Agenda Item:

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Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	30 May 2013
Officer	Director for Adult and Community Services
Subject of Report	**The Francis Enquiry – Lessons for Health Scrutiny in Dorset**
Executive Summary	The Francis Inquiry Final Report was published on 6 March 2013. It provides an analysis of the failure of those directly responsible for the standard of care at the Mid Staffordshire NHS Foundation Trust as well as those with supervisory, regulatory or scrutiny responsibilities who failed to recognise that all was not well. This paper highlights aspects in the report that directly addresses the role of scrutiny committees in the Mid-Staffordshire events with the aim of identifying specific learning that applies to the existing Health Scrutiny arrangements in Dorset and any changes to practice that might be required as a result. The Francis Inquiry makes a number of recommendations with regard specifically to local authority health scrutiny. The attached action plan suggests a way to begin putting some of the learning into practice whilst recognising that members may wish to add to this.
Impact Assessment:	<u>Equalities Impact Assessment</u> None.
	<u>Use of Evidence</u> The following sources were used in the compilation of this report: The Local Government Information Unit Policy Briefing – The

	Francis Inquiry into Mid Staffordshire NHS Foundation Trust – messages and implications. Christine Heron, 8 February 2013. The Mid Staffordshire NHS Foundation Trust Public Inquiry Chaired by Robert Francis QC Press Statement 6 February 2013, Executive Summary and Final Report part 1, Chapter 6.
	<u>Budget/ Risk Assessment</u> None.
Recommendation	That the Committee: (i) considers the attached action plan and adds to it if it identifies gaps or deficiencies; and (ii) monitors the implementation of this action plan at its next meeting and thereafter keep the action plan under regular review.
Reason for Recommendation	The work of the Committee contributes to the County Council's aim to protect and enrich the health and well-being of Dorset's most vulnerable adults.
Appendices	1. Action plan to address the issues raised and introduce change in the practise of health scrutiny in Dorset.
Background Papers	None.
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1. Introduction

1.1 The Francis Inquiry Final Report was published on 6 March 2013. It provides an analysis of the failure of those directly responsible for the standard of care at the Mid Staffordshire NHS Foundation Trust as well as those with supervisory, regulatory or scrutiny responsibilities who failed to recognise that all was not well or to make any meaningful intervention as they were required to do.

1.2 Local Authorities as such were not commented on in the report, but their health overview and scrutiny functions were, with considerable negative comment. *"The local authority scrutiny committee did not detect or appreciate the significance of any signs suggesting serious deficiencies at the Trust. The evidence before the Inquiry exposed a number of weaknesses in the concept of scrutiny, which may mean that it will be an unreliable detector of concerns, however capable and conscientious committee members may be" (Francis Report Executive Summary, page 47) .*

1.3 The purpose of this paper is to highlight aspects in the report that directly address the role of scrutiny committees in the Mid-Staffordshire events with the aim of identifying specific learning that applies to the existing Health Scrutiny arrangements in Dorset and any changes to practice that might be required as a result.

2. The Mid Staffordshire NHS Foundation Trust Public Inquiry (known as the Francis Inquiry)

2.1 The Francis Inquiry followed a series of investigations and reports including an investigation by the Healthcare Commission in 2009 and a previous report by Francis published in 2010.

2.2 The terms of reference for the Francis Inquiry were:

- To examine the operation of commissioning, supervisory, regulatory and other agencies in their monitoring role of Mid Staffordshire NHS Foundation Trust (Stafford hospital) between January 2005 and March 2009 to identify why problems were not identified and addressed sooner.
- To identify relevant lessons for how any future failing regimes can be identified as soon as practicable within the context of the NHS reforms.

2.3 The Inquiry took evidence from over 250 witnesses and over a million pages of documentary material. It made 290 recommendations covering a number of themes such as nursing, leadership, culture, value and standards. A number of recommendations were made with specific reference to local authority scrutiny. In the press statement made by Robert Francis on the day his report was published he said: *"This is a story of appalling and unnecessary suffering of hundreds of people. They were failed by a system which ignored the warning signs and put corporate self interest and cost control ahead of patients and their safety".* With specific reference to scrutiny the press statement went on to say: *"Local scrutiny groups were not equipped to understand or represent patient concerns or to challenge reassuring statements issued by the Trust" (Robert Francis QC Press Statement, 6 February2013).* The complete table of recommendations can be found via the following link: http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf

2.4 The Inquiry reported that the number of excess deaths between 2005 and 2008 was 492 people. Examples of poor care included:

- patients being left in soiled bedclothes for lengthy periods;
- lack of assistance with eating and drinking;
- filthy wards and toilets; and
- a lack of privacy and dignity;

2.5 Aspects that the Inquiry looked at were in relation to the hospital itself but also those organisations with an oversight role including the Department of Health, the Strategic Health Authority, the Primary Care Trust, national regulators, other national organisations, local patient and public involvement and local authority health scrutiny.

2.6 Chapter 6 (page 481 to 587) of the Inquiry report relates specifically to Patient and Public Involvement and Scrutiny. The Inquiry took evidence from councillors and senior officers with responsibility for health scrutiny in Staffordshire and made some particular observations and comments in relation to health scrutiny and these are set out below:

2.7 Lack of detail in the notes of some scrutiny meetings

The report comments that for the Inquiry to determine what scrutiny activity was carried out it had to consider the minutes of meetings and other evidence the committee knew about. This tasks appears to have caused some difficulty because *"the minutes, particularly those of the Borough Council, are brief to the point of being uninformative …there is no summary of the debate .. it gives little idea of what members of the committee actually contributed.."* The report goes on to say *"It was suggested that this form of minute was common local government practice. If this is so, the practice needs reviewing. While a Hansard style transcript is not required, it is unfair to councillors and obstructive to public involvement and engagement for there to be no record of the contributions made by the committee's members whether by way of observations or questions, and of responses given." .* The Inquiry concluded on this point that *"The proceedings of bodies performing a statutory scrutiny function should be more fully recorded than appears in many of the minutes considered by this Inquiry". (Francis Report, Chapter 6, page 527)*

2.8 Over dependency on information from the provider rather than other sources, particularly patients and the public, and the need to be more pro-active in seeking information

A councillor on Stafford Borough Council's Health Scrutiny Committee reflected to the Inquiry that the committee *..." did not get underneath what representatives from the hospital were telling it… Chief Executives usually talk up an organisation and put on a positive gloss" (Page 544)*

2.9 The expertise of some health scrutiny committee members

The report commented that neither the committee nor the council had the expertise to mount an effective challenge to the Trust's cost cutting proposals, and that there are occasions when lay people need expert assistance in interpreting information. Similarly, the scrutiny of the Trust's application for Foundation Trust status lacked any meaningful challenge. Robert Francis put it to one of the health scrutiny councillors *…" you would have had no basis at all to do anything other than accept what was being said to you by the trust, which was that this application was, putting it broadly, a good idea; would that be fair?"* The response from the councillor was *"yes". (Page 534)*

2.10 Scrutiny as a critical friend

The report suggests that scrutiny is better conducted at arms length rather than from the position of "critical friend". It noted a tendency to be deferential towards local trusts which can make challenging the quality of local health services more difficult. It goes on to note that a joint code of working emphasised the need for constructive dialogue and did not make it entirely clear that the committee could examine a specific issue of safety and quality at one provider, although there is nothing to suggest this could not be done either.

2.11 Conclusions on scrutiny in Staffordshire

The Inquiry report sums up its findings as follows: *" this committee appears to have been wholly ineffective as a scrutineers of the Trust. Councillors are not and cannot be expected to be experts in healthcare. They can, however, be expected to make themselves aware of,*

and pursue, the concerns of the public who have elected them". In terms of learning the report identifies that *.." the power of summoning the leaders of provider trusts to give account of their actions in public is a powerful tool, which, if used properly, proportionately and after preparation, could act as an incentive towards improvement and as a challenge to the public being offered inaccurate or superficial information". (Page 557)*

2.12 Quality Accounts

The inquiry also considered Quality Accounts which require Trusts to provide full and accurate information about their compliance or non compliance with the fundamental standards and enhanced standards that apply to them. It is noted that they should no longer be confined to reports on achievements as opposed to a fair representation of areas where compliance has not been achieved.

2.13 Recommendations relating to Health Scrutiny

- **Recommendation 47** The Care Quality Commission should expand its work with overview and scrutiny committees and foundation trust governors as a valuable information source.
- **Recommendation 119** Learning and information from complaints - overview and scrutiny committees and Local Healthwatch should have access to detailed information about complaints, although having due regard to the requirements of patient confidentiality.
- **Recommendation 147** Co-ordination of local public scrutiny bodies - guidance should be developed to promote the coordination and cooperation between Local Healthwatch, health and wellbeing boards and local government scrutiny committees.
- **Recommendation 149** Expert assistance - scrutiny committees should be provided with appropriate support to enable them to carry out their scrutiny role, including easily accessible guidance and benchmarks.
- **Recommendation 150** Inspection powers - 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 follow up inspections where appropriate, rather than receiving reports without comment or suggestions for action.
- **Recommendation 246** The Department of Health / the NHS Commissioning Board/ regulators should ensure that provider organisations publish their annual quality accounts information in a common form to enable comparisons to be made between organisations, to include a minimum of prescribed information about their compliance with fundamental and other standards, their proposals for the rectification of any non-compliance and statistics on mortality and other outcomes. Quality accounts should contain the observations of commissioners, overview and scrutiny committees, and Local Healthwatch.

3. Application and Learning for the practice of health scrutiny in Dorset

3.1 Part of the concerns raised by the Francis Report relate to service delivery being maintained against a backdrop of frequent NHS reorganisation and the significant changes under the current NHS restructure. The report is keen to stress that it does not wish to initiate further radical reorganisation but rather support all, through the recommendations, to make patient centred values real and where necessary change behaviours.

3.2 Some of the recommendations outlined above require legislative changes (such as giving scrutiny inspection powers), other issues can be used to inform and improve the way health scrutiny operates in Dorset immediately. The attached action plan suggests a way to begin putting some of the learning into practice whilst recognising that members may wish to add to this.

3.3 The Inquiry was also critical of the local Patient and Public Involvement forum and its successor the Local Involvement Network, and raises concerns about Local Healthwatch in the future. Given that the County Council is responsible for procuring and funding an organisation to deliver Local Healthwatch, the Committee may wish to consider its role in ensuring that Local Healthwatch is effective in voicing the concerns of local people, so this has been incorporated into the action plan.

3.4 The Committee already has established links to the Centre for Public Scrutiny which provides advice and support on scrutiny regulation, guidance and issues. This link is important to maintain so that the members can keep abreast of health scrutiny developments at a national level and best practice. The Centre for Public Scrutiny has a number of resources and a forum which members may find useful. http://www.cfps.org.uk/index.php

4. Next steps

4.1 The expectation of the Francis Inquiry and report is that *"All have the responsibility to consider what is exposed… and to consider how to apply the lessons themselves, individually and collectively". (Robert Francis QC Press Statement, February 2013)*

4.2 Members are asked to consider the attached action plan and add to it if they consider there are gaps or deficiencies. Progress on implementing this action plan should be reported to the next meeting of the Committee and thereafter kept under regular review.

Catherine Driscoll
Director for Adult and Community Services
May 2013

Action Plan – Learning for Health Scrutiny practice in Dorset from the Francis Inquiry - May 2013

Recommendation in Francis Report	Change in practice required	Actions needed	By whom	By When
Rec. 47 Working with the Care Quality Commission	Strengthen existing practice	1. Chair and another nominated member to meet on a regular basis with CQC Compliance Manager (South Region). 2. Share minutes of meetings and relevant scrutiny reports (already in place). 3. Discuss areas of concern as they arise.	1. Chairman 2. Democratic Services 3. Health Partnerships Officer	Schedule dates for meetings in 2013/14 by September 2013. Discuss issues as and when they arise.
Rec. 119 Learning and information from complaints	New practice	1. When relevant provider Trusts and NHS commissioning bodies to be asked for information on complaints and for that information to be considered by Committee and act on the information supplied by making appropriate recommendations. 2. Share information with Local Healthwatch whenever possible and practical to do so.	Health Partnerships Officer	Commencing from now as appropriate to issue under scrutiny.
Rec.147 Co-ordination of local public scrutiny bodies	Strengthen and develop existing practice	1. Build on existing relationships within Dorset context to ensure co-ordination in activity and the sharing of appropriate information.	Health Partnerships Officer	Continue to develop as the Health and Wellbeing Board and Local Healthwatch get established.
Rec. 149 Expert assistance	New practice	1. Ensure members are provided with access to relevant supporting / additional information when presented with reports / proposals from commissioners and providers to help further develop effective scrutiny.	Health Partnerships Officer and Democratic Services	Commencing September 2013

		2. Introduce pre-briefings for members to consider potential lines of enquiry to be used in scrutiny meetings.		
Rec. 150 Inspection powers	Strengthen and develop existing practice	1. Work with Local Healthwatch to develop a mutually supportive relationship which provides timely and relevant information for both bodies through the use of the Healthwatch Enter and View powers.	Health Partnerships Officer	Begin immediately discussion with Local Healthwatch community Engagement lead. Incorporate into the protocol to be developed between the Committee and Local Healthwatch.
Rec. 246 Quality accounts	Strengthen and develop existing practice	1. Continue with the existing task and finish group approach to scrutinising the Quality Accounts. 2. Ensure Local Healthwatch is invited to be engaged in this process. 3. Ensure Quality Accounts are cross referenced with information from CQC on compliance with Quality Standards and this is reflected accurately. 4. Ensure Quality Accounts are cross referenced with any information on complaints provided by Trusts outside of the Quality Account process.	Task and Finish Group Elected members supported by the Health Partnerships Officer and Democratic Services	On-going process

Other Issues for consideration	Change in practice required	Actions needed	By whom	By When
Helping to ensure an effective Local Healthwatch	New Practice	1. Work with Local Healthwatch in a pragmatic way and develop a mutually supportive protocol in this regard. 2. Feed into the contract monitoring arrangements of the County Council for the Local Healthwatch contract in terms of reporting on the Committee's experience of working with Local Healthwatch	1. The Committee supported by the Health Partnerships Officer. 2. The Chairman supported by the Health Partnerships Officer and DCC contract monitoring officers.	Commence discussion with Healthwatch representatives and with DCC contract monitoring staff now. Aim to have protocol ready for consideration by Committee in September.
Awareness of Safeguarding	Strengthen and develop existing practice	1. Provide appropriate training for members to enable them to identify issues within an NHS service that could give rise to potential safeguarding cases and know how to raise such concerns, particularly with regard to Quality Accounts. 2. Ensure any potential safeguarding concerns raised are reported appropriately.	1. DCC Safeguarding Managers co-ordinated by the Health Partnerships Officer.	As part of scrutiny training organised for the autumn of 2013.
Recording of Health Scrutiny meetings	Strengthen and develop existing practice	1. The Head of Legal and Democratic Services to review current practice for recording health scrutiny meetings in light of the comments made within the Francis Report.	1. DCC Head of Legal and Democratic Services	Within 6 months