1) Within the team we will still carry out our analysis of sentiment attached to providers on a regular basis. We will review whether a high level of negativity is meaningful, rather than due to data collection issues such as sampling. Where we feel this negativity is meaningful and may indicate a problem, we will investigate further and report this to the EP so that the EP has the facts at its disposal to make a meaningful recommendation. This investigation may include reactive engagement if necessary.
2) All stories on our database are read by various team members (coordinated by the Intelligence Officers), and their assessment will be fed back to the Intelligence officers, who will then re-review, so there is a regular opportunity for the Intelligence Officers to spot emerging issues and clusters.
3) We will continue to review all of our insight regularly for our schedule of reporting to providers and commissioners across Surrey. We already have many regular

meetings with a range of CCGs, Adult social care, primary care, public health, SABP, SECAmb. Over the coming year we will be adapting and extending this to include ICPs, and all the hospitals. During the preparation of these reports we will be analysing all the stories we hold for the relevant commissioner/provider, which provides an opportunity to identify clusters.

Using these three approaches we will report on clusters to the EP alongside the CONCS as part of the Escalations Tracker, so that the EP can see what action the team has taken in response to these clusters.

How we will keep the EP informed about what we are hearing about services

The tool which we have used to date to spot emerging issues is the sentiment attached to all our stories – negative sentiment prompts further scrutiny. The level of negativity which triggers additional scrutiny has changed over time but we have maintained sentiment as our key guide.

Over the last year, with new perspectives being brought from the staff team, we have been questioning whether this quantitative approach, based around sentiment, it a reliable guide. This came to the forefront when we thought that we had identified a higher than average level of negative sentiment attached to RSCH. In order to get to the bottom of this we carried out a "deep dive" into the last 6 months' worth of stories for RSCH. We also compared these to the last 6 months for Frimley. To cut a long story short, in the end we came to the conclusion that the negative sentiment we were attributing did not in itself mean anything significant.

This is due to a number of factors, including:

1) Hospitals in Surrey are different, have different specialities and see different types of patients. This may make a significant difference to the stories we collect as patient expectations and experiences may vary hugely. We aren't comparing apples with apples.
2) Trusts in Surrey cover a wide range of services/departments, and to look at overall sentiment for the Trust as a whole is not particularly helpful. Where possible we do look at individual services (eg within SABP we look at various mental health services), however we often don't have the volume to make this meaningful.
3) The source of our stories makes a big difference to the sentiment attached. The experiences which come in via our Helpdesk, website, CA champions and IHCA tend to be negative (that's why the person has taken the trouble to approach us proactively). Whereas the experiences we pick up on face to face engagement are much more mixed. Therefore, the mix of sources through which experiences have come in over the last 6 months can make a big difference to sentiment. This has been addressed at the EP through the addition of "source" information to the reporting but still leads to more questions.
4) One story from a member of the public can have many sub-topics within it. Each of these sub-topics is assigned a sentiment. Therefore, the sentiment for the provider can quickly become skewed by a small number of stories with many negative sub-topics, particularly for providers who we don't capture many stories about.

5) The providers with higher levels of negativity don't change much over time (mental health services, adults social care) – therefore the analysis has limited use.

This is not to say that we want to move away from sentiment analysis altogether. We still believe it is a useful tool to help the team identify areas for further investigation. However, the "Thematic analysis" report which goes to the EP is often too broad to be helpful. The same providers tend to crop up each time, and when a provider does crop up, the panel is often unsure what is giving rise to the negativity – there is no clear set of themes, therefore it is impossible for the panel to recommend action.

We feel it will be more efficient for the team to review insight on a regular basis, using sentiment as a tool. The team will review all stories for a particularly negative provider (as we did for RSCH) to try to identify what is giving rise to the negativity, or if it is a quirk of our engagement schedule and methods. Where the team perceive that there is a potential cause for concern, this will be reported to the EP with recommendations for further action.

The team will also be reviewing our insight on a regular basis for a wide range of WWH meetings. We also reach out to partners and volunteers to ask them to share with us "non-database intelligence" to ensure we have an ear to the ground. These activities will form the basis of a regular "Intelligence Report" which will keep the EP informed about what we are hearing and whether we have concerns.

We will maintain our practice of reaching out to our volunteer groups and partners such as Citizens Advice on a regular basis to ask if they are hearing of any concerns that aren't on our database ("non-database intelligence concerns") to supplement our own engagement feedback.

Therefore, instead of presenting a report based on sentiment analysis to the EP, we will prepare a regular Intelligence Report which will pull together the headlines of our analysis for the WWH meetings, the rolling review of the database, and our non-database intelligence concerns.

A note on Enter and View

We are planning to use our Enter and View powers in the following ways in 2020/21:

1) Under the Community Engagement Strategy, we will consider using E&V to reach those "behind closed doors" who would otherwise find it hard to engage with us, as we visit each ICP area on a rolling monthly cycle;
2) If we have a specific project where we feel E&V is the best tool to reach people (e.g. care home residents) then we will visit as part of the methodology for that project;
3) Where we hear a concerning case about a care home we will liaise with the CQC and if we feel it's appropriate we will carry out an E&V. If time permits we will discuss this at Escalations Panel in advance, however, if the CEO feels a more urgent visit is needed, we will not wait for the EP.

Recommendations

1. The remit of the EP is revised to become a panel which:

a) Reviews the Escalations Tracker and helps decide whether responses from providers/commissioners to individual escalations are satisfactory;
b) If responses are not satisfactory, helps decide what further action HWSy should take;
c) Receives an overview of intelligence across all sources, including clusters, and helps decide if more resource should be deployed on emerging issues.

2. HWSy continues to escalate all CONCS as business as usual. To assist with this, a sub-group of volunteers is established to help look at CONCS and work out what questions to ask.

Other improvements:

- All partners doing inputting to sign up to new guidelines which include flagging potential CONCS (now actioned as part of signing up to new SLAs for 2020/21);
- Training to be offered on how to identify a CONC if needed;
- Work to identify CONCS to be distributed amongst team members;
- Definition of "Reasonable Response" to our escalations to be agreed as part of this paper and reviewed in one year.

Appendix 1: Overview of our reporting for 2020/21

- Ongoing Escalations and activity tracker – with CONCS and clusters as a subset (in development)
- Regular Intelligence Report summarising headlines from the reports below (in development)
- Quarterly report for CQC
- Quarterly report for Heartlands ICS Quality and Performance Board
- Reports for each ICP after each monthly engagement focus
- "As and when" reports on soft intelligence for Surrey Heartlands JIG
- 6-monthly meeting with hospitals
- 6-monthly meetings with SABP
- Quarterly report for SECAmb (compiled by HW West Sussex)
- 6-monthly report for all public health-commissioned services
- Regular reports on sexual health for contract monitoring meetings

- Quarterly report for Adult Social Care

- Children's services – under discussion

Appendix 2: Definition of a "Reasonable response" to our escalations

To be classed as a "reasonable response" to one of our concerning cases, the response needs to be in plain English and meet the following criteria (each to be judged on a case by case basis, with some flexibility, as we recognise that each case is different):

1. Acknowledge receipt of our escalation
2. Provide or agree reasonable timeframe for full response – e.g. 3-4 weeks unless agreed otherwise; or a staged response if investigation needed
3. LISTEN: Acknowledge validity of the experience/issue (i.e. without saying they cannot investigate without more info)
4. RESPOND: Provide a response to all key issues raised/questions asked
5. IMPROVE: Provide a tangible demonstration that the experience/issue has been used to shape learning or improvement, leading to improved outcomes for service users:
    - If it's a failure to deliver service as per specification, or to comply with existing requirements: acceptance/explanation of what went wrong and of how issue will be used to improve learning in delivering current service/what steps will be taken to help ensure it doesn't happen again
    - If it's that the service doesn't meet needs: explanation of what steps will be taken to improve service as a result of issue raised; and a timeframe for change.

Other useful points:
Do they believe this is an isolated example or does it reflect what they have heard from other sources of feedback? In either case what action is being taken?

This definition will be reviewed after one year as we learn more about how decision-makers respond to us.