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| **Healthwatch Kingston Board Meeting (Part A)** | **Date:** Wednesday 31 July 2019 |
| **Report Title:** Chair’s Report | **Autho**r: Liz Meerabeau, HWK Chair, Trustee/Director |
| **PART A Agenda Item 5** | **Appendix: 5A** |

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| **FOR DISCUSSION AND/OR DECISION** |
| The Board is requested to note the content of this report. |

Healthwatch Kingston has been through a testing time in the past two months. The volume of our work has increased – particularly our activities involving people with learning disabilities and the Time to Change hub- at the same time as we have been busy recruiting new members of staff. We are delighted to welcome Jaimy as our Communications and Engagement Officer and look forward to welcoming three other new colleagues in August. We are also grateful to our Chief Officer, Stephen Bitti, and to Scott our Projects and Outreach Officer, for their effectiveness in driving our agenda forward and meeting deadlines, in particular the annual report to Healthwatch England.

At the time of writing we still have the same Secretary of State for Health and Social Care- Matt Hancock- but we are anticipating changes in local health care bodies arising from the NHS Long-Term Plan, and Healthwatches across south west London are considering the implications both for ourselves, and also for public and patient participation more widely.

**Primary Care Networks**

As highlighted in my March report, PCNs are considered to herald a great cultural change within the NHS. They have been defined as ‘groups of general practices working together with a range of local providers, including across primary care, community services, social care and the voluntary sector, to offer more personalised, coordinated health and social care to their local populations’, ‘normally based around natural local communities’, and ‘small enough to maintain the traditional strengths of general practice but at the same time large enough to provide resilience’.

The five PCNs in Kingston became operative on 1st July. Generally, they are geographically based, although one is not, as indicated by its name- Canbury, Churchill, Orchard and Berrylands PCN. The other four are Surbiton Health Centre PCN (the smallest, with a patient population of 31,605), Kingston PCN, Chessington and Surbiton PCN, and New Malden and Worcester Park PCN (the largest, with a patient population of 60,510). The national range established when PCNs were being set up was a minimum population of 30,000 except in very rural areas, and a maximum of 50,000 which was indicative; however a recent King’s Fund report states that nationally the majority of PCNs are over 50,000. The King’s Fund report states that community and mental health services will be expected to configure their services around PCN boundaries, although it is not clear how that would be achieved where the PCN is not a defined geographic area. They have been set seven service specifications, of which five, including structured medicine reviews, will be introduced in 2020. The other two, including addressing inequality, will be introduced in 2021, and the King’s Fund comments that ‘Practices will need to work with their patient participation groups and the wider local community’ to address population needs.

Having a PPG is an existing requirement in the GP contract, although they vary in their degree of activity. A piece of HWK work which had to be paused was a dialogue with PPGs to see how the relationship between them and HWK can be enhanced to mutual benefit, and we are pleased that Jaimy will be undertaking this activity.

**CCG merger**

It is anticipated that the six CCGs in south west London will merge in order to save 20% in management costs, but that 80% of activity will remain local; quite what that will look like is not yet clear. Since Healthwatches have each had a seat on the governing body of their respective CCG, discussions are underway on what the arrangements should be at the SWL CCG, encompassing Healthwatches, lay members of CCGs and the voluntary sector but not detracting from the clinical predominance in the CCG. Several Healthwatches consider that since they have a statutory duty to represent the views of a particular borough population, that cannot be delegated, and the advice of HW England is being sought. Sir Robert Francis, chair of HWE, has stated to the Health Select Committee that there needs to be formal representation of Healthwatch/the patient voice sub-regionally (e.g. south west London) but that it will require additional funding.

One potential model is to have a Borough Community Engagement Steering Group, interacting with a SWL Stakeholder Reference Group (see Appendix 5A), but greater clarity is needed on the potential agenda, and how directly it relates to CCG business. It would also require additional resources, and if it is intended to inform the CCG agenda, several weeks turn-round time.

**Integrated Care Systems**

Sir Robert Francis also expressed concerns to the HSC that proposals for ICSs had insufficient clarity on how residents will continue to maintain their influence in the larger arena of an ICS. It is likely that south west London will establish an ICS, and HWK is representing the south west London Healthwatches on the governance design group. The first meeting took place on 23rd July; the papers for it- an extract from the Long-Term Plan and ‘ways of working’ papers from three pioneer ICSs (South Yorkshire and Bassetlaw, Frimley and Suffolk and North East Essex) refer to lay or citizen involvement but don’t explicitly address PPE, nor mention Healthwatch.

**South West London Five Year Plan**

Lastly, we have been notified that a Five-Year Plan will be drafted in August for publication in November, building on the 2018 local engagement events and the April 2019 clinical conference. We have enquired whether HWK will be involved in the launch with staff and local people which is scheduled for September.