Committee Meeting

October 2014

Welcome and apologies

Anna Bradley

Minutes of the last meeting, actions log and matters arising

Anna Bradley

Declarations of interests

Committee Members

Chair's Report

Anna Bradley

Chief Executive's Report

Dr Katherine Rake OBE

Update on Care.data and Accredited Safe Havens

Sarah Vallelly

Healthwatch principles for Care.data

Below are the principles we will use to shape our response to Care.data, which also draw on our Healthwatch consumer principles:

1. People can access their own health and social care data and records to see what the system has collected and who they are sharing it with.

2. Data is collected and shared in a manner that does not unduly compromise people's anonymity, safety or treatment.

3. Collecting and sharing data cannot be used to justify treating people on an unequal basis with others.

4. Data collection and sharing will not have impact on a person's wellbeing by, for example, causing them additional anxiety or distress.

5. People are provided will all the information they require about Care.data to make an informed choice about whether they want to opt in or out.

Healthwatch principles for Care.data

6. Frontline professionals are upfront and honest about the benefits and dis-benefits of opting in or out of Care.data.

7. If an opt out is offered, it must be a genuine option (i.e. not unduly burdensome) and people must be told about the restrictions and limitations of this option.

8. If someone raises a concern or makes a complaint about the collection or sharing of their records it must be taken seriously and staff must take immediate action to address the concern and, if it relates to a breach of confidentiality, put safeguards in place to restore the person's anonymity.

9. People should be offered the opportunity to opt out of Care.data later if they change their mind about the programme.

10. People should be offered an opportunity to get involved in local decisions in their GP surgeries about whether or not records are shared with the Care.data programme.

Questions for the Committee

- Have we captured the right principles to shape our work on Care.data?

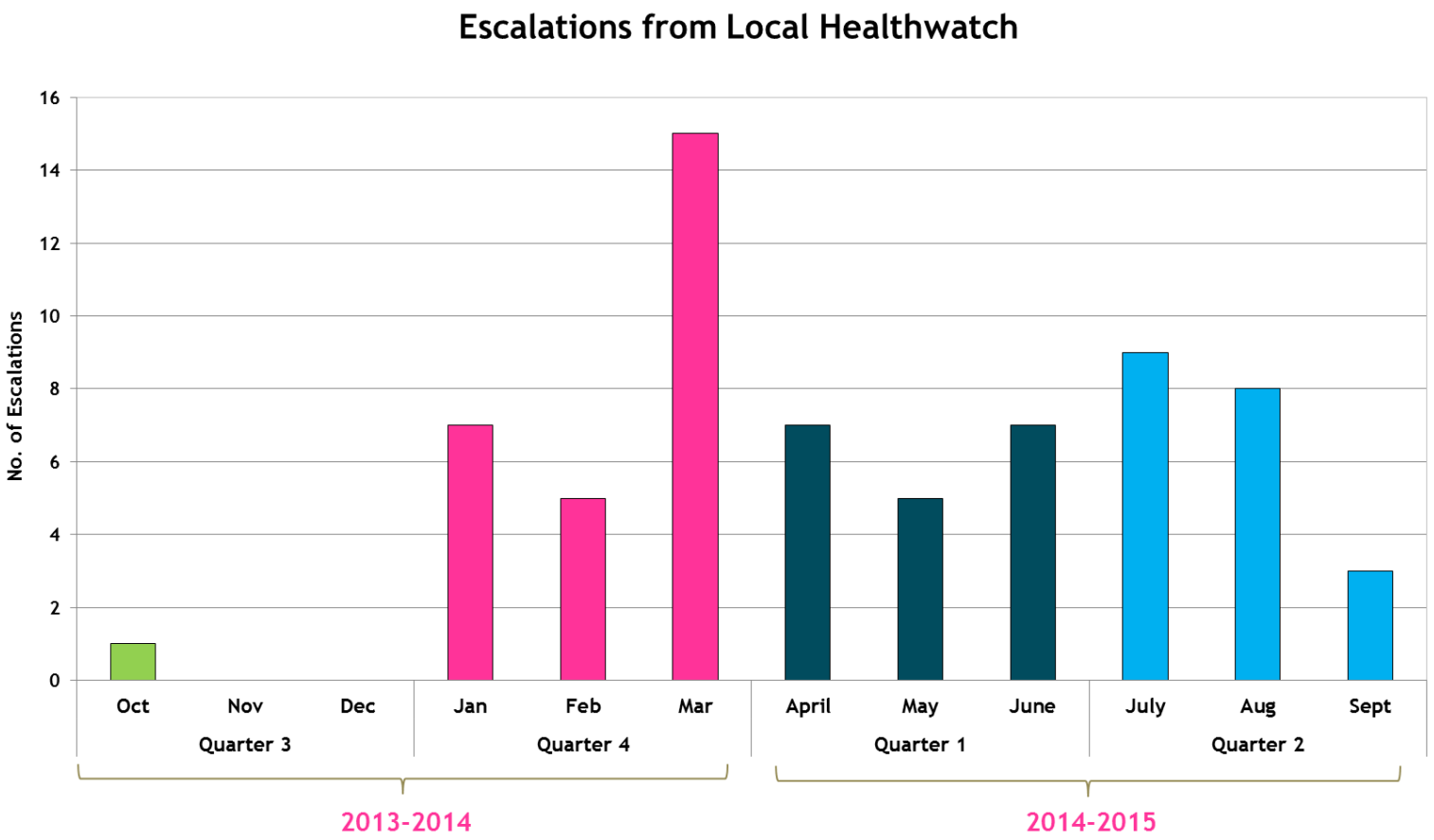
- Do you feel that we need to use our powers to give any additional advice on Care.data or Accredited Safe Havens at this stage?

healthwatch

Local Intelligence Report

Sarah Vallelly and Debbie Laycock

Escalations from local Healthwatch



The remit for the CAMHS special project

Dr. Marc Bush

What's the problem in a nutshell?

- Children and young people are unable to access psychological assessment and therapy services, and some who enter institutional care are not being treated in a dignified or compassionate way.

- This is because there is a crisis in Child & Adolescent Mental Health services (CAMHS), with low level support in communities (Tiers 1-3) being scaled back and an unnecessary reliance on secure and residential institutional provision (Tier 4).

- The crisis in CAMHS has resulted from:

  - disinvestment in preventative and lower level support (Tiers 1-3);
  - difficulties in sustaining the costs in the highest levels of support (Tier 4);
  - out-moded commissioning and stifled innovation in service delivery;
  - changing attitudes and expectations of both professionals and the public about mental health; and
  - increased identification of needs (and re-profiling diagnoses) in children and young people.

- This crisis has been well documented in the reports of the Children and Young People's Health Outcomes Board, the Chief Medical Officer, Public Health England (ChiMat), the Royal College of Psychiatry, Young Minds and NHS England.

CAMHS vital statistics

- 1 in 10 children and young people have a diagnosable mental health condition - that is around three children in every class;
- Half of all lifetime cases of psychiatric disorders start by age 14 and three quarters start by age 24;
- Around 1 in 12 children and young people deliberately self-harm, and over the last decade these has been a 68% increase in young people being admitted to hospital because of self-harm;
- Those with learning disabilities are more likely to develop a mental health condition, and particularly if they are on the autistic spectrum. This can be due to the isolation and treatment they experience in their lives;
- 95% of imprisoned young offenders have one or more mental health condition;
- Research by Young Minds shows that two thirds of local authorities had reduced their budget for CAMHS Tiers 1-3 since 2010, which has resulted in increased waiting times according to the Royal College of Psychiatry; and
- The number of NHS-funded CAMHS Tier 4 beds has increased from 844 in 1999 to 1264 in January 2014, at an estimated average cost of £186k per bed.

What are other people doing to address this crisis?

Following the Committee decision to investigate further, we have undertaken a scoping of the national CAMHS landscape and gaps in coverage.

•This has found that:

- DH has established a CAMHS taskforce, which will report on system-wide reform and action in Jan/Feb (TBA);
    - The plan behind the taskforce is to agree quick action to address emerging crisis and to propose more substantive reform for the next spending round; and
    - Anna and Christine both have seats on the taskforce.
- The Department of Health are tendering a significant piece of engagement with children, young people and families about use of CAMHS.
- NHS England is engaging children, young people and families (through Young Minds) in a piece of work about experiences in Tier 4 CAMHS (following on from their report).
- There remains to be a significant cross-party commitment to bringing about a parity of esteem between physical and mental health.

Emerging gaps in the national work

During our scoping work we identified a number of emerging gaps in the national efforts to address the CAMHS crisis:

- Transition from CAMHS to adult psychiatric and mental health services (apart from the difference in eligibility thresholds);
- Experiences of specific client groups (LGBT youth, young offenders, some BME groups (including those from conflict zones) and young people with a learning disability; and
- Experiences of children and young people who experience mental distress of trauma as a result of abuse or domestic violence (although well-covered elsewhere and on the Department of Health's radar for inclusion down the line).

Challenges in designing our own special project

- National stage is extremely crowded.
- Department of Health is also investing in a significant engagement programme with children, young people and families.
- Lifetime and activity of the taskforce is short. We will be influencing thinking and decision making.
- Lots of local Healthwatch are interested in the issue, but few have done any substantive work on it at present.

Proposal from the CAMHS task and finish group

The task and finish group proposed that the Committee:

- Hold back from direct engagement with children, young people and families to avoid duplication with existing programmes of work.

- **And instead use the seat on the CAMHS taskforce to:**
  - Review the existing taskforce membership and advise whether any other expertise needs to be around the table;
  - Ensure adequate reflection and representation of the issues faced by those who we have identified there being gaps around in the programme;
  - Take a particular interest in the engagement work with children, young people and families, and join a sub-group if it emerges; and
  - Explore the role we and local Healthwatch could play to ensure a legacy for the taskforce and to embed the conclusions.

- It was also proposed that we:
  - Set up a reference group of the Committee and local Healthwatch to shape our contributions to the work of the taskforce.

Diversity and Inclusion Update

Sarah Armstrong

Working relationship with the Care Quality Commission (Inspection Regimes)

Susan Robinson

Background

Survey of local Healthwatch
May/June

- 21 responded with their experience of the new CQC inspection
- This showed a patchy picture - extremely good relationship, not good or none at all
- 60% were not kept informed of inspection progress
- 60% were not invited to the quality summit or equivalent

Conference workshop
July

- Workshop at conference jointly run by Healthwatch and CQC
- Draft partnership working fundamentals and guidance presented
- The discussion reflected the survey – views included; inconsistent, one-way and disrespectful
- The fundamentals needed to be achievable

Package developed
July/August

- Revision of the MoU to incorporate new escalation policy
- Guidance for local Healthwatch on the new inspection regime
- Working relationship fundamentals
- Joint letter to all local Healthwatch and CQC staff from Dr. Katherine Rake and David Behan

New products

Other products and activities

- All local Healthwatch have a primary named contact of their local CQC inspection team, from the beginning of October

- A guide for local CQC inspection team on working together - this will provide guidance on engaging with local Healthwatch during inspections

Monitoring the implementation of the 'Fundamentals of the working relationship' via the annual return, individual inspection surveys, regional meetings and 1-2-1's

Next steps

- Case study collection on good local Healthwatch practice based on the ‘fundamentals of the working relationship’
- On-going information gathering about the learning from the inspections process
- Guidance to support LHW with specialist inspections e.g. MH, CYP and/or on particular themes e.g. social care.

Next steps - continued

- On-going review of escalations and possible policy implications;
- Organise and facilitate meetings and learning between our regional team and CQC's new regional structure . Work to develop the ‘contract’, depending on additional capacity.

Service Change Project Plan

Susan Robinson

Background

- The NHS and Local Government are in a period of unprecedented financial challenges with rising demand and limited resources.
- Reconfiguration has become loaded with negative meaning, although it is also an opportunity to create services fit for the future.
- Healthwatch England is passionate about real involvement and co-production, putting the voice of the public at the heart of commissioning.
- The ‘service change project’ will bring together our work on integration (Better Care Fund) and reconfiguration under the wider banner of service change.

Goals

Goal:

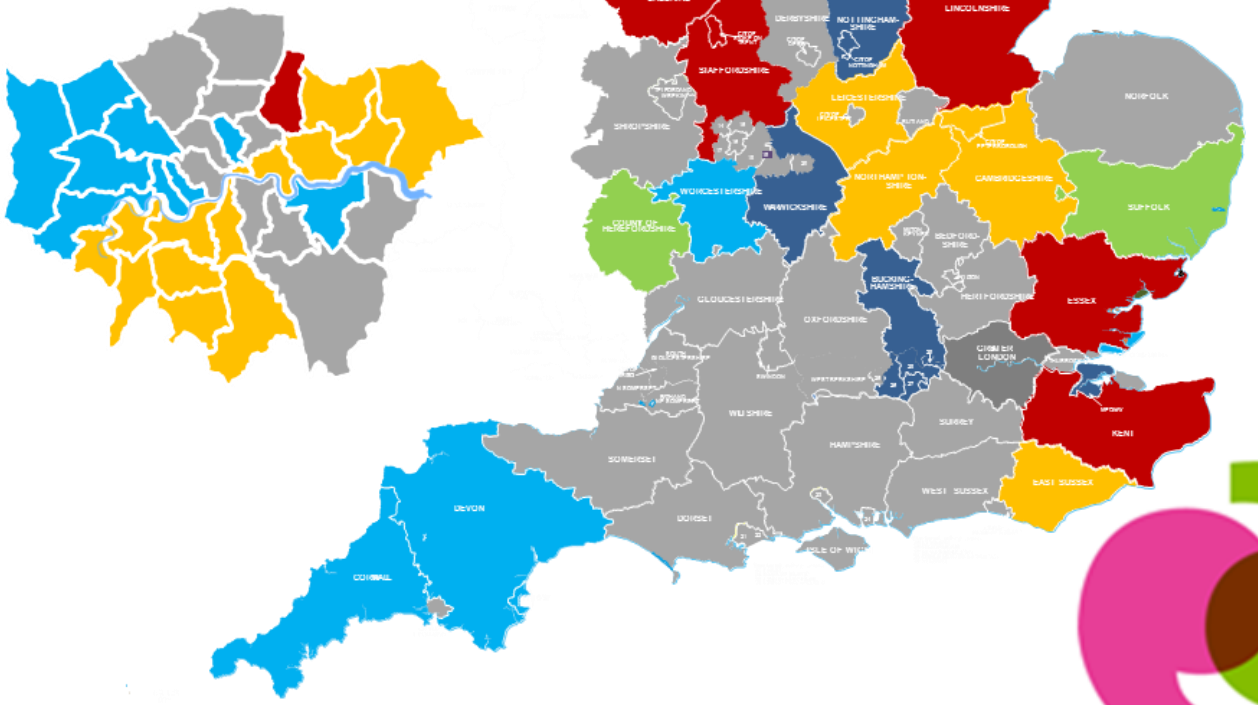
- Local Healthwatch have the foundations to meaningfully navigate, engage and influence service change that benefits all their communities.

- Providing local Healthwatch with the **resources** to increase confidence and build capacity.
- Creating **good practice** examples of local Healthwatch influencing service change.
- Provide **targeted support** to local Healthwatch in pressure point areas.
- To **bring back** local Healthwatch experience to key decision makers (Better Care Fund).

Service Change

Pressure Points Maps

- Challenged health economies
- Special measures
- Pioneer sites
- Escalations - service change
- Multiple



Journey

Quarter 1

Needs Analysis

- Local Healthwatch survey to baseline their involvement and current concerns, so we understand the levels of need, confidence and capability.
- Interview Better Care Fund pioneer sites to understand their experience of the process.

Quarter 2

Resource development - co-production

- Small group sessions to test assumptions and gather more specific examples.
- Conference workshops, presentation initial resource pack – online film, public views, key questions to influence and top ten tips (product testing).
- Provide feedback to Jon Rouse on the experience of local Healthwatch engagement in the Better Care Fund planning phase.
- On-going updates and guidance on Trust Special Administration and Joint CCG commissioning.
- Discussions with the network about the multiple pressures they face, such as the Healthwatch England committee meeting in Nottingham this summer.

This engagement helped identify the key activities and the content of the resource pack

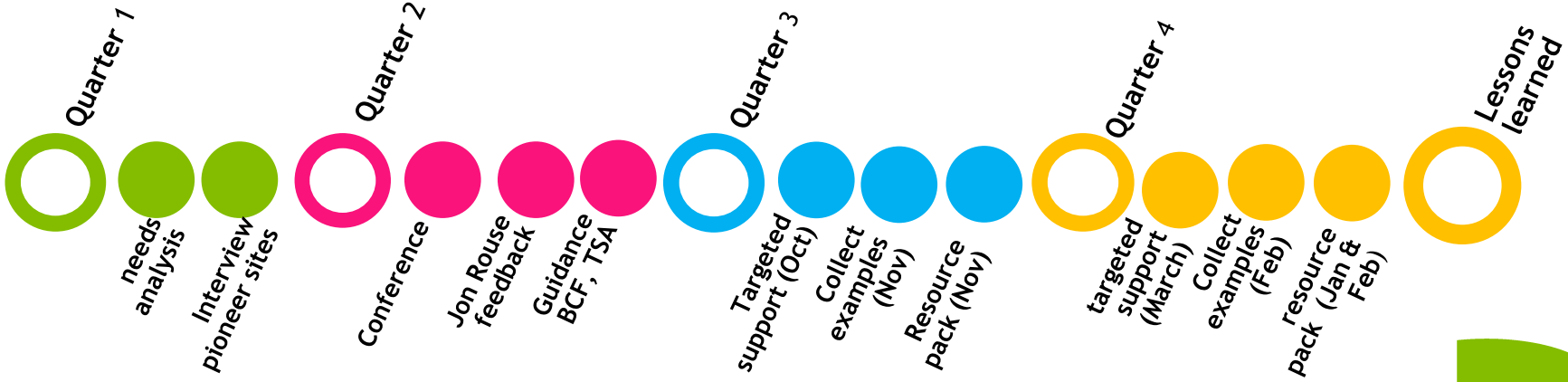
Themes of resource pack

Impact & Influence	• Negotiation and communication skills • 'Continuous line of influence' recording influence • Measuring impact
Engagement & relationships	• What good engagement looks like • The commissioning cycle and continuous improvement • Examples of good practice
Leadership	• Drivers for service change • Better Care Fund, Trust Special Administrator and CCG Joint Commissioning • After Francis – leadership role within the system
Resources	• Legislation and government programmes • Income generation; delivering engagement – conflicts of interest • Independence, transparency and accountability

Current activity

- Providing targeted support – starting with Greater Manchester CCG joint commissioning roundtable, 20th October.
- Drafting the content for the resource pack – starting with the drivers for change.
- Designing case study format – ensuring we capture the key influencing principles of good practice.

Project timeline 2014-15



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Public Participation

Enhanced Governance

Sarah Armstrong

Committee Forward Plan

Esi Addae

Audit and Risk Sub Committee Chair's Report

Jane Mordue

Committee Members update

Committee Members

Operational Update

Sarah Armstrong

Any other business and Close of session

Anna Bradley

Committee Meeting

October 2014