Bracknell Forest Council

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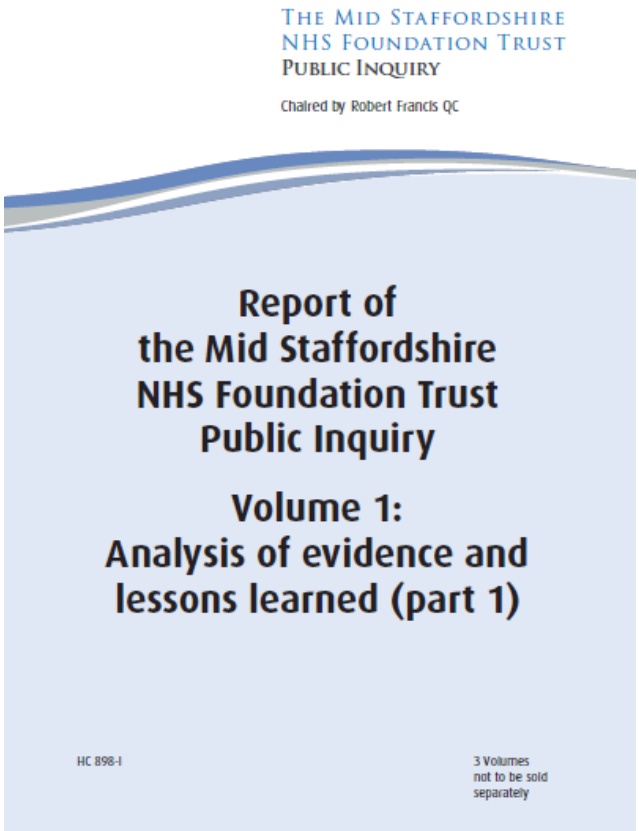
Applying the Lessons of the Francis Report to Health Overview and Scrutiny

by a Working Group of the Health Overview and Scrutiny Panel



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Bracknell and Ascot Clinical Commissioning Group
Dr William Tong Chairman
Sarah Bellars Director of Nursing

Centre for Public Scrutiny
Avril Davies Health Scrutiny Adviser

The Royal Berkshire NHS Foundation Trust
Ed Donald Chief Executive Alistair Flowerdew Medical Director
Caroline Ainslie Director of Nursing

Frimley Park Hospital NHS Foundation Trust
Nicola Ranger Director of Nursing

South Central Ambulance Service NHS Foundation Trust
Deirdre Thompson Director of Quality and Patient Care

Heatherwood and Wexham Park Hospitals NHS Foundation Trust
Philippa Slinger Chief Executive Dr Rob Loveland Medical Director
Thomas Lafferty Director of Corporate Affairs

Healthwatch Bracknell Forest
Clare Turner Chris Taylor

Bracknell Forest Council
Councillor Dale Birch Executive Member for Adult Services, Health and Housing
Glyn Jones Director of Adult Social Care, Health & Housing
Richard Beaumont Head of Overview and Scrutiny

1. Foreword by the Lead Member

1.1 This review was brought about as a direct result of the Francis report into the Mid-Staffordshire Hospital crisis and the deficiencies it highlighted in the Health Overview and Scrutiny function of the local authorities.

1.2 I must stress that this review was not convened through any concerns that our arrangements were in any way lacking but rather to determine whether there were areas where our Overview and Scrutiny practices could be enhanced in light of the Francis report and recommendations.

1.3 What this review has highlighted is that members must take an active role in Health Overview and Scrutiny in order to be fully aware of, and challenge when necessary, any changes that occur in the NHS and its agencies.

1.4 Not surprisingly I have a number of people to thank for their open, frank and incisive input to the discussions that have gone to making up a large part of this review, which I now do unreservedly.

In particular I would like to thank Richard Beaumont for all the work he has put into this review, it is fair to say that the review would not be what it is without his dedication to detail and ability to just get on with the job .

To Glyn Jones our Director of Adult Social Care, Health & Housing, our thanks for your input and attending so many of our Working Group meetings.

To Cllr Birch, Executive portfolio holder for Adult Services, Health and Housing for his input to this review.

To the numerous contributors from the NHS and its agencies which I have listed in the acknowledgements, on the contents page above.

Last and by no means least to my colleagues on the Working Group who applied themselves to the enormous amount of data coming out of the Francis report together with the lengthy meetings that they participated in.

Councillor Mrs Jennie McCracken
Lead Working Group Member

2. Executive Summary

2.1 The Inquiry by Robert Francis QC into the failings of the Mid Staffordshire Foundation NHS Trust concluded that the large number of excess deaths between 2005 and 2008 at Stafford Hospital and the incidence of very poor patient care there constituted a 'disaster' and 'one of the worst examples of bad quality service delivery imaginable'. In the Government's interim response to the Inquiry report, the Secretary of State for Health said *'This was a systemic failure of the most shocking kind, and a betrayal of the core values of the health service as set out in the NHS Constitution. We must never allow this to happen again.'*

2.2 Bracknell Forest Council's Health Overview and Scrutiny (O&S) Panel set up a Working Group to help ensure that the failures at Mid Staffordshire do not happen in our borough. This report describes the work of the Working Group Between May and November 2013, and it is organised in the following sections:

Part 3 Gives background information in respect of the Francis report, and summarises how we set about our review.

Part 4 Summarises the information and evidence gathered by the Working Group.

Part 5 Contains our analysis and the conclusions we have reached following our review, on which we have based a number of recommendations to the main NHS organisations providing emergency and inpatient health services to Bracknell Forest residents; to the Council's Executive; to the O&S Commission; and to the Health O&S Panel.

At the end of our report is a glossary of terms used and an appendix containing the approach we took to our review.

2.3 Our overall conclusions are that

- The NHS Trusts which provide most of the hospital, ambulance and other inpatient health services to Bracknell Forest residents are showing a seriousness of purpose in learning and applying the lessons from Francis. They were all clearly shaken by the appalling failures at Mid Staffordshire. The real changes and improvements they have embarked upon demonstrated to us their determination not to let similar failures happen in their Trust.
- Although the Council's Health O&S function has been active and effective, there are a number of improvements which can and should be made if the shortcomings in local authority O&S found by Mr Francis are not to be repeated in Bracknell Forest. Implementing these recommendations would require significantly more time commitment by Members and officers; this cannot be accommodated without hard choices being made by the O&S Commission and Panel.

2.4 Our recommendations to the NHS Trusts are in paragraph 5.7 and are in summary:

a) To include in their welcome pack for patients a brief guide to how to make a complaint or compliment.

b) **To publish detailed information on complaints, at least equal to the level used by the Royal Berkshire and the Berkshire Healthcare Trust. The published information on complaints should also include the outcome for the complainant and any learning points.**
c) **To give publicity to the role of local authority O&S.**

2.5 Our recommendation to the Council's Executive are in paragraph 5.28:

The Executive Member for Adult Services, Health and Housing should carry out a stock take of all the Council's external positions on NHS bodies, and works with Members to ensure that all suitable opportunities are taken up.

2.6 Our recommendations to the O&S Commission are in paragraphs 5.20, and 5.32-33 and are in summary:

a) **That public engagement mechanisms are kept under review, with the underlying aim of learning about residents' healthcare concerns as directly as possible, and – in concert with Local Healthwatch - by giving the public a voice.**
b) **Recognising that officer resources are already fully stretched, to decide, in consultation with the Health O&S Panel, how to meet the new demands on officer time arising from our recommendations.**
c) **To consider reviewing, and asking the other O&S Panels to review, the scope for replicating the improvements to Health O&S throughout the Council's O&S function.**

2.7 Our recommendations to the Health O&S Panel are in paragraph 5.9 onwards and are in summary:

a) **To agree on a refreshed statement of the aim and objectives of Health O&S, and the role of Members.**
b) **To adopt a selective and tiered approach to scrutiny of the local NHS service providers, which does not cover all services.**
c) **Each Member to have a specialist area of NHS activity to develop knowledge of, and to lead the Panel's O&S work on, including scrutiny of complaints information.**
d) **That members should receive induction, annual refresher and targeted training.**
e) **That a panel of people with clinician experience be recruited in a voluntary 'pro-bono' capacity and used to provide independent expert advice to the Panel.**
f) **To improve the information flow to members, concentrating on exception reporting, flagging of issues of possible concern, and to prioritise quite ruthlessly on where O&S should focus its efforts.**
g) **All Members should be encouraged to outreach into their respective wards to relay properly prepared and approved health information and issues to residents.**
h) **The Parliamentary and Health Services Ombudsman should be asked to re-consider their decision not to provide information to the Panel on complaints to the NHS Trusts.**
i) **The Panel's terms of reference are amended to recognise Healthwatch Bracknell Forest (HWBF) as an Observer, that regular feedback is sought from HWBF, and that the Panel assists in spreading awareness of HWBF.**

j) **To maintain regular contact with those BFC councillors on Trust Boards/Governing Bodies, including asking each councillor representative to report to the Panel at least once annually.**

k) **Inviting input from all Members including the Executive Member, also the Director, and the Public Health Consultant before commenting on the annual NHS Quality Accounts.**

l) **The specialist members concerned should maintain contact with the local CQC Manager, and attend any CQC 'Listening Events' with patients of the three hospitals and Berkshire Healthcare Trust in advance of their inspections. The Panel's specialist member should also actively engage in the CQC 'Quality Summits' for those Trusts we are focussing on.**

m) **The running of Panel meetings should be improved through: better forward planning and monitoring, better preparation for meetings, making discussions more conclusive, continuing the improved format of the record of meetings, and more systematic follow-up.**

n) **Not to agree the recommendations in this report unless all its Members are personally committed to putting in the time to deliver what is recommended as new responsibilities.**

o) **The Working Group's report is sent, together with our thanks to their representative for her input, to the Centre for Public Scrutiny for sharing widely.**

2.8 Members of the Working Group hope that this report will be well received and we look forward to receiving responses to its recommendations.

2.9 The Working Group comprised:

Councillor Mrs McCracken(Lead Member)
Councillor Mrs Angell
Councillor Angell
Councillor Baily
Councillor Kensall
Councillor Mrs Temperton
Councillor Virgo

From left to right rear: Richard Beaumont, Councillors Virgo, Baily and Angell

From left to right front: Councillors Kensall, Mrs McCracken, Mrs Temperton and Mrs Angell

3. Background

3.1 On 9 June 2010 the Secretary of State for Health announced a full public inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire Foundation NHS Trust. The Inquiry was established under the Inquiries Act 2005 and was chaired by Robert Francis QC.

3.2 The Francis inquiry[*] followed a series of investigations and reports, including an investigation by the Healthcare Commission in 2009 and an independent inquiry also conducted by Robert Francis QC.

3.3 The final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry was published on Wednesday 6 February 2013. The number of excess deaths between 2005 and 2008 at Stafford Hospital was estimated at 492 people. Examples of poor care include 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 such as people left naked in a public ward, and triage in A&E undertaken by untrained staff. The report describes the failings as a 'disaster' and 'one of the worst examples of bad quality service delivery imaginable'.

3.4 The Francis Inquiry report recommended that a fundamental change in culture was required which put patients and their safety first. Mr Francis made 290 recommendations, framed around:

- A structure of fundamental standards and measures of compliance
- A requirement for openness, transparency and candour
- Improved support for compassionate, caring and committed nursing
- Stronger, patient centred healthcare leadership, with increased accountability
- Accurate, useful and relevant information to allow effective comparison of performance by patients and the public.

3.5 The Francis Inquiry attributed accountability for the appalling care at Stafford Hospital to the Trust Board, but also pointed to a systemic failure by a range of national and local organisations – including the Health Overview and Scrutiny Committees of both the County and District councils concerned - to respond to concerns. The report indicated that this should not be regarded as a one-off event that could not be repeated elsewhere in the NHS. On O&S specifically, Mr Francis said, '*The Overview and Scrutiny Committees in Stafford were happy to take on a role scrutinising health services but did not equate this with responsibility for identifying and acting on matters of concern; and they lacked expert advice and training, clarity about their responsibility, patient voice involvement, and offered ineffective challenge.'*

3.6 In the Government's initial response to the Francis report, the Secretary of State for Health said in March 2013: *'The report of the Mid Staffordshire NHS Foundation Trust Public Inquiry makes horrifying reading. At every level, individuals and organisations let down the patients and families that they were there to care for and protect. A toxic culture was allowed to develop unchecked which fostered the normalisation of cruelty and the victimisation of those brave enough to speak up. For far too long, warning signs were not seen, ignored or dismissed. Regulators, commissioners, the Strategic Health Authority, the professional bodies and the Department of Health did not*

[*] All documentation relating to the Francis Inquiry can be found at http://www.midstaffspublicinquiry.com/

identify problems early enough, or, when they were clear, take swift action to tackle poor care. They failed to act together in the interests of patients. This was a systemic failure of the most shocking kind, and a betrayal of the core values of the health service as set out in the NHS Constitution. We must never allow this to happen again….Every individual, every team and every organisation needs to reflect with openness and humility about how they use the lessons from what happened at Mid Staffordshire NHS Foundation Trust to make a meaningful difference.'

3.7 An O&S officer attended the Centre for Public Scrutiny's annual conference on 11 June 2013, at which Mr Francis was one of the speakers. Mr Francis stressed the potential value of local authority O&S in safeguarding against similar failures to those in Mid Staffordshire. He drew particular attention to the need to make full use – and ensure the transparency - of performance information, to elicit information from various sources, and not to ignore the messages to be drawn from patients' complaints. At the same conference, Tim Kelsey, a Director of NHS England, suggested that Health O&S Committees needed professional support in interpretation of data, and they should not rely solely on information given by NHS Trusts.

3.8 At its meeting on 18 April 2013, the Health O&S Panel decided there was a compelling need to safeguard against the failings in Mid Staffordshire occurring in Bracknell Forest. The Panel decided to commence a Working Group ('the Group') with two main purposes:

- To review the steps being taken to implement the lessons of the Francis report by those nearby NHS organisations providing emergency and inpatient health services to Bracknell Forest residents.
- To recommend to the Panel what changes are needed to the Health O&S practices at Bracknell Forest in the light of the weaknesses in the Mid Staffordshire local authorities found by Mr Francis.

3.9 The Group held its first meeting on 9 May 2013, and subsequently agreed its key objectives and its scope as set out at Appendix 1. Mr Francis had identified a number of weaknesses in O&S and in order to complete our review in good time, we grouped these into five separate workstreams, with each councillor in our Group leading the detailed work on one of these:

- Redefining the objectives for health O&S and specifying which NHS trusts are to be routinely scrutinised
- Members' role and improving their effectiveness (including training, advice and support)
- Prioritising issues for O&S attention, and getting the right information
- Patients' complaints – systems and information flows
- Working with partners
- Preparing for, conducting and recording meetings of the Health O&S panel.

3.10 The Group gathered information from various sources, as set out in Section 4 of this report. We used that to arrive at a set of conclusions on which we then make a number of recommendations, as set out in Section 5.

4. Investigation And Information Gathering

Introductory Review Work

4.1 On **9 May 2013** the Working Group ('the Group') commenced its work. We elected Cllr Mrs McCracken as our Lead Member and we received an introductory briefing from the Council's Director of Adult Social Care, Health & Housing, and the Head of Overview and Scrutiny. The Group reviewed the relevant extracts from the Francis report, the government's response, and related briefing material.

4.2 The Group confirmed its overall purpose, as set by the Health Overview & Scrutiny (O&S) Panel at its meeting on 18 April 2013, as being to:

- recommend to the Panel what changes are needed to the Health O&S practices at Bracknell Forest in the light of Mr Francis' extensive findings and recommendations regarding inadequacies in local authority health scrutiny at Mid Staffordshire;
- participate in the workshop envisaged by the Health and Wellbeing Board (Glyn Jones (GJ) advised that a date for this had yet to be arranged);
- review the steps being taken to implement the lessons of the Francis report by those NHS organisations serving Bracknell Forest residents.

Members agreed that this would require a thorough review of the weaknesses in O&S highlighted by Francis, showing that the Council had responded properly to the lessons it offered. The Francis report clearly showed that Staffordshire Council's O&S had barely 'touched the surface' of the problems at that hospital. The Group recognised at the outset that it should reach a view on a methodical way for the Panel to decide what pertinent health data it needed, and to interpret and use that information to hold health service providers to account. Other matters arising in discussion were:

a) There is a complex range of NHS Trusts providing health services to Bracknell Forest residents. To make the task manageable, it would be necessary to concentrate attention and scrutiny coverage only on those NHS organisations which are significant local providers.

b) In deciding what level of review was needed of NHS organisations, care must be taken not to over-step the role of O&S into Local Healthwatch's (LHW) for example. Also, as it could be argued that the primary responsibility for O&S follow-up lay with the Health scrutiny committee of the local authorities where the NHS trusts are based, we decided to enquire of those councils what review work they planned to do.

c) The Group agreed to frankly reappraise what the objectives of Health scrutiny in Bracknell Forest are, and what the role and contribution of councillors should be.

d) The type and volume of complaints, and the systems around complaints were another focus of the Group's review. We considered that people tended not to complain unless it was important to them, so it would be important for Health O&S to take careful note of complaints made. This might involve reviewing individual complaints (with names erased), and seeing whether there was any connection for example with complaints about safeguarding. The Group recognised the need to be sensitive to and protect confidential patient information.

e) It could be argued that there should be a duty on General Practitioners (GPs) to follow through the experience of their patients when at hospital.

f) The NHS comprised a huge field of activity thus there was a great need for O&S to prioritise the issues it wanted to cover; which in turn required a flow of relevant information.

g) Historically, NHS managers had largely determined what information was provided to the Health O&S Panel. This needed to change with the Panel taking the initiative more in setting out what its requirements are and, for example, requiring that information be provided in advance of Panel meetings, to allow for proper preparation – which also needed, for example: forward agenda planning; Members thoroughly reading the material; and a pre-meeting to agree which Members would lead on which lines of questioning.

h) A key message of the Francis report was seen to be that Health O&S needs to get closer to the patients' experience. Visits to wards might well be in breach of patient confidentiality. There would be a need to work in collaboration with LHW.

i) The WG might well conclude that there were wider lessons for O&S beyond Health O&S, particularly on gaining a better understanding of residents' experience of using council services.

j) That as other councils would be similarly considering changes to their O&S practices in the light of Francis, we should seek input from the Centre for Public Scrutiny (CfPS) on the best way to approach the task, and experience elsewhere in local government

4.3 The Group discussed the approach to take to the review, and – following our meeting in June - this was subsequently finalised in the standard scoping document at Appendix 1. At the centre of our approach, we analysed each of the comments in the Francis report concerning O&S. These were then grouped under a number of headings. To make our work manageable, each Member of the Group then took responsibility for progressing – with O&S Officer assistance - one or more heading, and reported back to the Group on how they had pursued the issue, with their recommended actions on the way forward.

4.4 On **3 June**, the Group met **Avril Davies (AD), Health Scrutiny Adviser, Centre for Public Scrutiny** (CfPS), to explore any suggestions for emerging good practice, in terms of councils' O&S response to actions arising from the Francis report. AD summarised the CfPS's involvement through the Healthy Accountability Forum and elsewhere in interacting with councils endeavouring to respond appropriately to the lessons from the Francis report. That response was still at an early stage, with no obvious leaders of best practice, and most councils were trying to form a view on what information they should be seeking from the NHS, not falling into the trap of trying to micro-manage the NHS, and trying to build robust lines of questioning whilst recognising that elected Members are not health professionals. The Care Quality Commission (CQC) were similarly applying themselves to the task of learning from the Francis report, and AD encouraged Health O&S to engage with the CQC and get a fuller understanding of the CQC's outputs.

4.5 AD said the Francis report presented O&S with an opportunity to 'raise their game', particularly in terms of not taking entirely on trust information presented by NHS Trusts, and to look more closely at quality of service issues – and giving this priority over, e.g. real estate matters. Staffordshire Council had constructed a confusing arrangement of sharing health scrutiny responsibilities with the District councils, a complication which did not arise with unitary authorities. A central message from Francis is the need to understand better what issues are of concern to residents, and most councils needed a better 'public platform'. Members acknowledged that the

Council's Public Participation scheme for O&S was not generating any public engagement, and additional accessibility would be useful (we return to this in paragraph 5.18 below). Anecdotal cases can sometimes point towards wider service failures. The Director pointed out that the Clinical Commissioning Group (CCG) have a process by which doctors can raise concerns about hospital services; and the Council worked with the NHS on individual concerns such as inappropriate admissions from care homes to hospitals.

4.6 AD stressed the need to understand and examine Standardised Mortality Rates for local hospitals, and to make a start it might be advisable to have skilled advice on the make-up of these rates and the comparative position of each of the hospitals. A related issue was to look at the hospitals' wider clinical governance, particularly in drawing attention to service failures, also the health prevention agenda. Further information was available in the NHS Trusts' published Board papers. AD also encouraged the Group to consider inviting independent experts from 'Clinical Networks' to advise Members on topics under review. Other matters arising in discussion were:

a) It might be worth building and maintaining contact with the PALS service, though the limitations on patient confidentiality meant that they might not be very forthcoming. The dignity of patients is important.
b) Establishing a comprehensive picture of patients' experience required 'triangulation' of information from several sources, for example: the 'inpatient surveys', CQC reports, information provided by the NHS Trusts (such as Quality Accounts), anecdotal information from councillors' Ward surgeries, etc.
c) There is a vast range of issues around NHS services, well beyond the capacity of Member and officer time and resources to examine. This demanded rigorous prioritisation of the most important issues to devote O&S attention to. The number of Panel meetings could only be increased at the expense of other O&S activity, or if extra resources became available, neither of which are likely.
d) Presentations should be obtained in advance of meetings, to allow Members to prepare the questions they wanted to raise.
e) Preparation through pre-meetings was useful, and this could be built on, for example through making fuller use of the support from Council officers. It might also be worth having a de-briefing meeting shortly after each panel meeting.
f) Some Members saw a need for training on the interpretation of statistics, though it needed to be remembered that Members were not required, or expected to be health experts.

<u>Surrey County Council's Health Scrutiny Committee</u>

4.7 On **4 July** two Members of the Group participated in a meeting of Surrey County Council's Health Scrutiny Committee. Representatives of the NHS Hospital Trusts serving Surrey residents described their progress in addressing the lessons from the Francis report, and there was a discussion on the Committee's access to information on complaints by patients of those Trusts. As Frimley Park Hospital was included and Bracknell Forest has a clear interest in that, it was agreed that a partnership approach with Surrey would be worthwhile.

4.8 All representatives showed that their Trusts were taking Francis seriously and their work had identified the need for various improvements. They all showed a

commendable sense of responsibility, for example the Chief Executive of Epsom and St Helier made it very plain that 'the buck stops with me'. Recurring themes were:

a) responding to the cultural change
b) ensuring all staff understood the key points in Francis, e.g. through printing a message on their payslips about Francis
c) engaging all staff, e.g. by seeking their ideas about how to improve quality of care
d) reviewing/reorganising complaint handling processes. There is no national guidance on hospital complaints handling, making the sharing of consistent information challenging.
e) ensuring the 'duty of candour' is achieved
f) marshalling the work into workstreams, each led by a senior officer, and with Trust Board involvement/oversight
g) overall clinical leadership
h) the role of Ward Sisters is pivotal
i) a need to improve on listening to patients' experience and concerns, and to get regular feedback from them, e.g. through evening and week-end 'walk-arounds' aimed at seeing things from the patients' perspective.

4.9 The Chairman of Surrey's Scrutiny Committee requested that complaints data be shared with the Committee and Healthwatch when appropriate. The provider representatives confirmed their full detailed reports were being shared with their Boards of Governors, but there would be issues in sharing the complaints data due to the personally identifiable information these contained, and that there was not currently a consistent approach to the presentation and information Trusts made available. They would, however, look into how best to share this information with the Committee when required.

4.10 Our impressions of Surrey's Health O&S Committee were that:

a) It had been a well-run meeting, and holding it in the morning probably helped people's alertness. The good quality and incisiveness of the Surrey CC Members' questions suggested that each might have a specialist area of interest. One co-opted member is a GP.
b) The Trusts appeared to be taking a similar approach to applying the learning from the Francis report, and the approach to whistleblowing was of widespread interest.
c) It was appropriate that LHW were present (though apparently not co-opted).
d) Reference had been made to Surrey CC councillors being on the Boards of the local hospital trusts.
e) The regular item on 'action tracking' showed that the Committee were systematically following matters up, including previous recommendations. The WG recognised that Surrey has two officers supporting Health O&S, whereas in BFC there are fewer than two officers for all O&S support.

<u>Royal Berkshire Hospital NHS Foundation Trust</u>

4.11 On **5 July 2013** the Group met **Ed Donald (ED), Chief Executive, and Alistair Flowerdew (AF), Medical Director, of the Royal Berkshire NHS Foundation Trust (RBH).** This meeting – also the subsequent meetings with other hospital trusts and the Ambulance Service - had been arranged principally to learn about the Trust's progress in applying the lessons from the Francis report; and to explore the provision of routine information from the Trust for Health O&S on complaints and other related matters.

4.12 The Group was told that the RBH Trust puts emphasis on teamwork and a constant, balanced focus on four key factors:

Patient Experience – giving time to establishing the patient experience, and drawing directly on the knowledge of the Local Involvement Network and local patients groups. The RBH tracks the patient experience through 'NHS Choices' and other means. The latest survey (of c.4,000 patients annually) showed a continuing improvement, currently with 97% of respondents saying they would recommend the Trust to their family and friends. The NHS 'Patient Direct' site showed the RBH had moved from 3 stars to 4.5 (the same as Frimley Park Hospital).

Health Outcomes – and particularly survival rates. Professor Jarman had developed Summary Hospital-level Mortality Indicator (SHMI) rates, using data sets based on population and other factors. It was seen as alarming if a hospital has an SHMI rate in excess of two standard deviations above its standard rate. Each hospital's actual mortality rate could be analysed in detail, to individual patient level. The RBH actual mortality rate is closely in line with its standard rate, and the Trust aspired to significantly improve that position.

Value for Money – with reference to financial performance and stability. Indicators of soundness here were: achieving a risk rating of 3 from the regulator; having an affordable capital programme; and that the payroll costs should not exceed 60% of the whole (RBH are currently at 59%). Equally, payroll costs should not fall so low that there are insufficient staff frontline - it is a balance.

Staff Experience – Staff can be relied upon to give an honest assessment in their survey responses. Some 450-500 staff at the RBH have completed the survey (out of c.5,000 staff). Historically, the RBH had been in the lowest quartile for staff recommending the hospital, but had improved greatly and they are now in the top quartile. This was testament to moving away from a top-down management approach, towards staff empowerment, engagement and more teamwork.

ED stressed the need to achieve balance when pursuing these four aims, citing the error of Mid-Staffordshire NHS Trust in giving undue prominence to finance/value for money, at the expense of patient safety.

4.13 Mr Flowerdew (AF) gave a presentation on the key failures of Mid-Staffordshire as revealed in the Francis reports, together with a summary of the approach taken by the RBH to the lessons from Francis. The Chief Executive is the 'accountable officer', however the Board has accountability too. Various functions are delegated to the Medical Director, the Finance Director, and other specified senior postholders. The NHS had been undergoing a major transformation, with the drive to convert to Foundation Trusts. It had been crucially important to bring clinicians into the management process, and the RBH had moved a long way on that path.

4.14 AF described how all NHS organisations had been required to examine the recommendations in the Francis report, and to state the actions they were taking, as a consequence. The RBH Board was strongly committed to this, and a high-level steering group had been established. All the 149 recommendations pertinent to the Trust had been examined, and a gap analysis had been carried out on these to determine any new actions required. For the vast majority, the current position is positive. The proposed actions were to be presented to the Board in a published report later in July.

4.15 Other matters arising in discussion, and in response to Members' questions were:

a) ED did not see the Mid-Staffordshire faults being repeatable at the RBH. Patient experience and other information showed that the position is sound. The RBH has traditionally attracted high quality staff, also the General Medical Council give extremely good reports about the RBH. The stable workforce enhances safety and assists excellence, and there is limited use of agency staff. The Trust considers it is strong, without being complacent. ED added that the Francis report had made a difference, both at the RBH and across the NHS.
b) ED suggested that he most relevant information to be routinely reviewed by Health O&S should include:
    - On patients' experience, the percentage who would recommend the hospital to their friends and family
    - The staff recommendation rate (it being important to recognise the extended team, necessarily working together)
    - Related information beyond the Trust, for example discharge performance, and the capacity of Berkshire Healthcare Trust.
    - The extent to which the NHS Constitution standards are being achieved.
    - Information on complaints. ED suggested that the routine report to the RBH Board on complaints should suffice.
c) The Patient Advice and Liaison Service (PALS) concentrated on customer care. Any patient or their relative could take a concern to PALS. They aimed for early resolution to issues of concern, in collaboration with the doctors and nurses concerned. The Director of Nursing had identified areas of necessary improvement to PALS, such as the need to telephone the patient about their complaint, and to be less bureaucratic.
d) A Member of the RBH Executive telephones two patients each week, chosen at random, to check on their experience of the RBH's services.
e) The RBH's Francis action plan included some red and amber ratings on the complaints handling arrangements. The number of complaints rises when the hospital is under pressure. Complaints are examined by the relevant team, and ED personally signed all responses to complaints.

4.16 On **9 October**, a member of the Group met **Caroline Ainslie, Director of Nursing**, at the Royal Berkshire Hospital to enquire about the detailed arrangements for the trust's handling of complaints by patients. This was used to inform our conclusions and recommendations at paragraph 5.24.

<u>Examples Of Good And Less Effective Health Overview & Scrutiny</u>

4.17 The Group considered the factors which influenced the achievement of good and less effective Health Overview & Scrutiny, by reference to two examples from the Health O&S Panel 'archives':

- On 27 September 2012, the Panel met senior staff of the South Central Ambulance Service, concerning the Trust's performance on out-of-hospital cardiac arrest survival rates. There had been adverse media reports on survival rates in relation to out-of-hospital cardiac arrests in the South East when compared to other regions of the country.
- The Panel meeting on 26 April 2012, which had included substantive 'visitor items' on:
    1. A progress update from a Clinical Commissioning Group
    2. A briefing on the Joint Strategic Needs Assessment
    3. A briefing on the shadow Health and Wellbeing Board,
    4. A briefing on the transfer of Public Health Functions
    5. An update from an NHS Trust on a change to NHS services

4.18 The Group considered that the factors which had made the Ambulance Service meeting on 27 September 2012 good scrutiny had been:

- O&S officers keeping their 'ear to the ground' and spotting a media report on the topic, bringing it to the Panel chairman's attention, who agreed it should go on the Panel agenda
- Looked at an issue of public concern (people dying in ambulances when they might have had their lives saved by improvements in service) and use of volunteer 'Community Responders'
- All Members of the Panel had engaged in questioning
- Probing questions – Trust representatives clearly felt they had been held to account for their performance
- A commitment was given by the Ambulance Trust to action
- The Panel decided to return to the issue in six months, to see whether the position had changed
- There had been some pre-meeting preparation by Panel Members on the questions to raise with the Trust.

We did, however, think that the effectiveness could have been greater if:

- Information had been sought in advance from the Trust, particularly on differences of view on how data is collected
- Time permitting, there had been some research and briefing to Members regarding the national position and data issues before the meeting
- Clearer conclusions and recommendations had been reached by the Panel
- The Panel had not delayed its follow-up (which had been due to competing pressures on the Panel's agenda).

4.19 By contrast, the Group considered that the factors which had made the meeting on in April 2012 not very effective scrutiny had been:

- The items were more about receiving information rather than challenging something of concern
- The Panel could not really do justice to so many major issues at one meeting, consequently none were covered in sufficient depth
- Limited preparation
- Some visitors were kept waiting for quite a long time while other visitors presented their material
- Less than full Member participation
- Witnesses seemed to find the questioning relatively un-challenging
- The Panel had not been sufficiently assertive
- No clear outcomes from the Panel discussion, nor any conclusion on 'where do we go next'.

<u>Work of Other Councils' Overview and Scrutiny on Francis</u>

4.20 So as to avoid duplication, the scrutiny officer supporting our review notified the O&S officers of those adjoining councils where the three principal hospitals are sited that the Group would be approaching those hospitals to establish what their response to the Francis report had been. None of the councils raised any objections to that. We also enquired about their O&S approach to learning from Francis. The responses indicated that the other councils were not approaching this in similar depth to our approach, so we did not see any need to revise our approach.

Bracknell and Ascot Clinical Commissioning Group

4.21 On **9 August**, the Group met **Dr William Tong (WT), Chairman, and Sarah Bellars (SB), Director of Nursing, of the Bracknell and Ascot Clinical Commissioning Group** (CCG), to discuss the CCG's progress in applying the lessons from the Francis report, and their views on the progress by the local hospitals and the Ambulance Service, also the routine information needed for effective Health O&S, on complaints and other matters.

4.22 WT said that the Francis report pointed to a multi-level lack of patient care in Mid-Staffordshire. Many of the failings were basic, and various doctors, nurses, managers and others had failed in their duties. For the NHS, it raised the question of whether the failings were isolated, also what could be learnt to prevent similar failures occurring elsewhere. The CCG saw Francis as being highly relevant and were monitoring the quality of service by providers. Particular diligence was needed with Heatherwood & Wexham Park hospitals (H&WPT) due to current concerns there. The CCGs were to hold a workshop at the end of September with the local hospital trusts, with Local Healthwatch (LHW) present, to receive presentations from each Trust on their responses to Francis, and to have a challenge process on them, in an open forum. Local Authority representatives were also to join in the workshop. That workshop should enable the CCG to achieve satisfaction that the actions being taken by the three nearby hospitals, and Berkshire Healthcare Foundation Trust (BHT) and the Ambulance Service were properly applying the lessons of the Francis report. Following the workshop, the assessments and actions would be reported to the governing bodies in October, afterwards being sent to the Department of Health (DoH).

4.23 SB described how the CCG had reviewed all the Francis recommendations applying to CCGs. This had included a workshop to agree on actions needed, and that action plan was in the course of being agreed between the three East Berkshire CCGs. Some of the Francis recommendations would be challenging to implement without DoH support, for example concerning safe staffing levels. Drawing on her experience as a former Ward Sister, SB described how staffing needs should be properly assessed with reference to the presenting symptoms/conditions of each patient, and a standard minimum level could be insufficient at times of high demand from very sick patients. In reality, the staffing needs of individual wards varied from ward to ward, and from day to day. The particular staffing concern at H&WPT was the balance between permanent and temporary staff - the CCG did not see an insufficiency of staff numbers in total, neither were they aware of any restrictions on staffing numbers; the H&WPT financial position is not preventing them from engaging the staff they need. SB said that all hospital staff had a shared duty to uphold standards, and this was not solely the responsibility of Matrons (who have a distinct policing role in that regard). All staff need to challenge each other in a professional and courteous way, and the cultural environment should provide for that.

4.24 The CCG representatives told us that the 'Friends and Family' survey gives a valuable insight into privacy and other non-measurable aspects of the patient experience. WT said that the council could help the CCG by communicating knowledge of patients' experience, for example in relation to discharge from hospital. The positive 'Friends and Family' results for H&WPT were at odds with the clinical concerns about that Trust. SB commented that complaints to the CQC by H&WPT patients had peaked in February, tailing away in April-May.

4.25 Other matters arising in discussion, and in response to Members' questions were:

a) At Mid-Staffordshire, inspectors had failed to detect what had been going wrong. The position was now greatly changed, for example the CCG had been increasingly concerned about services at H&WPT from January 2013. A Quality Surveillance Group had been established with CQC, and this had triggered the CQC inspection of that Trust in May.
b) SB cautioned against relying too much on standardised mortality rates, even though they are a useful and important indicator. Being lagging annual figures, they are always dated, neither do they identify mortality 'hot spots' within a hospital.
c) SB stressed the importance of maintaining standards at all times, regardless of how heavy the pressure is on a hospital.
d) The Accident and Emergency pressure at Wexham Park had been exacerbated by

- The 'case mix' of A&E patients from South Buckinghamshire being more demanding than anticipated;
- Nationally, a much greater winter surge in A&E demand than normal.

e) Planning for the next winter's A&E demands was already in progress. H&WPT was in line to receive a good proportion of the recently - announced additional funding from the DoH for A&E.
f) Regarding the concern about the impact of weather extremes on the mortality of the elderly, WT said the emphasis should be on reducing all avoidable deaths.
g) NHS capacity constraints meant that GP's could not simply stop referring patients to under-performing hospitals. Instead, CCGs worked with hospital trusts to encourage and support them to perform to the required level. WT added, whilst not condoning in any way the poor quality found by CQC, that the position at H&WPT was not unsafe for patients, though it had been unacceptable and high-risk.
h) Patients' right of choice had resulted in some movement away from H&WPT, though there is no patient choice on A&E location. The right of choice already extended to three hospitals and private providers, and it is set to widen further.
i) The CCG is working to gain more information on the complaints made to the hospitals, and their resolution. The CCG welcomed BHT's initiative in giving thought to publishing summary details of complaints they receive. Hospital service providers were expressing difficulty in divulging confidential patient information in complaints. WT added that primary care providers were also thinking about how to achieve greater openness about complaints they receive.
j) Prescription errors can occur for a variety of reasons, such as: poor record keeping; lack of clarity about who is responsible for determining medication; hospital pharmacy opening hours; and uncertainty over the current medication of patients who are unconscious on arrival in hospital.
k) The CCG had established contact with LHW, who are undergoing an authorisation process. The CCG welcomes LHW as a critical friend, and regards them to be an integral part of their public forum.
l) The CCG was monitoring quality at H&WPT more closely and frequently than other trusts (Bracknell and Ascot CCG work with NE Hants and Surrey Heath CCGs around Frimley Park Hospital), and this included talking to patients directly about their experience of the service.
m) All doctors and nurses have a responsibility to ensure that drugs are kept secure.

Hospital Inpatient Survey Results

4.26 The Group reviewed the results of the CQC survey of 2,550 inpatients at FPH, RBH, and H&WPT hospitals, in the period September 2012 – January 2013, to which 1,244

people had responded. This gave very comprehensive and direct feedback on the patients' experience of various aspects of the hospitals' service to them. It was noted that the H&WPT responses would have been mainly from Wexham Park patients. The WG agreed that there was a need to present the in-patient survey results routinely to the Health O&S Panel, as a primary source of information about the patient experience, to be used to hold service providers to account. The WG was concerned to see the low satisfaction ratings for H&WPT, and we followed this up with that Trust at our Panel meeting with them in August.

Frimley Park Hospital NHS Foundation Trust

4.27 On **23 August** the Group met **Nicola Ranger, Director of Nursing, Frimley Park Hospital NHS Foundation Trust** (FPH), to discuss the Trust's progress in applying the lessons from the Francis report; and routine information for Health Overview and Scrutiny on complaints and other matters.

4.28 Nicola Ranger (NR) said that the Francis report had had an impact, particularly around the focus on nursing care, and summarised the FPH work to date flowing from Francis. NR described the new hospital inspection regime, noting that FPH, as a designated low risk hospital is to be subject to a full review in November, when 20 experts will examine a range of outcomes and other matters connected with the running of the hospital.

4.29 NR explained that a major issue of Francis concerns nurse staffing levels; Frimley Park has strengthened the nursing numbers, particularly on care of the elderly. FPH had been recruiting nurses including some from Portugal. English language ability is tested during the recruitment process. Some 70 newly qualified and good calibre nurses were due to commence in September, and mentors are provided to help them settle in to their role. New staff are given very clear information on the names and responsibilities of team Members. FPH employ some 3,000 staff of whom around 1,700 are nurses, midwives and nursing assistants.

4.30 NR regarded FPH to be performing well on the management of the complaints, though the process was being further improved. The Chief Executive and Director of Nursing read every complaint received, and NR personally met complainants when the matter involved poor care, so as to fully understand the issues. The 'Duty of Candour' was being worked on, with the aim of achieving complete honesty and openness. NR said that there is a standard NHS complaints procedure, and a recent audit of FPH's complaints process concluded that it was excellent. FPH are trialling a meeting with former complainants where they had similar themed complaints, to see whether they had been satisfied with any remedial actions taken. The PALS service, which had started 10 years ago, should be used for less serious complaints and enquiries. Occasionally, ward staff wrongly advised patients to contact PALS, instead of sorting out the patients' issues at source. A serious complaint – for example a miss-diagnosis – would be immediately referred to the Medical Director or NR, for a full investigation to be done within 25 days.

4.31 Board and staff engagement was assisted by monthly ward walk-abouts by non-Executive board Members, and by the presentations of performance information to the Board by clinical staff. This gave an opportunity for face to face discussions about matters of concern. In order to continue to improve this, the Trust was experimenting with a 'question time' session for staff. The Trust's Chief Executive continued to deliver monthly staff briefings. Other matters arising in discussion and in response to Members' questions were:

a) Staff are openly encouraged to raise any concerns they might have, and the whistleblowing facility had been used occasionally. NR has an 'open door' policy, and Staff Forums had also been used to help staff feel more able to raise concerns.
b) The role of Ward Sisters is being improved through a leadership programme, run jointly with the British military presence at FPH. This reinforced the Sister's role as being visibly in control and respected, and aimed to relieve them of bureaucracy as much as possible. Every ward will have a Ward Sister, visible and accountable for everything in the ward, assisted by a deputy. Each Matron will cover 5-6 wards. The title of Ward Manager will be changed to Ward Sister/Charge Nurse.
c) The military previously had a dedicated ward at FPH. Their work was now spread across A&E, Orthopaedics, surgery, etc, (though not in elderly care, for example). This was a huge benefit for FPH, bringing additional staffing resilience, as well as a 'fresh set of eyes' and extra objectivity.
d) The new form of reports from the CQC should be very useful assurance material for O&S. Other useful information was from patient and staff surveys. FPH responded to themes from these, for example in response to the low score on disruption to sleep, the Trust was considering issuing patients with ear plugs.
e) Information on complaints received would also be helpful to O&S, and a high level summary could be made available. Complaints sent to the Health Services Ombudsman would give an indication of how well complaints had been resolved locally.
f) NR suggested that the best assurance could be gained from seeing how well Ward Sisters carried out their duties, and offered to arrange a 'ward walk-around' for councillors. O&S might also consider meeting the FPH Executive Team and Governors occasionally.
g) NR expressed the view that the Francis report had helped to stop the continuous reduction of nursing numbers across the NHS.
h) A growing challenge is caring for the elderly, and dementia cases. A common source of complaints was from patients who had been unable to sleep due to other patients making noise throughout the night.
i) NR considered that the Local Health Watch (LHW) role should be useful and give a different viewpoint, but she had some concern about the proliferation of accountability routes. It would be important to achieve two-way communications with LHW.
j) NR considered that factors influencing FPH's success included: self-belief; an excellent long term post-holder of the Chief Executive position; the hospital being genuinely clinically-led; and high staff motivation. By contrast, poorly performing NHS organisations were often characterised by external agencies putting them under a deal of pressure, and the Chief Executive being driven too much by targets and finance issues.

<u>'NHS Choices' Information</u>

4.32 The Group reviewed the summary information available on the 'NHS Choices' website. This is the UK's biggest health website. It provides a comprehensive health information service, including more than 20,000 regularly updated articles. There are also hundreds of thousands of entries in more than 50 directories that can be used to find, choose and compare health services in England. The WG considered that the summary information relating to mortality, patient and staff recommendations, the current assessments of the Trusts by the CQC and MONITOR and other matters available on the NHS Choices website for the principal, local NHS Trusts and decided it would be useful to regularly provide this summary information to the Panel.

South Central Ambulance Service NHS Foundation Trust

4.33 On **9 September** the Group met **Deirdre Thompson, Director of Quality and Patient Care, South Central Ambulance Service NHS Foundation Trust** (SCAS), to discuss the Trust's progress in applying the lessons from the Francis report; and routine information for Health Overview and Scrutiny on complaints and other matters.

4.34 Deirdre Thompson (DT) described the significant work carried out by SCAS arising from the Francis Report, delivering a presentation covering:

- The area covered by SCAS, its background, the achievement of Foundation Trust status in 2012, its structure and staffing (some 2,900 and growing).
- The range of SCAS services, which extend well beyond the traditional emergency calls, to include commercial training, for example.
- The principal questions from Francis which had been addressed,
- Progress on SCAS's five improvement and change themes: Standards; Openness; Care and Compassion; Leadership; and Information
- The position on patient and staff satisfaction
- The high-level SCAS commitments
- Examples of feedback from patients on the impact of SCAS services

4.35 SCAS, in common with the whole NHS, had been shaken by the findings of the Francis report, and it had caused them to fundamentally re-visit what the ambulance service's role was. DT added that the report was timely, coming after the impact on the NHS of a severe winter. The failings in Mid-Staffordshire bore some relation to: the new NHS architecture shifting the focus away from patients; the combined effects of various reductions in public services; and some confusion over the service offerings of different NHS institutions. DT said that SCAS had moved quickly to respond to the lessons from Francis, and she was confident that the local hospitals also had Francis at the top of their agendas. For SCAS, the main change brought about was to talk more about culture and patient care. There was a realisation that services are not perfect, and there is a stronger commitment to do one's best for patients. SCAS was also moving the focus away from processes towards more openness, commitment to learning, and determination not to repeat mistakes.

4.36 DT said that SCAS had deliberately avoided the traditional action plan approach to the tasks flowing from Francis, instead mainstreaming this in their everyday work. An update on this was provided monthly to the Trust Board, as part of the standards and quality report. The integrated performance report to the Board brings together all the pertinent information, and a lot of attention is given to this to identify where any further actions are necessary.

4.37 DT described 'Openness' as being a large and important field of work. There had previously been a widespread tendency across the NHS to give priority to organisational reputation, financial position, etc. over patients' interests. The 'duty of candour' now required of all NHS Trusts meant that there had to be greater openness about things that had gone wrong. There was a nervousness about sharing such matters publicly, nevertheless SCAS was moving towards publication of suitably measured, balanced and anonymised information in this field. Internally within SCAS, there was traditionally good information sharing at local level of matters which had gone wrong. This was now being built on, for example to develop a more continual process of learning from complaints and compliments.

4.38 DT explained that recruiting, managing and appraising staff is central to improving Care and Compassion. SCAS had adopted the national 'Friends and Family' test for use in all their patient surveys. In that regard, much higher response rates had been obtained from telephone surveys, which supplement the postal surveys. SCAS were striving to learn more about individual patient 'journies', as much can be learnt from their overall service experience. On 'Leadership', DT mentioned that a local authority councillor had recently 'third manned' on an ambulance. That, and section visits are very powerful, and proceeding well, as is stakeholder engagement. The SCAS leadership is striving to ensure that customer-facing staff have sufficient time to spend with patients. DT explained that SCAS are giving more attention to the qualitative aspects of 'Information'. For example, more granular detailed information on patient experience is being presented to the SCAS Board. There had been a lot of progress on 'listening and learning' since February 2013.

4.39 DT highlighted the new 111 (non-emergency) telephone service, which she said SCAS had been progressing with well. DT said that the 'conversion rate' of 111 calls – i.e. the percentage passed on to the 999 response teams – was important and the SCAS rate of c.5% was better than the national average. This depended on having highly trained staff. DT described how SCAS had run a massive recruitment campaign, to reduce the usage of temporary staff. No agency staff are used. SCAS make use of nine private providers – being reduced to four - who operate their own ambulances with their own crews. SCAS monitor their performance closely.

4.40 The SCAS Board are involved in the work flowing from Francis, for example in visiting the heliport at Thruxton, and meeting the staff there. Previously, walk-abouts had been very ad-hoc. The board were also being provided with a lot more direct information on patients' experience.

4.41 SCAS had 58 live complaints, currently, and these usually involved other healthcare professional as well as SCAS. Independent complaints investigators are used when necessary. The SCAS response target of 25 days was being achieved in 62% of cases, and improvement to 80% was being aimed for. The 111 service had generated some one million additional phone calls annually, thus resources for complaints handling, including Patient Liaison, had been increased accordingly. The Patient Experience Group, chaired by the Chief Executive, sees summary details of all complaints. DT said that an increase in complaints can be viewed positively, as a sign that an organisation is more open. SCAS recognise the need to do more to spread the learning from complaints, and intended to increase reporting of information on complaints, possibly by theme (such as delays and staff attitude).

4.42 Other matters arising in discussion, and in response to Members' questions were:

a) 'Community First Responders' are volunteers, trained and equipped for first response, who are a very valuable part of the SCAS workforce, and offering a wealth of knowledge and insight.
b) The recent report by Mr Berwick offered a concise and succinct statement of the key actions identified in the Francis report
c) SCAS had recognised that their safeguarding arrangements had been too process-driven, and were deploying two more staff on that to improve quality.
d) Communication skills for call centre staff are all-important, and DT regarded the skills level to be very high at SCAS. The presence of clinical support staff (often experienced A&E nurses) in call centres was also very valuable.
e) SCAS receive a lot of feedback on their service, and enjoy a good standing with its service users, for example in receiving five times as many compliments as

complaints. Also, the SCAS staff survey results are more positive that the average for all Ambulance Trusts.

f) SCAS had engaged with the Urgent Care Boards throughout their area to prepare for the next winter. Provisions included enhanced care for people within their homes instead of taking them to hospital, with more nurses recruited to deliver this enhanced service.
g) Out of hours, doctors do have access to patients' medical records, though the access availability varies between areas.
h) On whether there should have been whistle-blowing at H&WP hospitals, DT said that staff should have raised any concerns with the Hospital Ambulance Liaison Officer. A transfer target of 15 minutes applied to Accident and Emergency (A&E) on receiving patients arriving by Ambulance, but there were widespread delays on this nationally last winter. Fines/penalties applied in the event of delayed admission by hospitals, and there was now double-verification of timings by both hospital and SCAS staff.
i) SCAS experience some hoax and unnecessary calls, though a patient's perspective on need was understandably subjective.
j) A lot of work was done by the NHS on preventing falls, which continued to be a frequent cause of accidents.
k) SCAS operate a range of different vehicles and crewing arrangements to assist efficient and appropriate responses to calls.
l) The Patient Transport Service operated by SCAS is separate from the emergency response function, and is particularly useful for older people who are unable to drive. Some nine formal complaints had been received in 2013-14 to date, and an example of learning was introducing umbrellas to keep patients dry on their journies to and from the vehicles. SCAS regarded an acceptable waiting time to be one hour, but over-runs occasionally arose. We asked DT to look further into the incidence of delays.
m) Call centre dispatchers decide which hospital each ambulance should take a patient to, with reference to the treatment needed, current loading at each hospital, proximity to a person's home address, etc.
n) SCAS might be able to send the Health O&S Panel information on complaints by number and theme, divided into CCG areas.
o) It was noted that information on mortality rates, whilst useful, was complex and subject to various limitations.

<u>Heatherwood and Wexham Park Hospitals NHS Foundation Trust</u>

4.43 On **15 August**, a member of the Group met **Thomas Lafferty, Director of Corporate Affairs of Heatherwood and Wexham Park Hospitals NHS Foundation Trust** (H&WPT), at Wexham Park Hospital to enquire about the detailed arrangements for the trust's handling of complaints by patients. This was used to inform our conclusions and recommendations at paragraph 5.24.

4.44 On **7 October**, the Group met **Philippa Slinger, Chief Executive, and Dr Rob Loveland, Medical Director, HWPT,** to discuss the Trust's progress in applying the lessons from the Francis report; and improving Health Overview and Scrutiny through routine information on complaints, and other matters.

4.45 Philippa Slinger (PS) said that the whole of the NHS had been shocked by the revelations about Mid Staffordshire, and this pointed to widespread corporate and professional malaise. It was very difficult to see why the failures had not surfaced earlier, given the proliferation or organisations involved with the Trust and the complaints from patients and their families (which were largely ignored). The NHS

post-Francis was very different, with a greater willingness by Trusts to look dispassionately and critically at their services.

4.46 Dr Rob Loveland (RL) made the point that everyone needs to be aware that another incident like Mid Staffs could happen; there must be no 'corporate blindness', Trusts cannot afford to cruise, and the price of good patient care is constant attention. Mid Staffs Trust had not taken proper notice of statistical data which pointed to problems, instead their focus was on achieving Foundation Trust status. The CQC report on H&WPT had been the Trust's 'Mid Staffs moment'. PS had been encouraged to see that many people at the Trust were ashamed at CQC's findings, which gave her hope that they would be committed to making improvements. The CQC report had led the Trust to taking a completely different focus by concentrating on patient care. PS added that that this required some bravery, as it put the achievement of traditional targets as secondary. Whilst the experience of the CQC review had been horrible, the outcome was a blessing in disguise.

4.47 PS said that H&WPT was a most challenging organisation to work for, with new 'issues' constantly coming to light some years after they occurred. The improvements being worked on depended on everyone working together with a strong focus on patient care. The previous culture, of a tolerance of poor practices, was taking time to remedy. Particular attention was being given to the 95 front line clinical leaders, supported by coaching and action learning sets. The prospective merger with Frimley Park hospital meant that there would be two years of managerial turmoil at H&WPT. H&WP was organisationally separate from FPH, though efforts were being made to standardise ICT work for example. PS observed that FPH works well for a variety of reasons, some of which could not be replicated in the H&WPT area, for example the differing patient population would require adjustment to their operating model.

4.48 PS said she saw every complaint against H&WPT. The PALS service was active and valued, and tended to deal with lower-level issues. The complaints process can be demanding because of the backdrop of potential liabilities and negligence claims. Historically, complaints had not always been responded to well enough or fast enough. Improvements were being made to the H&WPT process, for example senior staff now usually met complainants face to face when reviewing their complaint, and there is a greater emphasis on remedial actions and learning from complaints. Nevertheless, there continue to be cases where, having listened to patients' views and suggestions, the Trust chooses not to adopt them; and in such cases it is important to explain the reason for that course. There had been instances where the investigation of a complaint had resulted in dismissal of a Trust employee. On the provision of information concerning complaints, PS said that the Patient Safety reports to the Trust Board provided useful summary information, which Members could ask for supplementary information on as they saw fit. However, the Trust would not be able to release information which risked identifying an individual.

4.49 Other matters arising in discussion, and in response to Members' questions were:

a) The Keogh list of hospitals had been compiled from the list of the worst mortality statistics. But the differing measures of mortality showed different hospital 'rankings', illustrating the importance of being aware of different data and interpreting them carefully.
b) The CQC report illustrated that many staff at H&WPT had ceased asking for things they need, as they did not expect requests to be met. Some had also evidently not been seeing things for what they were; people had tended to limit their sense of responsibility to their immediate duties and to 'walk past' matters which needed attention. The 'helpdesk' which all staff could report their equipment

needs to had proved to be very successful (though it now showed a need for more porters), and the building and other works now underway were transforming Wexham Park Hospital.

c) We observed that Trusts could 'hit the target but miss the point'. There was general agreement that if Trusts concentrate on the person and their care, the performance on many of the set targets should be satisfactory. To that end, there needed to be some 'shelter' in terms of Trusts not being criticised for under-performance on targets consequent on priority having been given to patient care.
d) PS suggested that a useful source of information for O&S would be to ask Trusts to notify whenever they receive an 'outlier alert' from the CQC. A recent example was an alert regarding fractured neck and femur cases; H&WP had examined the contributory causes thoroughly and followed this up to good effect. Another suitable source of regular information is the Patient Safety report to the Trust Board.
e) PS encouraged O&S to make use of the work of LHW, as independent , non-clinical people offered a valuable role in continual monitoring and inspection, as did HWP staff unconnected with the service under review.
f) The Trust has a whistleblowing policy, though the whole policy area of the means for raising concerns was currently under re-development.

<u>Executive Member for Adult Services, Health and Housing</u>

4.50 On **7 October**, the Group also met **Councillor Dale Birch, the Council's Executive Member for Adult Services, Health and Housing** to hear about his priorities from the Francis report.

4.51 Councillor Birch (DB) drew attention to the Mid Staffordshire failures having come to light because one person would not accept what was being said by that NHS Trust. He referred to the Health and Wellbeing strategy, which is predominantly concerned with priorities for prevention. There is a need to look at how the appalling patient suffering in Mid Staffs can be prevented in future. DB considered that we should all try and avoid responding from some form of righteous indignation and focus on what matters here locally. Councillors are at a disadvantage in terms of the information available, but the Mid Staffs councillors clearly failed to do their job properly. There is a need to recognise that some other NHS Trusts are close to having similar failures to Mid Staffs, and DB encouraged Members to keep these concerns in mind and put the interests of protecting residents uppermost. In that connection, DB said there was a need to tell residents that that they can raise any concerns about the health issues with the Council, and councillors need to be familiar with the routes open to residents to pursue those concerns.

4.52 DB encouraged Members to build their learning and understanding of the NHS, and to raise their concerns openly if they considered an NHS Trust was failing. DB stressed the importance of effective relationships with NHS partners, and observed that Health O&S Members had occasionally been over-assertive, creating an aggressive environment. A better approach would be for Members to express the source of their concerns, raising them in a supportive manner. DB suggested that O&S would get more value if they fulfilled their 'critical friend' role by adopting a challenging yet supportive stance. DB encouraged O&S to scrutinise compliance with the principals in the NHS Constitution. He said the roles of the Executive, the Health and Wellbeing Board, and O&S were clearly defined. Social Care and Health were being increasingly integrated. He saw Members' priority as being to 'up their game'; this required becoming more knowledgeable and availing themselves of training opportunities. DB illustrated this by reference to making an input to the commissioning process, on which there was to be a Member development event. DB

also suggested that O&S should ask NHS Trusts how they track mortality rates, and how many patients exit the system with an impaired outcome. He regarded the culture within health service providers as being very important.

4.53 DB summarised his priorities from the Francis Report as being:

a) Building the understanding and knowledge of councillors on health issues, including training.
b) Encouraging O&S Panels to work together, in a similar way to Health and Wellbeing Boards. The O&S role in working effectively with LHW might be better defined, and O&S should work in concert between local authorities.
c) Completing the establishment of LHW, and informing residents about how to engage with LHW. DB said that the H&WB Board emphasised the need to concentrate on actions – and that included by LHW - rather than receiving information updates. Members queried whether more value could be added by promoting LHW to residents, rather than simply passing on residents' concerns, also by helping to make it clearer how to raise a complaint.
d) To broaden the network of contacts with health service providers, for example with the Boards of the acute Trusts nearby. Information is passed more easily when good relationships exist. There was a need for the Council to change its culture, in the same way the NHS is having to change its culture.

Healthwatch Bracknell Forest

4.54 On **21 October** the Group met **Clare Turner and Chris Taylor of Healthwatch Bracknell Forest** (HWBF), the Local Healthwatch organisation for the Borough, to discuss O&S collaboration with HWBF in applying the lessons from the Francis report, with particular reference to sharing information on complaints and HWBF's direct knowledge of NHS service providers.

4.55 HWBF said they had recognised a need to communicate more proactively with Members on how HWBF was discharging its role. We were shown a diagram illustrating HWBF's role in relation to complaints handling, with particular reference to ensuring that complaints were dealt with promptly. HWBF would refer people to SEAP as necessary for advocacy assistance, and whilst SEAP would keep HWBF informed of progress generally, they would – correctly – not share personal data. HWBF had embarked on a wide programme of public engagement to learn about people's views of health and care services, and to publicise LHW's role. In that regard, the Clinical Commissioning Group had asked GP Practices to publicise LHW, and HWBF intended to ask the hospital Trusts to publicise LHW too, perhaps in their 'welcome pack' for new patients.

4.56 One Member suggested that Ward Members might raise awareness about HWBF in their ward work, and another Member suggested that Town and Country might be used too. HWBF were keen to know of local events which they could join in on.

4.57 HWBF made the point that complaints tended to be raised at a time of crisis, and HWBF had a valuable role in assisting resolution and preventing unnecessary escalation. Chris Taylor described a recent survey by Healthwatch England (HWE), which had concluded that nationally, the NHS complaints system was not working very well. As a consequence, HWBF was gathering information from service providers on the numbers of complaints and their resolution, and would inform the Health O&S Panel of the outcome of that work. HWBF would be using this to establish trend information. In that regard, they had attended an 'LHW Forum' meeting with the Royal Berkshire Hospital recently, and HWBF was establishing working parties to establish relationships with each of the service providers.

4.58 One Member, referring to an inpatients survey showing low levels of satisfaction with information on how to make a complaint, observed that people may be disinclined to make a complaint, thus the information on complaints received would not give a full picture of patents' concerns. The Group felt that if all NHS providers matched best practice in asking patients for their views about the service – both complaints and compliments – a much fuller picture would be available of the patients' experience overall.

4.59 Other matters arising in discussion, and in response to Members' questions were:

a) If a complainant is dissatisfied with the response to their complaint, HWBF would pursue it and escalate it as necessary. They might also act on a theme, for example if there was a run of complaints about the quality of meals in a particular hospital, they might visit that hospital and directly seek the opinions of patients there.
b) HWBF would be aiming to establish a relationship with the Health Service Ombudsman.
c) The Council produces annual reports about statutory complaints received regarding Children's also Adults' social care, additionally on public health issues, and offered to provide further information to HWBF.
d) HWBF would give regular feedback to the Health O&S Panel on the pattern of complaints themes.
e) The intended specialisation of Health O&S Members would include a focus on the work of HWBF.
f) A Member thanked HWBF for responding quickly to their concern about some GP Practices requiring patients to telephone them using a – higher charged - 0844 rather than an 01344 number.
g) A Member suggested that HWBF might usefully investigate why the act of obtaining a GP's appointment was much harder with some GP Practices than others.

4.60 On **24 October**, two Members of the Group participated in a workshop with the Health and Wellbeing Board and HWBF to forge partnership working and a sense of common purpose in the health arena.

<u>Berkshire Healthcare NHS Foundation Trust</u>

4.61 The Group reviewed the published documents summarising Berkshire Healthcare Trust's (BHT) actions from the Francis report, and noted that that BHT was due to be inspected by the CQC later in November. The Group noted the BHT's positive actions from Francis, though one Member commented that the actions lacked full target dates.

<u>Parliamentary and Health Service Ombudsman</u>

4.62 The role of the Parliamentary and Health Service Ombudsman (PHSO) is to investigate complaints that individuals have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England. They are statutorily independent of the NHS, and review complaints where people have not received what they regard to be a satisfactory response from the NHS organisation which provided them with a service.

4.63 In an endeavour to gain a fuller understanding of the more serious complaints made against the local NHS service providers, we asked the PHSO whether they could

supply us with regular information about their decisions about our three local hospitals. The PHSO's Deputy Director of Health Investigations responded that they are not currently equipped to service requests for regular information updates, but they were planning to put more information about their casework in the public domain via their website, and from April 2014 an online summary of each investigation, possibly naming the organisations complained about. They also had plans to share information with MPs about decisions made about organisations in their constituencies. The PHSO suggested that the easiest and quickest method of obtaining the information we sought is to contact the complaints departments of the relevant hospitals.

4.64 The Group met for the last time on **20 November**, when it considered its draft conclusions and recommendations for incorporation into a report. We also received a briefing on the Government's detailed response to the Francis report, published the previous day, and we evaluated how our review had been carried out, considering the learning points for future O&S reviews.

5. Analysis, Conclusions And Recommendations

5.1 Anyone who cares about the National Health Service and its treatment of patients must have been truly shaken by the reports by Robert Francis QC about the failings at Mid Staffordshire NHS Trust. The number of excess deaths at Stafford hospital between 2005 and 2008 has been estimated at 492 people, and there were dreadful failures to ensure the safety, dignity and comfort of many other patients. The Francis report describes the failings as a '*disaster*' and '*one of the worst examples of bad quality service delivery imaginable*'.

5.2 Anyone who cares about local authorities standing up for residents' interests in relation to getting good services from the NHS must have been shaken by Mr Francis' comment that '*The local authority scrutiny committees did not detect or appreciate the significance of any signs suggesting serious deficiencies at the Trust…. The Overview and Scrutiny Committees in Stafford ….. did not [*take*]… responsibility for identifying and acting on matters of concern; and ……offered ineffective challenge.'*

5.3 Bracknell Forest Council's Health Overview and Scrutiny (O&S) Panel commissioned this review because it cares greatly about the quality of NHS services to residents, and because we want to ensure we scrutinise those services effectively. In short, we are determined that the appalling failures of the Stafford Hospital, and in local authority Overview and Scrutiny there, should not be allowed to happen in Bracknell Forest.

5.4 We have been mindful of the Secretary of State for Health's words: '*This was a systemic failure of the most shocking kind, and a betrayal of the core values of the health service as set out in the NHS Constitution. We must never allow this to happen again.'* Our main reason for having the review was therefore two-fold:

- To establish whether the NHS Trusts providing most of the essential health services to Bracknell Forest residents were taking the lessons from the Francis report seriously; and
- To see what improvements were needed to the way the Council carries out its statutory duty to scrutinise local NHS services.

5.5 From its investigations, the Working Group (the Group) has drawn the following conclusions, on which we have based a number of recommendations to some of the NHS Trusts, to the Health Overview and Scrutiny Panel and other parts of the Council.

The NHS Trusts Providing Most Of the Acute Health Services to Bracknell Forest Residents

5.6 The Group reviewed the actions taken by those NHS Trusts which provide most of the hospital, ambulance and other inpatient health services to Bracknell Forest residents:

- Frimley Park Hospital
- Heatherwood & Wexham Park Hospitals
- Royal Berkshire Hospital
- South Central Ambulance Service
- Berkshire Healthcare Trust

As set out in section 4 of this report, our review included appraising published reports on actioning the Francis recommendations, face to face meetings with senior representatives of most of these organisations, discussions with the Clinical Commissioning Group and Local Healthwatch, and visits to two of the hospitals. We are very appreciative of the willing co-operation and candour shown by all the people we met.

5.7 The Group was impressed by the seriousness of purpose by all the Trusts in learning and applying the lessons from Francis. The people we met were all clearly shaken by the appalling failures at Mid Staffordshire. The very real changes and improvements they had embarked upon demonstrated to us their determination not to let similar failures happen in their Trust. Whilst we are greatly encouraged and reassured by this overall response, we do have a few observations and recommendations for further improvement:

a) All the Trusts seemed to us to be striving to ensure that their Boards and staff are fully engaged in understanding the Mid Staffs failures and in making the improvements within their own Trusts. We believe this to be a significant achievement, given the many pressures on NHS staff.
b) The nationally-run Inpatient survey showed very low levels of satisfaction with information being available on how to make a complaint, and we heard similar feedback from patients at a CQC 'Listening Event' which we attended. **Recommendation**: **All Trusts should include in their welcome pack for patients a brief guide to how to make a complaint or compliment.**
c) The Group was encouraged by the Royal Berkshire's development of their 'Patient Safety' reports to include more information on complaints. Also, we were impressed by the level of detail on complaints included in the published 'Patient Experience' reports of the Berkshire Healthcare Trust. **Recommendation**: **All Trusts should publish detailed information on complaints, at least equal to the level used by the Royal Berkshire and the Berkshire Healthcare Trust. The published information on complaints should also include the outcome for the complainant, for example – whether the complaints were upheld, lessons learnt and any settlements.** We note that our recommendation is consistent with the new requirements required by the Government in their detailed response to the Francis report, of 19 November 2013.
d) **We recommend that the Trusts display on their website and PALS notice board a postcard summarising the role of O&S and welcoming views (but not individual complaints) from patients to the Health O&S Panel (See paragraph 5.28 (iv) below).**
e) The Working Group wish to thank the people they met for their helpful views on what information they thought the Local Authority Overview and Scrutiny Panel should be receiving routinely from the NHS, and in their willing co-operation to ensure that such information needed is received from them. Full use of their ideas have been made in recommending the improvements the Working Group want to see made to Health O&S at Bracknell Forest.

Improvements Needed to Bracknell Forest's Health Overview and Scrutiny

5.8 There are many learning points arising from the Francis report which could be equally applied to any other O&S Panel and the O&S Commission, but at the heart of the matter is the need for councillors carrying out Health scrutiny to have both researched and be prepared to obtain and scrutinise information on the service users' experience by asking sometimes uncomfortable but pertinent questions. It is equally important that there is an ethos of systematically following matters up through action tracking.

We have grouped our conclusions and recommendations using the themes of the Francis report, as below.

Redefining The Objectives For Health O&S and the Role Of Members

5.9 Francis identified the need for more clarity over what functions/objectives Health O&S intend to follow when scrutinising the NHS. The starting point for this must be the **Health and Social Care Act 2012** and related legislation which gives powers to upper-tier local authorities to: review and scrutinise any matter relating to the planning, provision and operation of health services in their area; to make reports/ recommendations to local NHS bodies, NHS-commissioned providers, and the Secretary of State; to require the attendance of NHS staff and to require information to be provided. The Act also requires NHS bodies to consult the local O&S committee (including joint committees) on matters of substantial development or variation to services. Separately, the CfPS has recommended that council scrutiny is an opportunity to act as the eyes and ears of the community. Also, we must ensure that there is no duplication with or conflict with the Health and Wellbeing Board roles and responsibilities.

The Group recommends to the Health O&S Panel that:

The overall aim of Health scrutiny should be:
'Through constructive challenge and accountability, to work with the Executive, the Health and Wellbeing Board and Health Service Providers to help ensure good health services are provided to residents of Bracknell Forest, reducing health inequalities, and helping everyone to stay fit and lead healthy lives.'

Within that overall aim, **the objectives for Health Scrutiny should be**:

i. To exercise democratic accountability, representing the interests of Bracknell Forest residents in regard to health services. This entails constructively and transparently holding service providers to account in meetings open to the public, and making recommendations for improvements.
ii. To achieve and maintain knowledge of the patients' experience.
iii. To monitor the performance of the major providers of health services to our residents, with reference to the findings of NHS regulatory bodies, challenging underperformance and encouraging improvement.
iv. To review proposals for substantial service change.
v. To recognise that the vastness of the NHS and the limited time available for O&S means that only those matters deemed to be of greatest significance are scrutinised.
vi. Consequently, to make the best use of the resources available to O&S, by focussing attention on those issues which O&S members judge:
    1. affect a large number of residents, or
    2. are significant service failures or matters of public concern

In delivering these objectives, **the role of Members** is not to be medical experts. Instead, and in line with Mr Francis' reported view, councillors are expected to make themselves aware of, and pursue, the concerns of the public who have elected them.

Which NHS Service Providers Should be Regularly Scrutinised?

5.10 There are a large number of organisations involved in providing NHS services to Bracknell Forest residents. Regrettably, resources available to O&S do not permit them all to be scrutinised, so it is necessary to adopt a tiered approach based on

councillors' views of priority. **The Group recommends to the Health O&S Panel the following approach**:

Organisation	Proposed Approach to O&S	Comment
Health and Wellbeing Board (H&WBBd)	One Member to take lead in monitoring the activities of the H&WBBd, drawing matters to Panel's attention as necessary. Panel to review each year the annual refresh of the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy	H&WBBd Chairman attends Panel meetings routinely
Clinical Commissioning Group (Bracknell Forest and Ascot)	One Member to take lead in monitoring the activities of the CCG. Panel to meet the CCG Chairman and Accountable Officer at least once every two years.	
General Practitioner Practices	GP Patient Survey results to be presented to Panel, which will consider questioning any under-performing GP Practices	
Broadmoor Hospital	No O&S to be carried out, as very low significance for Bracknell Forest health services	Patients drawn from whole south of England
Heatherwood and Wexham Park Hospitals Royal Berkshire Hospital Frimley Park Hospital Berkshire Healthcare Trust	• Review NHS Choices information (includes staff and patient survey results, Friends and Family scores) at each Panel meeting • One Member to take lead in monitoring the complaints made to each hospital, particularly serious and Ombudsman cases, drawing matters to Panel's attention as necessary for follow-up. • Regular follow-up of significant issues, e.g. FPH/H&WP prospective merger, and instances of under-performance • On-going Panel review of any inpatient survey results, CQC and MONITOR reports • Respond to annual Quality Accounts • Formally meet each Trust at least once every two years	Though based outside the Borough, these three hospitals and the Healthcare Trust provide the majority of acute healthcare for Bracknell Forest residents
King Edward VII Hospital Dentists Opticians Pharmacists	O&S Officer to maintain watching brief on any CQC reports/news items and bring anything of concern to nominated Member(s) attention, for them to conduct further enquiries/draw matters to Panel's attention as necessary.	
Other hospitals	No O&S to be carried out, as lower volume of services for Bracknell Forest residents	Reliance to be placed on O&S by those councils in whose areas these hospitals are sited
NHS England & Specialised commissioning	O&S Officer to maintain 'light watching brief' on any news items and bring anything of concern to Panel Chairman for them to conduct further enquiries/draw matters to Panel's attention as	

	necessary.	
South Central Ambulance Service	One Member to take lead in monitoring the activities of/complaints to the SCAS, drawing matters to Panel's attention as necessary. Panel to review SCAS performance at meeting at least once every two years	
Public Health	One Member to take lead in monitoring the activities of/complaints to Public Health, drawing matters to Panel's attention as necessary. Panel to scrutinise annual budget, also to review performance at meeting with Director of Public Health at least once every two years	
Local Healthwatch	Support Healthwatch Bracknell Forest and obtain regular feedback from them on their findings. O&S Officer to maintain 'light watching brief' on any news items and bring anything of concern to specialist member for them to conduct further enquiries/draw matters to Panel's attention as necessary.	Local Healthwatch to be invited to attend all Panel meetings
Private sector providers of NHS commissioned services	No O&S to be carried out, as currently of low significance for Bracknell Forest health services	To be reviewed if 'contracted in' services grow significantly

Note – some of the services referred to in the table above are delivered at the Royal Berkshire Bracknell Clinic.

This frequency of coverage would mean that there is at least one substantive 'visitor item' at each of the Panel's four meetings annually.

<u>Improving Members' Effectiveness (To Include Training, Advice And Support)</u>

5.11 The Francis report said of O&S in Staffordshire: *'It confined itself to the passive receipt of reports…..Difficult though statistics can be to understand, it should have been possible to grasp that they could have meant there was an excess mortality that required at least monitoring by the committee.'*

5.12 The NHS is a vast and multi-faceted operation, such that it is impracticable for any one Councillor to develop an all round knowledge and understanding of the whole organisation, at a sufficient level to achieve effective scrutiny. To attempt to do so - as at present - risks "skating over the surface", the very essence of the Francis report. The Group considers that Member involvement in Health O&S, and the efficiency, quality, depth and effectiveness of scrutiny, could, potentially, be better served by each of the Panel Members concentrating on one defined and major area of NHS services - for example hospital services - and to lead the Panel's scrutiny work on that area. By specialising in an area of choice, and building a relationship with the respective organisation, each Member would develop knowledge of their area, thereby enhancing the O&S approach and greater distribution of the questioning between Members. This approach of having each Member taking the lead on an area of questioning has already been trialled very successfully at the Panel meeting with a hospital Trust on 19 August 2013. Knowledge – building would benefit from continuity of Panel Membership, so Members should be encouraged to view Membership of the Health O&S Panel as a four-year commitment.

The specialist areas for Members would need to be set by the Panel, but a possible grouping of topic areas could be two members each on:

1. Hospitals
2. Mental Health & Ambulance Service
3. Primary Care, to include the CCG, GPs, Dentists, Opticians and Pharmacists
4. Public Health, Health and Wellbeing Board, and Local Healthwatch.

It would be important for each Member to voluntarily take on one of these areas, and collectively they should cover all the areas deemed to be important by Members. Furthermore, each specialist Member should report back to each Panel meeting on scrutiny progress in their designated area, in a standardised report co-ordinated by O&S officers.

The Group recommends to the Health O&S Panel to adopt the focussed, designated Member approach as articulated above and in so doing implement appropriate training for such designated Members.

5.13 The importance, complexity, and continual evolution of the NHS means that Members carrying out Health O&S need regular training if they are to be effective. Use might be made of the training material provided to newly appointed Non-Executive Directors of NHS Trust Boards.

The Group recommends to the Health O&S Panel and to the Director of Adult Social Care, Health and Housing that training should be delivered primarily by officers in the Adult Social Care, Health and Housing Department, and comprise:

a) induction training for all Members new to Health O&S on the NHS structure, functions and local delivery organisations, and on the powers and role of Health O&S;
b) annual refresher training on major developments, to coincide with the annual update of the Joint Strategic Needs Assessment (which sets out the 'health profile' of the borough's population); and
c) targeted training in whichever topic area is selected for a focussed O&S review.

5.14 It is clear to us that expert advice is needed in various fields if Health O&S is to be effective. Members are not equipped with specialist knowledge for the clinical/medical questioning required. We would propose that a pool of experts is established for us to call upon depending on Members deciding what is needed for each aspect of the work. The pool could consist of GP's, be they retired or practicing also Nursing experts in hospital and caring environments. There may be others that Members come forward with. Hopefully these people would give their time to the community free of charge in the knowledge that their time would not be unreasonably used. Depending on the subject before Members, it would be helpful if our specialist expert was present at a scrutiny meeting. We could then take 'time outs' to seek guidance from answers given and, thereby obtain a sensible supplementary examination. The Health Panel will need to exercise care in deciding on the suitability of prospective members of this advisory panel.

The Group recommends to the Health O&S Panel that a Panel of people with clinician experience be recruited in a voluntary 'pro-bono' capacity and used to provide independent expert advice to the Panel on: priority health issues which should be reviewed, the questions which need raising, interpreting the results, and forming value-added recommendations.

Prioritising Issues For O&S Attention, And Getting The Right Information

5.15 There are many different aspects to health services, which are vast, and an O&S Panel which meets four times annually cannot hope to scrutinise more than a small part of those services. This needs to be openly recognised. The slender resources available to O&S means there is a clear need to keep the flow of information to Members of manageable size, to concentrate on exception reporting, flagging of issues of possible concern, and to prioritise quite ruthlessly on where O&S should focus its efforts. The O&S work programme needs to be of manageable proportions for Members, and be more actively shaped and led by Members than has previously been the case. Members might consider prioritising three or four headings to be scrutinised over a two year period, and once finished, then move on to another set of priorities. We think that it would be good practice to redefine the activity after each high level work plan is completed, even if no changes are identified.
The Group recommends to the Health O&S Panel that a process be put in place to facilitate Members identifying and bring forth for scrutiny such matters as they deem appropriate and necessary, for the Panel to agree on one or two issues to focus on, and determine its work programme for each municipal year.

5.16 The CfPS has recommended that council scrutiny should consider establishing a range of 'triggers for action' using data and information to monitor trends. The Panel needs to receive a regular flow of relevant and timely information about the quality of NHS services provided to Bracknell Forest residents. This information should not come just from the NHS organisations themselves (as has usually been the case) but from a variety of relevant sources, in order to arrive at a well-informed and balanced viewpoint. That said, Members must not be buried in mountains of information. Instead, there should be a selective approach, which as mentioned above could be achieved by each Member specialising in one of the principal fields of NHS activity. Each Member, advised by the O&S officer, should decide what matters should be brought to the Panel's attention from their designated area, and they should each lead the Panel's questioning in their respective area. Examples of the information specialist Members would be expected to refer to the Panel would be the in-patient survey results and the GP Patient survey.
The Group recommends to the Health O&S Panel that individual Members work with the O&S Officer to receive and review a regular flow of relevant and timely information about the quality of NHS services provided to Bracknell Forest residents.

5.17 The Group considered the standardised mortality figures* in some detail, and we see some limitations in placing too much emphasis on them. For example, they are a single figure for a whole hospital and could mask a high mortality in some areas, and it is not readily possible to get useful breakdowns of the figures. We considered that the summary mortality information should be regularly reported to the Panel, but other information is needed too. This could include a periodic analysis of the numbers of all types of death in Bracknell Forest, using information from the Coroners Service.

Public Participation

5.18 The Council's published Values include the following statement: 'The Council exists to serve and lead the local community therefore residents are at the heart of everything we do. While serving residents we will be friendly and approachable - we will be open, listening and straightforward.' Furthermore, the Centre for Public Scrutiny (CfPS) has established four core principles to help people understand the most important activities of O&S, including that O&S, 'enables the voice and concerns of the public and its communities'. This forms part of the CfPS 'Good Scrutiny Guide'.

5.19 The Francis report said, *'It [O&S] made no attempt to solicit the views of the public. It had no procedure which would have encouraged Members of the public to come forward with their concerns…..It showed a remarkable lack of concern or even interest in the HSMR [Hospital Standardised Mortality Rate] data…..Scrutiny ought to involve more than the passive and unchallenging receipt of reports from the organisations scrutinised.'*

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* **Summary Hospital-level Mortality Indicator (SHMI)**

The SHMI is used for reporting mortality (i.e. deaths) at hospital trust level across England. It indicates where the mortality of a provider is higher or lower than expected when compared to the England average, given the characteristics of the patients treated. SHMI data is presented in two ways – as a ratio and as a banding.

Ratio
SHMI is calculated as a ratio of A:B , where **A** is the total number of patient admissions to the hospital which resulted in a death either in-hospital or within 30 days after the patient left the hospital, and **B** is the expected number of deaths based on the characteristics of the patients treated (for example patient's age, gender, and reason for admission to hospital)

The baseline value is 1 – a Trust would get 1 if the number of patient deaths were exactly the same as the number of patients expected to die (i.e. A = B)

Banding
A range is calculated within which a mortality rate is to be expected. A Trust's mortality rate is considered to be higher/lower than expected if it falls outside of this range. A Trust's mortality rate is judged to be outside of this range if it is 2 standard deviations away from the baseline of 1. Standard deviation measures how much spread there is within the data. A measure of 2 standard deviations will equal to the top and bottom 2.5% of the data and, therefore, represents the extreme ends of the spread of data.

Trusts have been banded into three categories, showing how their mortality compares to the average:
1 – where the trusts mortality rate is higher than expected
2 – where the trusts mortality rate is as expected
3 – where the trusts mortality rate is lower than expected

We noted that RBH and HWPT were currently in Band 2, and FPH was in the top Band 3.

Separately, the CfPS has recommended that Health O&S needs to monitor information about the patient experience, hearing about people's experiences of services, and the public should be given an opportunity to raise issues.

5.20 There is a public participation scheme for O&S at Bracknell Forest, but it has been accessed only rarely, and achieving greater public engagement with O&S is an elusive challenge for the majority of councils. There is an argument that the Public Participation scheme for O&S should be as accessible as that for the Health and Wellbeing Board (which only requires 15 minutes advance notice of questions before Board meetings).
The Group recommends to the O&S Commission and the Health O&S Panel that public engagement mechanisms are kept under review, with the underlying aim of learning about residents' healthcare concerns as directly as possible, and – in concert with Local Healthwatch - by giving the public a voice.

Wider Intelligence Gathering

5.21 Gaining a regular flow of relevant, but not excessive information, would also be assisted by the O&S officer scanning newly released reports by the NHS regulatory bodies, also piloting the use of internet alerts to summarily review media reports containing criticisms, of the NHS organisations selected for regular review. Members should also notify the O&S officer of any adverse media reports they become aware of. Also, the NHS Trusts identified for O&S coverage should be asked to notify the O&S Officer whenever they receive an 'outlier alert' (indicating materially sub-standard performance) from the Care Quality Commission. The O&S officer would then draw any issues of concern from these sources to the relevant 'Specialist Member' and Panel Chairman as appropriate, for them to determine whether, and if so how, to follow the matter up.
The Group recommends to the Health O&S Panel that this information gathering and dissemination process commences.

5.22 **The Group recommends to the Health O&S Panel that it should routinely receive at Panel meetings:**

a) **The summary information from the 'NHS Choices' website on Hospital Standardised Mortality Rate data, Friends and Family ratings, etc**
b) **Regular feedback from Local Healthwatch about any concerns they might have come across**
c) **Regular feedback from the Clinical Commissioning Group about any major concerns they have with the quality of services provided**
d) **Inpatient survey results**
e) **GP survey results**
f) **Any reports issued by the Care Quality Commission and MONITOR about the three hospitals, Ambulance Service and the BHT.**

Information on Patients' Complaints

5.23 Mr Francis recommended that: '*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.'*

5.24 The Working Group invested some time in research and in visiting two of the Trusts to learn about complaints systems and processes. There is a plethora of information on complaints and so the Panel should be discerning of what information would be useful. Whilst each NHS Trust follows the national regulations for NHS complaints, our research has shown that each Trust deals with complaints in a slightly different

way. We have seen an example of a serious complaint report, and we regard that to be too detailed for O&S purposes. Instead, the quarterly Patient Safety Report, published by each of the NHS Trusts for their Board meetings in public, provides good summary information to gain a good general impression of complaints 'traffic', and does not endanger individual confidentiality. The Specialist Member for this area should request any supplementary information that may be required and brought to the attention of the Health O&S Panel, for example, there may be an upsurge in one type of complaint and so more information may be required beyond the Patient Safety Report. Also a summary of the Ombudsman cases and other more serious complaints may be requested. The Specialist member should relay all relevant information to all Panel members and advise the Panel if it was felt that an issue was big enough and serious enough to warrant action to be taken. It would be beneficial if the specialist member monitoring the complaints, together with all specialist members could present a routine report on their area of speciality at every Overview & Scrutiny Panel meeting. The Panel should seek a regular flow of information from Local Healthwatch, who should relay any concerns that are relevant. Also the Panel should receive the quarterly and Annual report from SEAP (the Complaints Advocacy Service) as this information is at present only available through Local Healthwatch. **The Group recommends to the Health O&S Panel that all specialist members apply the processes above when considering complaints in their specialist areas.**

5.25 It appears that residents do not necessarily associate their ward members with local health issues and so **the Group recommends to the Health O&S Panel that all Members should be encouraged to outreach into their respective wards to relay properly prepared and approved health information and issues to residents living in their wards.**

<u>The Parliamentary and Health Services Ombudsman</u>

5.26 When people who complain are dissatisfied with the response they receive from an NHS Trust, they can take their complaint to the Parliamentary and Health Service Ombudsman (PHSO) for them to use their independent statutory powers to investigate. Following the clear direction from Francis to O&S on complaints, we therefore see it as important to establish an information flow from the PHSO to learn of the number of cases received and the outcome, particularly in terms of whether the Ombudsman had asked for further apology, compensation or other action to be taken by a Trust (sometimes termed a 'local settlement'). We approached the Ombudsman to seek such information and were disappointed to have had our request declined. Whilst there may be some confidentiality issues to address and resolve, we do not regard this to accord with the spirit of Francis, nor helping local authorities to fulfil their statutory duty to scrutinise the NHS, and it would be preferable for us to receive information on Ombudsman complaints directly from the PHSO rather than from the NHS Trusts.
The Group recommends that the Health O&S Panel ask the PHSO to reconsider the Council's request for information on complaints.

<u>Working With Partners</u>

5.27 Mr Francis said in his report: '*It [O&S] took no steps to consider the implications of the announcement of an investigation by the HCC [Health Care Commission] or to follow its progress.* And Mr Francis' recommendation no 47 was: '*The Care Quality Commission should expand its work with overview and scrutiny committees…… as a valuable information resource.'*

5.28 For Health O&S to operate well, we need to work with various organisations providing Health Services, and related regulatory and other bodies. The Group regards our relationships to be generally good and productive, but we consider that some improvements could be made:

(i) Local Healthwatch

We had a constructive meeting with 'Healthwatch Bracknell Forest' (HWBF) during the course of our review and the Panel is actively helping HWBF settle into its important, new role to champion patients' interests. We must continue to encourage Local Healthwatch to build and maintain regular contact with patients of the three hospitals, Ambulance Service and the BHT, and feed back any key concerns to the Panel. Local Healthwatch (LHW) was represented (though apparently not as a co-optee) at the Surrey Health O&S Committee meeting we attended. We believe this is entirely appropriate, to emphasise the important role of Local Healthwatch and to build/maintain good working relationships. Our Health O&S Panel has already acted on this by agreeing with HWBF that they should come to all Panel meetings as an Observer (not co-opted onto Panel Membership, as they have a statutory participative role in the Health and Wellbeing Board, which is an Executive function).
Recommendations: a) That the practice of having a Local Healthwatch Observer be formally recognised in the Health Overview & Scrutiny Panel Terms of Reference;
b) That the Panel obtains regular feedback from HWBF on their view of the complaints processes, trends and outcomes.
c) That Panel Members spread awareness of HWBF in their Ward work.

(ii) Councillors On Trust Boards, etc

Some Bracknell Forest councillors have places on NHS Trusts, sometimes as part of their constitutional arrangements. Examples are the Berkshire Healthcare NHS Foundation Trust, and a Governor position at the Heatherwood and Wexham Park NHS Foundation Trust. We are unaware of the full extent of these positions, and there is no regular contact between the Panel and those councillors on Trust Boards/Governing Bodies to collaborate and share information on activities. This is a missed opportunity, and the Council should ensure it takes up its full representation.
The Working Group recommends:

a) **That the Executive Member for Adult Services, Health and Housing carries out a stock take of all the Council's external positions on NHS bodies, and works with Members to ensure that all suitable opportunities are taken up.**
b) **That the Health O&S Panel maintains regular contact with those BFC councillors on Trust Boards/Governing Bodies, with the aim of working in concert with them to best represent the interests of our residents. This should include asking each councillor representative to report to the Panel at least once annually, subject to their trust boards' confidentiality rules.**

(iii) NHS Quality Accounts

All providers of NHS healthcare services in England, whether they are NHS bodies, private or third sector organisations must publish an annual Quality Account. Quality Accounts are annual reports to the public from providers of NHS healthcare services about the quality of services they provide. Healthcare providers publishing Quality Accounts have a legal duty to send their Quality Account to the O&S Committee (or Panel) in the local authority area in which the

provider has its registered office, inviting comments on the report from O&S prior to publication. This gives O&S the opportunity to review the information contained in the report and provide a statement on their view of what is reported. Providers are legally obliged to publish this statement (of less than 1000 words) as part of their Quality Account.
The Group recommends that the Health O&S Panel should invite input from all Members including the Executive Member, also the Director, and the Public Health Consultant before commenting on the annual Quality Accounts.

(iv) NHS Trusts

We should be very careful about making hospital visits, as patients might regard this to be an unwelcome intrusion. This is particularly the case where their dignity could be at risk, for example in Accident and Emergency. Instead, reliance should be placed on the hospital visits made by the CQC and Local Healthwatch. If, exceptionally, a hospital visit is made, this should always be by prior arrangement with hospital management, and be accompanied by them or one of their NHS professionals.

As part of the drive to get O&S better known and closer to residents, t**he Group recommends that the Health O&S Panel request each of the three hospitals, the Ambulance Service and the Berkshire Healthcare Trust to display on their website and PALS notice board a postcard summarising the role of O&S and welcoming views (but not individual complaints) from patients to the Health O&S Panel.**

(v) NHS Regulatory Bodies

We set out above how Health O&S should make better use of information from the Care Quality Commission (CQC) and MONITOR. A Member of our Group attended a CQC 'Listening Event' on 7 November to hear at first hand the views of patients about their experience as patients at Frimley Park Hospital, and this helped get us much closer to seeing things from the patients' point of view.
The Group recommends that the Health O&S Panel specialist members concerned should maintain contact with the local CQC Manager, and attend any CQC 'Listening Events' with patients of the three hospitals and Berkshire Healthcare Trust in advance of their inspections. The Panel's specialist member should also actively engage in the CQC 'Quality Summits' for the Trusts we are focussing on.

(vi) Centre for Public Scrutiny

The Group appreciated the advice of the CfPS Health Scrutiny Advisor at the outset of our review, and we think the improvements this report seeks to achieve would be of interest to other councils' Health O&S organisations. **Recommendation: That the Working Group's report be sent, together with our thanks to their representative for her input, to the Centre for Public Scrutiny for sharing widely.**

Improving The Running of Panel Meetings

5.29 The Group consider that some improvements can and should be made to the conduct of meetings, and **our recommendations to the Health O&S Panel are**:

(i) Collectively Planning Ahead and Taking Stock of Progress

The agenda-setting meetings should be held 6 weeks before each panel meeting and be open to all Panel Members, and expanded to:

- provide an opportunity for a de-brief on the previous Panel meeting, and
- be a forum for general discussion on health O&S priorities and progress.

In setting agendas for meetings, there is a clear need for keener prioritisation, including turning down some of the requests by the NHS to address the Panel on issues which the Panel does not see as its priorities.

(ii) Preparation for meetings

Preparation for Panel meetings has benefitted from pre-meetings, which should continue, but there is still a lot more to do, both collectively and by individual Members, if best value is to be obtained from Panel meetings. On our visit to Surrey Council's Health O&S Committee, we observed that the members were evidently well prepared, and they all participated well in the meeting, asking good quality questions. BFC Members need to ensure they are fully briefed and prepared, and be confident to ask challenging questions, seeking advice from the O&S and departmental officers as necessary.

As a matter of routine, any presentations to be delivered should be circulated to members at least a few days in advance, to allow them to prepare for meetings well.

(iii) Summing Up Discussions

The Panel Chairman has recognised the need to arrive at a clear conclusion at the end of each agenda item, ideally ending with a voted motion, possibly containing a recommendation. Inconclusive meetings are of limited value, and this discipline should continue.

(iv) Official Record of Health O&S Panel Meetings

Mr Francis said, '*It has been far from easy to determine [what scrutiny activity was carried out]… as the minutes… are brief to the point of being uninformative: they register that a topic was discussed and summarise presentations made …… but there is no summary of the debate….. In many cases, the decision was often merely to "note" a presentation. It was widely accepted by witnesses that this style of minute taking was inadequate'.*
Officers have revised the format of our Health O&S Panel minutes in line with the Francis criticism, to more comprehensively record the questions raised and the answers received. No objections have been raised to the improved format, which should continue.

(v) Proper Follow-up to Panel meetings

Health O&S Panel Members should be reminded that follow-up questions can be sent in writing as necessary, after Panel meetings.
In our visit to Surrey, we observed that there is a regular agenda item on 'action tracking' (systematically following matters up, including previous recommendations). Subject to resources being available, this would be a good addition to the Health O&S Panel's procedures.

Resourcing the Recommended changes to Health O&S

5.30 Mr Francis recommended in his report that, '*Scrutiny Committees should be provided with appropriate support to enable them to carry out their scrutiny role*' (recommendation 149).

Member Resources

5.31 Implementing the Group's recommendations would add noticeably to the time demands on Members. **The Panel should not agree to the recommendations in this report unless all its Members are personally committed to putting in the time to deliver what is recommended as new responsibilities.**

Officer Resources

5.32 Implementing the Group's recommendations would also add noticeably to the time demands on officers. The Panel currently has around 0.3 full-time equivalent of an O&S Officer to support its work. By contrast, we observed that Surrey Council had two officers supporting Health O&S, however the two are not directly comparable: it is possible they have other duties; besides the Health O&S responsibilities for Surrey are more numerous than for Bracknell Forest. We must also recognise that the recommendation regarding member training would be a significant new demand on officers in the Adult Social Care, Health and Housing Department too. Pending experience of the actual resource implications, it is vital that we grasp this nettle either we may need to increase/divert resources, or openly acknowledge that we will not be able to implement all the learning points from Francis.

Our priority is - through scrutiny – to ensure that good health services are delivered to our residents. **The Group recommends that the Health O&S Panel, in consultation with the O&S Commission decides how to meet these new demands on officer time. One possible solution could be to not implement the more resource-intensive of our recommendations (e.g. recruiting and maintaining a panel of expert advisors; information gathering for the specialist member; and action tracking).**

If no option is taken up, it would be unfair and unrealistic to ask our existing officer resource - which is already hard-pressed - to just accommodate these extensive new demands, so there could be no expectation that our recommended improvements could be implemented.

Applying the lessons of this review to other O&S Panels

5.33 The Group is confident that adopting the recommended improvements in this report will make Health scrutiny more robust and effective when monitoring the actions of the NHS Trusts that serve the residents of Bracknell Forest. By gathering and scrutinising information from a number of different sources the Panel will be in a strong position to act and advise if action is deemed necessary. We also believe that many of the improvements envisaged for Health O&S could be applicable to the conduct of O&S by the O&S Commission and other O&S Panels. For example, other Panels could benefit by considering whether they should obtain corresponding information on complaints to obtain a better understanding of the service user's perspective.

The Group recommends that the O&S Commission and Panels consider reviewing the scope for replicating the improvements to Health O&S throughout the Council's O&S function.

Glossary

A&E	Accident and Emergency
BHT	Berkshire Healthcare Foundation Trust
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CfPS	Centre for Public Scrutiny
DoH	Department of Health
FPH	Frimley Park Hospital NHS Foundation Trust
GP	General Practitioner
H&WBBd	Health and Wellbeing Board
H&WPT	Heatherwood & Wexham Park Hospitals NHS Foundation Trust
HOSC/P	Health O&S Committee/Panel
HWBF	Healthwatch Bracknell Forest
HWE	Healthwatch England
LHW	Local Healthwatch
LINk	Local Involvement Network
O&S	Overview and Scrutiny
PALS	Patient Advice and Liaison Service
PHSO	Parliamentary and Health Service Ombudsman
RBH	The Royal Berkshire (Hospital) NHS Foundation Trust
SCAS	South Central Ambulance Service NHS Foundation Trust
SEAP	Support Empower Advocate Promote
SMHI	Summary Hospital-level Mortality Indicator
'The Group'	The Working Group of the Health Overview and Scrutiny Panel

APPENDIX 1

BRACKNELL FOREST COUNCIL

HEALTH OVERVIEW AND SCRUTINY PANEL
MAY 2013

WORK PROGRAMME 2013 – 2014

Terms of Reference for

FRANCIS REPORT - OVERVIEW AND SCRUTINY WORKING GROUP

Purpose of this Working Group / anticipated value of its work:

1.	Review the comments regarding Health O&S practices in the report by Mr Francis on the failings surrounding the Mid Staffordshire NHS Hospital
2.	Recommend to the Panel what improvements are needed to the Health O&S practices at Bracknell Forest in the light of Mr Francis' report
3.	Participate in the workshop for key partner organisations run by the Health and Wellbeing Board, regarding Francis
4.	Review the steps being taken to implement the lessons of the Francis report by those principal NHS organisations serving Bracknell Forest residents.

Key Objectives:

1.	To thoroughly review the weaknesses in O&S highlighted by Francis, showing that Bracknell Forest Council has responded properly to the lessons it offers
2.	To determine the type and frequency of information (particularly on complaints) needed from which NHS organisations serving Bracknell Forest residents
3.	To re-appraise Members' health O&S role, and identify how to improve their effectiveness (to Include training, advice and support)
4.	To identify improvements to Health O&S practices, including prioritisation and the summing up and minuting of Health O&S Panel meetings

Scope of the work:

1.	The implications for Health O&S arising from the report by Mr Francis of the failings at Mid Staffordshire hospital

Not included in the scope:

1.	Care must be taken not to over-step the role of O&S into – for example - Local Healthwatch's role
2.	Anything outside the Francis report and its immediate implications

Terms of Reference prepared by: R M Beaumont

Terms of Reference agreed by: The Working Group

Working Group structure: Councillors Baily, Finch, Heydon, Kensall, Mrs McCracken, Mrs Temperton, and Virgo.

Working Group Lead Member: Councillor Mrs McCracken

Portfolio Holder: Councillor Birch, Executive Member for Adult Services, Health and Housing

BACKGROUND:

1. The Francis Inquiry followed a series of investigations and reports, including an investigation by the Healthcare Commission in 2009 and an independent inquiry also conducted by Robert Francis QC. The failings at Stafford Hospital have been well reported in the media. The number of excess deaths between 2005 and 2008 is estimated at 492 people. Examples of poor care include 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 such as people left naked in a public ward, and triage in A&E undertaken by untrained staff. The report describes the failings as a 'disaster' and 'one of the worst examples of bad quality service delivery imaginable'.

2. In the Government's initial response to the Francis report, the Secretary of State for Health said in March 2013: *'The report of the Mid Staffordshire NHS Foundation Trust Public Inquiry makes horrifying reading. At every level, individuals and organisations let down the patients and families that they were there to care for and protect. A toxic culture was allowed to develop unchecked which fostered the normalisation of cruelty and the victimisation of those brave enough to speak up. For far too long, warning signs were not seen, ignored or dismissed. Regulators, commissioners, the Strategic Health Authority, the professional bodies and the Department of Health did not identify problems early enough, or, when they were clear, take swift action to tackle poor care. They failed to act together in the interests of patients. This was a systemic failure of the most shocking kind, and a betrayal of the core values of the health service as set out in the NHS Constitution. We must never allow this to happen again.'*

3. The Francis Inquiry 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 – including the Health Overview and Scrutiny Committees of both the County and District councils concerned - to respond to concerns. The report indicated that this should not be regarded as a one-off event that could not be repeated elsewhere in the NHS.

4. The Inquiry looked at the hospital itself and the roles of the main organisations with an oversight role; it made 290 detailed recommendations. Many respondents to the inquiry indicated that they were not aware of the extent of the problems at the hospital and that failings had not been brought to their attention. The report disagrees with this stance, indicating that clear warning signs were available.

5. At its meeting on 18 April 2013, the Health O&S Panel decided to commence a Working Group with the broad purposes to:

    - recommend to the Panel what changes are needed to the Health O&S practices at Bracknell Forest;

- participate in the workshop envisaged by the Health and Wellbeing Board;
- review the steps being taken to implement the lessons of the Francis report by those NHS organisations serving Bracknell Forest residents.

SPECIFIC QUESTIONS FOR THE PANEL TO ADDRESS:

1.	Which NHS Trusts are to be scrutinised*, and what information is needed from them?
2.	What follow-up action on Francis is being taken by the Health scrutiny committees of the local authorities where the trusts are based?
3.	What should the scope and objectives of Health scrutiny in Bracknell Forest be, and what is the role and contribution of councillors to that?
4.	Are there wider lessons for O&S beyond Health O&S, particularly on gaining a better understanding of residents' experience of using council services?

INFORMATION GATHERING:

Witnesses to be invited

Name	Organisation/Position	Reason for Inviting
Representative	Centre for Public Scrutiny	To learn about best practice in O&S follow-up to Francis
Representatives	NHS Trusts principally serving Bracknell Forest residents	To review how they are applying the lessons from Francis
Cllr Dale Birch	Executive Member	To discuss his priorities from Francis, and the conclusions of the review
Glyn Jones	Director, Adult Social Care, Health and Housing	To discuss officer support. Link Officer for review.
Representative	Local Healthwatch	To ensure O&S and LHW roles are complementary

Site Visits

Location	Purpose of visit
Surrey County Council	Lead Member and Panel Chairman to join in discussion with Surrey CC O&S Members to see if a partnership approach is feasible to the O&S approach to Frimley Park Hospital
Possibly 3-4 Hospital sites	To possibly meet PALS complaints teams to understand their role and the flow of information?

Key Documents / Background Data / Research

1.	Report by Mr Francis QC on the failings of the Mid Staffordshire Hospital

TIMESCALE

* Now determined by the Working Group to be: Heatherwood & Wexham Park, Frimley Park, the Royal Berkshire, and South Central Ambulance Service. Views will also be sought from the Clinical Commissioning Group.

Starting: May 2013 Ending: November 2013 (this might extend to January 2014)

OUTPUTS TO BE PRODUCED

1. A report to the Health O&S Panel with the Working Group's recommendations for improvements
2. A clear commitment by the principal NHS Trusts to future information flows.
3. Relationship building with Local Healthwatch

REPORTING ARRANGEMENTS

Body	Date
Health Overview and Scrutiny Panel	12 December 2013

MONITORING / FEEDBACK ARRANGEMENTS

Body	Details	Date
Health Overview and Scrutiny Panel	Progress reports to each Panel meeting	11 July 2013 and subsequently
Health and Wellbeing Board	To advise the Board of the review's commencement, and – in due course – its conclusions	TBC

For further information on the work of Overview and Scrutiny in Bracknell Forest, please visit our website on http://www.bracknell-forest.gov.uk/scrutiny or contact us at:

Overview and Scrutiny, Chief Executive's Office, Bracknell Forest Council, Easthampstead House, Town Square, Bracknell, Berkshire, RG12 1AQ,
or email us at overview.scrutiny@bracknell-forest.gov.uk
or telephone the O&S Officer team on 01344 352283

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