Safety, Quality, Trust

Briefing for Council Scrutiny about the Francis Report

cfps Centre for Public Scrutiny

accountability, transparency, involvement

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Introduction

In February 2013 Robert Francis published his report in to the failings at Stafford Hospital run by the Mid Staffordshire NHS Foundation Trust. In response, CfPS urged all NHS bodies to pledge to refresh their culture and values because better care is likely from commissioners and providers who are transparent, inclusive and accountable - whereas those who are unapproachable or unclear about outcomes risk losing touch with patients and families – which happened at Stafford Hospital with catastrophic results.

Poor clinical and management practices contributed to what happened – patients received poor care on the wards and the Board were not checking what was happening. Performance management systems designed to check up on poor practice showed on many levels that Mid-Staffordshire was a successful Trust – whilst in reality it was failing patients. Variations in performance were recorded and explained in ways that made it difficult to be clear what was happening to patients – and concerns about operational performance were overshadowed by apparent strategic successes. Accountability is not just about publishing data – this is important but should be linked to mechanisms that bring a reality check to make sure that patient's experiences are properly reflected.

Robert Francis identified that it was difficult for anyone 'on the outside' to check what was happening in the hospital. Scrutiny by local councillors is an important part of the framework of health service accountability, but their role is different from the Care Quality Commission (CQC) or local Healthwatch. We urge councils and the NHS to embrace the value we know scrutiny can provide and support and resource council scrutiny well. Everyone with a role to hold the NHS to account needs to work together to make sure they combine their powers and the information they gather so that stronger lines of accountability are developed for strategic direction and operational performance.

Responding to Francis

The Department of Health published an interim response 'Patients First and Foremost' and during July and August 2013 held a series of events around the country jointly with the CQC, NHS England and Health Education England about implementing the Francis recommendations.

In the interim response, the Department indicated an expectation that local Francis Action Plans should be in place in health and care organisations across the country by the end of 2013. The Department will be publishing a full response to each of the 290 recommendations in the autumn of 2013.

In light of the Francis Report and other issues relating to the inspection of hospitals and care homes, the CQC held its own series of consultation events about 'A New Start, changing the way the CQC

regulates, inspects and monitors care'. The CQC has appointed Chief Inspectors of Hospitals, Social Care and Primary Care.

Sir Bruce Keogh was commissioned to review performance at 14 hospitals with Hospital Standardised Mortality Ratios (HSMR) similar to those at Mid Staffordshire. As a result some hospitals are receiving additional support to improve the quality of services. In July 2013 NHS England published its first Friends and Family Test results about whether patients would recommend the place they received treatment to their friends and family and in August 2013, Don Berwick published a review about improving the safety of patients.

Ann Clwyd MP is leading a review aimed at ensuring all hospitals listen to and act on the concerns of patients. Complaints can be the earliest symptom of a problem within an organisation and the NHS should use them to learn from and improve their service. The review will recommend how a much more rigorous and effective system for handling complaints can be introduced across the NHS.

Alongside published data and recommendations for improvement coming from various reviews, NHS England has established Quality Surveillance Groups (QSGs) covering every locality. The role of QSGs is to identify possible problems and share information with key players.

What is this briefing about?

This briefing is about how council scrutiny can support improvements in quality and patient experience and help the local NHS put patients first and foremost. Robert Francis had clear messages about council scrutiny and this briefing suggests some first steps for council scrutiny to consider in responding and improving scrutiny practice and outcomes in relation to holding the NHS to account.

What specific recommendations were made for council scrutiny?

The recommendations can be found in Chapter 6 of Volume 1 of the Francis Report (page 481)

43 - Those charged with oversight and regulatory roles in healthcare should monitor media reports about the organisations for which they have responsibility.

147 - Guidance should be given to promote the co-ordination and co-operation between local Healthwatch, Health and Wellbeing Boards, and local government scrutiny committees.

149 - Scrutiny committees should be provided with appropriate support to enable them to carry out their scrutiny role, including easily accessible guidance and benchmarks.

150 - Scrutiny committees should have powers to inspect providers rather than relying on local patient involvement structures to carry out this role, or should actively work with those structures to trigger and follow up inspections where appropriate rather than receiving reports without comment or suggestion for action.

What other lessons from the overall conclusions and recommendations can be applied to council scrutiny?

The Francis Report highlighted what can go wrong when patients, their families and the public struggle to have their voices heard. Council scrutiny has a key role to play in the participation of patients and the public in health service provision – but this requires co-ordination with others and effective resources and support to make an impact.

Council scrutiny needs to establish ways to monitor data or information about the experiences of people who use health and care services, alongside 'triggers to act' when things seem to be going wrong. Council scrutiny does not need to duplicate what others are doing but should maintain a wide network of intelligence so that it can use its powers effectively to hold the NHS account - having a clear understanding about the quality, safety and value of healthcare services and challenging providers and commissioners when it seems that good outcomes elsewhere are not being matched locally.

1. Involve people who use services, their families and the public.

There is one obvious, overriding characteristic of the Mid Staffordshire events – patients' or their relatives accounts of their experiences were either not heard, not understood or ignored. The Francis Report identified that council scrutiny should have been more proactive about responding to local concerns and that it should have been less trusting of hospital managements' explanations of performance – council scrutiny needs to be clear about its role as a 'critical friend'.

Giving the public an opportunity to raise issues independently and outside the scrutiny work plan can be a way to hear about people's experiences of services. This might range from written questions to open 'public platform' opportunities. In Staffordshire a series of 'accountability sessions' facilitated through council scrutiny gives hospital managers a chance to hear and respond directly to the public.

In light of the Francis Report it is important to consider developing these opportunities locally (other examples are Buckinghamshire, City of York).

Public forums can be a powerful way to hear about issues and concerns – but it needs to be clear that council scrutiny is not a way to resolve individual complaints (there is a separate NHS complaints process – currently under review). Council scrutiny should not ignore personal stories but should have ways to test whether personal experiences are symptomatic of wider problems – amplifying the voices and concerns of the public where necessary to affect change.

Councillors are at the heart of their communities. They meet and speak to members of the public every day, they have relatives in hospital, they experience the NHS themselves, they meet other councillors with those experiences. Of course that alone can be construed as a 'town hall bubble' and councillors do not have exclusive access to information, but councillors' everyday experiences can be wisely used as a warning indicator. That said, council scrutiny is not 'privileged access to the NHS' - it is an unprecedented opportunity to act as eyes and ears of the community and to invite the public to place their experiences and concerns on the record, giving them due weight and consideration, investigating them or taking them further using council's scrutiny powers. The skill is to move from 'the anecdote to the evidence'.

2. Use information that is available: media reports, public Board papers, complaints data and published statistics about health and care outcomes.

Keeping 'a finger on the pulse' is an overworked metaphor in the health sector, but spot on in this case. What appears in the local and national press may often warrant further investigation and local interpretation. The news angle may be obscuring something more fundamental and may be worth investigating independently with the health service. The point of keeping an eye on local press, individual anecdotes and complaints data is to follow up trends or significant anxieties.

Council scrutiny should consider establishing a range of 'triggers for action' using data and information to monitor trends. Asking providers where and how data is recorded and published and commissioners about how they monitor and address performance and outcomes is a good starting point. The key point from the Francis Report is that council scrutiny should not passively accept responses from providers or commissioners but should seek to test these in light of what people who use services say about their experiences (relying only on results of Friends and Family tests and other formal surveys may not be effective). The Patient Association has on several occasions told patients stories with dramatic effect, triggering task and finish reviews in to care standards and responses to those stories. Patient Opinion is an example of an online review and response tool for patients to let providers know about their experiences and for providers to respond.

The Francis Report and Keogh Review have brought Hospital Standardised Mortality Ratios (HMSR) and other data and statistics into the spotlight and some councils have already brought in experts to help councillors understand their significance and interpretation. CfPS will be publishing a guide about using publicly available data and statistics in the autumn of 2013. A practical example of council scrutiny using data and statistics to hold the NHS to account is the award winning review by Westminster City Council looking at a reporting break in waiting list statistics.

Many councils have multiple NHS providers and Clinical Commissioning Groups in their areas. They will all have Francis Action Plans that council scrutiny can use as an opportunity to establish mechanisms to focus on safety and quality of services.

3. Collaborate to avoid duplication and complement the work of others.

Health and Wellbeing Boards and local Healthwatch

Health and Wellbeing Boards (HWBs) are committees of upper-tier Councils. Council scrutiny will already have well developed relationships with Health and Wellbeing Boards. The role of HWBs is to develop a strategy for the delivery of health, healthcare and social care in collaboration with CCGs and the remit of scrutiny is to monitor and challenge the effectiveness of Board strategies to reflect priorities and deliver outcomes.

Local Healthwatch is the consumer champion for health and social care. Commissioned by councils with social care responsibilities local Healthwatch will gather and present the views of people who use services and communities to those who plan and deliver services. Local Healthwatch is a statutory member of HWBs and has a role in providing information to patients and the public about services available. If commissioned to do so by councils, local Healthwatch can have a role in complaints advocacy. CfPS published a guide for council scrutiny, health and wellbeing boards and local Healthwatch in 2012 with better outcomes for local people as a focus for working together.

Examples of early work to develop protocols with local Healthwatch are in Staffordshire, Bury and Oldham. Case studies of the work done to embed the health reforms in 14 scrutiny development areas has been published in 'Spanning the System: Broader Horizons for Council Scrutiny' which demonstrates how council scrutiny can add value to the reforms.

Quality Surveillance Groups

It will be important to quickly establish an understanding of roles with the new Quality Surveillance Groups set up by NHS England and build working relationships. Council scrutiny is not a defined member of Groups, whereas local Healthwatch is.

Care Quality Commission

Council scrutiny also needs to work effectively with the Care Quality Commission. CfPS has been supporting joint learning between council scrutiny and CQC assessment staff and this will continue in to 2014. The CQC publish a monthly e-bulletin for council scrutiny and a guide for Overview and Scrutiny Committees - 'Working with the Care Quality Commission'. Details about the Chief Inspectors and the new inspection regime are set out on the CQCs website.

Quality Accounts

There is a requirement for NHS Trusts to engage council scrutiny in the production of annual Quality Accounts. In Warwickshire innovative work has been done with George Eliot NHS Hospital Trust, one of the 14 hospital trusts investigated by the Keogh Review into mortality rates. A scrutiny Task and Finish Group has been part of the Trust's Quality Account Review arrangements working with patient advocates, officers from clinical audit, external auditors, the Director of Nursing and Medical Director.

Currently, council scrutiny does not involve a legal right to inspect premises where services are provided. While we wait to see if the Francis recommendations on the right for scrutiny to inspect become reality, scrutiny must rely on well developed communications and a good working relationship with local Healthwatch and other groups to enhance the eyes and ears of scrutiny, improve the effectiveness of reviews and add information and evidence if challenging local providers.

4. Training and knowledge will lead to improved performance.

To effectively hold the NHS to account council scrutiny cannot rely only on information and presentations by the NHS at times the NHS chooses, but must find a range of ways to be proactive and seek to build productive relationships based on mutual respect for roles and responsibilities, independent of personalities or political influence.

Being proactive may require hearing more effectively from patients and the public, using a range of techniques such as social media and asset-based approaches and establishing 'triggers for action' when things seem to be going wrong. Seek out if necessary independent clinical or operational opinions from clinical reference groups or clinical senates for example, or expert help when interpreting statistics. CfPS has published a short 'Questioning Skills' briefing and can provide expert adviser member training sessions to develop other knowledge bases or assist in tackling a review or an issue.

Regional scrutiny networks for councillors and officers are often valuable places to learn about practice from other areas and to discuss common issues across wider geographical areas. CfPS Regional Advocates are also sources of advice.

Twice a year the CfPS Healthy Accountability Forum brings together representatives from networks around the country.

Conclusion

The Francis report is a ‘wake-up call’ to the whole NHS. The recommendations present both opportunities and challenges for council scrutiny. Firstly, an opportunity to review and strengthen local health scrutiny practice through the support and resources made available by councils and the NHS itself to enhance the value of scrutiny across the spectrum of health improvement, healthcare and social care. Secondly, an opportunity to open and develop a constructive dialogue with providers and commissioners who are all finding their place in the new NHS, to keep scrutiny at the heart of the reforms. Thirdly, an opportunity for scrutiny to renew and invigorate its relationship with the public, patients and their representatives.

One of the challenges for council scrutiny is to balance the expectations of the function – council scrutiny has some important powers that only democratically elected councillors can exercise but there is a risk of unrealistic expectations being placed on the function. The role of scrutiny in monitoring safety, quality and value is to identify issues of local concern, investigate them further and use the intelligence collected to have an informed exchange with the NHS and others before considering action or recommendations for improvement.

Patient safety and care issues are on the national agenda. The challenge is for all councils to reflect on the criticisms of scrutiny in the Francis Report whilst guarding against the risk that scrutiny might be regarded as ‘failing’ or be blamed if safety and quality issues emerge.