Engaging patients and the public in the annual health check

Feedback to overview & scrutiny committees

October 2006

The story so far…

Our invitation

What matters to patients, carers and service users matters to the Healthcare Commission. We are committed to putting their interests at the heart of our work because we believe that is the best way to improve health and healthcare for everyone. People have told us that we should give greater weight to the experiences of patients and the public when assessing the performance of the services they use. We shall keep on trying to do this more effectively and we have made a start by inviting overview and scrutiny committees (OSCs) and patient & public involvement forums (PPI forums), as well as strategic health authorities (SHAs), and foundation trusts' boards of governors to submit comments on the performance of their trust(s) against the core *Standards for Better Health*, measured in the annual health check.

The response

We received 1,985 responses to our invitation. These provided 11,472 separate 'items of intelligence' (pieces of information and opinion) that applied to the 24 core standards. The standard that attracted the most comment was core standard 17: this checks if the views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services. Other standards that attracted a great deal of comment were: core standard 18, which looks at equal access to health services, core standard 16 which is concerned with ensuring that healthcare organisations make information on treatment, care and after-care available and accessible to patients and the public, and the first element of core standard 22, which checks that healthcare organisations are working together to promote, protect and improve the health of their local communities.

What we did with the information

Each 'item of intelligence' was given a weighting of 'high', 'medium' or 'low', reflecting the strength of relationship that the item had with a particular standard, and how well it was supported with evidence. This resulted in 361 of the items (3% of the total) being weighted as 'high' intelligence, 6,335 (55%) as 'medium' and 4,776 (42%) as 'low'. Items of intelligence were also coded as positive or negative commentary: more than three quarters were coded positive. The 'items of intelligence' were put together with all the other data used to check trusts' self-assessments.

Comments have been weighted 'high' or 'medium' if they include some or all of the following:

- information relevant to the current annual health check
- comments that refer to particular standards and discuss specific issues mentioned in those standards
- detailed statements that are supported by evidence
- specific examples to illustrate points made
- information or observations based on regular interaction with a trust

The Healthcare Commission cross-checked the 'items of intelligence' against its own bank of information about trusts' performance, which includes some 2,000 items of data. This resulted in 69 trusts being selected for risk-based inspections.

What the overview and scrutiny committees provided

Overview and scrutiny committees provided 807 of the 1,985 commentaries, relating to 419 trusts. From these, 2,108 items of intelligence were identified (that is 18% of all the items of intelligence extracted from commentaries). Forty nine (2% of the total from overview and scrutiny committees) were classified as 'high' quality intelligence, 1,245 (59%) as 'medium' and 814 (39%) as 'low'; 1,491 items (71%) were coded as 'positive'.

This intelligence was used to select the 69 trusts that had risk-based inspections. Of these, eight would not have been selected without the contribution of the overview and scrutiny committee commentary. There were also four trusts that did not get a risk-based inspection because of intelligence included in the commentaries of overview and scrutiny committees.

Overview and scrutiny committees were able to comment because:

They have access to reports:
OSCs have access to, and have been able to comment on, reports on consultations and reconfigurations. They have also had access to specific reports, for example on healthcare acquired infection and access for disabled people.

They attended presentations:
Some OSCs had received presentations on reports, for example one OSC had received a presentation from the director of public health and this was used to inform their work programme.

They were involved in developing initiatives:
OSCs had been involved in developing new initiatives, including the development of a strategy for childhood obesity. One OSC had been assisted by their trust in setting up a health scrutiny conference. A wide range of stakeholder organisations, including user and carer representative organisations, had attended this.

They had knowledge of issues:
Their familiarity with NICE guidelines, for example, has meant that they have been able to assess whether guidance is being followed.

They conducted scrutiny reviews:
Scrutiny reviews conducted over the year included reviews of stroke services, childhood obesity, older people's mental health services, adult day care services, alcohol consumption in young people, and access to mental health services - including early intervention services which provide quick diagnosis and intensive support.

They used their own observations:
OSCs had been able to observe changes in the delivery of services following consultation with patients, as well as how far trusts were working in partnership with other agencies, such as social care and crime and disorder services.

They were able to challenge trusts and influence change:
OSCs have been able to challenge trusts' self-assessments on the basis of their observations and their scrutiny reviews. This has included challenging a trust's assessment in relation to healthcare acquired infection (HAI). They have also been able to influence change; examples include the appointment of a communications manager to help staff feel more involved, and changes made to IT systems used by NHS organisations and local authorities, to make them more compatible. References were also made to instances where OSCs have referred a trust to the Secretary of State for Health, because they considered that proposed changes in services did not reflect the needs of local people.

Standards they were able to comment on

Standards C17, C18 and C22a were the ones most commented on by OSCs. The following gives a flavour of the comments made about these standards, and the kind of 'intelligence' that could be drawn from them.

C17 *The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services.*

OSCs' commentaries produced 310 positive and 76 negative items of intelligence relating to this standard.

Overview and scrutiny committees were able to comment on their own involvement with trusts and more generally on patient and public involvement within trusts.

There were comments from OSCs who had good working relationships with their trusts, were invited to attend various committees and subgroups, and had participated in Patient Environment Action Team (PEAT) inspections. There were examples of trusts responding positively to OSCs' recommendations, for example by improving parking facilities for patients and visitors.

Some OSCs however, felt that they were not able to contribute to the design and planning of services because they had not been brought into the process at an early stage. Others reported that trusts had not responded to recommendations made by them.

There were examples given of robust inclusive consultation processes that had led to decisions being changed. Some OSCs had been involved in overseeing consultations and had witnessed good involvement that had influenced and changed delivery of services. Others mentioned trusts that were working well with patient and public involvement forums (PPI forums).

There were also some examples of poor communication by trusts, both in bringing issues to the attention of patients and the public and also in reporting back the

outcomes of consultation. There were also examples where trusts were considered not to have given adequate time for consultation.

C18 *Health care organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.*

Commentaries from OSCs provided 107 positive items of intelligence on this standard and 128 negative items.

A wide range of issues were commented on in relation to access.

These included positive reporting of: interpretation and translation services, 24-hour crisis services for mental health problems, successful choose and book systems, and re-provision of specific services following consultation, for example minor injuries units. One OSC commented on the significant achievement made by an inner city trust in meeting the needs of its diverse population.

There were also some concerns about the impact that financial shortfalls were having on access. The shortage of immediate care beds in some areas, and long waits for screening services in other areas, were of particular concern.

Some services particularly attracted negative commentary on access, for example there were concerns about race equality in mental health services and emergency response times in ambulance services.

C22a *Health care organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by co-operating with each other and with local authorities and other organisations;*

Commentaries from OSCs provided 272 positive items and 32 negative items of intelligence relating to this standard.

There were positive comments about joint working and whole system working across health and social care sectors to reduce health inequalities, with some cross borough/county working.

Examples of strong links between primary care trusts and their local strategic partnerships, and inter-agency working between health service and police, were also provided. These partnerships had enabled organisations to share best practice, and had direct and measurable impacts on outcomes for patients and service users in their areas.

Many OSCs were also positive about the support they had received from trusts in carrying out health scrutiny.

Negative comments were made about communication between some trusts and GPs.

What next?

We invited overview and scrutiny committees to comment and they responded well. We really appreciate the hard work that went into providing commentaries that produced so much useful intelligence.

The Centre for Public Scrutiny is producing further guidance for overview and scrutiny committees for the 2006/2007 annual health check. This incorporates what has been learned from the first year and will be helpful to overview and scrutiny committees in planning and preparing commentaries for next year.

In addition, the Healthcare Commission is developing general guidance for organisations that are asked to provide comments for the annual health check. This will be available shortly.

Patient and Public Engagement Team October 2006