

A large abstract graphic on the left side of the slide. It features a large pink shape on top and a large green shape below it, both with curved, organic forms. A small white circle is positioned on the right side of the green shape.

**Committee Meeting**

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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

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# Update on Care.data and Accredited Safe Havens

Sarah Vallyelly



# 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 with all the information they require about Care.data to make an informed choice about whether they want to opt in or out.
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# 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.
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# 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?



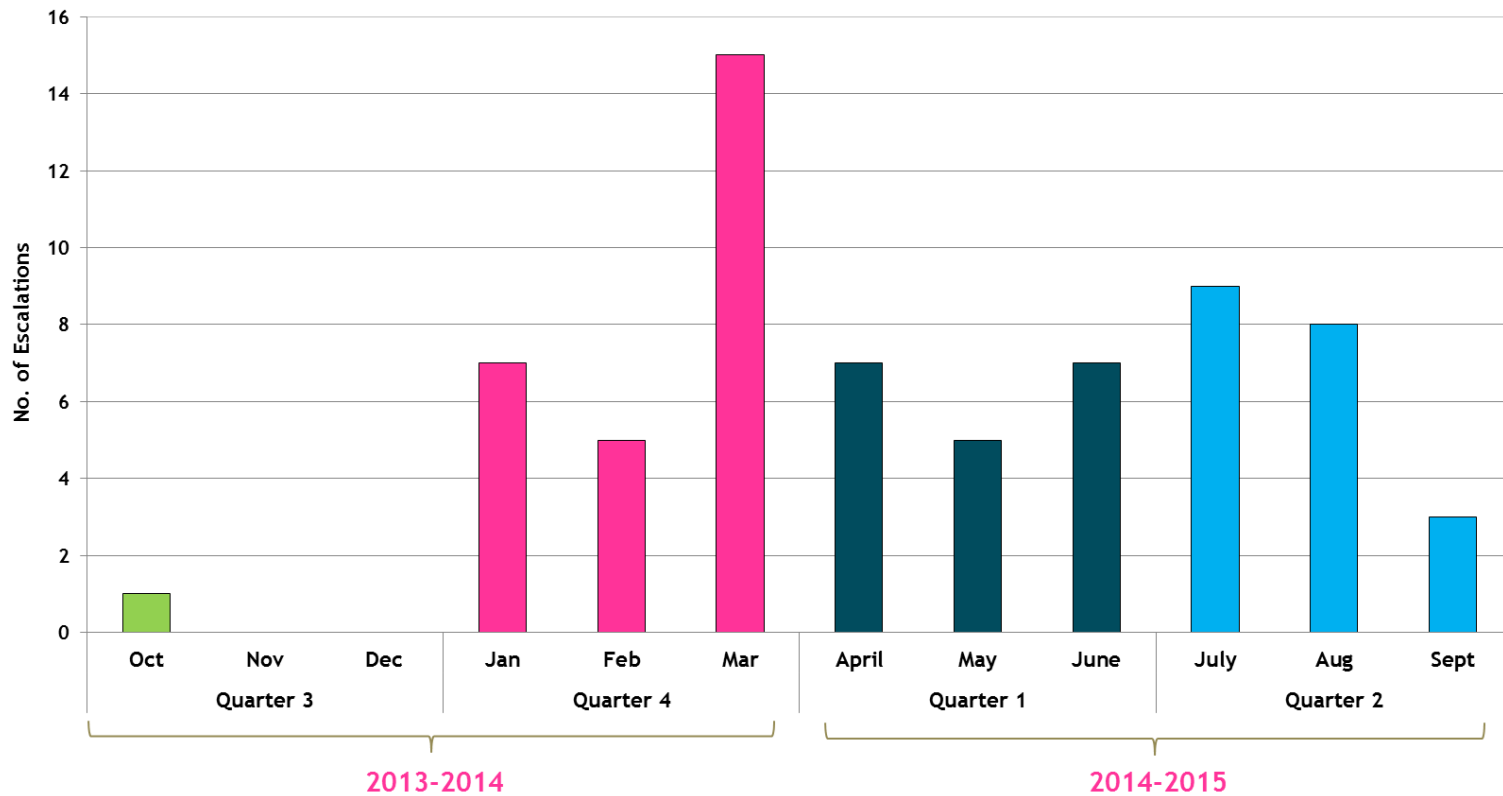


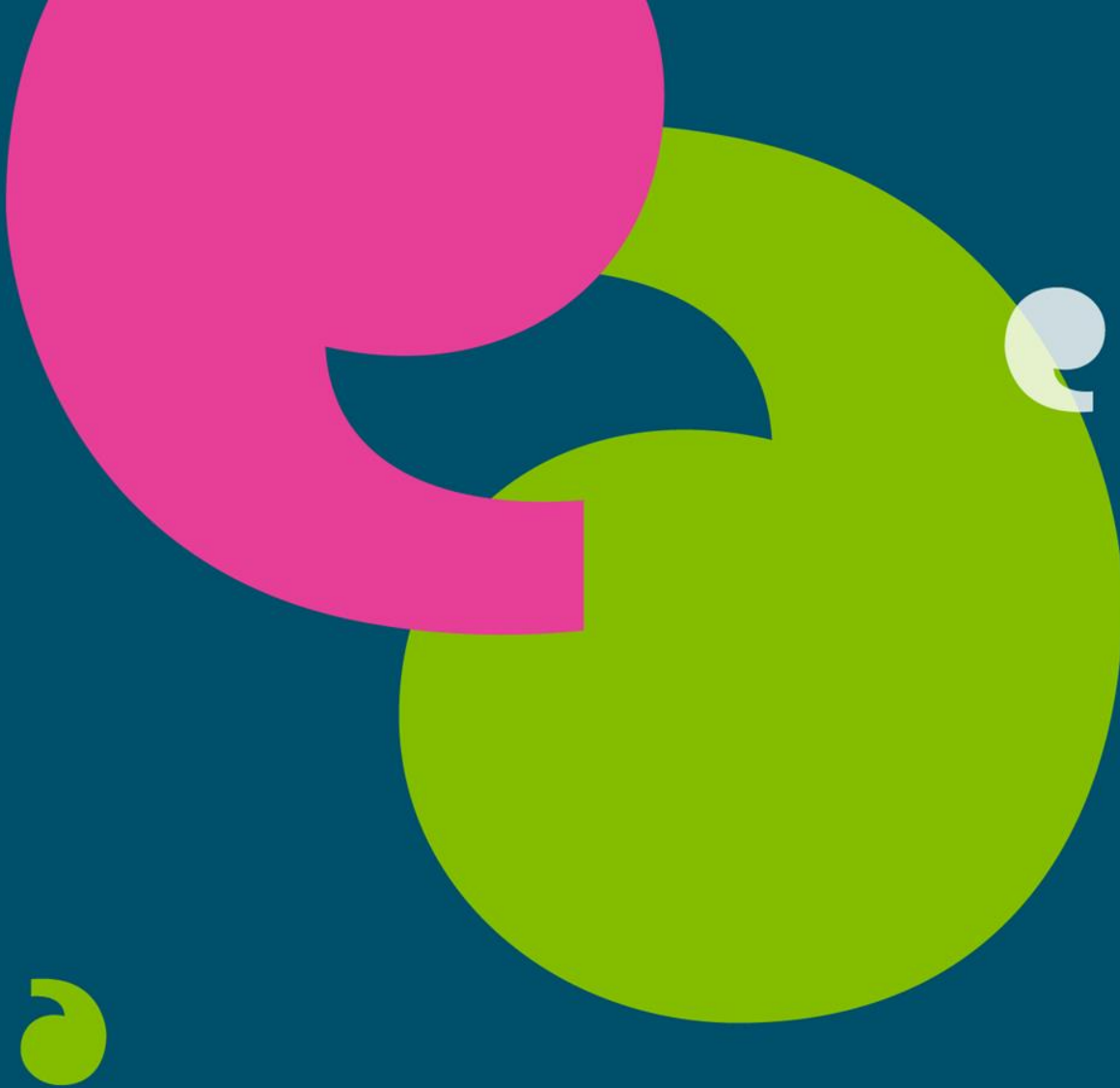
## Local Intelligence Report

Sarah Vallely and Debbie Laycock

# Escalations from local Healthwatch

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 there 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 conditions;
  - 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.
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# 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

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# 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



Dear local Healthwatch manager and chair,

The Care Quality Commission and Healthwatch England have produced a joint briefing for all local Healthwatch on how CQC and the Healthwatch network can work together.

The briefing accompanies this letter and is also available to download from the Healthwatch England website.

This is a significant step for CQC and Healthwatch England. It signals the importance of a regular two-way relationship between your Healthwatch and the relevant local CQC inspection teams. It recognises the value CQC places on evidence from local Healthwatch and the whole Healthwatch network about people's experiences of care.

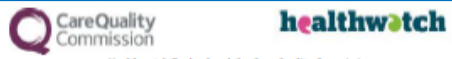
Your Healthwatch will have contact with all CQC inspection teams, but your lead contact will be our local primary medical services inspection team.

We will be sharing their contacts with you as soon as we can.



## Fundamentals of the working relationship

<p><b>Relationship</b></p> <p>Every local Healthwatch has an effective two-way relationship with CQC, which is coordinated by the primary care integrated care team manager, and meets at least every three months.</p> <p>During inspection activity the relevant CQC inspection team (primary, hospital, social care) will engage directly with the local Healthwatch.</p> <p>Local Healthwatch and CQC will share work to avoid duplication and identify opportunities for a coordinated approach.</p> <p>CQC inspection teams need to take into account the capacity of their local Healthwatch.</p>	<p><b>Evidence</b></p> <p>CQC will share information, such as profiles and recent findings from inspections.</p> <p>Local Healthwatches will share people's experience data and reports from engagement with their local communities with CQC, such as Enter and View reports.</p> <p>CQC will actively involve local Healthwatch in thematic reviews of user groups or care pathways.</p> <p>Healthwatch England and CQC will investigate the use of the Healthwatch CRM to support the sharing of information.</p>
<p><b>Inspection</b></p> <p>Local Healthwatch will be invited to contribute evidence and advice on inspections.</p> <p>Local Healthwatch will be invited to advise and support CQC in how it undertakes community engagement.</p> <p>CQC inspection teams will keep the local Healthwatches informed of anything that is of interest to the public, such as the suspension of a service.</p> <p>Local Healthwatch will be involved in the quality summit (or equivalent mechanisms).</p>	<p><b>Improvements</b></p> <p>Local Healthwatches will receive feedback from inspection teams on any need to stop.</p> <p>CQC will provide local Healthwatches with information on improvements made following inspections, as a channel to inform the public.</p> <p>Local Healthwatch will have an ongoing opportunity to share their insight on provider progress and to flag any continuing public concerns.</p> <p>Local Healthwatch will inform CQC where improvements have been made to services as a result of their engagement.</p>



## Healthwatch England and the Care Quality Commission 'How we all work together'

### REQUESTING INFORMATION AND THE USE OF STATUTORY INFORMATION AND ADVISORY POWERS

This document sets out the process by which Healthwatch England will request information from CQC (not using its statutory powers), and the process when Healthwatch England uses its statutory advisory and informational powers with CQC.

#### Requesting information (not using powers)

**Healthwatch escalation process**

When members of the public raise a concern with local Healthwatch the onus is on local Healthwatch to resolve this issue locally. In instances where the issue is unresolvable locally it can be formally escalated to Healthwatch England. Healthwatch England will then investigate the issue and seek a resolution. In some instances, in order to seek a resolution Healthwatch England may require information from CQC. This will be a formal request for information but, unless stated, will not be a use of Healthwatch's formal powers.

When requesting information, Healthwatch England will send the following information to the Director of Engagement at CQC. CQC will be expected to acknowledge the request, indicate the responsible CQC staff member who will take up the request and the date by which Healthwatch England can expect a response.

- Date submitted;
- Brief description of the issue and information requested;
- Date/time period the concern relates to;
- Local Healthwatch organisation's (or others) involved;
- Service the concern relates to;
- Short timetable of investigation so far - including local resolution attempts with providers, CCGs and CQC regionally;
- Key contact at Healthwatch England - name, email address, telephone

#### The use of Healthwatch advisory and informational powers

Healthwatch England's powers in addition to its legislative responsibilities with regard to local Healthwatch, Healthwatch England is empowered (under Health and Social Care Act 2008 45A 1 to 7) to provide the Secretary of State, NHS England, Monitor, and English local authorities with information and advice on:

- The views of people who use health or social care services and of other members of the public on their needs and experiences of health and social care services;
- The views of local Healthwatch organisations and of other persons on the standard of provision of health and social care services and on whether or how the standard could or should be improved.

The organisations provided with information and advice must inform Healthwatch in writing of their response or proposed response.



## Memorandum of understanding concerning the expectations and relationship between Healthwatch England and the Care Quality Commission

### Purpose

This document is intended to provide a common line of action and understanding between Healthwatch England and the Care Quality Commission, in relation to supporting both Healthwatch England, the Healthwatch Network and Local Healthwatch organisations.

This document sets out how the strategic partnership between Healthwatch England and the Care Quality Commission will operate on a day-to-day basis.

### Background

Healthwatch England was established in accordance with section 181 of the Health and Social Care Act 2012 as a committee of the Care Quality Commission with the purpose acting as an effective, independent consumer champion making demonstrable differences to consumers of health and social care.

The Care Quality Commission regulates, inspects and reviews all hospitals, care homes, dental and general practitioners, surgeries, and all other care services in England to ensure they provide people with safe, effective, and encourages them to make



## The Care Quality Commission and the Healthwatch network: working together


September 2014



## 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

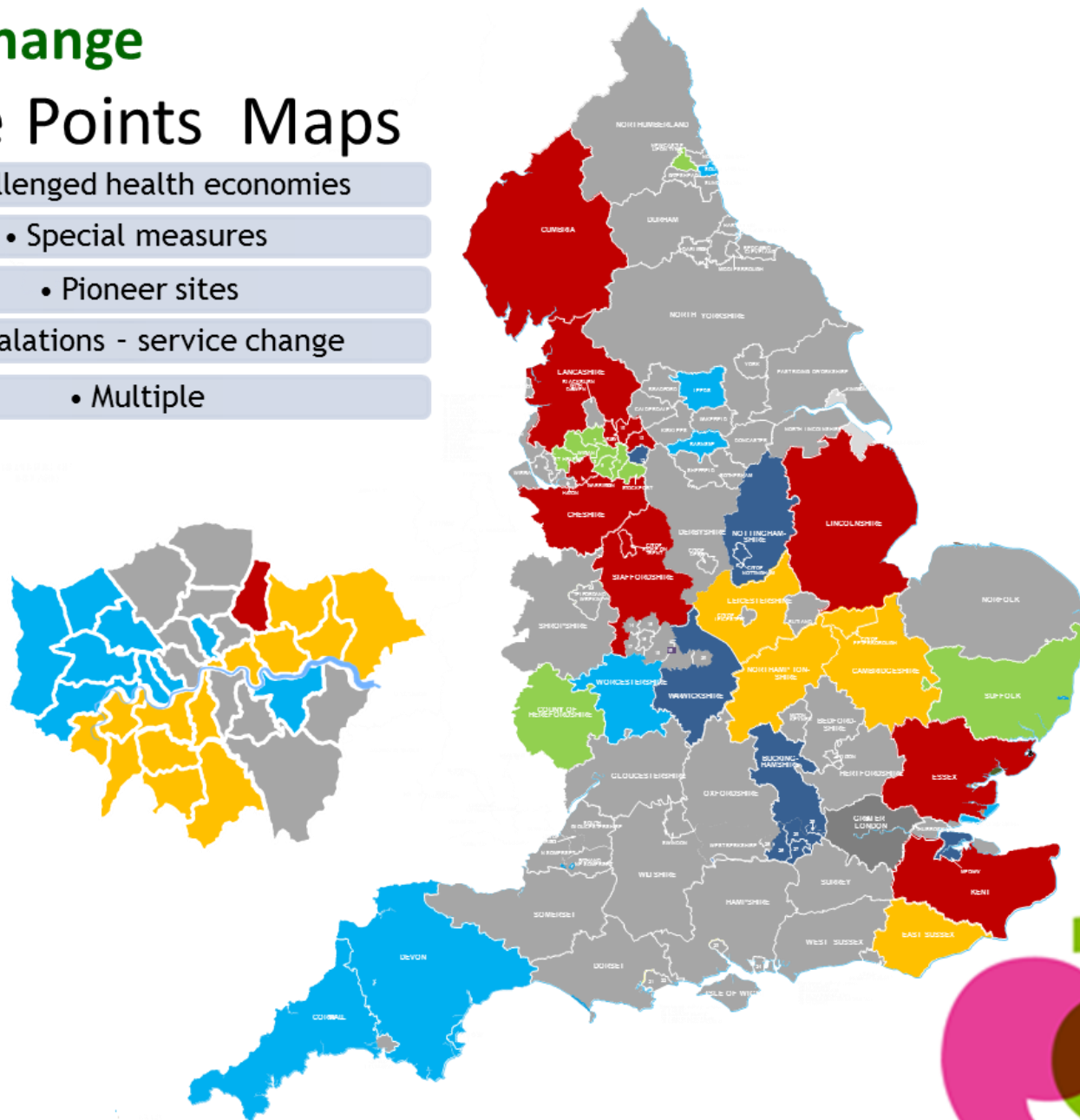
## Goal:

- 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).
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# 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

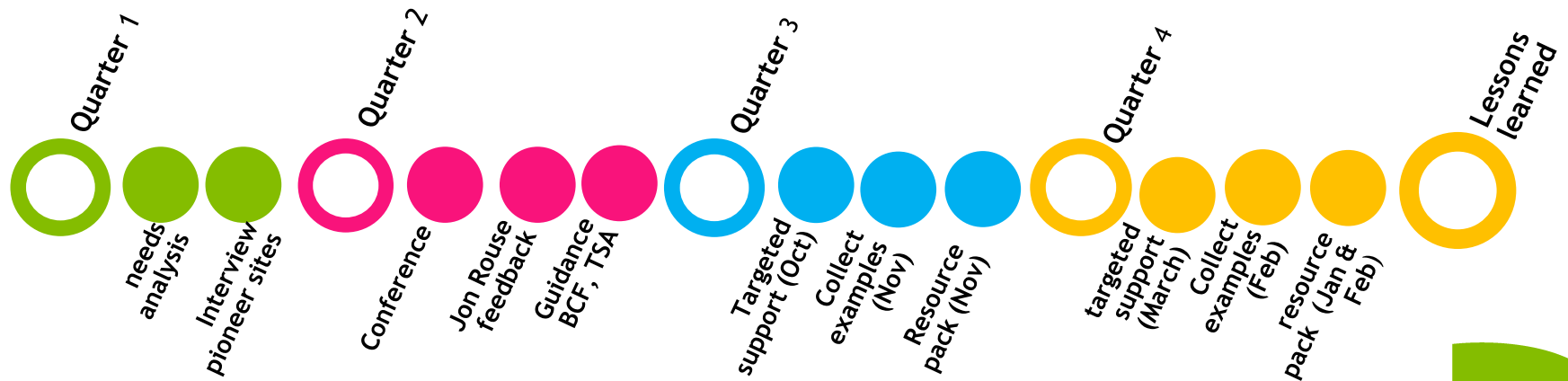
- Legislation and government programmes
- Income generation; delivering engagement - conflicts of interest
- Independence, transparency and accountability



# Current activity

- Providing targeted support - starting with Greater Manchester CCG joint commissioning roundtable, 20<sup>th</sup> 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





# 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**



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# Committee Meeting

October 2014