Agenda

For enquiries on this agenda, please contact:
Stephen Hardisty 020 8974 6629
Stephen.hardisty@healthwatchkingstonuponthames.org.uk

This agenda is available on:
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Board Meeting – Part A

Date: **Wednesday 23 September 2015**

Time: **5pm – 6.30pm**

Location: **Small Committee Room, Kingston Quaker Centre, Fairfield East, Kingston upon Thames, KT1 2PT**

1. **Welcome, introductions and apologies**

2. **Declarations of Interest**

3. **Minutes of the meeting held on 14 August 2015**
   To approve the minutes of the last meeting

4. **Matters Arising**
   Not covered on the agenda

5. **Chair's Report** **Appendix A**

6. **Manager's Report** **Appendix B**

7. **Task Group Reports** **Appendix C**

8. **Strengthening Community Engagement** **Appendix D**

9. **Document Review 2015** **Appendix E**

10. **Any Other Business**

DATES OF FUTURE MEETINGS
Wednesday 21 October 2015 5pm-7pm
Thursday 13 November 2015 10.30am – 12.20pm
Wednesday 16 December 2015 5pm-7pm

Minutes of the Healthwatch Kingston Board Meeting

14 August 2015

12.30pm – 2pm at the Kingston Quakers Centre

Present:
Grahame Snelling (Chair, **GS**), Nigel Spalding (Trustee, **NS**), Kim Thomas (Trustee, **KT**), James Davitt (Trustee, **JD**), Joel Harrison (Trustee, **JH**), Eleanor Levy (Active Affiliate and Chair of Community Services Task Group, **EL**), Graham Goldspring (Active Affiliate and Chair of Mental Health & Hospital Services Task Groups, **GG**), Marita Brown (Active Affiliate, **MB**), Tony Williams (Active Affiliate, **TW**), Anne Macfarlane (Active Affiliate, **AM**), Glen Davies (Active Affiliate, **GD**), Patricia Turner (Kingston Voluntary Action, **PT**), Jenny Pitt (Staff, **JP**), Sophie Bird (Staff, **SB**).

1. Welcome and apologies

The Chair welcomed those present. Apologies were received from Stephen Hardisty (Manager, **SH**), Caroline Cunliffe (Active Affiliate, **CC**) and Jo Boxer (Active Affiliate, **JB**).

2. Minutes of the last meeting and actions

The notes of the last meeting on 22-07-15 were agreed as an accurate record.

3. Launch of Annual Report 2014/2015

3.1 Chair's Statement
GS introduced our Annual Report. In our first year we focused very much on governance and internal workings, so in Year 2 we were much more able to be more outward facing. Our Affiliate Membership has grown by 54%, and we've carried out 8 Enter & View visits. GS thanked former HWK manager Rianne Eimers for her input and her significant contribution. JP gave a brief summary of the Young People's Enter & View visit to Kingston Hospital.

3.2 Manager's introduction
In SH's absence, GS talked briefly about the report, highlighting work around the Care Act 2014 and a planned joint partnership project with Refugee Action Kingston designed to profile the health needs of a particularly marginalised group. EL highlighted the work of the Community Care Task Group and is looking to cultivate a more collaborative approach with RBK and commissioners.

3.3 Impact Story 1 – HWK & Kingston Mencap
JP explained how HW England had been commissioned to carry out work around learning disability by Royal Mencap, and that HWK and Kingston Mencap held a local forum to ensure that Healthwatch was aware of the issues and challenges faced by people in the learning disability community.

3.4 Impact Story 2 – Royal Eye Unit

SB highlighted an Enter & View visit at the REU in July 2014, and talked about the recent visit last month with the blind and visually impaired volunteers. All members discussed the difficulties with communication and GG suggested this should be a priority area for HWK.

4. Priorities for 2015-16

GG reported that the Mental Health Task Group is keeping a close eye on the Community Wellbeing Service. GG and TW have joined the CWS board as HWK reps. TW explained that the board is really about partners focusing on delivery and targets achieved, rather than outcomes. GG explained that as he and TW are not HWK board members, they are not included in the decision making. GS talked through the priorities document (published on HWK website) and highlighted future work areas such as learning disability, end of life care, cancer waiting times at Kingston Hospital, concerns around CAMHS and the Kingston Co-ordinated Care Programme. GG made a strong request for Communications to be a priority and JD made a research request of HWK staff, to see if there is a national document in this area. GS highlighted an organisational priority in that HWK needs to start conversations with Parkwood and RBK as our initial contractual date end approaches.

5. Question & Answers

NS asked whether anyone knew why the portfolios had changed at RBK, for example why has Cllr. Julie Pickering moved. TW said there are official docs explaining the portfolio change and has distributed these to HWK Staff. PT commented that there is an opportunity here for HWK in these changing forums with a new perspective on engaging with communities.

AM asked about HWK partnerships. How are they set up and what agreements are in place? SB explained the agreement with RAK and how this brings people who are of BME origin into our organisation.

EL asked about the relationship with HW England. How does HWK contribute nationally, and what does it receive in return? JP explained how we submit info and liaise with Georgina Bream, and JH suggested that HWE is finding its place nationally in comparison with local Healthwatch.

TW said it has been tough breaking into local mechanisms of health and social care. It makes the work of task groups much harder. We might want to think about our place within various governance mechanisms to ensure our voice is heard.

GS asked if members and colleagues felt that HWK is getting it right.

EL said that HWK is well positioned and can see where we have influence. HWK board and staff are supportive of volunteers.

GG said that it has been a learning experience. Volunteer ethos is excellent and that volunteers are happy and interested in their work.

JH said that HWK seems to be the most professional organisation he is involved in, with excellent staff. He felt that there was a need to set long term strategic direction to ensure sustainability.

TW highlighted that HWK is trying to do 3 things: voices heard, deciding big ticket items and speaking with one voice. Since SH has arrived more work is happening to get voices heard. Need to make sure people are listening to those voices.

6. Any Other Business

None.

Signed by the Chair of the Board of Trustees

Dated 23rd September 2015

Healthwatch Kingston Board **Appendix A**

23 September 2015

Agenda Item 5: Chair's Report

Report by the Chair of the Board of Trustees

Purpose

To update the Board on the Chair's involvement with local strategic partnerships, governing bodies, scrutiny processes and other matters of interest.

Recommendations

The Board is requested to note and discuss the report.

Health Overview Panel

1. The last meeting of the Health Overview Panel was held on 3 September 2015. Agenda and reports are available online[1].

2. On this occasion HWK was not able to be directly represented. The minutes of the meeting will be available shortly. There was a lengthy Q and A session before the start of the agenda. The main agenda items related to a consultation about the future of Gosbury Hill Walk in Centre in Chessington, A and E performance at Kingston Hospital and progress towards 7 day working. The online reports describe how Kingston Hospital is concerned about recent poor waiting time performance and the measures it is taking to rectify this, and spell out what each provider is doing locally to meet the 7 day a week operational target. In respect of Gosbury Hill, HWK will want to be involved in the conversations but recognising the historic issues about how the GP led service was set up and the range of diverse opinions, HWK will primarily want to ensure that emerging proposals are evidence based, and do not adversely affect patients who currently use the service.

3. The next meeting of the Health Overview Panel will be held on 24 November 2015. On this occasion HWK will be presenting a report on our Enter and View activity over the last few months. A key area for HWK to consider is how public attendance and active engagement at the HOP and the HWBB can be maximized in future.

4. Some comments about the HOP meeting have been received from Patricia Turner who attends as the representative from Kingston Voluntary Action. They are as follows:

[1] http://moderngov.kingston.gov.uk/ieListMeetings.aspx?CommitteeId=233

- Gosbury Hill GP Led Health Centre Consultation Questions - the HOP had been asked to look at the Consultation plan and advice and comment. There was concern expressed about the amount of wording in the introduction to the consultation. The focus of the plan seemed to be weighted toward the population in the South of the Borough and Surbiton and there was concern that the service the CCG are looking to relocate is for the whole of the borough and therefore there is a need to consult as widely as possible. KVA pointed out that there exist a number of networks of voluntary and community groups that would be able to raise awareness of the consultation and offer engagement opportunities for the CCG during the consultation period in addition to those already planned with the refugee, traveller and homeless community. It was explained at the meeting the relationship between the GP practice and NHS England in commissioning GP services which will be impacted by this change and that there is to be a second consultation running at the same time for those affected by the proposed closure of the GP Practice at Gosbury Hill by NHS England.
- Update on A&E performance at Kingston Hospital (against the 4 hour A&E standard) - since the report the waiting time performance has continued to improve. The notion of winter pressure now seems to run throughout the year. The demographic of those attending A&E – traditionally thought to be the frail and elderly is changing – now a high proportion of users are very young children and young adults – a need therefore to tailor the message about when to go to A&E and the alternatives
- Seven Day Working (Local progress) – this links to the proposal/consultation on provision of a 'walk in centre' - there was some discussion about the delays to discharge and that the hospital is looking at its systems to address this. The success of the Rapid Response programme run by Your Healthcare was also mentioned as contributing to bringing down non-elective admissions.

Kingston Clinical Commissioning Group (CCG) Governing Body

5. The last meeting of the CCG's Governing Body was held on 8 September 2015. Agenda and reports are available online[2].

6. I attended this meeting for HWK. The main points discussed were:

    - Gosbury Hill consultation arrangements – as above. Full details of the process and proposed changes are included in the online document bundle. HWK has contributed to Equality Impact Assessment
    - Re-procurement of 111 and Out of Hours services – the re-procurement plan were agreed but HWK will need to be alert to the service specifications and penalty clauses in respect of poor

[2] http://www.kingstonccg.nhs.uk/about-us/kcc-meetings.htm

performance given previous concerns expressed by member of the public to HWK in 2013/14

- SW London Collaborative Commissioning – the governing body received a report about how this project is developing. It is concerned with bringing about change in SW London in a time of financial savings, and is the third iteration of an attempt to do this. There is some concern about ensuring that this time it is effective and I asked for details of how much the whole exercise was costing, given financial constraints on the NHS. I am promised this information next time. There was a reminder about the Kingston consultation event on September 10th
- Public engagement – a brief paper was presented about plans to strengthen patient and public engagement. A year book detailing what has been achieved in the last year has been produced to which HW have contributed
- CCG committee updates – the main aspect I addressed was the question of the CCG planned surplus, contrasting this with the deficit at Kingston Hospital. Whilst there is no direct relationship I pointed out the public image of the CCG holding on to money whilst a key provider was in difficulty. This launched some debate but which ended with the Director of Finance agreeing to review how figures were presented to show a more accurate picture, arguably where, in effect there is no real surplus

7. The next meeting of the CCG's Governing Body will be held on 3 November 2015.

Health and Wellbeing Board

8. The last meeting of the Health and Wellbeing Board was held on 8 September 2015. Agenda and reports are available online[3].

9. Nigel Spalding attended for HWK on my stead, and I am enormously grateful to him. He has made comprehensive notes available to board members which are not copied here. Nigel raised 4 issues that had been identified as emerging themes, each with a body of evidence and the source of that evidence made clear. This is a helpful way of presenting our issues and we will repeat the process at the next meeting. The themes were: hospital discharge, dementia, refugees and grass roots initiatives. Nigel's notes highlight the following issues:

    - There is a report about the impact of benefits changes being brought to a council committee – not sure which one
    - Seeking clarity over the reductions of the Public Health grant (£646k)
    - Nigel challenged KH over 'over performance' comment and public perception of this
    - Refugee issues and consultation arrangements in Kingston were brought to the meeting by Cllrs Davies and Pickering

[3] http://moderngov.kingston.gov.uk/ieListMeetings.aspx?CId=488&Year=0

- Better Care programme – protracted debate about a DoH invitation to the HWBB to lower its target for reducing non-elective admissions with the final outcome being to agree to reduce the target with work taking place outside the meeting to work up details so as to avoid failure and the need for another recovery action plan
- Joint Health and Wellbeing Strategy – MH theme. There was discussion about the challenges facing MH services at present and some speculation about the reasons for this. Nigel raised the issue of how the activity reports related to the strategy which was light on metrics. This was acknowledged and will be addressed.
- Nigel expressed concern about the fact that only one decision was reached and no members of the public were present. It will be good to link with the council to see if HW can be a catalyst for improving this picture

10. The next meeting of the Health and Wellbeing Board will be held on 19 November 2015. We shall need to identify and back with evidence three or four key themes.

South West London Collaborative Commissioning

11. An engagement event was held on 10 September 2015 as part of the South West London Collaborative Commissioning process to develop a five-year plan to improve health services across the region. An 'Issues Paper' and further information is available online[4]

12. I attended for HWK and joined a table of residents and reps from organisations for a conversation about out of hospital care arrangements and how these can be improved. There was a consensus about the key proposals and reasoning put forward by the CCGs across SW London, matched with a reluctance to shift too much resource from hospitals. The format of the evening as then that the groups fed back their ideas – there were also groups around mental health, maternity services, cancer care, children's services, transforming primary care, planed care and emergency care. These are the 8 work streams for the Collaborative commissioning process to consider. This exercise was to gather the public's thoughts and ideas. After a break I joined the children's group and learnt about the Children's Network of health and social care providers that is meeting to consider potential collaborative arrangements and I put forward the idea of a children's reference group – perhaps sponsored by SW London HWs. This has gone into the mix, and the group also picked up about the value of preventative services for children benefitting whole families in terms of enhanced resilience.

13. HWK could be involved in helping to arrange a sequel to this event when the more detailed proposals emerge. There were around 80 people there who had been recruited by the CCG and it was good to see many fresh faces in the audience. However my main concern was

[4] http://www.swlccgs.nhs.uk/

that the residents on my table were seemingly unaware of HWK and its role. This had been echoed in other SW London boroughs too. There is therefore a challenge for us to see if we can become much more widely known.

Other Matters

14. After a quieter summer period the consultation season is hotting up again and there is much to keep our eyes on locally in Kingston and across SW London. A key aspect of this is to make sure we are effectively horizon watching for both actual dates of meetings to make sure we are always represented and able to ask the right sort of questions, and opportunities to initiate dialogue. Probably neither the board nor the staff have the capacity to be at everything so it feels right to do several things at the same time:

- Make sure we have clear calendar of events
- Agreeing priority attendance
- Mobilising our active affiliates to attend as many events as possible, including council and CCG meetings, as much as to demonstrate public interest in the issues being debated
- Preparing well-argued succinct submissions to present at key meetings
- Ensuring all who attend any meetings or consultations are well briefed.

15. When we attend meetings and make forceful, evidence based contributions, these are becoming recognised by partners as having great value and so it is imperative that we sustain the approaches that we have developed especially over the last six months. My sincere thanks, as ever, to the staff, board members and active affiliates who make this happen.

Healthwatch Kingston Board **Appendix B**

23 September 2015

Agenda Item 6: Manager's Report

Report by the Manager of Healthwatch Kingston

Purpose

To update the Board on operational matters that impact on the role of Healthwatch Kingston (HWK) and to keep the Board informed of development opportunities and useful resources.

Recommendations

The Board is requested to note and discuss the report and approve next steps.

Schedule of important meetings

1. Annex I to this report details the important meetings that are planned to take place up to 31 March 2016. These meetings include those applicable to the role of HWK such as Board and Task Group meetings as well as other meetings such as the Health and Wellbeing Board, the CCG's Governing Body and the Health Overview Panel, which are attended by the Chair or a nominated deputy who must be a Trustee. These meetings, however, are public meetings and HWK Active Affiliates are encouraged to attend and to ask questions (with the agreement of the Chair or nominated deputy) in accordance with each meeting's public participation process (e.g. advance notice is recommended).

2. The schedule also includes the dates of two NHS Trust Board meetings. At present HWK does not attend these meetings although there would be benefits in doing so, such as raising the visibility of HWK, learning about what is going on, asking relevant questions and providing feedback to the Board and Task Groups. Notice of Trust Board AGMs and the CCG's Governing Body AGM held this month have been circulated to Trustees and Active Affiliates and notices published on the website.

3. The aim of this report item is to request that the Board considers nominating representatives either from the Board and/or Task Group Active Affiliates to attend NHS Trust Board meetings and to encourage greater participation at other public meetings. It is important to note that all HWK Trustees and Active Affiliates must abide by relevant policies relating to representing HWK at meetings, such as the Code of

Conduct (if in doubt Trustees and Active Affiliates should seek advice from the Chair or the Manager).

Proposed Grassroots Led Community Engagement Initiative

4. In response to HWK's commitment to support the development of grassroots led initiatives (as detailed in Agenda item 8) a weekly drop-in session has been provisionally booked at the Kingston Quaker Centre. The opportunity is based on a partnership with Recovery Initiative Social Enterprise (RISE), a grassroots led organisation, who will run a community café from 1pm-4pm every Wednesday. The principal aim of this arrangement is to harness the strength within our community to build a network of people who can use their shared experiences of health and social care services to influence change for the better and to use the voice of the community to establish a new approach to community engagement (e.g. grassroots led) that is about making the system respond to individuals and groups, rather than the other way round.

5. For HWK there will be a number of benefits having a dedicated weekly slot for anyone from the community to visit and, if requested, talk to a member of staff or Trustees and Active Affiliates. This could be on a drop-in basis or by prior arrangement. Either way having the time to interact with people in an informal, vibrant and relaxed venue, should support HWK to reach out further into the community and contribute to strengthening the delivery of its statutory functions. For instance, there could be opportunities:

    - To encourage people to visit the café so that they can convey their views about health and social care services in a variety of ways as suggested by them. HWK can use this information to identify emerging themes and trends in a systematic and evidence based fashion as well as gathering stories for impact reporting.
    - To provide social leadership so that people who feel they have been marginalised can contribute to the work of HWK so that they can influence change, in ways which also support people's personal development. This approach will help HWK to nurture the leadership potential of people, providing opportunities to get involved, as well as offering resources, peer support and networking opportunities.
    - To invite other grassroots led groups to participate in café activities such as setting up information stalls to publicise their work and improving the social capital of people by increasing their access to social resources locally and nationally. HWK can benefit from its position as the consumer champion for health and social care services to support the establishment of a viable, sustainable and independent community network of people that can come together under one roof, once a week.
    - To use the space to promote community assets that can be used, for instance, to ensure that those who commission and provide services continue to recognise that people who have lived

experience of using services have the best understanding of how services can be improved. This could include displaying material about HWK and the rights of individuals to have their views heard.

6. The aim of this report item is to seek endorsement from the Board. If approved the community café will start on 7 October 2015 and will run until the end of March 2016. There will be an official launch sometime in November. An evaluation will take place towards the end of February. RISE will provide the resources to run the café including the costs of refreshments and light snacks.

Proposed Enter & View visits

7. As previously reported to the Board it is intended to produce a schedule of Enter and View visits for the next three years, which is currently being coordinated by the Task Groups. As a first step this proposal has required the revision of the existing Enter and View policy and procedure, which is included in the document review detailed in Agenda item 9. Once the new document (and related policies) has been approved it is proposed to launch an Enter and View campaign on the website to attract wider involvement from the community, including recruiting new Active Affiliates to undertake visits, gathering views and feedback from the public and working in partnership with the Care Quality Commission (CQC). Due to the complexity of this proposal and the current capacity issues faced by HWK it is unlikely that the campaign can be effectively implemented until early next year.

8. In the meantime it is business as usual and there are a number of Enter and View visits planned to take place over the next three months. These include return visits to Kingston Hospital's A&E Department and the Paediatrics Department by the fledgling Young Healthwatch as well as a first visit to Tolworth Hospital. Furthermore a Spotlight visit has been arranged to Kingston Eco-op on 24 September.

9. At the time of writing there have been developments that require the Board to consider additional Enter and View visits or recommend another course of action. These include the announcement of a CQC visit to Kingston Hospital in January 2016, concerns about specific service providers raised by the Adult Safeguarding Board and negative feedback about a GP practice received from several local people during HWK's attendance at the Cambridge Road Estates Fun day held on 5 September. If agreed it is recommended that the relevant Task Group make the necessary arrangements.

Active Affiliates

10. Volunteers or Active Affiliates as they are known are vital to the success of HWK. Their huge contribution was recognised and applauded at the Garden Party held on 14 August. Over the last

couple of months the staff team have recruited and provided Enter and View training for:

- Blind people and those with visual impairment
- People from refugee and asylum seeker backgrounds (with the support of Refugee Action Kingston)
- The Learning Disability Parliament
- Young people of school age

11. These new volunteers provide HWK with opportunities to reflect the diverse nature of the community and to broaden its range of skills, experience and knowledge. To build on these achievements the Board is asked to approve and to participate in an event that brings together as many Active Affiliates as possible to help plan for the future. This could include identifying training needs or refresher courses, encouraging experienced Active Affiliates to provide peer support or act as mentors, nominating champions for specific service areas and exploring new ways to engage with the community and recruit more volunteers. If approved it is proposed to hold the event in December.

Q 1 & 2 Key Performance Indicators/Outcome Measures

12. The Board is asked to note that a report setting out achievements against HWK's KPIs and outcome measures will be circulated prior to the next Board meeting in October. The report will include progress against work plan outcomes (Task Group and operational), activity targets and will detail any performance and service delivery issues.

Representation on external bodies

13. There is a plethora of planning groups, boards, networks and other meetings in operation across the health and social care system both locally and regionally. Some of these meetings are attended by staff and/or Trustees and Active Affiliates. Some are not. In order to ensure that HWK uses its limited resources to cover as much ground as possible it would be helpful to undertake an audit of HWK participation, by whom and why. The Board is asked to approve this process with a view to presenting a paper at the October meeting for further discussion.

Monthly Meeting Schedule 2015-16 @16/9/15 **Annex I**

Name of Meeting	October 2015	November 2015	December 2015	January 2016	February 2016	March 2016	HWK Attendees
HWK Board Meeting	Wednesday 21st, 5pm-7pm, KQC	Friday 13th, 10.30am-12.30pm, KQC	Wednesday 16th, 5pm-7pm, KQC	Wednesday 13th, 5pm-7pm, KQC	Friday 12th, 10.30am-12.30pm, KQC	Wednesday 9th, 5pm-7PM, KQC	Trustees/Active Affiliates
HWK Community Task Group		Wednesday 25th, 2pm-4pm, KQC		Wednesday 6th, 2pm-4pm, KQC		Wednesday 30th, 2pm-4pm, KQC	Trustees/Active Affiliates
HWK Hospital Services Task Group	Wednesday 28th, 10am-12pm, KQC		Wednesday 9th, 10am-12pm, KQC	Wednesday 13th, 10am-12pm, KQC	Wednesday 24th, 10am-12pm, KQC		Trustees/Active Affiliates
HWK Mental Health Task Group		Monday 2rd, 10am-12pm, KQC	Monday 14th, 10am-12pm, Sessions House	Monday 25th, 10am-12pm, KQC		Monday 7th, 10am-12pm, KQC	Trustees/Active Affiliates
HWK Learning Disability Project Group		Tuesday 3rd, 10am-12pm, Sessions House	Monday 7th, 10am-12pm, Sessions House	Monday 18th, 10am-12pm, Sessions House	Monday 22nd, 10am-12pm, Sessions House		Trustees/Active Affiliates
Health Overview Panel		Tuesday 24th, 7.30pm, Guildhall		Tuesday 26th, 7.30pm, Guildhall		Thursday 3rd, 7.30pm, Guildhall	Chair or nominated deputy
Health and Wellbeing Board		Thursday 19th, 6.30pm, Guildhall		Thursday 28th, 6.30pm, Guildhall			Chair or nominated deputy
CCG Governing Body		Tuesday 3rd, 1pm-3pm, Guildhall		Tuesday 12th, 1pm-3pm, (venue tbc)		Tuesday 1st, 1pm-3pm, (venue tbc)	Chair or nominated deputy
Kingston NHS Foundation Trust Board		Wednesday 25th, 10am–1pm, Kingston Hospital		Wednesday 27th, 10am-1pm, Kingston Hospital		Wednesday 23rd, 10am-1pm, Kingston Hospital	None
South West London & St George's Mental Health NHS Trust	Thursday 1st, 9am-11am, Springfield Hospital	Thursday 5th, 9am-11am, Springfield Hospital	Thursday 3rd, 9am-11am, Springfield Hospital	Thursday 14th, 9am-11am Springfield Hospital	Thursday 4th, 9am-11am Springfield Hospital	Thursday 3rd, 9am-11am Springfield Hospital	None

Healthwatch Kingston Board **Appendix C**

23 September 2015

Agenda Item 7: Task Group Report

Report by the Chairs of the Task Groups

Purpose

To update the Board on the work of the Task Groups.

Recommendations

The Board is requested to note and discuss the report.

Community Care Task Group Update

1. The last meeting of the Community Care task Group took place on 12 August 2015. A key item was an update on the Kingston Information and Advice Pilot Project (KIAPP) provided by Fernando Ruz from Kingston Citizens Advice Bureau.

2. The group's current priorities include:

    - RBK commissioned care agencies - the plan is to send out a survey to users of RBK care agencies. The group is assessing the results of a recent RBK survey to determine questions to avoid duplications.
    - Enter & View - a schedule of GP visits will be drawn up, according to our Healthwatch rating (based on the national GP Patient Survey data).
    - End of Life Care – the group is keeping a close eye on Kingston CCG plans in this area

3. The next meeting will take place on 30 September 2015 and will include an update on the Kingston Coordinated Care Programme and carers services.

Hospital Services Task Group

4. There has not been a meeting of the Hospital Services Task Group since the last Board meeting. The next meeting, however, will take place on 16 September 2015 and if possible a verbal update will be provided for this Board meeting. Agenda items will include matters related to Kingston Hospital such as aftercare and discharge, complaints and arrangements for an Enter and View visit to A&E.

Mental Health Task Group

5. The last meeting of the Mental Health Task Group took place on 29 September 2015.

6. The group's current priority is to plan the Enter & View visit to Tolworth Hospital. A date is at present being firmed up but it will be mid October. The group is refining patient questionnaires for Lilac and Jasmines ward. The group met with Jonathan Mason, Service Director last Month to have a tour of the wards and make observations of the staff behaviours and environmental conditions. The questionnaires are being designed around those observations and various pieces of feedback collected from members of the public. The group is also following the progress of the South West London & St Georges Trust Discharge from secondary to primary care policy report. They have fed into the consultation process and are ensuring the points they have raised have been included – to improve the discharge process of patients and their carers. The member of staff in charge of that policy will attend the next meeting to report back on its progress and his actions. The group has been evaluating the effectiveness of the Kingston Wellbeing Service. There was research carried out and a series of FOI requests for data made to gain more evidence to prove if certain areas are not performing well. It was then decided that more service user feedback is needed.

7. The next meeting will take place on 21 September 2015.

Learning Disability Project Group

8. The last meeting of the Learning Disability Project Group took place on 2 September 2015.

9. At present the group has 2 priorities – to plan an Enter & View visit to Surbiton Health Centre and to check the services of Annual Health Checks and Health Action Plans for people with learning disability in Kingston. The group has received negative feedback from people with a LD who attend Surbiton Health Centre, it has been noted staff are not being helpful and understanding of their needs. Group members have received Enter and View training and are currently awaiting their DBS forms. At the next meeting the group will be planning a date for the Enter & View visit and will produce a list of observations and patient questionnaires. The group is currently distributing annual health check questionnaires amongst people with learning disability and their carers, the report will be completed at the next meeting. The group's main objective is to recruit more members from the wider community, the learning disability project group lunch and launch event helped to raise its profile and gain new members.

10. The next meeting will take place on 3 November 2015. At this meeting the Chair will be asked to attend future meetings of the Board.

Healthwatch Kingston Board **Appendix D**

23 September 2015

Agenda Item 8: Strengthening Community Engagement

Report by the Manager

Purpose

To update the Board on Healthwatch Kingston's involvement with the Community Engagement Steering Group and to present a concept for an integrated community engagement network.

Recommendations

The Board is requested to note and discuss the report and agree next steps.

Key Points

A. Following attendance at a community engagement workshop hosted by the CCG in May Healthwatch Kingston was invited to join a Community Engagement Steering Group.

B. A report by the Chair of the Steering Group was presented to the June meeting of the Health and Wellbeing Board where it is recorded in the minutes that the Board "resolved that the principles set out in the report are endorsed and the Board notes that reports will be brought back to relevant decision makers at appropriate points in the programme."

C. Strengthening community engagement is a work stream of the Active and Supportive Communities Project accountable to the Kingston Coordinated Care Programme and the Health and Wellbeing Board.

D. A draft action plan, which incorporated outputs from the May workshop, was presented at the July meeting of the steering group, which detailed next steps including principles and guidelines for the implementation of a new delivery model for engagement. Healthwatch Kingston took the opportunity to propose a way of working, informed by the action plan, that aims to deliver an integrated community engagement network.

E. This paper explains this model and seeks endorsement from the Board to share this work with key stakeholders for comment and to present it to a future meeting of the steering group if it is considered to be of value.

Introduction

1. The report presented to the June meeting of the Health and Wellbeing Board makes a number of statements about existing community

engagement processes that suggest the current way of working is not effective, such as organisations not aligning their work programmes resulting in a confusing engagement landscape, potential duplication of effort and inefficient use of time and resources.

2. As the statutory body responsible for championing the consumer voice Healthwatch Kingston is committed to having a positive impact on the development of improved, inclusive and effective community engagement processes. Consequently Healthwatch Kingston proposes a way of working that offers an integrated approach based on the community engagement principles set out in the Joint Strategic Needs Assessment (JSNA) Community Voice:

    - **Inform** people about services that affect them by providing balanced and objective information
    - **Consult** with people so that they have a direct say about decisions and services that affect them
    - **Involve** people in the co-production of services including allowing people to see for themselves the results of their participation
    - **Collaborate** with people so that alternatives to service delivery can shape service development (i.e. supporting grassroots led initiatives)
    - **Empower** people to have a say in decision making such as allowing communities to take action for themselves

3. As a member of the Health and Wellbeing Board Healthwatch Kingston will work collaboratively with partners to ensure the community benefits form a joined up, streamlined and integrated engagement process and in so doing Healthwatch Kingston will seek to be seen as an authoritative, credible and effective voice for the public.

Definition

4. For the purposes of this paper and in accordance with the principles set out above, community engagement will be defined as any type of interaction with the public that aims to involve them in decisions about the commissioning, delivery, monitoring and evaluation of health and social care services (hereafter services).

Key Themes

5. Developing a collective approach to community engagement by changing the culture and the way services respond to the community (i.e. community engagement is part of every organisation's governance arrangements, performance management processes and is included in outcome measures).

6. Organising a community-wide network of people that is empowered to decide for itself what needs to be done to improve services (i.e. pre-consultation engagement and developing solutions together such as service re-design options).

7. Sharing intelligence about what the community says about local services so that the voice of the public influences change for the better across the health and social care system (i.e. start planning service change early with the people who use services and the community in which they live).

8. Expanding the range and scope of community engagement activities and their impact (i.e. understand people's experience of services through on-going dialogue, case studies, user led initiatives and user led facilitated events).

Description

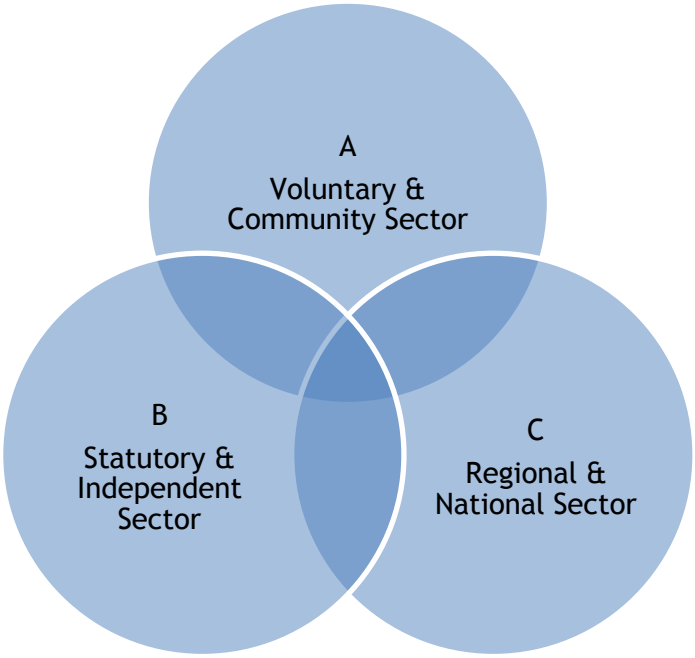
9. The proposed model is based on the premise that community engagement should be everyone's business (i.e. applies across the health and social care system) and that mechanisms for involving the public are embedded in all stages of the commissioning cycle and the provision of services. To achieve this a way of working is required that delivers an integrated approach based on shared outcomes that forms part of health and social care contracts, service specifications and key performance indicators, to ensure that services are equitable, accountable and responsive for all members of the community. This model recognises that community engagement can be a challenging, complex and time consuming process for many organisations, which is why integrating resources and learning from one another can only serve to maximise impact, reduce "consultation" fatigue and may even reduce costs.

10. In essence the model attempts to address a long-standing criticism of community engagement that raises expectations there will be some change, but overtime there is no recognisable long-term impact. This can lead to disengagement, apathy and loss of trust with some members of the community, specifically that the voice of the community will not make any difference to the way services are commissioned and provided. Furthermore some members of the community, particularly those with disabilities, long term conditions, vulnerable backgrounds, Black and Minority Ethnic (BME) communities, refugees, asylum seekers and migrants, face a series of barriers that may prevent them becoming involved in community engagement processes such as communication and language difficulties, inequalities, discrimination, social isolation, stigma and lack of cultural or condition related awareness.

11. Community engagement has to be joined-up, flexible, innovative and responsive in order that the potential barriers to involving individuals in processes that deliver positive results can be overcome. The proposed Integrated Community Engagement Network (hereafter network) attempts to address the issues outlined above by supporting the integration of existing community engagement resources through a lead agency arrangement (hereafter agency), which will function as a single point of contact, responsible for coordinating and ensuring that all community engagement initiatives are aligned towards one overarching goal: responding to the needs of the local population, based on their

experience, and their desired outcomes. For the system the agency will aim to create effective partnerships by aligning the interests of consumers, the needs of the community and the goals of organisations.

Diagram 1: Integrated Community Engagement Network



12. As can be seen in diagram 1 the model comprises three components each representing a sector of the current health and social care economy (commissioning, provision and regulation of services):

    A. Voluntary and community sector – e.g. charities, social enterprises, community and special interest groups.
    B. Statutory and independent sector – e.g. the local authority, CCG, NHS Trusts, care homes.
    C. Regional and national sector – e.g. NHS London/England, Care Quality Commission, Healthwatch England

    The agency lies at the centre of this model where all three sectors overlap. Consequently it is ideally placed to act as the network's coordinating body that is responsible for receiving, managing and distributing information concerning community engagement activity across the network and making it widely available through a number of communication channels and processes. The agency must be seen to generate impact and it will do so by influencing and challenging network partners in the following areas:

    - Ethos and culture
    - Commissioning and planning
    - Delivery
    - Outcomes and outputs
    - Diversity and equality of opportunity

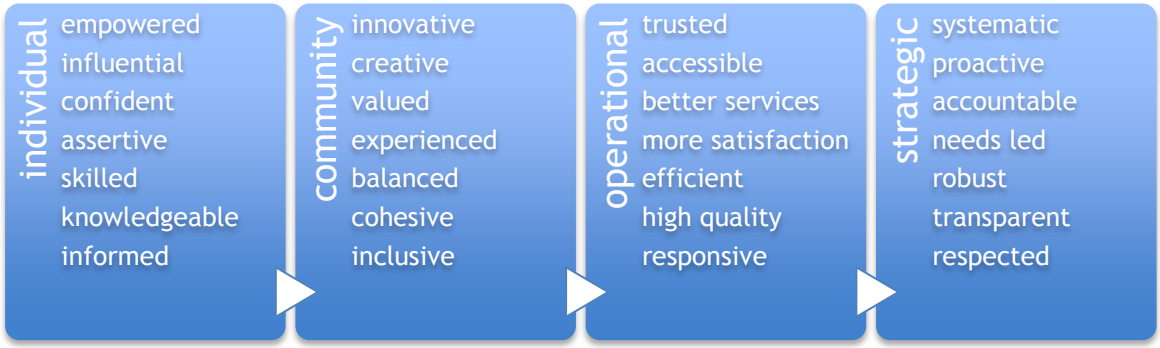
13. As a whole the model represents the health and social care system locally, regionally and nationally. Individually each component will have its own forms of community engagement processes, which can be independent from each other but also interdependent depending on the nature of the community engagement activity. For instance a commissioner and/or a provider may engage with the community on a matter related to a specific area, such as a change of premises which will involve the organisation developing a direct relationship with the people using that service but may also be of interest to the wider community; hence the overlap with the voluntary and community sector. Alternatively there may be plans to design a new model of health and social care that requires a joined up response from the voluntary and statutory sectors to engage with the whole community, or a regional or national activity requiring a much broader range of community engagement activities involving all sectors, which could be a coordinating function of the agency.

14. Importantly these components are related to potential spheres of influence for the public and will require, where appropriate, all health and social care organisations to work together to ensure that community engagement opportunities are proactively aligned so that they can anticipate and respond to the public developing an interest in any particular service area and planning for themselves the best form of community engagement (i.e. grassroots led initiatives). Hence the need for the sharing of intelligence about what the community says it wants, which, centrally located and easily accessible via the agency, can be viewed as a community asset and a central repository for community feedback. Placed at the centre of this model, where all three spheres of influence meet, the agency, will be able to interact with the community on an on-going basis and, therefore, coordinate community engagement activity across the health and social care landscape, ensuring organisations remain accountable to the community they serve. Part of this process will involve creating, developing and updating a community map of where and when engagement will take place.

15. For the network to function in an integrated fashion all partner organisations must sign up to working collaboratively in an open, honest and transparent manner. Making this a specific service specification requirement will allow the agency to identify poorly performing organisations and make recommendations for future improvements as well as promoting areas of good practice and excellence. The aim of this approach is to create an environment in which individuals, the community and health and social care organisations can work equitably together, understand each other's position and build cohesive and sustainable relationships to deliver mutual benefits for all. Diagram 2 shows what this relationship can look like in practise and the associated benefits. It is a horizontal pathway based on the notion that the community is best placed to say how they want to be engaged (i.e. a bottom up or grassroots led approach) as opposed to the traditional top down vertical approach. Put another way community engagement is

about making the system respond to individuals and groups, rather than individuals and groups having to respond to the system.

Diagram 2: Benefits of integrated community engagement



Delivery

16. In order that the community is placed at the heart of this model (i.e. central to the network's purpose), it is proposed that the network is managed by the agency, which may be an existing resource or one created for the purpose. The agency must have excellent links and established relationships with the community and services so that it is able to carry out its role effectively. It must be able to provide leadership and have in place an infrastructure for the day-to-day activities that will be undertaken once the network is implemented. A key deliverable will be making the best use of existing community engagement and communication processes by working across organisational boundaries. The model anticipates that the agency will require a dedicated workforce.

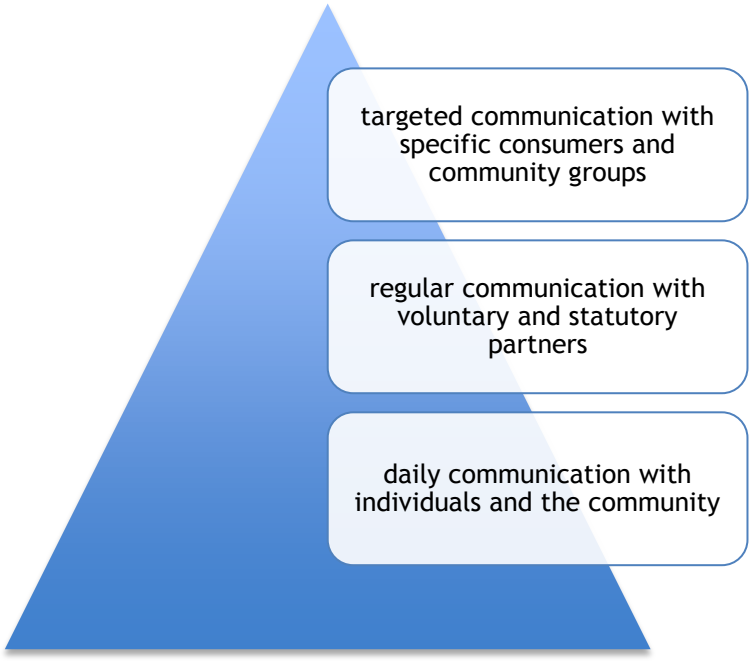
17. With adequate staffing the agency will be able to use a wide variety of communication tools to increase the number of people and organisations aware of and contributing to the work of the network. Key deliverables will include:

    - Working in collaboration with statutory and voluntary sector partners, to make the most of the agency's capacity to communicate and raise awareness across the community.
    - Engaging creatively and meaningfully with the public from every part of the community, empowering them to speak up and champion, for instance, the voice of those who struggle to be heard.
    - Listening to what the public say matters most to them, so the agency can communicate these messages across the network.
    - Supporting wider participation and better communication with the community, particularly those groups/or individuals that are underrepresented.

18. Good communication is vital for effective community engagement processes and is key to strengthening links with individuals and the community as well as voluntary and statutory partners. Diagram 3 shows

a tiered approach to communication across the network, each tier corresponding to a narrower group of people and organisations, each having different communication needs dependent on the nature of the community engagement activity. For instance, it is anticipated that most of the day-to-day business of the agency will be related to delivering core functions such as gathering intelligence, liaising with community representatives and groups and updating the network. Consequently it is vital all communication activity needs to be inclusive, varied, timely, accurate, accessible, and on going.

Diagram 3: Communication across the integrated community engagement network



19. The agency will be a relatively small resource in a complex and extensive health and social care system and there are many organisations with existing responsibilities to put the community at the centre of their work. The agency will have to work closely with key stakeholders from the statutory and voluntary sector, particularly, working with relevant community engagement teams. The agency must not replicate work already being done by others, nor should it recreate expertise others already have.

20. The agency will use its communication resources to deliver the widest possible views from the community, particularly those voices that struggle most to be heard. The agency will support the network to target specific groups using a variety of communication approaches as advised by individuals from relevant groups. In order to seek a diverse range of views and reach out further into the community the agency will act on behalf of the network to help broaden the voice of the community. This will enable the agency to develop a culture based on a bottom up or grassroots led approach to community engagement, for example, responding to the issues, trends and themes that are voiced by the community and as a result of local, regional and national priorities as advised by network partners. This two-way flow will enable the

agency to deliver a joined-up way of working that will be vital to successful integration.

21. As indicated earlier in this paper there are different levels of community engagement as indicated in the principles set out in the Joint Strategic Needs Assessment (JSNA) Community Voice. They range from simply informing the public, right through to empowerment, where power and responsibility is entrusted to the community. This does not mean that empowered communities are, or should be, the ultimate objective of community engagement. What is important is that the network knows what options are most suitable depending on what needs to be achieved. Put another way some approaches may be more useful than others. For instance in some cases the community only needs information and with others, seeking to empower communities may be more appropriate for a particular community engagement activity. As objectives and priorities change over time, approaches can be adapted or expanded to meet the needs of the network and the community. It is essential the agency is viewed as a source of expertise in these matters and is valued for the support it provides to the network. For instance a key deliverable will be the ability for the agency to recommend what types of community engagement techniques or methodologies would be appropriate for a particular level of activity. This could be done by offering a menu of different approaches or a directory of resources, which are evidence based and seen as examples of good practise, which could be included in a community engagement toolkit.

22. The agency will act as a single point of contact for the network. As such a key deliverable will be to ensure the network promotes good practise, monitors activity and reports on outcomes by adopting a consistent approach to community engagement. The agency will have a clear role to play in ensuring effective community engagement takes place across the network. For example the agency could support the use of the questions below as a checklist for community engagement activities and partner roles within the network:

Question	Yes	No	Evidence
Clarity of purpose and priorities			
Is the issue a local, regional or national priority and how does it fit with existing commissioning plans/intentions?			
Has this work already been done by somebody else? Has the community been engaged on other similar issues before?			
Do you have an engagement plan with specific targets and milestones and how does it relate to other engagement activities?			
Do you really know your area and/or community? What is your research and analysis base?			

Is someone else already looking at this issue? Would it be better to contribute to their work instead?			
What are your intended outcomes? How will you collect and present your evidence to show outcomes?			
How will you monitor and evaluate the work? What will be your success criteria to show impact?			
How do you plan to communicate? How will you let others know what is happening and show that the work has made a difference?			
Clarity of roles and responsibilities			
Are you clear about the policy and statutory context within which community engagement is planned?			
Do you have an engagement strategy that is up to date and incorporates your organisation's role within the network?			
Why is the community engagement happening and do you understand what is required? What's the bigger picture?			
Have you identified who will have lead responsibility for community engagement within your organisation?			
Is there a genuine commitment from the organisation to be part of the network? Are relevant staff aware of their responsibilities?			
How have you assessed what you are doing will impact on, or be influenced by, the network?			
Have you established how engaging the community is intended to inform the services you are responsible for and the network?			
Have you considered what organisational issues may need to be addressed to ensure community engagement is meaningful?			
How have you evaluated the differing levels of interest and influence network partners have in engagement processes?			
Clear, effective and transparent engagement processes			
Has the community been consulted over the type of involvement that it wants to have in any planned developments?			
Is there practical support to ensure the community can fully participate? Who will provide this?			
Has the community been kept informed about what is planned, or what is happening? Have you informed the network?			
Is the community involved in making an informed judgment about the success or			

effectiveness of what is happening?			
Has the community had the opportunity to contribute to the decisions that are being made?			
How do you tell the community about the difference they can make by getting involved? How do you manage expectations?			
To what extent do you consult with the community to learn from them how best to engage with them?			
What co-production techniques do you use? Does this involve the community in developing service specifications for instance?			
How do you involve the community in all stages of a procurement process, service evaluation or review?			
Robust performance management and governance processes			
Do your governance arrangements include commitments to engage with the community? Does this include being part of the network?			
Do you have a Board member who acts as a lead to champion community engagement? Does this person work with the network?			
Does your Board receive community engagement progress reports? What do these say about involvement with the network?			
Do you have a performance management framework that includes KPIs for community engagement?			
Do you have outcome measures that reflect those of the network? How do you address shortfalls in performance?			

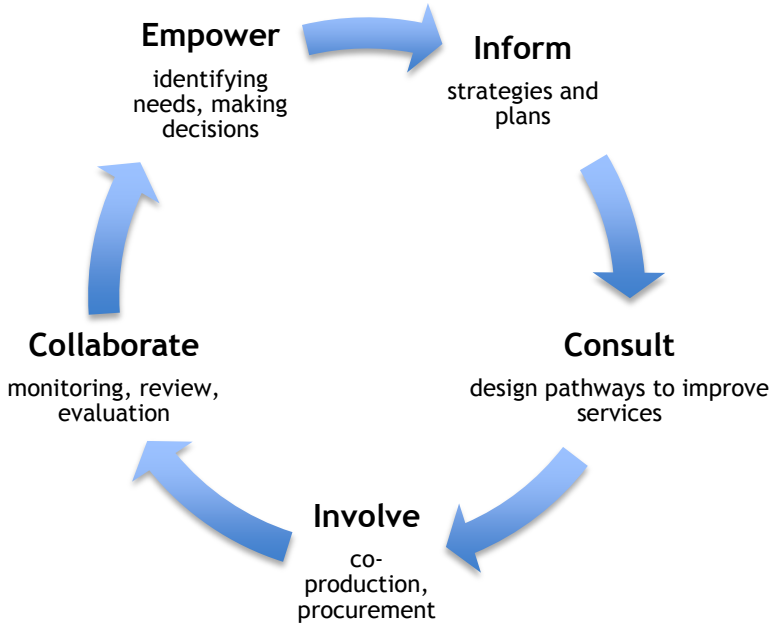
Outcomes

23. There are many ways to measure community engagement outcomes and most services publish what they have achieved in some form or another. There is also a great deal of national legislation, guidance, research and policy statements that detail the outcomes expected from involving people in all aspects of service commissioning, delivery and review. This model is not concerned with replacing what is already being done (much of which is a statutory requirement) but to propose the development of a shared common outcomes framework, which can be applied and monitored across the network. In order to do so this paper suggests that the principles set out in the Joint Strategic Needs Assessment (JSNA) Community Voice should form the basis for a generic set of outcome measures.

24. These outcome measures should complement existing arrangements and not be viewed as an additional burden by services. After all for the network to be successful it must be seen to be operating in an integrated manner and its shared outcomes must reflect this. Using the levels of engagement as a guide the outcome measures should

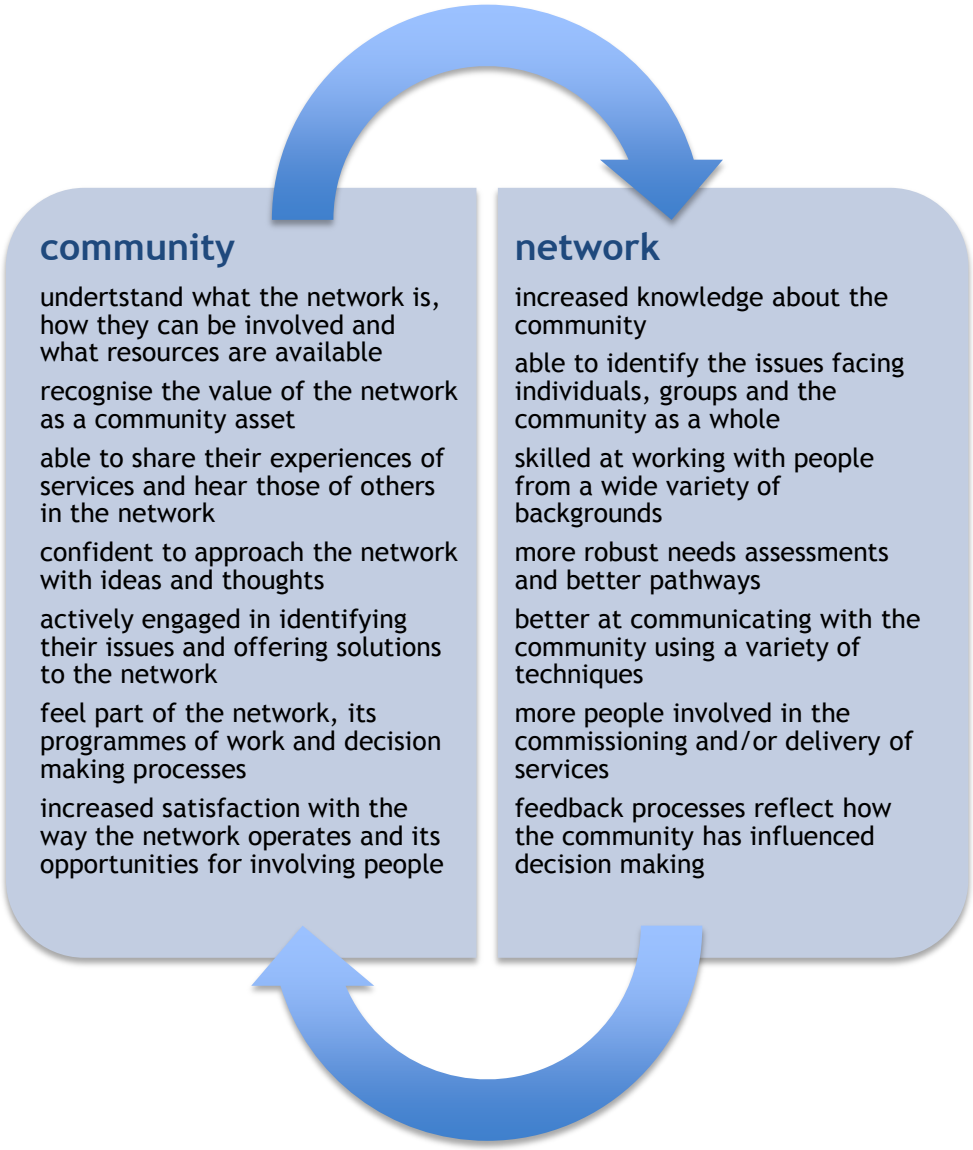
determine what is expected to be achieved and what the success criteria should be. This will depend on the nature of a particular type of engagement activity as mentioned earlier in this paper but also be related to the system as a whole. For instance engagement could be viewed as a cycle that mirrors commissioning processes. Outcomes and subsequent evaluations of the network could incorporate to what extent the community has been involved in this cycle. Diagram 4 shows how this could be interpreted alongside the levels of community engagement:

Diagram 4: The Engagement Cycle



25. What these outcome measures will look like in practise and what value they bring to the network and the community will be dependent on a number of factors, such as impact evidence to be collected at a strategic level; the nature of existing partnerships between services and the community; and the detailed outcomes of specific engagement projects determined by and with the community. Consequently it is anticipated that a set of generic outcomes measures will be used to inform, shape and improve community engagement, as well as improving the way services are commissioned and delivered. Diagram 5 shows the potential relationship between outcomes for the community and the network:

Diagram 5: Shared Outcomes Framework



Evaluation

26. Evaluation (including consultation, monitoring and review) is core to community engagement and the success of the network. Evaluation processes such as peer reviews, 360 degree feedback and stakeholder surveys, can provide evidence to show how the network has, for example:

- Developed an open, transparent and inclusive culture
- Gathered the views of the community, their needs and interests
- Mobilised the community to participate in work programmes and provide responses to barriers to engagement
- Improved partnership skills, organisational commitments and ownership

- Assessed impact against an agreed set of shared outcome measures
- Informed good practise, new ways of working and better economies of scale

27. It is anticipated the agency will be evaluated against a combination of quantitative and qualitative results. The agency will be expected to develop an evaluation framework that builds on the evaluation of the network, although the network will be expected to do so in a more systematic and comprehensive way.

Governance

28. If implemented the agency will have to have robust governance arrangements (independent from those of network partners) in place to ensure it is accountable to its partners and the community. What this will look like will be determined by whatever process is put in place to implement the network model.

Risk Assessment

29. Potential network partners will not co-operate or want to be part of the network. Seeking support from the Health and Wellbeing Board to approve the establishment of the network supported by commitments from each organisation to work together in an integrated manner and to ensure a timely implementation process will mitigate this risk.

30. Once established network partners may fail to meet their obligations to work with other partners or carry through their commitments to engage with the community. Ensuring involvement with the network forms part of their contractual duties will mitigate this risk.

Resources

31. Although a dedicated workforce is recommended, it is not the intention of this paper to propose what level of funding will be required to deliver the network model.

Healthwatch Kingston Board **Appendix E**

23 September 2015

Agenda Item 9: Document Review

Report by the Manager

Purpose

To update the Board on the progress to review policies and procedures and other documents related to the delivery of Healthwatch Kingston's functions and governance.

Recommendations

The Board is requested to note and discuss the report and agree next steps.

Key Points

A. Healthwatch Kingston (hereafter HWK) must have a full range of up-to-date policies and procedures to enable it to function effectively and to support robust governance arrangements.

B. All policies and procedures and other related documents must be reviewed annually and amendments made to incorporate good practice, changes to operational procedures and/or meet the requirements of new legislation and regulations.

Introduction

1. This paper sets out the policy review process as part of the Board's governance arrangements for HWK.

2. The process is intended to ensure consistency and robust standards in the development of policies, timeliness in the provision of information to the Board and a clear audit trail for the approval and authority of HWK policies.

3. In this process the word 'policy' covers all policies, procedures, codes of practice, standing orders and other documents that are approved by HWK and are binding on Trustees, staff and volunteers (known as active affiliates).

Process

4. This report identifies the policies that have been reviewed. Some of the policies have been previously approved by the Board whilst others have not. Most require some form of amendment ranging from minor changes

to extensive revision or a new document. Board approval will be required for any new or substantially changed policy.

5. The review considered a number of factors against each policy:

   (a) When was the policy last approved by the Board?
   (b) Is the policy relevant to the functions of HWK, specifically its relationship to governance and operational procedures?
   (c) Are there opportunities to streamline, merge or replace a policy with an improved version?
   (d) Does the policy incorporate the findings of the review undertaken by the Board in 2014?
   (e) Is there consistency across relevant policies?
   (f) Has the policy been published on the website?

6. The review did NOT include policies related to the employment of the staff team as they are Parkwood Healthcare employees and as such are bound by the policies and procedures set out in their Terms and Conditions of Employment. In keeping, however, with previous versions, each policy includes a Parkwood Disclaimer.

7. Due to the contractual arrangements all matters relating to financial policies are the responsibility of Parkwood who are accountable to the Council for the effective management of HWK's finances.

Effective date

8. The 'effective date' of the updated or new policy will be when it has been given final approval by the Board and Parkwood.

Review

9. Policies will normally be reviewed on a yearly cycle unless otherwise directed by the Board.

Outcomes

10. Annex I details what action has been taken to date against each policy. All the policies included in this review have been amended to some extent or a new policy created. Each draft policy has been circulated to the Chair in advance of this report.

11. Where appropriate each policy includes links (highlighted in yellow) to other policies which when published on the website will be navigable. This includes related policies and procedures, regulations and web based resources. The benefit of this approach includes creating interdependencies between policies. For instance the Governance Structure and Operational Arrangements document demonstrates how each policy is related to the critical features of good governance as well as relevant legislation

12. If applicable each policy includes references to other publications such as Healthwatch England and Local Government Association guidance.

Consultation

13. It is proposed that the draft policies should be published on the website for an 8 week consultation period starting on the 1st October 2015 so that members of the public can contribute to their development as well as any other interested party. After which a final version of each policy can be approved by the Board at their December meeting.

Next steps

14. The Board is requested to approve the document review process and to agree how it wishes to review each policy.

Document Review 2015 @16/9/15 **Annex I**

Document Title	Impact	Original Author	Date Adopted by Board	Webpage Location	Extent of Revision	Comments
Active Affiliate Resource Pack	Operations	Healthwatch	unknown	None	Extensive	Replaces volunteer toolkit
Active Affiliate Policy & Procedure	Governance/ Operations	Parkwood/ Healthwatch	12.13	Volunteer for us	Extensive	Includes recruitment process
Code of Conduct	Governance	Parkwood/ Healthwatch	21.01.15	None	Moderate	
Communication, Engagement & Media Policy	Governance/ Operations	Parkwood/ Healthwatch	n/a	None	Extensive	Incorporates Healthwatch England's media and social media guidelines
Complaints Policy & Procedure	Governance	Parkwood/ Healthwatch	22.10.14	None	Moderate	
Confidentiality and Data Protection Policy & Procedure	Governance	Parkwood/ Healthwatch	n/a	None	Extensive	Incorporates Parkwood's data protection and database policies (Parkwood are the designated Data Controller/Processor)
Conflict of Interest Policy & Procedure	Governance	Parkwood/ Healthwatch	22.10.14	None	Minor	
Decision Making Policy & Procedure	Governance	Parkwood/ Healthwatch	n/a	None	Extensive	
Enter & View Policy	Operations	Parkwood/ Healthwatch	n/a	None	Extensive	
Enter & View Procedure	Operations	Parkwood/ Healthwatch	n/a	None	Extensive	
Equality & Diversity Policy	Operations	Parkwood/ Healthwatch	22.10.14	None	Minor	Replaces statement of intent

Escalation Policy and Procedure	Operations	Healthwatch	n/a	None	Extensive	Only applies to escalations to Healthwatch England
Freedom of Information Policy & Procedure	Governance	Parkwood/ Healthwatch	22.10.14	None	Extensive	
Governance Structure & Operational Arrangements	Governance/ Operations	Healthwatch	unknown	Governance	Extensive	
Safeguarding Policy and Procedure	Governance	Parkwood/ Healthwatch	n/a	None	Extensive	

Key

RAG Rating		**Extent of revision**	
Red	No document in place	Minor	Changes to numbering and headings, most of content unchanged
Amber	Revised document previously approved by Board/Parkwood	Moderate	Changes to numbering, headings, document order, additional paragraphs, some content amendments
Green	Document approved by Board/Parkwood and published on website	Extensive	Comprehensive rewrite or new document