Health Improvement Partnership Board

Date of Meeting: Thursday 23rd April 2015

Title of Report:

Final Public Involvement Network Lay Representative Report

Is this paper for:	**Discussion**	**Decision**	**Information**
			X

Purpose of Report: To summarise Public Involvement Network Lay Representatives' perspective of their 18 month tenure, in support of the Health Improvement Board.

Action Required:

Consider in relation to new Healthwatch Oxfordshire Ambassador responsibilities and priorities.

Impact on users and carers:

Assure continued public representation on Health Improvement Board, public engagement, involvement, feedback and scrutiny across Oxfordshire health and social care priorities.

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Executive Summary:

This is not intended as comprehensive analysis – it is an overview of the main highlights and conclusions of Public Involvement Network Lay representatives', Aziza Shafique and Paul McGough, time supporting the Health Improvement Board – from end September 2013 until end March 2015. The paper is our personal independent view of the 18 month period. Not that of Healthwatch Oxfordshire or any other organisation.

During our induction we met Public Involvement Network Lay Representatives from the preceding year, plus the newly recruited peer Representatives from the Children and Young People's Partnership Board and the Adult Health and Social Care Partnership Board. Early on we met Healthwatch Oxfordshire colleagues too. It was a helpful and motivational introduction to our role. We attended our first Core Public Involvement Network Group meeting in October 2013, read many documents, discussed and defined our focus with County Council engagement officers in relation to the Board's priorities. By early December 2013 we had written and circulated our plan, setting out 6 one year goals:

1. Devise and deliver an effective Public engagement and involvement plan targeting Asian Community and focusing on Oxford University Hospital (OUH) Trust staff, members, patients and other priority groups.
2. Attend Public and Patient meetings and consultation forums
3. Build effective networks to seek views on specific Health Improvement Board priorities
4. Feedback Public views and themes to Health Improvement Board - and as appropriate to any partner organisations (Anonymously respecting Patient and Public confidentiality).
5. Develop core questions and questionnaire templates
6. Support Outcomes Based Commissioning approaches

Our remit was centred on the Health Improvement Board priorities – focusing on preventive health and wellbeing – however in view of the health and social care reform changes, we opportunistically drew on our related acute sector interaction and experience – as acute hospitals are in transition, shifting their emphasis towards more rapid assessment, diagnosis and community centred home based care and preventive health strategies.

The chart .1 below summarises our activities in priority areas covering these six goals. Our overview does not attempt to evaluate our contribution.

Chart 1

Health Improvement Board Priorities:	**Main Public Involvement Network - Plus associated activities:**
Priority 8: Preventing early death and improving quality of life in later years	**Asian Women's Group Project:** (refer to highlight section) **Outcomes Based Commissioning of services**, focusing on the new models of care – to address the challenges facing primary and community care; contributed to public engagement consultations on maternity services and new approaches to diabetes care. Sat on evaluation panel for Outcomes Based Commissioning Most Capable Provider selection for Older People services across Oxfordshire; took part in **Oxford University Hospitals Patient and Staff Peer review assurance programme** – focused on whether services are safe, effective, responsive caring and well led. Took part as trained member the Patient-Staff Peer review team. Also took part in **Healthwatch Oxfordshire Enter and View visits**, to gain insight into the patient hospital discharge process in acute and community hospitals. **Contributed to various locality Group and other consultations**. Working Group on Friends and Family Test system procurement, as well as participating in Public engagement with the **Academic Health Science network.** And took part in **NHS England Clinical Commissioning Group Assurance,** as Lay Leaders and Lay Advisory Panel members to Thames Valley Team Patient Strategy Group. **Workshop: Muslim Faith & Wellbeing Workshop 29th April 2014.** Led by Faith & Community elders. **Older People's Partnership Board Open Meeting June 3rd 2014** – presentation and working groups session with carers and people. **Public Forum consultation meeting:** Public, Patients and Carers to a discuss **dementia service awareness and mental health services in North Oxfordshire.** The North Oxfordshire Locality Group (Chipping Norton) 18th June 2014**.**

	National Workshop: - NHS England 'Improving Experience of Care Through People' 13th Nov 2014. **Workshop:** on **strategy to promote mental wellbeing** and prevent mental ill health in Oxfordshire. 27th Nov 2014 **Workshop: on Medicines Optimisation** (last meeting this morning 23rd April 2015) – about the safe and effective use of medicines to enable the best possible outcome. *(*Academic Health Science Network)
Priority 9: Preventing chronic disease through tackling obesity	**Workshop: Healthy Weight** to develop the action plan for the healthy weight strategy 2ndJuly 2014.
Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness.	**In response to national budget cuts, and Oxfordshire County Council's proposed 38% budget cuts on Housing related support,** Public Involvement Network Lay representatives collaborated to produce a letter and paper to express public concern about potential impact. This was sent to the Oxfordshire County Council Director for Social and Community Services and Health Improvement Board and other stakeholders. The paper and subsequent correspondence highlighted the difficulties faced by vulnerable groups; people with disabilities and long term health issues – including mental health and wellbeing - and on the impact of housing support cuts, for example on people with learning disabilities and victims of domestic abuse. This initiative was lead by lay representative Marie Tidball from the Adult and Social Care Board, in close liaison Health Improvement Board lay representatives. The aim was to raise the profile of key issues and called for robust impact assessment of any cuts on at risk groups. **Workshop - Health Improvement Board - on Housing-Related Support Proposals**, attended on 29th May 2014. **Conference - attended on Domestic Abuse Awareness in the Community** 18th October 2014 Oxford pastors Forum - in partnership with Oxfordshire County Council Social Services, Thames Valley Police, NHS, Oxfordshire Safeguarding Board and various organisations that work

	with victims of domestic abuse.
Priority 11: Preventing infectious diseases through immunisation.	**Antibiotic microbial resistance Health Protection Research Unit research projects Working Group.** Patient and Public Involvement Group representative. (Research centres on whole genome and antibiotic resistance - not immunisation per se).

Highlights:

Much of our efforts centred on attending public meetings and making contributions to Clinical Commissioning Group Strategic and Locality Group forums, GP Patient Participation Group meetings, Public Involvement Network Core Group Bubbling up sessions, Health Improvement Board meetings and various workshops (see chart 1) to help understand public issues and themes, and to give ongoing feedback to the Health Improvement Board.

A particularly significant contribution was the Asian Women's Well-being research project. Researched and report written by Aziza Shafique and published June 2014.

The research was sponsored and supported by Healthwatch Oxfordshire and The Asian Women's Group, who decided that a research project engaging with Asian women - to probe their experiences and attitudes around three areas - access to GP services, domiciliary care, and mental health was a priority.

The research drew attention to the specific health risks and health needs of the Asian community and examined cultural barriers surrounding these three areas.

http://www.healthwatchoxfordshire.co.uk/sites/default/files/asian_womens_group_-_health_watch_final_report_19_9_14_rc_0.pdf

We focused for a period on NHS Healthcheck – in 40-74 year old men and women without pre-diagnosed medical conditions and upon their uptake of this free screening service and the barriers to update; amongst minority ethnic groups in Oxford City; Polish (mixed gender) and Asian men and women – engagement was carried out separately.

We were pleased to have been invited to contribute to the development of the OUH-OCC Joint Public Health plan and to start to see its implementation through the Public Health Steering Committee – and especially to see the innovative work that is happening in Oxford University Hospital and being planned for the wider community.

What we would have liked to have done:

Had we had the time and the resource – to ensure wider social engagement - and had there been more of us:

- **Street level** (Supermarket, Shopping precincts, coffee shops)
- Elderly Lunch clubs as a forum to seek views on Health and wellbeing matters
- **Local companies** (Corporate sector) including manual public services through to "blue chip" companies – i.e. to broadly reflect social groups
- **Key influencer organisations** (more with Faith Groups, Men's and Women's Groups and clubs - Oxfordshire Community Sports and Social clubs, and health activity promoting organisations)
- **Grass roots research** - working collaboratively with other organisations and health and social care professionals on specific intervention - collaborating with Community Dieticians targeting healthier eating cooking demonstrations – linked to healthy weight and exercise - particularly at risk ethnic minority groups.
- **Attend hobby / interest / community and home based activity events** to target predetermined age, gender and ethnic groups in health-social profile (refer to Aziza Shafique's work on how and where she engaged in different ways to reach out to Asian women, through the Asian Women's Group).

Biggest disappointments:

Public not being able to stave off planned cuts of £133K in 2016/17 on Domestic Abuse services budget - on a budget of £331K. We believe these costs will, in reality, not turn into real savings, but will be transferred and picked up by other parts of the social care, emergency services and health care system – we feel these savings are not savings, but merely regrettable cost shifts.

Not being able to take forward the issue of Asian community need to have an URDU speaking General practitioner in Oxford City (particularly for the elderly), plus greater access to other face-to-face language support (as oppose to remote translation services). This issue was seen to be outside of the remit of the Public Involvement Lay Representative per se, however we decided to take this forward independently ourselves. Meetings were held with NHS England and the relevant GP Practice and a commitment was made in June 2014 to run a workshop about Rose Hill Community centre GP practice possible development - to engage with the public about this. Nearly a year later this has not materialised nor followed through by commissioners.

Conclusions:

1. A key issue we identified early on was the scope of the role and the demands on the Public Involvement Lay Representative (a voluntary part time role suggested to be around 10 hours a week commitment). In relation to our ability to reach out across Oxfordshire in the defined Health Improvement Board priority areas, across a wide geographic region, with only two part time voluntary Lay

Representatives – this was, in reality, not possible. We did strive to attend meetings in Oxfordshire localities and take part in bubbling up and large group events – however we have to be upfront and declare that there were inherent limitations on the coverage and face to face public engagement and involvement opportunities we could create in the time available, with only two part time voluntary Lay reps.

2. That said, we felt energised and wholly committed – so we set our agenda, wrote and circulated our plan, and opportunistically targeted our time and own resources where we felt we could add some value and have impact - in consultation with County Council colleagues. We cannot claim it was representative of the Oxfordshire region, but it was based on the priorities set by the Health Improvement Board. We drove our own activity agenda with the four priorities and our six one year goals in mind. In practice we put many more hours in than 10 per week, to create public involvement and engagement opportunities. There were no tangible resources we could call upon - not even a display stand – we had to buy our own flip chart stand and paper for one meeting outside a mosque because no exhibition stand was available.

3. On the basis of our experiences and voluntary contributions over 18 months we believe it is important to reaffirm, from our perspective, the need to have independent appropriately supported Public representation on the Health Improvement Board. Maintaining 'arms length' independence was, we feel, essential to the success of the role; as it was also vital to have the support of Health Improvement Board members throughout our tenure. This was appreciated and helped us to keep going.

4. Occasionally it was a challenge to balance our Public Involvement Representative roles, to seek views and to scrutinise on behalf of the public whilst at the same time holding to an official corporate strategy. At a personal level we felt we were well supported by County Council engagement officers, particularly in our early months in post, as we navigated through some of these issues and the impact of national political decisions. Throughout we were well supported too by Healthwatch Oxfordshire and the County Council Public Health team. We too had some very positive collaboration with peer Public Involvement Network Representatives on the other partnership Boards – especially Adult Health and Social Care on the issue of Housing support.

5. We believe that coming from non-mainstream NHS or local government backgrounds made it easier for us to ask the questions the public were asking, or wanted us to ask, as their representatives. Aziza in particular was able to utilise her strong Asian community connections opportunistically and proactively diffuse health and social care system changes, on occasion. This was outside of the remit of the role, but sensible in the circumstances, to fill occasional communication void.

6. Whilst throughout we remained wholeheartedly committed to the Health Improvement Board's priorities, goals and ambitions, the general public and community were sometimes understandably at variance with the national decision to cut local government expenditure, due to its impact on health and social care budgets. In this regard, occasionally we felt the need to voice public concerns and not infrequently we found ourselves having to make it clear that we were not representing the Health Improvement Board itself when expressing opinions or highlighting issues to the public, or to other health or social care provider organisations. We sometimes had to identify 'which hat we were wearing'. We tried to be constructive and pragmatic to safeguard public interest where we could.

7. When we were in doubt about the extent of our remit in voicing public views and concerns, as well as taking advice from the engagement team - we took as our overriding guidance; 'The seven principles of public life' on how to view or role and how to act. (Appendix 1: The Committee on Standards in Public Life. January 2013, Fourteenth report Cm 8519.) These principles we feel remain fundamental and should be embedded in the new Healthwatch Ambassador role – as indeed in all public life roles – and be kept in mind at all times.

8. During the few occasions when there were complexities and differences of perspective, we appreciated the Board's understanding and acceptance of this dissonance, indeed we saw this as a 'litmus test' of the healthy Public-Professional partnership we felt existed on the Health Improvement Board.

9. We would like to independently state - as Public Involvement Network Lay Representatives that we felt we had sufficient freedom to fulfil our brief to the public and had the full support from the Board to do so. We couldn't change everything we wanted to, but we felt we had some influence on health and social care strategy focused on health improvement, as a result of feeding back Public views and contributing to performance reviews and other agenda items.

10. Finally we would like to say - time restriction was a major constraint, as were resources. We were self-motivated, largely self-supporting and self-sustaining volunteers who supported each other well, playing to each other's' strengths. In practice we gave up to two or three days of our time regularly each week for periods on Public Involvement Network (including associated related voluntary work). Going forward, wholly relying on such volunteers alone we believe would limit community outreach and public engagement and impact. We believe as well as the new Healthwatch post-holders having sufficient time and commitment - importantly sufficient budget will be required to take Public representation to the next level in the area of Health Improvement. This is the challenge for the CEO of Healthwatch Oxfordshire and County Council and Clinical Commissioning Group colleagues, to determine what vision, priorities, scope, requirements and importantly resources they can allocate to support the new Healthwatch

Ambassador roles, in order to take the role to the next higher level of Public Involvement and influence on decision making.

Acknowledgements:

We would like to formally thank the Board for embracing our commitment, for supporting our independence and our personal style and passion, in the way that Board members did. It was greatly appreciated by both of us, as was the support of Healthwatch Oxfordshire colleagues and Public Involvement Lay Representatives on the other Partnership Boards. Aziza and I enjoyed working together, supporting the Health Improvement Board. Indeed, it was a privilege for us to represent the public voice, to take an active part in the health and wellbeing improvement evaluations and scrutiny on a wide range of health improvement initiatives in Oxfordshire.

With best wishes and thanks to all our colleagues – it was a pleasure working together with you.

Paul McGough and Aziza Shafique April 23rd 2015

Public Involvement Network Lay Representatives Health Improvement Board.

APPENDIX 1.

The seven principles of Public Life*

- ***Selflessness***... 'act solely in terms of public interest...'
- ***Integrity*** *(in this particular context of the lay role and public life in general, we feel it legitimate and appropriate to broaden the word integrity to also mean 'Independence')*...This sits well with the stated principle ... 'freedom from obligation to people or organisations that might try inappropriately to influence them in their work...' For example to not allow political pressure to mute public voice, nor suppress public interest or public representation. (also refer to Openness)
- ***Objectivity***...'act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias...'
- ***Accountability***...'act and take decisions impartially, fairly, and on merit, using the best evidence and without discrimination and bias
- ***Openness***... 'act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.'
- ***Honesty***...'be truthful'
- ***Leadership***...'exhibit these behaviours in their own behaviour ...and actively promote and robustly support the principles and be willing to challenge poor behaviour when it occurs.'

*Standards Matter; A Review of Best practice in promoting good behaviour in public life; Committee on Standards in Public Life, January 2013, Fourteenth report Cm 8519.