



Centre for Public Scrutiny

Review of Leicester City Council Health and Wellbeing Scrutiny Commission

Summary

This report has been produced by the Centre for Public Scrutiny (CfPS) at the request of Leicester City Council's Health and Wellbeing Commission (the Scrutiny Commission). It outlines a review of the methods of working and the skills of the Members of the Council's Health and Wellbeing Scrutiny Commission in response to the recommendations of the Francis Inquiry. The review was undertaken between September and December 2013.

The report makes a series of recommendations to Leicester City Council in response to the Francis Inquiry and best practice in health scrutiny. The recommendations aim to improve the effectiveness of the Scrutiny Commission and to ensure that it is fit for purpose in the current climate of economic and resource pressures within the public sector. The recommendations focus on:

- Improved public and community involvement
- Clarification of relationships
- Effective prioritisation of issues to scrutinise
- Member skills development

CfPS looks forward to working with the Scrutiny Commission to develop and sustain its effectiveness.

Background

The report by Robert Francis QC into the serious failings of care at Mid Staffordshire NHS Foundation Trust was published on 6 February 2013. Whilst the report attributed accountability for the failures at the Trust to the Trust Board, it also identified a systematic failure by a range of national and local organisations to respond to concerns about patient care. This included identifying the role of scrutiny locally and failings in how scrutiny had been undertaken. The recommendations from the Inquiry to the Secretary of State included some that were directly related to overview and scrutiny committees.

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

- 119 - 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 respect for patient confidentiality.
- 147 - Guidance should be given to promote the co-ordination and co-operation between local Healthwatch, Health and Wellbeing Boards, and local government scrutiny committees.
- 149 - Scrutiny committees should be provided with appropriate support to enable them to carry out their scrutiny role, including easily accessible guidance and benchmarks.
- 150 - Scrutiny committees should have powers to inspect providers rather than relying on local patient involvement structures to carry out this role, or should actively work with those structures to trigger and follow up inspections where appropriate rather than receiving reports without comment or suggestion for action.

The Francis Report also highlighted what can go wrong when patients, their families and the public struggle to have their voices heard. Council scrutiny has a key role to play in the participation of patients and the public in health service provision and in strengthening their voice. It needs to establish ways to monitor data or information about the experiences of people who use health and care services, alongside 'triggers to act' when things seem to be going wrong. It should not duplicate what others are doing but should maintain a wide network of intelligence so that it can use its powers effectively to hold the NHS account - having a clear understanding about the quality, safety and value of healthcare services and challenging providers and commissioners when it seems that good outcomes elsewhere are not being matched locally.

All NHS bodies were required to produce action plans in response to the Francis report by the end of December 2013. These may provide scrutineers with information about how health services are adapting practice in response to the lessons learnt. All local authorities are also encouraged to consider the issues identified in the Francis report and whether there is a need to change their scrutiny practice to ensure effectiveness. Leicester City Council is therefore committed to ensuring that its health scrutiny provisions are fit for purpose now and in the future.

Methodology

The methodology of the review was agreed between the CfPS and Leicester City Council as follows:

- Discussion with the Chair and Members of the Commission
- Desk research considering the terms of reference and processes of the Commission
- 360⁰ Feedback to be sought from key local stakeholder organisations
- Training and development needs self-assessment by members of the Commission
- Observation of a Commission meeting

It was agreed that the review report would make recommendations based on the insight gained from these activities.

Outcomes from review activity

i. Desk research and discussion with Chair and Members of the Commission

The research undertaken has identified the need to clarify and promote the role and principles of the Health and Wellbeing Scrutiny Commission. There is evidence that the public, some members of the voluntary and community sectors, independent and NHS providers, and other organisations may not understand the role of health scrutiny especially with the new arrangements. At a development meeting facilitated by CfPS, Commission Members agreed with the four principles of effective scrutiny, i.e.

- To provide a critical friend challenge to the executive policy makers and decision makers;
- To enable the voice and concerns of the public and communities to be heard;
- To carry out scrutiny by 'independent minded governors' who lead and own the scrutiny process;
- To drive improvements in services and find efficiencies.

The Members added two further local principles:-

- To prevent duplication of effort and resources;
- To seek assurances of quality from stakeholders and providers of services.

It was suggested that these might be included in the 'information for members of the public' section of Commission agendas.

Members of the Scrutiny Commission acknowledge their difficulties in prioritising issues for scrutiny. This appears to lead to long agendas and insufficient time to consider issues in detail. No evidence was identified of applying tools or recognised assessment methods to set priorities. For example, it is not current practice for the Commission to base its priorities on the main causes of death, ill health or health inequalities as identified by the local Director of Public Health or to assess where scrutiny can have most influence. Similarly, the Commission has not considered its potential role in looking at what changes are needed in the provision of health services due to population change in the future. The Chair and Members of the Commission have, however, developed a close working relationship with the local authority Public Health service and recognise the value that public health data may provide to priority setting and question development.

The research indicates that relationship between the Commission and Leicestershire County Council and Rutland Council has been relatively dormant in the past 12 months. The previous joint committee hasn't met recently and there have been no informal meetings between Chairs, although support officers do have regular email and telephone contact with each other. Members of the Commission stated that there were merits and economies in undertaking joint scrutiny with the Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee to avoid duplication on

major topics of interest where health trusts wished to consult all three Councils. By having one discussion at a Joint Scrutiny Committee instead of a trust visiting all three local authorities could be beneficial to all concerned. It was suggested that a shared protocol might enable the re-establishment of joint working and could take into account the resource pressures experienced by all three local authorities.

The research undertaken indicates that the Scrutiny Commission does monitor local media reports, as referred to in recommendation 43 from the Francis Enquiry, and that information about local health services that is gleaned from the media is used to inform discussions in meetings and less formally with NHS representatives.

No evidence was found that the Scrutiny Commission had applied any available guidance to promote the co-ordination and co-operation between local Healthwatch, Health and Wellbeing Boards and its role. Whilst the long awaited national guidance for health scrutiny had not been published at the time of the research or the drafting of this report, guidance has been produced by CfPS which Leicester City Council and Leicester Healthwatch might find helpful in clarifying roles and building relationships. This is addressed further in the recommendations section.

ii. 360⁰ feedback from partners and stakeholders

Feedback was invited from a number key stakeholders who have interacted with Leicester City Council's scrutiny functions in the past 12 months. A list of stakeholders contacted is attached as Appendix A. No attempt was made to contact either NHS England or the Care Quality Commission as CfPS was advised that there had been no contact between them and the Scrutiny Commission in the past year. The recommendations from the Francis Inquiry have led to changes in practice for both CQC and NHS England at a local level, resulting in changes to the CQC inspection methodology and the implementation of Quality Accounts by local NHS trusts and establishment of Quality Surveillance Groups by local area teams within NHS England. We would encourage the Scrutiny Commission to build relationships with CQC and NHS England to share insight and intelligence and to help the Scrutiny Commission to gain a clear picture of the state of health services within Leicester. It would be particularly beneficial for the Scrutiny Commission to develop a relationship with the local Quality Surveillance Group which will identify issues of concern with local services.

The feedback was collected using a standard telephone questionnaire and focussed on asking for information about the relationship between the organisation and the Scrutiny Commission, comments about their perception of the effectiveness of scrutiny, and up to 3 suggestions of actions that could improve scrutiny in Leicester City in the light of the Francis Report.

Common themes identified were:

- ✓ the strength of leadership provided by the current Chair;

- ✓ the respect and realism that the Scrutiny Commission provides to NHS organisations;
- ✓ the benefits of regular informal liaison between the Chair and NHS organisations which helps to create a 'no surprises' culture;
- ✓ some NHS participants stated that they were confused about the relationship between the Health and Wellbeing Board and the Scrutiny Commission and would welcome greater clarity;
- ✓ interest was expressed by the majority of respondents in participating in discussions to develop the Scrutiny Commission's work plan and in identifying priorities and timescales for scrutiny.

The main recommendations received from stakeholders were:

- to make use of the opportunity to take an overview of issues and see them within a wider context, e.g. to see winter planning issues within the wider Urgent Care agenda, and then scrutinise the issues of concern;
- the need to re-establish the joint committee with Leicestershire County Council and Rutland Council and ensure better liaison and joint scrutiny of services across all three authorities;
- the need for more sustained engagement with the local voluntary and community organisations, especially in priority and agenda setting;
- the need for more engagement of all Members of the Commission in scrutiny to enable the process to be led by the Scrutiny Commission as a whole;
- to work with partners to ensure there is a clearer understanding across organisations of the relationship between the CCG, Health and Wellbeing Board and Scrutiny Commission.

iii. Development needs self-assessment

Members of the Scrutiny Commission were invited to complete a self-assessment form aimed at identifying their development or training needs in 3 areas:

- a) Community leadership
- b) Knowledge
- c) Scrutiny and challenge

Five completed forms were received and analysed. The outcomes identified similar areas for development.

a) *Community leadership*

All respondents were comfortable in taking a community leadership role in scrutiny of health and wellbeing issues and identified a level of confidence requiring no further training or development. However, it was suggested by one respondent that it would be helpful to have a development

session for the current Scrutiny Commission Members to refresh their skills in this area. It was also suggested that every year the new Scrutiny Commission should attend training that included explaining the community leadership role.

b) Knowledge

All respondents recognised the challenges in understanding the new health and social care landscape and identified the need for training on understanding structures and relationships between organisations nationally, regionally and locally. Particular concern was highlighted about the need for more understanding about Healthwatch, the Health and Wellbeing Board, and the Clinical Commissioning Group and their relationships with the role of the Scrutiny Commission.

c) Scrutiny and challenge

Not all respondents identified the need for training or development around the competencies identified within the 'scrutiny and challenge' section. However, the majority asked for support in developing presentation skills and in improving their questioning and probing skills. There was also some identification that Members required training on the local priorities to address health inequalities and health improvement.

iv. Meeting observation

The aims for observing a meeting were as follows:

- a) To understand how a member of the public attending a meeting would perceive how scrutiny was undertaken;
- b) To consider the process of scrutiny and how local issues were scrutinised;
- c) To gather data about how Members of the Scrutiny Commission interact with each other and with witnesses;
- d) To observe the questioning skills;
- e) To consider how effective the scrutiny process is at holding local NHS bodies to account.

A summary of the observation is attached as Appendix B.

The observation demonstrated that NHS stakeholders took the role of the Scrutiny Commission seriously and are prepared to actively participate in its work by fielding senior members of staff and through attendance by Chairs and Non-Executive Directors where considered appropriate. However, at times this may result in more NHS attendees than is required by the Scrutiny Commission resulting in more of a discussion amongst peers than scrutiny holding to account. It was clear that there was a longstanding relationship between some NHS representatives and some Commission Members which might at times seem more 'friendly' than challenging.

The agenda was very long (204 pages) with 7 agenda items and 9 additional update reports from a previous meeting. The meeting that was observed in part lasted for 3.5 hours. This suggests Commission may be trying to address too many issues in one meeting and would benefit from looking at models for prioritising its workload and different methods of scrutiny, such as mini scrutiny or 'scrutiny in a day'.

Whilst Healthwatch representatives are invited to participate as members of the Scrutiny Commission, there appears to be no additional input from the public or voluntary and community sector organisations in either the meeting or agenda setting process. This might be considered as a way to identify issues of local importance and their relative priority.

The meeting room was not set out to enable a member of the public with no local government experience to gain a clear understanding of the scrutiny process and at times members of the public would have been unable to hear the ongoing discussions and strength of questioning.

Conclusions

The review has identified both clear strengths within the Scrutiny Commission and themes for development. Most were identified by both the members of the Commission and the local stakeholders and there is a strong level of consensus.

Strengths of current practice include:

- ✓ the consistent and clear leadership by the Chair
- ✓ the apolitical approach to scrutiny that focuses on issues for local people rather than political issues
- ✓ the diversity of skills and expertise of the different members of the Scrutiny Commission
- ✓ the provision of dedicated officer support
- ✓ the commitment to working with NHS bodies and stakeholders

Areas for development include:

- the need for clarification about relationships with other parts of the local authority especially the Health and Wellbeing Board
- the length of the agenda, which may restrict the effective scrutiny of issues of importance
- the need for stronger engagement in the scrutiny process of all Scrutiny Commission members, to scrutinise as a group rather than as individuals
- the need to make use of local data, including public health data, and insight from local people to set priorities.

Recommendations

The following recommendations aim to address the issues raised through the review and to ensure that the Scrutiny Commission is fit for purpose in response to the Francis Inquiry.

a) Improving practice

Community Leadership

- the Commission needs to find a way to reduce the length of agenda's and maximise the time in meetings spent on scrutiny whilst still ensuring that Members have adequate information. Some other authorities provide information in the form of written briefings, whilst others provide short, verbal briefings organised at a time when councillors are available to attend and open to all Members;
- include the principles of effective scrutiny agreed by the Scrutiny Commission in the 'information for members of the public' section of agendas, to enable anyone observing or attending meetings to be clear about its role;
- clearly inform witnesses and stakeholders invited to attend Scrutiny Commission meetings why they are being invited and who should attend. If more representatives turn up, limit the number who are able to participate so that the discussions remain focussed on the issues identified by the Commission;
- develop and implement a consistent approach to prioritising items in the work plan and agendas. There are different approaches that might be used, e.g. identifying annual priorities based on public health data or local concerns, or both, or assessing issues against a set of criteria;
- consider using different approaches to scrutiny of different issues, e.g. appreciative inquiry, mini scrutiny and the CfPS Return on Investment models.

Involving and listening to local people

- Undertake further discussions with Healthwatch and Leicester Voluntary Action representatives about building local concerns into the work of the Scrutiny Commission. This might include looking at how service users views can be incorporated into the beginning of reviews, which is a practice used in some other authorities.
- It is recommended that the Scrutiny Commission considers building an opportunity for members of the public to ask questions at its meeting. Some local authorities have effectively enabled this through incorporating a 'question time' session within their agendas in addition to dealing with petitions. The inclusion of questions has been agreed with local NHS bodies so that the questions may be asked of the NHS representatives as well as the

Scrutiny Commission. This would enable Members of the Scrutiny Commission to hear some of the public's views.

Questioning and Listening

- Make more effective use of pre-meeting by considering reports, identifying lines of inquiry and key areas for questioning, and discussing how questions may be articulated. Use the review meeting to reflect on what went well and what could be improved in the future.
- Develop an approach to 'active listening' to what local people are telling individual councillors and the committee, to what anonymised complaints data shows, and to the stakeholders that present at meetings or act as witnesses.
- Work more effectively as a 'team' rather than as individuals in questioning and probing witnesses.

b) Working with other stakeholders

- The review highlighted that the Scrutiny Commission has not yet developed a working relationship with NHS England or the Care Quality Commission. This should be addressed and consideration given to the role of scrutiny in relation to Quality Surveillance Groups organised by the local area team of NHS England and to the new approaches to CQC inspection and implications locally. The Scrutiny Commission may also want to scrutinise services commissioned by NHS England such as community primary care services (including dental health) and specialised services.
- We recognise that establishing processes for joint working and joint committees can be challenging. However some issues need to be scrutinised jointly. It is recommended that the Scrutiny Commission reviews the experience of joint scrutiny with Leicestershire County Council and Rutland Council and establishes a joint protocol that establishes processes for stronger and more effective joint scrutiny before it is required.
- In response to the confusion amongst stakeholders that was identified in the 360⁰ feedback, we recommend that Leicester City Council develops a common understanding between the Health and Wellbeing Board and the Health and Wellbeing Scrutiny Commission about roles and how each adds value and influence.
- We recommend that an annual work programme event is held that involves the voluntary, community and advocacy sectors to help inform the Scrutiny Commission about the state of health and health services in Leicester. This might take the form of an inquiry day or form part of a development session for Members.
- Build the use of local public health data, such as health inequalities into priority setting and approaches to questioning.

c) Member development

- It is recommended that one or more development sessions are held, open to all councillors, to present and discuss local public health data and priorities.
- Organise a development day for the existing Scrutiny Commission members to include, an overview of the NHS system, prioritisation skills, training on questioning and active listening skills and to look at how scrutiny in meetings can be outcome focussed.
- Recommend that there is mandatory training for all new health scrutiny councillors that includes how the system works, questioning skills, active listening, and how the Scrutiny Commission relates to other systems of accountability.
- Hold a development session for members of the Scrutiny Commission to discuss the implementation and implications of national guidance soon after it has been published.

It is recommended that Leicester City Council considers reviewing progress in the implementation of these recommendations twelve months after the acceptance of this report.

**Centre for Public Scrutiny
December 2013**

Appendix A

List of Stakeholders invited to provide 360⁰ feedback

Health and Wellbeing Board (Executive), Leicester City Council

Adult Social Care Scrutiny Commission, Leicester City Council

Public Health Department Leicester City Council

Partner authorities in the Joint Health Scrutiny Committee (Leicestershire County Council and Rutland Council)

Leicestershire University Hospitals NHS Trust

Leicestershire Partnership NHS Trust

Leicester City Clinical Commissioning Group

Local Healthwatch

Leicester University

Voluntary Action Leicester

Appendix B

Summary of meeting observation 18 November 2013

These notes summarise the outcomes of an observation exercise carried out on the first 2 hrs 15 minutes of the meeting of Leicester City Council Health and Wellbeing Commission on 18 November 2013. The observation focussed on the following four areas:

- Accessibility of the meeting and its content to members of the public
- Provision of information and focused agenda
- Questioning skills of Members of the Commission
- Evidence of influencing health outcomes

1. *Accessibility to the public*

- The room was physically accessible and well lit
- There was no clear area for the public to be seated. Room set out with board room style table in the centre and sofa's against the walls. It was therefore unclear whether people sitting on the sofa's were members of the public or witnesses/presenters waiting to be called to the meeting at the table.
- The room acoustics were not good from the sofa without Members using microphones. Although microphones were provided not all speakers initially used them. Part way through the meeting the microphones started to pick up discussion from a meeting in another room so a decision had to be taken not to use them. This resulted in the observer being unable to hear some of the discussions.
- No indication whether an audio loop was provided was observed although the agenda does state that one was available.
- Copies of the agenda were available from the Democratic Services Officer. The agenda was 204 pages long and an additional item was added as representatives from the NHS attended resulting in a very long meeting.
- Speakers/witnesses were not always introduced and asked to speak clearly.
- The aims and functions of the committee were not explained at the beginning of the meeting and not included in the information for members of the public in the agenda.

2. *Agenda*

- The agenda was extremely long and could not be taken chronologically so at times became confusing.
- Some NHS organisations were represented by 3 or 4 witnesses who all wanted to participate in discussions. This increased the length of discussions that might have been dealt with more succinctly with less NHS participants.

3. *Questioning*

- Not all Members of the Commission actively participated in questioning.
- Some good strong questions that demonstrated Members as community leaders were asked. More follow up probing could have been undertaken.
- Some questions were prefaced by long statements which deflected the focus from the question asked. If the questions had been asked in a more focussed and succinct manner they might have had more impact and also made more effective use of the time available.

- It would be helpful to summarise the issues raised and actions expected at the end of each discussion.

4. ***Evidence of Influence***

- The level of seniority from NHS organisations attending the meeting might be seen as an indicator for how the role of the Commission is valued but not as a level of influence.
- It was clear that some of the questions made participants uncomfortable, especially about statistics, and that there was a likelihood that the Trust would look more closely at the issues raised and return to the Commission with more information.
- No evidence was shown from the discussion about oral health promotion about how the Commission's work might influence the improvement of oral health in Leicester.