HEALTH SCRUTINY PANEL
28 MARCH 2013
ISSUES FOR HEALTH SCRUTINY ARISING FROM THE FRANCIS INQUIRY
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 To consider issues and implications for health scrutiny arising from the findings of the Mid Staffordshire NHS Foundation Trust Public Inquiry (known as the Francis Inquiry) into care at Stafford Hospital between 2005 and 2008.

2. Action required

2.1 The Panel is asked to consider the findings of the Francis Inquiry insofar as they relate to health scrutiny and determine if any changes to the operation or approach to health scrutiny in Nottingham are required to ensure that it operates as effectively as possible.

3. Background information

3.1 The Mid Staffordshire NHS Foundation Trust Public Inquiry (known as the Francis Inquiry) examined the appalling care and serious failings at Stafford Hospital between 2005 and 2008. The number of excess deaths between 2005 and 2008 was estimated at 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, lack of privacy and dignity. The report describes the failings as a 'disaster' and 'one of the worst examples of bad quality service delivery imaginable'. The Inquiry looked at the hospital and the roles of the main organisations with an oversight role including the Department of Health, the strategic health authority, the PCT, national regulators, other national organisations, local patient and public involvement and health scrutiny. It made 290 detailed recommendations.

3.2 The report attributes accountability for the appalling care at Stafford Hospital to the Trust Board, but also points to a systemic failure by a range of national and local organisations to respond to concerns. This includes the two local authorities who have both publicly acknowledged that they could have done more.

3.3 The primary means for local authorities to do this is through the use of the health scrutiny powers available to them. Given that the Council

holds these powers there would be a reasonable expectation that if similar problems identified in Stafford were happening in Nottingham (and the report indicates that this should not be regarded as a one-off event that could not be repeated elsewhere in the NHS) the Council would be aware and take strong early action. Consequently, the Council needs to ensure that its health scrutiny function operates as effectively as possible and to this end there is potential to learn lessons from the comments and recommendations relating to health scrutiny made in the Francis Inquiry report.

3.4 Chapter 6 of the Francis Inquiry report relates to Patient and Public Involvement and Scrutiny. The inquiry took evidence from councillors and senior officers with responsibility for health scrutiny in Staffordshire and the report goes into some detail in its observations and comments concluding that "the local authority scrutiny committees did not detect or appreciate the significance of any signs suggesting serious deficiencies at the Trust".

3.5 <u>Comments relating to health scrutiny</u>
In its commentary on the role and operation of health scrutiny in Staffordshire the report identifies a number of issues:

3.5.1 Lack of detail in notes of some scrutiny meetings – the report commented "…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."

3.5.2 Over-dependency on information from the provider rather than other sources, particularly patients and the public, and the need to be more proactive in seeking information – Councillor Edgeller of Stafford Borough Council's Health Scrutiny Committee accepted the committee "…did not get underneath what the representatives from the hospital were telling it…Chief Executives usually talk up an organisation and put on a positive gloss. If the same happened again, then I would look deeper and ask questions to the people below…e.g. nurses, doctors and consultants."

3.5.3 Questions about expertise of some health scrutiny members – for example 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, scrutiny of the Trust's Foundation Trust application was unchallenging, with Councillor Edgeller accepting that the process was meaningless.

3.5.4 Scrutiny can be better conducted at arms-length rather than as a 'critical friend' – the report suggests that there is a tendency to be deferential towards local trusts and this can make challenging the quality of local health services more difficult.

3.5.5 Lack of resources, particularly in small borough committees

3.5.6 Need for clarity about the role of district and county health scrutiny committees

3.6 Recommendations relating to health scrutiny
The report makes the following recommendations relating directly to overview and scrutiny:

3.6.1 The Care Quality Commission should expand its work with overview and scrutiny committees and foundation trust governors as a valuable information resource. For example, it should further develop its current 'sounding board events'. (Rec 47)

3.6.2 Overview and scrutiny committees and Local Healthwatch should have access to detailed information about complaints, although respect needs to be paid in this instance to the requirement of patient confidentiality. (Rec 119)

3.6.3 Guidance should be given to promote the coordination and cooperation between Local Healthwatch, Health and Wellbeing Boards, and local government scrutiny committees. (Rec 147)

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

3.6.5 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 suggestions for action. (Rec 150)

3.6.7 Department of Health/the NHS Commissioning Board/regulators should ensure that provider organisations publish in 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 be required to contain the observations of commissioners, overview and scrutiny committees, and Local Healthwatch. (Rec 246)

3.7 The government is due to respond to the report and recommendations by the end of March 2013.

3.8 While some of the recommendations would require legislative changes (such as giving scrutiny inspection powers), other issues highlighted in

the report can inform and improve the way in health scrutiny operates in Nottingham immediately.

3.9 The report is also critical of the local Patient and Public Involvement Forum and its successor LINk, and raises concerns about Local Healthwatch in the future. Given that the Council is responsible for appointing and funding a host for Local Healthwatch, the Panel may wish to consider its role in ensuring Local Healthwatch is effective in voicing the concerns of local people.

4. List of attached information

None

5. Background papers, other than published works or those disclosing exempt or confidential information

None

6. Published documents referred to in compiling this report

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry February 2013 http://www.midstaffspublicinquiry.com/report

7. Wards affected

Citywide

8. Contact information

Jane Garrard
Overview and Scrutiny Co-ordinator
jane_garrard@nottinghamcity.gov.uk
0115 8764315