AGENDA ITEM

REPORT TO EXECUTIVE

SCRUTINY COMMITTEE

5 JULY 2013

REPORT OF DIRECTOR

OF LAW AND DEMOCRACY

ADULT SERVICES AND HEALTH SCRUTINY – IMPROVED APPROACH TO MONITORING QUALITY (INCLUDING RESPONSE TO THE FRANCIS INQUIRY)

SUMMARY

The arrangements for quality assurance, and specifically the role of the Adult Services and Health (ASH) Select Committee, have been reviewed in light of public concern, national guidance and inquiries, and the impact of the health reforms. This report summarises work to date and outlines areas for improvement. It also includes the response of the health scrutiny function to the relevant recommendations of the Francis Inquiry into the failure of care at Mid-Staffordshire NHS Foundation Trust.

RECOMMENDATIONS

Executive Scrutiny Committee are recommended to comment on and endorse the revised approach to monitoring the quality of local services as outlined at Appendix 1, including the response of the health scrutiny function in relation to the relevant recommendations of the Francis Inquiry.

DETAIL

1. The closely linked issues of dignity, quality of care and protection from abuse in adult and health services have been regularly in the spotlight in recent years. Nationally, there have been a number of developments including high profile public cases that have highlighted major failures to provide basic care, some cases of abuse, and concerns about the potential impact of efficiency targets on the quality of care. There is a renewed emphasis on outcomes and the quality of care in the commissioning of services, and safeguarding of vulnerable adults has become increasingly important.

2. In addition, there has been considerable change in the health sector involving changes associated with the recent NHS reforms and increased local authority involvement in the planning of health services. The independent role of scrutiny provides an opportunity to add value to these new arrangements by providing an added level of challenge and assurance.

National cases

3. A number of high profile cases have brought some of these issues into sharper focus and there is a need to learn from their outcomes. The situation at Mid Staffordshire

NHS Foundation Trust has been the subject of two major inquiries. The second and most recent Public Inquiry (the 'Francis Inquiry') concentrated on the role of the commissioning, supervisory, and regulatory regime overseeing Mid-Staffs Trust. This reported in February 2013. The Francis Inquiry looked at the role of overview and scrutiny committees (OSCs) in more detail and made recommendations, after taking evidence including from Stafford and Staffordshire Councils.

4. Members will also be aware of the Winterbourne View scandal, which prompted a national review by the Care Quality Commission (CQC), and there have been concerns about the quality of home care, which also prompted a national review.

5. These are examples of where care has failed and the large scale national response that followed. Within this context, the challenge is to ensure that locally there are processes in place to monitor quality and safety to achieve a high level of assurance for Members.

Local Response

6. As well as responding to the specific recommendations from the Francis Report, there is scope for general improvement and increased clarity of responsibility locally, both in terms of how health scrutiny operates in and outside of the Council, and in conjunction with new partners in the health system.

7. The wider context for suggested improvements is the increased powers for health scrutiny, particularly its ability to require attendance at committee from any provider of NHS funded services (public sector or otherwise), and the need to make best use of an independent scrutiny function that is complementary to the new bodies set up as part of NHS reform, but which is proportionate in its actions.

8. Stockton's Health Scrutiny function has established a good working relationship with local health commissioners and providers, and this will provide a sound platform for future work.

Francis Report Recommendations

9. The Francis Report makes a number of recommendations aimed directly at health scrutiny functions, together with a number of other recommendations for other bodies which also have relevance. The Report focuses its criticism on the lack of a caring culture within the Trust, the focus on financial matters to the detriment of ensuring patient safety and quality services, and the failure of the regulatory and oversight system as a whole.

10. The Francis Report discusses the clarity of roles between the District and County councils, role of other partner agencies including LINk (nb. this role has been since been superseded by HealthWatch), quality and frequency of questioning at Committee, the sources of information used, and the ability or otherwise to query the messages put forward by senior Trust management. When discussing the role of the local scrutiny committee(s) and the balance of their work programme, the Inquiry Chairman suggested that the distinction between 'operational' and 'strategic' matters is essentially a false one, when all that really matters is the outcomes for patients.

11. Although a relatively small part of this system of oversight and not a formal regulator, the view expressed was that it was reasonable to expect the local scrutiny committee(s) to have undertaken more of a challenging approach to local services.

The nature of scrutiny at both Councils differed but in general, Councillors were criticised for accepting what they were told at Committee by senior Trust staff at face value, not investigating the high mortality figures in more depth, and not being more in tune with the concerns of local residents.

12. The challenge for all Authorities is to ensure that scrutiny is effective, contributing to the oversight of quality issues and adding value in the new NHS system.

13. The first recommendation of the Inquiry is that '**all commissioning, service provision, regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work'**. The report recommends that each organisation outlines its response and reports on its progress on a regular basis.

14. A number of recommendations have a direct impact on the health scrutiny arena and these are:

No.	Francis Report Recommendation
47	The Care Quality Commission should expand its work with overview and scrutiny committees and foundation trust governors as a valuable information source. For example, it should further develop its current 'sounding board events'.
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 the requirement of patient confidentiality.
147	Guidance should be given to promote the coordination 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 suggestions for action.
246	Department of Health/the NHS Commissioning Board/regulators should ensure that provider organisations publish in their annual quality accounts information in a common form to enable comparisons to be made between organisations, to include a minimum of prescribed information about their compliance with fundamental and other standards, their proposals for the rectification of any non-compliance and statistics on mortality and other outcomes. Quality accounts should be required to contain the observations of commissioners, overview and scrutiny committees, and Local HealthWatch.

15. There are also a number of other related recommendations and comments relating to patient and public involvement in health services, the monitoring of data, communication between bodies and with the public, the introduction of fundamental standards of basic care, and the duty of all in healthcare organisations to be truthful when providing information to regulators and commissioners.

What we do now and proposed improvements

16. In relation to the NHS, work to date has focussed on North Tees and Hartlepool NHS Foundation Trust as the main provider of acute hospital and community services in the area. However future work will need to take account of the increasing range of providers, and to continue to take into account the scrutiny of NHS Trusts that span several local authority boundaries.

17. Existing oversight is mainly undertaken by Adult Services and Health Select Committee (ASH). ASH Committee's work programme as with all scrutiny committees at Stockton is mainly based around undertaking in-depth topic based reviews, however in addition the ASH Committee undertake a number of additional roles in relation to health scrutiny, based on statutory duties, good practice, and evolving policy.

18. This report, and the Francis recommendations, focuses on health services, however consideration has also been given to increasing the oversight of adult care services, and it is proposed that a range of performance reports will be considered.

19. **Appendix 1** summarises the current good practice that will be maintained, and some areas for development. Relevant Francis Recommendations are highlighted where appropriate.

20. **Appendix 2** provides the evidence and includes a themed overview of the current approach, together with an assessment of how scrutiny performs against each of the Francis Recommendations (including a Red –Amber – Green - RAG rating), together with suggestions for improvement for both the areas highlighted by Francis and some related proposals.

FINANCIAL IMPLICATIONS

21. There are no specific financial implications associated with this report.

LEGAL IMPLICATIONS

22. The powers and duties in relation to the operation of health scrutiny are outlined in the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. Associated statutory guidance is being developed by the Department of Health.

CONSULTATION INCLUDING WARD/COUNCILLORS

23. The approach to monitoring quality and improving quality assurance is being developed in conjunction with relevant senior SBC officers, and NHS representatives. Adult Services and Health Select Committee, and Cabinet will also be consulted.

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Appendix 1

ASH Select Committee - Revised approach to monitoring quality

1. Co-ordination between Health and Wellbeing Board (HWB), HealthWatch Stockton, and Health Scrutiny (Francis Recommendation 147)	
Maintain	The joined up and partnership approach already established in Stockton; continue to engage closely with HealthWatch; continue to undertake in-depth reviews (potentially at the request of the HWB) on issues of local priority.
Improve	Ensure there is clarity of roles through the development of local guidance where appropriate and close working relationships with new contacts and organisations (eg. CCG, HWB, HealthWatch, North of England Commissioning Support)
2. Quality of information and support to scrutiny committee (Francis Recommendation 149)	
Maintain	Continue the flow of internal/external information; maintain the individual Member Training Needs analysis development; and ensure links with CMT / key officers are maintained.
Improve	Review health scrutiny training needs to enable members to more effectively challenge the information they are presented with; to improve and challenge the quality, range and ease of understanding of information provided to Committee; identify an appropriate method of being presented with information on the work of the relevant Quality Surveillance Group (QSG - a new sub-regional networks set up including CQC, commissioners, LAs, HealthWatch to detect early signs of quality failure).
3. Complaints (Francis Recommendation 119)	
Improve	Ensure more detailed annual reports on complaints (including information on themes, service area, trends) are reported to ASH Select Committee. It is proposed that this takes place when the 6-monthly in-depth adult care performance reports are considered at ASH Committee (November) for Adult Services, and when the Quality Account is considered for NHS services (Trusts are mandated to publish Quality Accounts annually and they set out a review of quality performance and priorities for next year).
4. Quality Accounts (Francis Recommendation 246)	
Maintain	Continue working with HealthWatch when considering the Quality Account in order to benefit from the patient and carer viewpoint; always ensure that the draft Quality Account is provided at the relevant Committee meeting; and maintain the practice of always providing a

	comment to ensure SBC input into the priorities of the Trust.
Improve	Reinforce Member's awareness of ASH Committee's role and ensure all Members are aware of the opportunity to feedback to the Committee their views on the Trust in advance of the Quality Account being considered; request more detailed information particularly in relation to benchmarking and complaints.
5. Working with Care Quality Commission (Francis Recommendation 47)	
Maintain	Continue to provide copies of agendas, minutes, final reports following reviews of Adult Care/NHS services, and any comments submitted to Quality Accounts from ASH Select Committee, to the CQC; continue providing the weekly CQC inspection reports email alert to Committee/lead Members.
Improve	Circulate the weekly CQC inspection reports to all Members (including information on the Ward location of services where applicable); invite CQC local leads to ASH Select Committee on an annual basis to give an overview of their work (this could potentially be aligned with the report on the work of the relevant QSG); respond to any further engagement and proposals from the CQC itself following its new strategy and its response to Francis Report.
6. Local Inspection (Francis Recommendation 150)	
Maintain	Continue ongoing dialogue with HealthWatch; continue to circulate the CQC inspection reports and inform its work; maintain approach to Select Committee site visits when relevant to a review (whilst acknowledging that they are not formal inspections).
Improve	Consider requesting that HealthWatch Enter and View visits (mini-inspections) are undertaken on particular types of service locally to inform a particular type of work or respond to concerns; ensure that all Enter and View reports are considered by the Committee as an agenda item to allow HealthWatch to formally report on their activities (this may be on a themed basis depending on number of Enter and View reports produced).
7. Scrutiny of NHS services that cover more than one local authority area	
Maintain	Continue the close working relationships with partner councils and standing joint committees; continue to seek to ensure an issue is considered by the most appropriate health scrutiny committee; continue feeding back from regional and sub-regional committees to ASH Select Committee.
Improve	Formalise and clarify the arrangements for joint scrutiny (ie. ensuring quality reports from regional Trusts are considered at the most appropriate Committee). The operation of the Tees Valley Joint

	Committee has been reviewed to ensure it meets the resources available during Stockton's period of supporting it, including a formalised the process of establishing the work programme of the Tees Valley Joint Committee including consultation with public health and NHS partners, including specific reference to quality issues.
8. Foundation Trust Governors	
Maintain	Ensure that Foundation Trust Governors appointed by Stockton Council continue to be members of Cabinet (to ensure clear lines of responsibility).
Improve	Governors appointed by the Council should report back on their role, and this could be included in the annual overview meetings.
9. Adult Care	
Maintain	Continue the current process for monitoring agreed recommendations and receiving the annual overview of Adult Services, and the approach to circulating CQC reports (see number 5).
Improve	Arrange for Stockton's Local Account be reported to ASH Select Committee during its preparation (July), and the Quality Standards Framework in September; this will complement the in-depth adult social care 6-monthly performance reports due to be considered at ASH Committee, together with the more detailed summary of complaints as suggested above; ASH Committee to receive an overview of the Council's performance in relation to adults safeguarding (similar to what is already received at CYP Committee regarding children's) and this to take place in July.
10. Supporting Measures	
Maintain	The flexibility in ASH Committee work programme will be maintained in order to deal with any 'quality' issues that may arise.
Improve	Each agenda of ASH Select Committee will contain an item on 'Quality of Care', as an umbrella item for the consideration of matters proposed in the report. Discussions to take place with Legal and Procurement to consider including a requirement to attend scrutiny committees when requested in contractual obligations for Council-commissioned health and social care service providers as a 'back-stop' to all other attempts to improve performance, and to match the similar duties on NHS providers. Review the style of minutes taken, with the aim of including more detail when taking evidence from witnesses (Responding to comment in Francis Report).

Appendix 2

Review of Current Practice

1. Co-ordination between Health and Wellbeing Board (HWB), HealthWatch Stockton, and Health Scrutiny

Rec 147	Guidance should be given to promote the coordination between Local HealthWatch, Health and Wellbeing Boards, and local government scrutiny committees.	Amber

a) As Francis recognises, it is important to be clear on the respective roles of the HWB, local HealthWatch, and health scrutiny functions. National guidance has been and continues to be produced.

b) The HWB and its members will plan and commission services. HealthWatch will be a HWB member and the intelligence it gathers should inform its work, at the same time as being a strong voice for the users of local health and care services. Health scrutiny continues to play an important role within the new arrangements and should be independent of the commissioning and provision of local services.

c) A key role for health scrutiny will be to focus on providing additional quality assurance, together with undertaking in-depth reviews. Crucial to the co-ordination of the work of these bodies in the new health system will be clarity on roles and responsibilities.

d) A key relationship is with HealthWatch. During the operation of the LINk, representatives attended relevant Committees and shared information. The LINk had regular contact with the Scrutiny Team and co-ordination with the Council as a whole occurred through regular relationship meetings attended by Policy/Adult Care/Scrutiny, and latterly Public Health.

e) HealthWatch is now undertaking LINk functions. It will also have a signposting and advice role.

f) The relationship meetings will continue with HealthWatch. This will allow for sharing of work programmes and highlighting of issues that need action. Democratic Services have been proactive in meeting with PCP the main LHW providers and have established good communication with the lead members of staff. A regional event was attended in March which set out the new players in the health system and was attended by scrutiny representation and PCP.

g) HealthWatch will identify a representative to attend ASH Committee and Children and Young People Committees as observers. This will allow HealthWatch to input into in-depth scrutiny reviews and raise any issues of concern.

h) HeathWatch has the ability to make a formal referral to scrutiny committees if they do not receive a satisfactory response from the provider/commissioner of the health or care service following a report directed to them. The benefit of this is that the

Committee is then able to hold the providers to account in a public meeting if necessary, utilising the scrutiny powers that exist.

i) The following is therefore proposed:

Maintain	The joined up and partnership approach already established in Stockton; continue to engage closely with HealthWatch; continue to undertake in-depth reviews (potentially at the request of the HWB) on issues of local priority.
Improve	Ensure there is clarity of roles through the development of local guidance where appropriate and close working relationships with new contacts and organisations (eg. CCG, HWB, HealthWatch, North of England Commissioning Support)

2. Quality of information and support to scrutiny committee

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

a) Support for scrutiny is primarily provided through the Scrutiny Team. Link officers may be identified from council services/partners to assist a committee during the course of a policy development review. This has proved useful as a source of evidence, information and guidance.

b) It will be important to continue utilising the knowledge and expertise of CMT and the wider Council, particularly with the introduction of Public Health. Although internal/NHS link officers have been identified in the past for in-depth reviews, if the issue is one of assessing quality of care, it may also be preferable to have access to a more independent viewpoint. Should the Council undertake such a review, consideration should be given to co-opting an expert (potentially including public 'experts by experience') to the committee.

c) Training has been provided to Members. Previous CfPS training was provided in September 2008, and this was followed by internal health scrutiny training was provided in December 2011 and May 2012. This has covered health scrutiny regulations, NHS reforms and a brief overview of safety and quality issues. The second session incorporated aspects of the training provided in January 2012 by Professor Stephen Singleton to health scrutiny Members at a regional event; this focussed on the best questions to ask when faced with a service change proposals and some light touch training on how to interpret data. Generic questioning skills training was provided to all Members in December 2011 and April 2012, and generic 'how to undertake a review' training was provided in spring 2012 for each Committee.

d) Benchmarking and other information provided is dependent on the topic under consideration. Some comparative data is examined as part of the Quality Account

process, and a number of data sets are now required by the DoH (see below). Increased use of appropriate benchmarking, understandable data, and use of key tools (such as funnel charts), should be considered. A range of independently available sources of information can support Members in their work (for example, the Health and Social Care Information Centre).

e) Essentially the issue is of being able to present Members with suitable information, together with relevant comparator information where necessary, and equipping them with the skills to be able to effectively investigate the issue at hand.

f) The following is therefore proposed:

Maintain	Continue the flow of internal/external information; maintain the individual Member Training Needs analysis development; and ensure links with CMT / key officers are maintained.
Improve	Review health scrutiny training needs to enable members to more effectively challenge the information they are presented with; to improve and challenge the quality, range and ease of understanding of information provided to Committee; identify an appropriate method of being presented with information on the work of the relevant Quality Surveillance Group (QSG - a new sub-regional networks set up including CQC, commissioners, LAs, HealthWatch to detect early signs of quality failure).

3. Complaints

Rec 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 the requirement of patient confidentiality.	Red

a) More work is needed to meet the requirements of recommendation 119. The Quality Accounts process (outlined below) includes consideration of NHS Trust complaint information. The data currently presented is in the form of a high level summary of total complaints/compliments received. However, the North Tees Quality account does now include 'you said, we did'-style quotes, following a suggestion by the Committee. The Quality Account process only covers the community and secondary services. Consideration may wish to be given to how assurances are given about the quality of primary care (eg. GP practices).

b) Committees have received social care complaints data in summary form as part of recent EIT and scrutiny reviews however there is currently not a systematic approach to reviewing complaints data at scrutiny committees for council services.

c) The following is therefore proposed:

Improve	Ensure more detailed annual reports on complaints (including information on themes, service area, trends) are reported to ASH Select Committee. It is proposed that this takes place when the 6-monthly in-depth adult care performance reports are considered at ASH Committee (November) for Adult Services, and when the Quality Account is considered for NHS services (Trusts are mandated to publish Quality Accounts annually and they set out a review of quality performance and priorities for next year).

d) Further work is needed to consider the approach to the quality of primary care which is now mainly commissioned by the NHS England Area Team. Aspects of this will be covered by the ASH Committee's scrutiny review of Access to Urgent/GP care.

4. Quality Accounts

Rec 246	Department of Health/the NHS Commissioning Board/regulators should ensure that provider organisations publish in their annual quality accounts information in a common form to enable comparisons to be made between organisations, to include a minimum of prescribed information about their compliance with fundamental and other standards, their proposals for the rectification of any non-compliance and statistics on mortality and other outcomes. Quality Accounts should be required to contain the observations of commissioners, overview and scrutiny committees, and Local HealthWatch.	Amber

a) Currently, unless an in depth review is undertaken, the main vehicle for considering quality in the NHS is through the Quality Account process. Each year, provider Trusts are obliged to produce a document that reports on their performance and identifies priorities for improvement in relation to the quality of their services (defined in the NHS as relating to: patient experience, clinical effectiveness, and patient safety). It is proposed that the Quality Account becomes the key opportunity for the Committee to review and comment on NHS quality.

b) In relation to North Tees and Hartlepool Trust, the Committee has a well-established procedure whereby the Trust consult the Committee in the autumn on their suggested priorities for improvement. In the spring Members have the opportunity to consider the proposed priorities (and ideally the draft Account itself – this has not always occurred), and provide a statement of assurance. This was done jointly with the LINk for the last 4 years, since Quality Accounts were introduced. (Hartlepool Council and LINk also produced statements due to being the other main area covered by the Trust.) The ability to comment is currently a voluntary one but any comments that are provided must be published verbatim; Stockton's health scrutiny function has provided comments in every Account published to date.

c) The joint statement with the LINk has been seen as good practice locally as the Committee benefitted from the insight gained by LINk participation in various hospital involvement mechanisms.

d) Quality Accounts have a relatively fixed format set by the NHS in that there is set of information that each Account must contain. A range of quality indicators are included including mortality data, and this is a key way of assessing local care. Improvements to the benchmarking information contained have been suggested by the Committee, and further improvements are expected following the Francis Report. Consideration of the data that is presented is a key factor; however lay observers will only be able to give qualified assurances without access to clear benchmarking and information from a range of sources.

e) There is less certainty in relation to Trusts that cover more than one area. The Regional Committee has considered the NE Ambulance Services quality account but not on a consistent basis. Tees, Esk and Wear Valleys NHS Foundation Trust have taken an approach that involves hosting an event to which a variety of stakeholders have been invited to help set priorities and report back on performance. The Chair of ASH Committee has attended such TEWV consultation events previously. Scrutiny of Trusts covering more than one area is discussed further below.

f) The following is therefore proposed:

Maintain	Continue working with HealthWatch when considering the Quality Account in order to benefit from the patient and carer viewpoint; always ensure that the draft Quality Account is provided at the relevant Committee meeting; and maintain the practice of always providing a comment to ensure SBC input into the priorities of the Trust.
Improve	Reinforce Member's awareness of ASH Committee's role and ensure all Members are aware of the opportunity to feedback to the Committee their views on the Trust in advance of the Quality Account being considered; request more detailed information particularly in relation to benchmarking and complaints.

5. Working with the Care Quality Commission

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

a) Since 2009 the CQC has undertaken engagement work with OSCs, and events have been attended and guidance circulated to Members. Two guides have been produced; one is a general guide for Members, and another is specifically in relation to joint working with OSCs. The guides have been provided to Members attending the Health Scrutiny Training Sessions in December 2011 and May 2012.

b) CQC itself are further developing its engagement approach; in response to both Francis and its new strategy. CQC has outlined plans to maintain a strengthened and more consistent level of formal and informal contact with local partners, including HWBs/OSCs/ HealthWatch etc. The Scrutiny Team has been proactive in making contact with the local leads. Links to Committee agendas and copies of reports are sent to the local CQC lead automatically. The local CQC lead attended a Member seminar in December 2012.

c) Every week the CQC provide a list of reports that will be published following inspections of health and care settings across the NE region. These are sent to OSCs and LINk contacts, and are now forwarded to the ASH Committee and Cabinet Member for Adult Services and Health. The Adult Strategy Team also receives these. Any reports following national CQC reviews of particular issues (eg. Services for people with Learning Disabilities) are also provided to the Committee.

d) In order to provide a focus for scrutiny reviews of relevant health and social care topics, the Scrutiny Team's scoping document seeks to identify any of the CQC essential standards that are relevant to the particular review.

e) The Government's initial response to the Francis Inquiry outlined that CQC will become increasingly an inspector of quality rather than 'merely' a regulator of compliance. The CQC is developing a more differentiated approach to inspection dependent on the type of provider it is inspecting, and there will be more focus on: is the service safe? Does it work? What are users' experiences? And what is the leadership, culture and governance like? CQC is also increasing its reactive/unannounced inspection approach (as opposed to its original risk based approach). However it is still reliant on information sent to it to inform the development of its Quality Risk Profiles it holds on every provider registered with it, and the information supplied by scrutiny committees is a key part of this.

f) A consistent approach to the supply of information provided to and from CQC should continue and be improved.

g) The following is therefore proposed:

Maintain	Continue to provide copies of agendas, minutes, final reports following reviews of Adult Care/NHS services, and any comments submitted to Quality Accounts from ASH Select Committee, to the CQC; continue providing the weekly CQC inspection reports email alert to Committee/lead Members.
Improve	Circulate the weekly CQC inspection reports to all Members (including information on the Ward location of services where applicable); invite CQC local leads to ASH Select Committee on an annual basis to give an overview of their work (this could potentially be aligned with the report on the work of the relevant QSG); respond to any further engagement and proposals from the CQC itself following its new strategy and its response to Francis Report.

6. Local Inspection

Rec 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 suggestions for action.	Red

a) Ultimately, gaining the true picture of what is happening within any health and care provider is through inspection. The Francis report recommends that scrutiny committees have the ability to either undertake inspections or request them. A government response to this will be required.

b) The main inspectorate is the CQC, and in addition HealthWatch can undertake Enter and View visits (previously the LINk). These are effectively mini-inspections undertaken by appropriately trained community representatives that can pick up on quality and the essence of care issues, and can also be unannounced. Copies of Enter and View reports have been circulated by email in the past.

c) CQC also provide their reports as noted. Whether or not the Government extends the power of inspection to local authority scrutiny, utilising the work of CQC and HealthWatch would work towards meeting this recommendation.

d) Better awareness of inspection results will also inform the local evidence base in relation to information submitted to CQC, and the comments made on Quality Accounts.

e) The following is therefore proposed:

Maintain	Continue ongoing dialogue with HealthWatch; continue to circulate the CQC inspection reports and inform its work; maintain approach to Select Committee site visits when relevant to a review (whilst acknowledging that they are not formal inspections).
Improve	Consider requesting that HealthWatch Enter and View visits (mini-inspections) are undertaken on particular types of service locally to inform a particular type of work or respond to concerns; ensure that all Enter and View reports are considered by the Committee as an agenda item to allow HealthWatch to formally report on their activities (nb. this may be on a themed basis depending on number of Enter and View reports produced).

7. Scrutiny of NHS services that cover more than one local authority

a) The Francis report also outlined concerns in relation to the co-ordination of scrutiny in Staffordshire where several councils were involved. This was due to more than one

council being involved in overseeing health services at the same location. The situation in the North East is generally speaking simpler in that there are no district/county council division of responsibilities. However, there are a number of health trusts that cover several local authority boundaries and there is scope to be clearer about who is doing what in relation to quality issues.

b) In practice issues are considered at the appropriate level; however there is scope to formalise this. It is therefore suggested that a clear schedule of minimum responsibilities for each committee in the region is drawn up. This aims to share the workload and does not prevent more localised work in any area. This will need discussion and formal agreement with other authorities but could for example look like:

Committee	Leads on
NE Regional Health Scrutiny Committee - This meets twice yearly as minimum and consists of all 12 north east authorities - Supported by informal officer group/ host authority (rotated)	Reviewing and responding to regional-level proposals and services (eg. NHS111, Ambulance Service, Children's Heart Surgery) **Providing scrutiny response to NEAS Quality Account**
Tees Valley Joint Scrutiny Committee - This consists of the 5 TV authorities. Hambleton has observer status, and Durham attends by invitation - Supported by informal officer group/ host authority (rotated)	Reviewing new proposals and health services provided on a Tees/sub-regional basis (eg. sexual health, out of hours GP care) **Responding to TEWV Trust's Quality Account for the Tees Valley area** Sharing of work programmes and information on the performance of major local Trusts including South Tees, North Tees, TEWV
SBC Adult Services and Health Committee - Support by Scrutiny Team	Reviewing the provision and quality of local health services Conducting local in-depth reviews **Responding to North Tees Quality Account for Stockton** Working in partnership with HWB, LHW, and CQC

(NB. It is important to note that should significant variations to NHS services involving more than one local authority be proposed, the above joint committees can only consider the

matter if it affects all of their membership. Otherwise a separate statutory joint committee must be formed comprised of only those Councils affected.)

c) The chairing and support arrangements for the Tees Valley Joint Committee are rotated on an annual basis. The chair for 2013-14 is held by Stockton. Currently the Committee meets monthly and the meeting frequency has been amended to 6 weekly in order to mirror the reduced resource available for support.

d) **Appendix 3** sets out the role of elected Member scrutiny in relation to the new health landscape.

e) The following is therefore proposed:

Maintain	Continue the close working relationships with partner councils and standing joint committees; continue to seek to ensure an issue is considered by the most appropriate health scrutiny committee; continue feeding back from regional and sub-regional committees to ASH Select Committee.
Improve	Formalise and clarify the arrangements for joint scrutiny (ie. ensuring quality reports from regional Trusts are considered at the most appropriate committee). The operation of the Tees Valley Joint Committee has been reviewed to ensure it meets the resources available during Stockton's period of supporting it, including a formalised the process of establishing the work programme of the Tees Valley Joint Committee including consultation with public health and NHS partners, including specific reference to quality issues.

8. Foundation Trust Governors

a) Each NHS Trust in the region is now a Foundation Trust (FT). As is required in each FT, beneath the executive Board, a Council of Governors is in place. Governors are in place to represent the views of the Foundation Trust's Membership, and the wider public. Governors have the power to appoint and remove the chair and non-exec directors, and approve the appointment of chief executives. They hold the Board of Directors to account, need to approve significant transactions/mergers/acquisitions, and have a say in the amount of private income the Trust is able to secure.

b) Each FT has a number of public and staff governors, together with appointed Governors including from local government. From Stockton, Cllr Beall is appointed to North Tees and Hartlepool, and Cllr McCoy is appointed to Tees, Esk and Wear Valleys Trust. The North East Ambulance Service has appointed LA reps from Northumberland, Gateshead and Newcastle Councils.

c) The following is therefore proposed:

Maintain	Ensure that Foundation Trust Governors appointed by Stockton Council continue to be members of Cabinet (to ensure clear lines of accountability).
Improve	Governors appointed by the Council should report back on their role, and this could be included in the annual overview meetings.

9. Adult Social Care

a) This report has mainly focussed on the quality of health services but as described there are clear opportunities for social care.

b) The Local Account is a new method of reporting on Adult Social Care performance in a given Council area. It is seen as part of the national Adult Social Care Outcomes Framework (ASCOF) introduced in 2011.

c) Currently the Children and Young People Select Committee receives an annual report from the Local Children's Safeguarding Board. This will be replicated at ASH Committee for adults, together with more regular performance reporting.

d) The following is therefore proposed:

Maintain	Continue the current process for monitoring agreed recommendations and receiving the annual overview of Adult Services, and the approach to circulating CQC reports (section 5).
Improve	Stockton's Local Account be reported to ASH Select Committee during its preparation (July), and the Quality Standards Framework in September; this will complement the in-depth adult social care 6-monthly performance reports due to be considered at ASH Committee, together with the more detailed summary of complaints as suggested at section 3; ASH Committee to receive an overview of the Council's performance in relation to adults safeguarding (similar to what is already received at CYP Committee regarding children's) and this to take place in July.

10. Supporting measures

a) It is proposed that each agenda of ASH Select Committee contains an item on 'Quality of Care'. This will be the umbrella item for the consideration of issues such as Enter and View reports as proposed in the report, and be an opportunity for Members to raise any issues of concern.

b) The work programme is already flexible enough to accommodate new issues that arise, for example NHS service change proposals. This flexibility should be maintained in order to deal with any quality issues that may arise.

c) Increasingly both local authority and NHS services are being provided by a mixed economy of providers. The new health scrutiny regulations mean that any provider of NHS funded services must attend a health scrutiny committee if required. Currently Select Committees have not had difficulty in securing attendance at meetings from partners and providers in the spirit of partnership and in order to inform a review of a particular topic, however there may be resistance to attending to discuss poor performance.

d) Regarding the documentation of action taken, the Francis Report is critical of the approach adopted in relation to minutes by local Councils, particularly Stafford Borough Council. It states: 'it has been far from easy to determine [what activity has taken place] as the minutes […] are brief to the point of being uninformative; they register that a topic was discussed and summarise presentations made by external bodies, or formal questions put, but there is no summary of the debate, merely a series of very short reports of any decision taken. […] it was suggested that this form of minute was common local government practice. If this is so, it needs reviewing.' In summary, 'the proceedings of bodies performing a statutory scrutiny function should be more fully recorded than appears in many of the minutes considered by this inquiry.'

e) SBC practice for scrutiny committees is for short minutes that bullet point the key points made but do not outline particular questions put, in the majority of cases.

f) Therefore the following is proposed:

Maintain	The flexibility in ASH Committee work programme will be maintained in order to deal with any 'quality' issues that may arise.
Improve	Each agenda of ASH Select Committee will contain an item on 'Quality of Care', as an umbrella item for the consideration of matters proposed in the report. Discussions to take place with Legal and Procurement to consider including a requirement to attend scrutiny committees when requested in contractual obligations for Council-commissioned health and social care service providers as a 'back-stop' to all other attempts to improve performance, and to match the similar duties on NHS providers. Review the style of minutes taken, with the aim of including more detail when taking evidence from witnesses (Responding to comment in Francis Report).