Healthwatch Committee Meeting

February 2014

Welcome and apologies

Anna Bradley

Minutes from last Committee Meeting

Anna Bradley

Declarations of interests

Anna Bradley

Chair's Report

Anna Bradley

Chief Executive's Report

Dr Katherine Rake

Issues arising from the network

- Patient Transport Services – Local Healthwatch across the Northwest have been investigating changes to eligibility criteria and poor customer service being provided by patient transport services;

- GP Access – Oxfordshire, Birmingham, Bradford, Surrey, Portsmouth and Stoke have all released stories about patient experience of GPs, in particular looking at trouble getting appointments;

- A&E – Worcester, Stoke, Brighton, Nottingham, Hull, Lincolnshire, Portsmouth, Essex have all issued warnings about the pressures on A&E;

- Enter and View – Leicester, Leicestershire, Camden, Hull, Lancashire, Derby and Bradford have all issued press releases about how enter and view powers are enabling them to spot concerns and drive improvement in a range of services, from struggling A&E departments to failing care homes;

- Fuel poverty – Healthwatch Norfolk ran a story about the impact of fuel poverty on health inequalities;

Issues arising from the network

- Parking charges – Dudley, Stockport, Northampton, Cumbria have all registered complaints about price rises for parking or the introduction of charges in previously free hospital car parks;

- 7 day services – Portsmouth, Oxford and Blackpool have all highlighted the need for hospitals and GPs to start providing services 7 days a week;

- Care.data – Devon, Cambridgeshire and York have also raised serious concerns regarding NHS England's plans to share personal medical records;

- Locums – Southampton and Suffolk both raised concerns about the amount being spent on locums services and the impact this is having on other services;

- Unsafe discharge – Central West London, Suffolk and Hartlepool issued stories about unsafe discharge and the impact this is having on vulnerable groups.

Audit and Risk Sub Committee Chair's Report

Jane Mordue

Operational update

Sarah Armstrong

Our team development programme

Recognition	Investment	Vision
Recognising the achievements so far	Building on the achievements	Consistently achieving
Considering the learning	Using the learning	Constantly fresh with new learning
Saying thank you to everyone who made this happen	Strengthening the team	Continue to invest in the team
	Stabilising the team	Growing capacity
Admiring the individual and collective energy, sense of fun and informality	Asking questions of the team… what would you like?	Reaching and realising potential
The energising phase	**The stabilising phase**	**The performing phase**

Members' update

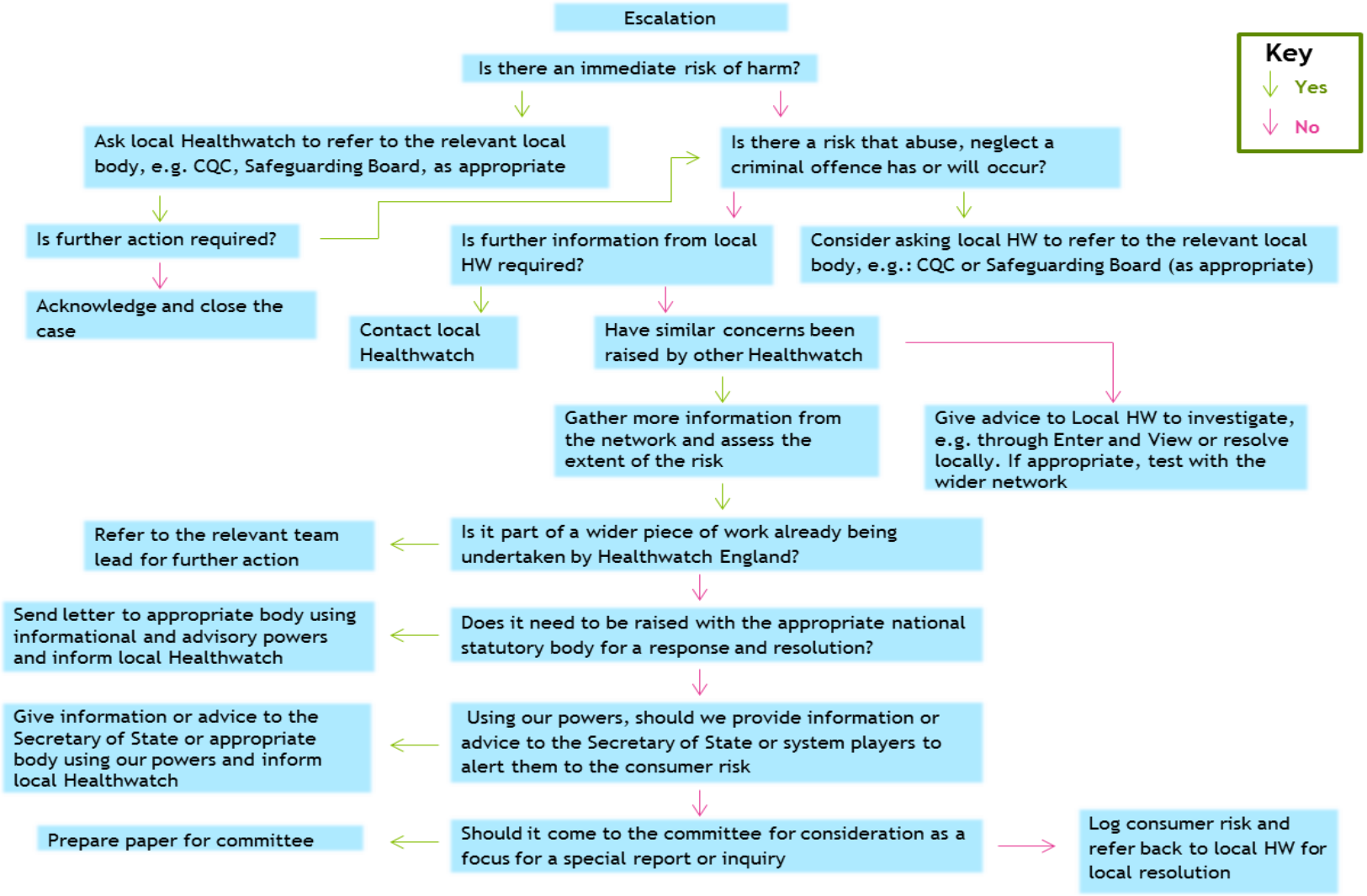
Anna Bradley

healthwatch

Escalation Report

Dr Marc Bush

Escalation group progress



Strategic Partnerships

Dr Katherine Rake

Business Plan and Budget 2014-15

Dr Katherine Rake

Local Healthwatch Strategy

Claire Pimm

What we will deliver

• Building our communities and expertise	• Deliver support to local Healthwatch to engage across their communities, e.g. provision of materials to support their work with people with learning disabilities • Develop communities of interest, identity, practice and place are established, including Chairs and Chief Executives' network • Deliver regular Healthwatch regional events, Healthwatch network events, local Partnership Days and Healthwatch conference
• Efficiency and effectiveness	• Customer Relationship Management system rolled out across the network, enabling improved data sharing and analysis • Data collection delivered giving indications of state of health of network • Annual Report demonstrates the impact of the network, and analyses returns from local Healthwatch
• Capability and capacity building	• First stage implementation of models of engagement with CQC and Chief Inspectors in the new inspection regime • Training in e.g. escalation, leadership and governance, media • Deliver support on service change, including reconfiguration and service closure and the integration of health and care services
• Realising and promoting our impact	• Communications strategy shared with the network • Case studies developed • Sharing information with the network about national influencing and special inquiry progress

Diversity and Inclusion Strategy

Katherine Rake and Sarah Armstrong

Why we are doing this

- Because inequalities both affect, and result from, health and care systems;
- Because this is a key to supporting strategy for the work of Healthwatch England;
- Because it is critical to the quality of our evidence gathering for a rounded picture of everyone's experience in health and care;
- So we can learn from Healthwatch and act as a role model to the network;
- To be compliant with legal duties:
  - To ensure Healthwatch England is independently compliant with all relevant legislation, particularly the Equalities Act;
  - To support local Healthwatch, even though not legally bound, to work in the spirit of the legislation.

Our approach

- Our aspirations are bigger than the current legislative framework e.g. coverage of children and young people/carers;

- We have consciously chosen diversity and inclusion, which builds upon an equalities framework but is more active and less bound by consideration of protected characteristics;

- We aspire to the principle of mainstreaming, but also recognise that we need a standalone strategy that is independently monitored;

- To deepen our existing work on values, bringing to life our first value ‘Inclusive’:

  - We start with people first;
  - We work for children, young people and adults;
  - We work across health and care;
  - We work for everyone, not just those who shout the loudest.

The mainstreaming principle in action

This strategy will underpin everything we do:

- our direct work at a national level;
- our support to the network;
- our communications and engagement approach;
- our approach to monitoring evaluation and learning;
- our recruitment and employment policies for Committee and staff;
- how we prioritise our work.

Indicators for success

- Gaining greater insight into communities, particularly those affected by health and care issues whose voices aren't always fully represented;
- A staff and committee who feel fully able to understand and address equalities issues;
- Healthwatch England is able to contribute to national debates in a way that promotes parity of esteem and reduces inequality;
- Our work at a national level supports development of diversity and inclusion work across the network.

It will result in our work being accessible and meaningful to all.

How we will do this

- Ensure strategies are reflective of local thinking. Hold webinar with local Healthwatch;
- Use this as a further opportunity for staff engagement;
- We will consider how we integrate D+I within our staff and committee development programme so that everyone has the confidence to integrate this in their work and to provide challenge across the organisation;
- We will publish a short statement as part of a finalised strategy in April to engage with local Healthwatch, learn from them and start the process of sharing practice.

Next steps

- Develop and agree a diversity and inclusion statement as part of our final strategy document;
- Healthwatch webinar to gather together interested and expert local Healthwatch;
- Further staff development of these principles in March/April 2014;
- Monitoring framework in place for 2014-15.

Special Inquiry Remit

Dr Marc Bush

Background

At the September public meeting, the Healthwatch England committee agreed to undertake a special inquiry into unsafe discharge using our s. 45C powers.

Based on early intelligence from the Healthwatch network the committee wanted a specific focus on the experiences of three consumer groups:

- Older people
- People who are homeless
- People with mental health conditions

We use this power to undertake thematic reports and inquires into consumer concerns that require an in-depth exploration or investigation.

Based on the findings of the inquiry, we will use our s.181 powers to provide recommendations, information and advice to the Secretary of State, and any relevant statutory bodies, about changes that should be made to policy, guidance or practice.

What is the focus of the inquiry?

Concerns have been raised that people are being discharged from hospital, nursing or care homes, or other secure settings unsafely without adequate assessment of their on-going needs or arrangement of sufficient support in their own home, residential care, temporary accommodation or their community.

Stakeholders are concerned that this increases the risk of emergency re-admissions to hospital, escalation of needs and crisis.

Particularly, we have been told about the impact on older people, those with mental health conditions or who are homeless.

For example, recent research suggests that:

- Inadequate care, support or rehabilitation in the community leads to people's quality of life deteriorating and risk of emergency readmission increasing.
- In 2012-13, almost 1 in 5 emergency admissions were readmissions.

What is the emerging definition?

Our emerging definition of unsafe discharge is:

When people are discharged from a hospital, nursing or care homes, or other secure settings too early, at the wrong time or without a continuity of support or a sufficient care package put in place or to an inappropriate or inadequate location.

We used the term ‘unsafe discharge’ to signal the impact this situation has on people’s lives and were keen to move away from a single focus on hospitals.

However ICF GHK, in their evidence review for the inquiry, identified that unsafe discharge is not a widely used term:

‘Unsafe’

- Implies a neat distinction between ‘safe’ and ‘unsafe’
- “There is no such thing as a risk-free discharge”
- A ‘good’ discharge is one that anticipates, balances and manages risk

‘Discharge’

- ‘Discharge’ focuses attention on what hospitals are doing
- It also implies a single event, rather than an ongoing process
- ‘Transfers of care’ is a more useful and inclusive term

They propose thinking instead about ‘risks’ to ‘transfers of care’.

This is an important reflection and whilst we do not think that ‘transfers of care’ comes from the consumer view-point we want to explore this further with the committee and panel members.

What will we learn?

The inquiry will seek to:

- Determine the scale of the problem (including within the defined groups).
- Explore the risks of an unsafe discharge from a hospital, nursing or care home, or secure setting and the factors influencing it based on consumer experience.
- Better understand the experiences of older people, people who are homeless and those with mental health conditions and their ideas for improvement and change.
- Learn from best practice in the UK and abroad.
- Co-develop recommendations for system players to avoid unsafe discharge in the future.

How will we add value?

- Ensuring the ideas of people who have experienced unsafe discharges are at the heart of our explorations.
- Bringing together the collective concerns of consumer interest groups to ensure improvement works for all consumes and particularly those who are older, homeless or have mental health problems.
- Looking at the broader picture, by looking at factors that may lie outside of the health and social care systems (i.e. housing and justice).
- Consolidating existing evidence as there is quantitative work on unsafe discharge (by the Nuffield Trust, Kings Fund, Dr Foster, and others), and some qualitative work by academics and charities (including Age UK, Homeless Link, Rethink) have touched upon the issue, as there is not a substantive investigation across the board or relating to the three consumer groups.
- Increasing the visibility of unsafe discharge in national policy making by using our statutory powers to ensure action is taken by system players.
- Using our informational and advisory powers to the Secretary of State and statutory bodies in health and social care.
- Using our seat on the Ministerial group overseeing the Better Care Fund to ensure unsafe discharge is adequately focused upon in the pioneer areas.

Questions:

- Should we refine the focus of the inquiry and use something else instead of ‘unsafe discharge’?
- Is there any other way we could be adding value or maximising the impact of our findings?

What is the format of the special inquiry?

It will reach a diverse range of communities (both rural and urban) and we will link up with related work (i.e. the sites of the CQC mental heath crisis care review and pilot inspections).

An inquiry panel will be established and will:

- Go on site visits to meet people to talk about their experiences of being discharged from hospital, a nursing or care home, or secure setting.
- Hear evidence from people who have experienced an unsafe discharge, organisations, commissioners, providers, frontline professionals, system players (like NHS England, the LGA and CQC) and experts in the area.
- Explore existing research and data.

To inform the panel's deliberations, Healthwatch England will:

- Conduct focus groups.
- Collect written evidence on behalf of the panel.
- Undertake or commission evidence reviews of existing literature and data.

All of the evidence and discussions would be collated into an inquiry report, with supporting resources and launched at a dedicated event.

The inquiry will begin in February 2014 and report in September 2014.

Which consumer groups will we be targeting ? 1/2

1. People who are homeless:

- **Long-term (entrenched) homeless:** (particularly those with mental and physical health needs and have experienced drug or substance misuse, immigrated, are transient rough sleepers)
- **Recently made homeless** (particularly young people and immigrated)

2. Older people:

- **Frail older people** (particularly those who are isolation and those on a low-income)
- **Older people with complex needs and/or long-term conditions** (particularly those with chronic relapsing conditions or multiple long term conditions)
- **Older people who are deemed to lack mental capacity** (particularly those with dementia or learning disabilities)

Which consumer groups will we be targeting? 2/2

People with mental health conditions:

- **People with long-term or complex (enduring) mental health problems** particularly those living with personality disorders)
- **People with enduring mental health conditions who interact with the secure estate and justice systems** (particularly with a history of violence)
- **People with both a physical and mental health condition** (particularly those whose primary presenting needs overshadows the other)
- **People with a mental health condition caused by or associated with substance abuse** (particularly those living with an addiction)
- **People who have self-harmed or are suicidal or attempted suicide** (particularly young people)

Questions:

- Have we focused on the right consumer segments?
- Are there places where we could narrow down the remit further?
- Should we give equal weight to all the consumer groups?
  - Our analysis would suggest focusing:
    - primarily on people with mental health conditions
    - do deep dive activity into homelessness
    - lighter activity for older people as there is a significant amount of existing evidence that we could draw on

What are the inquiry panel and advisory group?

	Inquiry panel	Advisory group
Responsibility	ensuring the inquiry delivers to the remit and terms of reference for the inquiry agreed by the Healthwatch England committee	responsible for providing insight, reflection and guidance to the inquiry panel based on their knowledge, experience and inquiry activity they engage in
Membership	▪ Healthwatch England committee ▪ local Healthwatch ▪ CQC mental health crisis review	▪ people who experienced an 'unsafe discharge' ▪ the chair of a health and wellbeing board ▪ frontline professional ▪ systems expert ▪ barrister
Focus	centred on the evidence, experiences and ideas of consumers	centred on wider context relating to the evidence, experiences and ideas of consumers
Activity	attend five panel meetings and engage in at least one wider inquiry activity	attend three advisory group meetings and engage in inquiry activity
Ways of working	▪ panel meetings and discussions are accessible to all panel members ▪ establish ways of working and the format and design of the meetings, touch points and deliberations ▪ Healthwatch England to provide secretariat	▪ panel meetings and discussions are accessible to all panel members ▪ establish ways of working and the format and design of the meetings, touch points and deliberations ▪ Healthwatch England to provide secretariat

Who will be on the inquiry panel?

Panel position	Rationale for approaching
Chair	Ensure the inquiry progresses and remains within the agreed scope
Local Healthwatch representative (x3)	Encourage greater transparency and more joined up working across the network
Healthwatch England Committee member (x2)	Relevant expertise and interest in substantive areas of the inquiry
Representative from CQC Mental Health crisis review team	Ensure close working between our inquiry and the crisis review team site visits

Who will be on the inquiry advisory group?

Advisory position	Rationale for approaching
A person who has been homeless and experienced an unsafe discharge	Ensure we have someone championing the insight we collect from the consumer group
An older person who has experienced an unsafe discharge	Ensure we have someone championing the insight we collect from the consumer group
A person with a mental health condition would has experienced an unsafe discharge	Ensure we have someone championing the insight we collect from the consumer group
Chair of Health & Wellbeing Board	Ensure transparency
Clinician with front line experience of unsafe discharge	Ensure we can understand practice in context, taken from Professional Standards Authority suggestions and list compiled from ICF GHK
Health and social care systems expert	Ensure we can understand policy in context, taken from existing advice to organisation
Barrister / QC who has made case law in the area	Ensure we can understand legislation and case law in context, targeted list based on portfolio and experience

Questions:

- Do you have any reflection about how the inquiry panel or advisory group will work?
- How will we best use the time of the people on the inquiry panel and advisory group?

What themes are emerging from the evidence?

Our evidence review and conversations with stakeholders have already identified a number of lines of inquiry that cut across the consumer segments. These include:

- Failures occurring at moments of transition or transfer within or between systems
- Differences between premature discharge, delayed discharge, out of hours discharge and self-discharge
- Breakdowns in communication
- Establishing responsibility for discharge and care
- Flows of data and information (within and between systems)
- Use and adequacy of discharge protocols and arrangements in place in a setting
- Access to, and availability of community based services (i.e. mental health crisis teams, district nursing, adult social care, voluntary sector hospital to home schemes)
- Access to, and availability of, rehabilitation and therapy services
- Risks associated with poly-pharmacy and medicines reconciliation
- Movement between hospitals and care homes
- Assumptions about family and/or community support networks
- Adequacy of hostel and housing agencies and connections with health and social care

Questions:

- Have we captured all the important lines of inquiry in our emerging themes?
  - Are there any other themes we should be exploring based on the evidence you have come across?
  - Are there places where we could narrow down the remit further?

Special inquiry timescales

Milestones	Dates	Committee touch points
Scoping the remit and lines of inquiry	Dec 2013 – Feb 2014	Update via email end Jan 2014
Recruitment of Special Projects Manager	Jan 2014	Introduce to committee once they have started
Testing the remit	Jan – Feb 2014 – 29th Jan roundtable with statutory leads	Discuss and sign off proposed remit / media partnership at Feb committee meeting
Undertaking (and updating) an evidence review	Jan – Mar 2014	Interim report to Feb meeting
Launch of inquiry / media partnership	TBC late Feb 2014	Nominated committee members attend the launch
Site visits / media spikes	Mar – May 2014	Committee members on inquiry panel to attend
Proposed sync with new CQC pilot mental health inspections	May 2014 (TBC)	Committee members on inquiry panel to attend – to report back at subsequent committee meeting
Public hearings	Jul 2014	Interested committee members to participate
Draft report agreed	Aug 2014	Circulated to the committee for comment
Launch activity	Aug 2014	Committee members attend the launch

Questions:

- Are there any risks you want to explore, or assurance you need, at this stage about the planning for the inquiry?

Duty of Candour

Dr Marc Bush

Duty of Candour – what have we said previously?

A statutory duty of candour applying to all health and social care staff and organisations is crucial to promoting consumer rights and should be implemented without delay. The duty must:

- apply to all health (including mental health) and social care services and should cover both the public and private sectors.
- apply to individuals to mark out those who wilfully cover up incidents, do not provide honest accounts or obstruct others from being candid themselves.
- apply to any moderate or higher harm which has come to a person as a result of poor treatment or wrongful omissions of care

Criminal sanctions for covering up information about serious incidents could be important in avoiding the escalation of the situation and further abuse, neglect and preventable death occurring.

However, our legal advice suggests that there are a number of avenues that could be pursued using existing tools such as maladministration, obstructing an inspection, misconduct in public office, professional disciplinary procedures relating to fitness to practice and contractual sanctions. Only if these options are found wanting should a new offence be introduced.

Duty of Candour – what have been doing?

Since we agreed our interim position on the Duty of Candour we have:

- Used our informational and advisory powers and wrote to the Rt. Hon. Norman Lamb MP, Minister for Care & Support with our position on duty of candour and specifically the question of whether to apply criminal sanctions.
- Met with the Minister and Rt Hon. Jeremy Hunt MP, Secretary of State for Health to discuss Healthwatch priorities, including Duty of Candour and Hard Truths.
- Given oral and written evidence to the joint review of Prof. Norman Williams (President of the RCS) and David Dalton (CEO of Salford Royal Hospital) commissioned by the Secretary of State into proposals to enhance the duty of candour in the NHS.
- We have been developing our position on duty of candour based on the committee's steer and now need to finalise our position so that we can publish our final position and inform the Minister and Secretary of State's final decision.

What should our final position be? (1\2)

Below are our proposed positions on outstanding areas:

- Francis recommends that the duty should be triggered when a person 'believes or suspects' that treatment may have caused harm, do we think this is the right trigger?– we propose 'reasonably suspects'
- Do we agree with Francis and Berwick that 'near misses' should not be included in the duty? – we propose accepting this recommendation.
- How should failures to perform an act that led to harm (omissions) be dealt with? – we propose a definition that focuses on failure to provide a generally accepted standard of care, which lead to harm
- Many interventions have 'known complications', which the person will be informed of and have consented to should this be taken into account when assessing the application of the duty? – we propose consent should be treated as a factor in fulfilment of the duty

What should our final position be? (2\2)

Below are our proposed positions on outstanding areas:

- Should sanctions should be imposed and what the nature would be (given we have rejected new criminal sanctions)? – we propose significant caution around criminal sanctions and instead propose either civil sanctions in the forms of fines, or professional and employment sanctions as the primary methods of enforcement

- Liability arising from the duty will alert people to harm they may not have previously been aware of and will impact behaviour and practices (particularly with proposed changes to indemnity insurance), so how should we treat disclosures? – we propose duty of candour disclosures would not be used in civil or criminal actions (though the facts could be) and clearer oversight of compliance as it is inappropriate for a potentially opposing party to counsel the other (because of severe conflict of interest)

Public participation

Healthwatch Committee Meeting

February 2014