Health and Wellbeing Scrutiny Committee

Quality and Performance in community services and beyond Spotlight Review

January 2017

1. Recommendations

The Task Group ask the Health and Wellbeing Scrutiny Committee, Cabinet and the NHS in Devon to endorse the report and recommendations below. The Task Group also recommends that the Health and Wellbeing Scrutiny Committee receives a progress update in 3 -6 months' time.

	Recommendation	**organisation**
1/	Clarity in communications from the NHS specifically: - Presentations to committee to last no longer than 10 minutes - A limit on verbose reports. Scrutiny needs effective, short, data rich reports - Communications with everyone to be in plain English (no acronyms or assumptions made)	All witnesses and presenters including DCC and NHS
2	Health and Wellbeing Scrutiny Committee to receive regular performance reports from providers co-ordinated by the relevant CCG. These reports to be based on a co-produced dashboard of indicators between scrutiny committee and the NHS	Scrutiny committee/CCGs/Providers
3	When substantial variation to services is planned the health and wellbeing scrutiny committee to be notified using a pro-forma that has been agreed in advance by health scrutiny.	CCGs

2. Introduction

2.1. The Health and Wellbeing Scrutiny Committee initiated this piece of work to resolve how the committee can ascertain if a service is working well and what warning signs to look for if it is underperforming. This is particularly timely when set against the significant change that is currently underway in the NHS.

2.2. The scope of the work was:

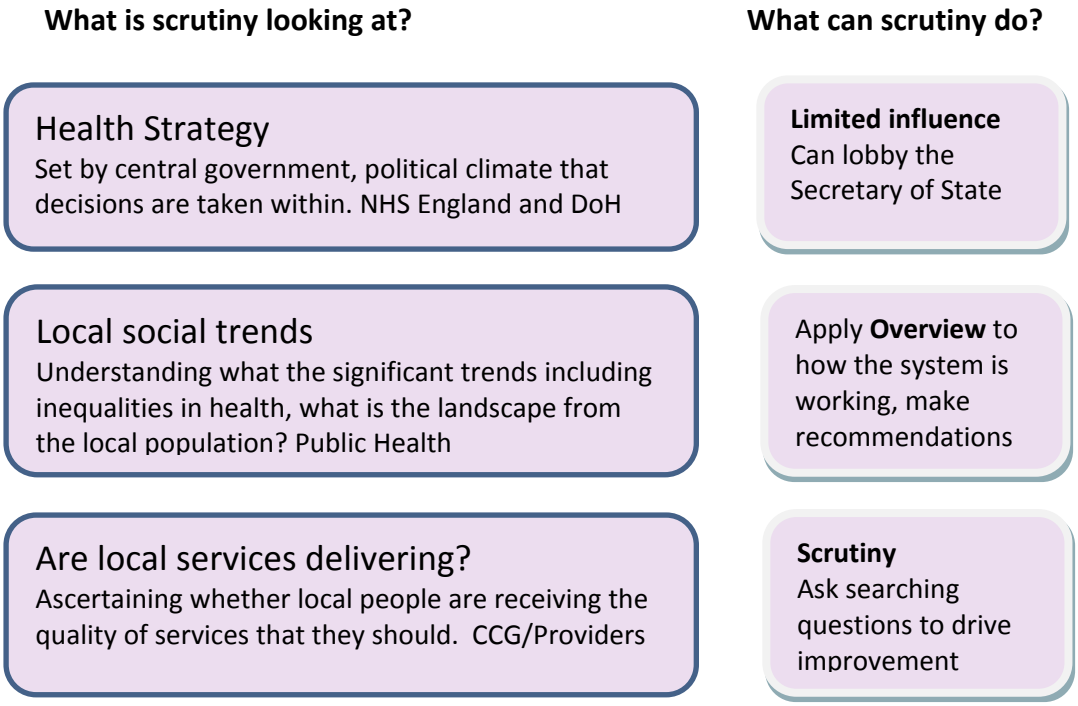
- To clearly establish the principles of evaluating service change using quality metrics and data about community healthcare as presented by NHS providers.
- For members to review and agree the information provided to committee to monitor quality. As well as to agree how and on what basis quality measurements should be reported and presented to committee.

2.3. The spotlight review took place in one meeting on the 17th November which was attended by the North Devon Healthcare trust and NEW Devon CCG. Although much of the discussion and performance metrics were led by Northern Devon it is the intention of the scrutiny committee to extrapolate this work so that is it applicable to all providers as the principles are universal.

2.4. The outputs from this piece of work including recommendations have been written with all providers in mind.

3. What is quality?

3.1. The scrutiny spotlight review was clear that there are three themes for scrutiny consideration that quality can be understood against. This is important to establish as often members of scrutiny can blur the distinction between quality of decisions, national strategy and local performance against targets in their quest to understand whether NHS services are working to the benefit of local health populations.



3.2. This spotlight review focussed upon the last point, looking at information that enables the committee to understand whether services are providing the best possible service to patients and how this performance tracks over time.

3.3. To begin this discussion the spotlight review sought to ascertain the way in which the NHS works to ensure quality. The spotlight review was informed that the commissioner engages in a contract with the provider to run a particular service. To ensure that this works there are integrated performance and assurance monthly meetings. This is part of contract management. There are mandatory targets that have to be met in 4 areas:

- Cancer waits
- Referral to treatment
- A&E waits
- Agency spend

However the exact way the process to record and monitor the data may vary across the three localities in NEW Devon and may be different. The spotlight review also heard that there is funding associated with the achievement of targets. North Devon is one of the top performing trusts in the Country.

3.4. The spotlight review heard that when there is a planned service change providers started by tracking back to source to understand what it is that is trying to be understood by measuring performance. For example when looking at community hospital bed closures in North providers began by asking themselves the question of

'how will we know if the new model isn't working?' Listening to the concerns of the public a major fear was that people would find themselves in crisis at night with no support if they were in the community rather than in a hospital bed. On this basis it would be reasonable to expect that if this happened there would be more calls to ambulance services and a greater attendance at A&E. These were consequently some of the things that were measured. Providers ask themselves 'Do the measures answer the right questions?' data from Public health analysis and National reporting can help to build a more complete picture.

3.5. There is an enduring frustration where information presented by the NHS is not believed or trusted. There needs to be a better balance of listening, both people listening to the NHS but also the NHS listening to the public. The NHS faces critical challenges about how to communicate change and introduce the idea that a different model of care can work. Frequently the discourse is stuck on the disadvantage to few rather than the benefits to the majority. GPs can be helpful in this discussion but they are also private businesses and may financially benefit from one option over another.

3.6. Members of the committee have the challenging task of steering a course through facts and opinions. This is difficult when constituents are presenting an alternative point of view. To assist in any recommendations or conclusions from scrutiny, members need to be supported to be clear about the benefits of change. This is the thinking behind Appendix 1, to clearly co-design the template of specific questions that need to be answered.

3.7. In future quality data needs to be understood in the context of Context of the current situation of the NHS. There is significant challenge, including the local financial challenge. In addition to this 25% GPs are going to retire in next ten years. Within acute sector 10-12% nationally consultant post are unfilled, and junior doctors numbers aren't there. This will all have an impact on performance and may be areas that scrutiny can look at and contribute to the debate.

Quality Accounts

3.8. Scrutiny reviews provider's quality accounts yearly in April/May. Healthcare providers publishing Quality Accounts have a legal duty to send their Quality Account to the OSC in the local authority area in which the provider has its registered office, inviting comments on the report from the OSC prior to publication. This gives OSCs 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.

3.9. The committee have previously taken the approach that a nominated member of the committee will review one quality account in liaison with the scrutiny officer. This has had limited success, in some areas working well, but not in others. If performance were more of a regular feature of scrutiny it may be that the quality accounts would have more resonance.

4. What does scrutiny need to see?

4.1 The spotlight review identified a disconnect between the aim of providers and what is translated to Members. A key point was that communication can be improved. In particular members asked for presentations to committee to be succinct, with detail being teased out in questions. This should also be supported with clarity in reports, not

lengthy tomes of difficult to decipher data. A quote from the spotlight review said that the committee have:

'Too much info not enough data.'

Members of the committee also recognised their role in being succinct in questioning not grand standing or relating anecdotes. The committee agreed that the first question should be – 'What does this mean for the public?'

4.2 The spotlight review also spoke about the use of language, both to the public and to scrutiny. Providers need to lead on clarity. Plain English is very important, and where it is not possible because technical terms are used they need to be explained.

4.3 There was significant discussion in the spotlight review about the format and method for presenting information to members at committee and in general. Members of the spotlight review identified the particular need of the Health and Wellbeing Scrutiny Committee to receive information. There was some discussion about the most effective way to do this, summarised below.

Format	Pros	Cons	How to improve?
Committee meetings Usually involving a report and presentation. Often lengthy. The committee will have asked for a report on this topic but may not have been specific.	The committee have asked for this issue to be presented. It may well be of public concern and or represent a major change. Members can scrutinise in public which calls to account.	Lengthy presentations focus on what officers think members want. This is often not the case.	- Short presentations - Short, data rich reports - Members to be clear on what they want - Members to ask succinct questions
Masterclass sessions	A dedicated time to review a topic in greater detail solely for information.	Many members don't turn up and to programme in a masterclass session is not reactive to immediate information gaps.	- More work on what information is needed - Members to take ownership
Briefing e-mailed sent round to members	Quick, succinct, can be a good source of information for those who are interested	Easy to miss important information in weight of other e-mails Can clog up inbox further	- Member champions can help to filter info

4.4 When performance data is presented as part of a service change it can often look like the data supports the conclusions of the NHS recommendations. It can be difficult for members of the committee to separate whether the NHS have come to conclusions on the basis of the evidence, or whether the conclusions have been reached and then evidence used to support them. This is particularly the case when campaign groups start to make allegations.

4.5 It is important for the successful functioning of scrutiny that there is trust in the relationship between officers and councillors. Scrutiny needs to have assurance that

presenters are candid and full in their sharing of information. The view of the spotlight review is the current system does not engender this. In part this may be because data is presented to support a decision being taken. Where the committee have not had the opportunity to identify conclusions for themselves whatever is presented looks like propaganda.

4.6 Members have repeatedly asked about whether they could have access to complaints and concerns data in an effort to hear what local people think of their health services. However the spotlight review was informed that it is not as simple as sending a file of this data. For a start compliments are not routinely collected. Then with complaints the focus of the process is more focussed on learning points. Beyond this there are two forms of patient experience data that are collected and reported nationally. These are Ombudsman complaints and the friends and families test.

5. Conclusion

This was a short investigation with the remit of trying to improve data that the health scrutiny committee were receiving. The discussion and subsequent recommendations have exceeded the brief and looked at how to make the most of the dialogue between health providers, commissioners, and Councillors.

Health scrutiny needs to normalise the presentation of performance data with regular monitoring and understanding. To assist in a better understanding of data, officers presenting information need to try to be as succinct and clear as possible, in tandem with members asking clearly about what they want and what they are trying to ascertain. Health scrutiny should also take a more balanced view to consider the actions and policy decisions of other providers, not just the usual suspects.

6. Sources of evidence

Witnesses

The Task Group heard testimony from a number of sources and would like to express sincere thanks to the following for their involvement and the information that they have shared as well as to express a desire of continuation of joint work towards the fulfilment of the recommendations in this document.

Organisation	Person	Role
NDHT	**Katherine Allen**	**Director**
NDHT	**Dr Chris Bowman**	**Director**
NEW Devon CCG	**Jenny McNeil**	**Associate**

7. Task Group Membership

Membership of the Spotlight Review were as follows:

Councillors Richard Westlake (Chairman), Debo Sellis, Andy Boyd, Brian Greenslade, Chris Clarence, Rufus Gilbert, Robin Julian, Eileen Wragg and Claire Wright,

8. Contact

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APPENDIX 1 Information on service change or development

NHS Organisation	
Date	
Contact	
What is the proposed change or development? **(What happens now – what might happen in the future?)**	
How will patient's be affected (what area and how many people)?	
How will staff be affected?	
What is the rationale for making this change?	
What is the timescale for this to happen?	
What consultation has taken place and what are the results? How have patients been involved in decision making? **If consultation is planned – how can patients affect the outcome?**	
What National evidence is there to support this way of working?	

APPENDIX 2 Performance Dashboard

Community services

- How many people cared for at home?
- Is this more or less than last report?
- How long were visits for?
- Recruitment of staff – are there vacancies?
- Agency Spend

Acute

- Waiting times?
- Against national averages?
- A&E admissions
- Agency spend
- Discharge delay?

Hearing from members of the public

- Friends and families test broken down by org?
- Complaints themes?
- Other ways of capturing the views of the public – Healthwatch?

National comparison on headlines?