Scrutiny Review – North Middlesex University Hospital Application for Foundation Trust Status

1. Introduction

Review Panel

1.1 The review panel consists of 4 Members and is due to meet twice (November 19th and December 12th).

1.2 The terms of reference for the review were agreed as: "to consider and comment as appropriate on the proposed application for foundation status by the NMUH Trust and, in particular, its overall strategy and governance arrangements". In its deliberations the panel has sought to focus on 5 key objectives:

- The process of application (consultation)
- Accountability issues raised
- Impact on partnerships and the local health economy
- Impact on local people
- Financial implications of acquiring FT status

1.3 The review panel has heard evidence from the NMUH and is due to receive written evidence from Haringey TPCT.

1.4 It is intended to produce a short review report of the evidence received and recommendations made by the panel. This review will be submitted in to the formal consultation process for the NMUH application for FT status.

2. Process

2.1 The consultation period for FT status runs from 22nd October 2007 through to January 13th 2008. The consultation period conforms to the recommended 12 week standard.

2.2 The NMUH has consulted Overview and Scrutiny Committees in both Enfield and Haringey. The NMUH has also made a formal presentation to the scrutiny review panel in Haringey and has responded to Member questions.

2.3 The NMUH has produced a consultation document which has outlined plans and priorities for the hospital should its application for FT status be successful. The document also details the new governance arrangements for the FT, sets out a number of consultation questions and provides an opportunity to feedback responses. Approximately 25,000 copies of the consultation document are intended to be circulated to patients, staff, local residents, community groups and partner agencies. The document has been translated in to a number of community languages and is available in Braille and on audio cassette upon request. A short film has also been commissioned to support the consultation process. NMUH anticipate a consultation response below 2% (500 responses).

2.4 The NMUH has scheduled 5 public consultation events across Haringey and Enfield and additional meetings are planned (but as yet unpublicised). The NMUH has also indicated that it will attend meetings of local community and

voluntary groups to hear their views about its proposals for FT status. Similarly, NMUH will also indicated that it be meeting with key partners to discuss these proposals.

2.5 All responses to the consultation and attendances at public meetings will be audited in respect of age, gender, ethnic background and disability. This will provide the NMUH with an overview of the penetration of the consultation process within the community. All those that provide a formal response to the consultation, will be notified of any changes

2.6 It is intended that the application for FT status will be submitted to the Secretary of State in early 2008. If the application is cleared, this will then proceed on to the FT regulator (Monitor). The full application process is expected to run through to June 2008.

Suggested issues for consideration by the Panel:

- **How will the NMUH Hospital address concerns raised within the consultation?**
- **How will comments and feedback obtained from the consultation be fed back to those that participated and to the wider community?**

3. Accountability

3.1 Governance Structure

There are three tiers of governance within FT's:

- A broad based Membership which is made up of patients, staff and members of the public.
- A Board of Governors which is a predominantly elected body drawn from constituencies of the Membership (patients, public and staff) and nominated partner agencies (e.g. Primary Care Trusts & Local Authorities).
- A Board of Directors made up executive directors and non executive directors, the chairman and chief executive.

3.2 Membership – National Context

- As of the end of 2006/7 the total membership of NHS FT's was 766,000 (made up of 477,000 public members, 206,000 staff members and 83,000 patient members). Total membership in the sector is forecast to rise to 840,000 by the end of 2007/8 (Monitor, 2007).

- The size of individual FT's membership varies considerably: Heart of England has 77,000 members compared to the Royal Orthopaedic Hospital which has just 3,000 members. The size of the membership is determined by the size hospital and the recruitment process employed (i.e. opt in or opt out models). As of March 2007, the average Membership of FT's was 13,000.

- Research evidence (Healthcare Commission,2005) would appear to indicate that there may be a number of benefits in operating a FT Membership:

  - The provision of data and intelligence about the quality and accessibility of services can be a significant resource;
  - Improved public engagement, such as increased attendance at FT public meetings.

- There is considerable debate about what constitutes an appropriate level for FT Membership and indeed, that nature and level of Membership which may constitute a democratic or representative body. What would appear to be important however, is that the Membership is 'active' and has sufficient opportunities to engage with and influence Governors.

- There is some evidence to suggest that FT's have thus far failed to reach traditionally under represented communities through the operation of the Membership (Healthcare Commission, 2005). Thus it would seem important that the Membership should not be seen as a public and patient involvement strategy in itself, but where additional patient contact strategies (such as surveys and consultations) will be needed to further inform patient and public involvement within the FT.

3.3 Membership – Proposals from NMUH

- The NMUH aims to develop a Membership of between 5,000-10,000 people by the time that final FT application is presented to Monitor in 2008.

- The NMUH plans to develop a membership strategy under the stewardship of the Board of Governors. It is anticipated that a Equality & Diversities Impact Assessment of this strategy will be undertaken and any necessary adjustments (in recruitment processes) will be made in accordance to with resultant findings.

- The NMUH is proposing 4 Membership constituencies:
  - Residents 12 years and over in Haringey (public voluntary);
  - Residents 12 years and over in Enfield (public voluntary);
  - Patients and carers (non geographical) (patient voluntary);
  - NMUH staff (staff automatic).

Issues for consideration by the Panel:

- **How will the NMUH support Member engagement, particularly from those communities which may be hard to reach?**
- **Will the NMUH develop a public and patient involvement strategy?**
- **Is the 5,000 to 10,000 Membership target ambitious enough?**

3.4 Governors – National Context

- The Board of Governors is made up of patient, public and staff governors (who are elected from their respective Membership constituencies) and nominated governors (from local partner agencies). The actual size and composition is at the discretion of local FT's, though whatever size the Board of Governors is decided upon, public governors (patients and public) must be in a majority on the Board of Governors.

- The Board of Governors have a number of formal powers which are:
    - To appoint/ remove Chair and Non Executive Directors,
    - Approve the appointment of Chief Executive,
    - Agree remuneration,
    - Appoint / remove auditors,
    - Receive annual report & accounts and advise
    - To be consulted on strategic developments.
- Cursory analysis of the size of the Board of Governors at other FT's indicate this ranged from 21 to 53. The number of staff governors ranged from 4 (statutory minimum) to 13. Nominated governors (from partner agencies) ranged from 5 to 15. This same analysis also indicated that less than ½ of FT's have dedicated patient constituencies or Governors.
- Audits of FT's, have raised concerns about how representative Boards of Governors are to their communities given that in some instances over 60% are made up from retired populations and that over 1/3 of public and patient governors are NHS staff, ex NHS staff or had family associations within the NHS (Day & Klein,2005).
- Analysis of public constituency ballots demonstrate that small numbers of people are electing FT governors: in one FT 125 people voted (from a membership of 229, to elect 3 governors. Elections will be held every three years by postal ballot. Average turnout at FT elections of Governors is 36%, though this average varies by the type of constituency: public 53%, patient 27% and staff 26% (Lewis, 2005)
- Governors provide the critical link between the Membership and the FT. This link provides the route through which the community is engaged & involved and establishes a line of accountability between the FT and the wider public. Survey data among Governors however, found that communication with Membership constituencies was poor, indicating that there were problems around defining their constituents, a lack of training in involvement techniques and inadequate resources to facilitate engagement. As such, just 32% of governors reported that they had effective channels to communicate with their constituent membership (Lewis, 2005).
- Whilst there is national guidance that Governors should adopt one of three roles (advisory, guardianship or strategic), in practice, much confusion has arisen as to the exact nature of their role. A number of reports have indicated that Governors experience a high degree of initial uncertainty as to their role and responsibilities (Lewis, 2005; Chester, 2005).
- Evidence would suggest the need to provide a systematic and ongoing programme of training for Governors has been highlighted to provide support and help develop their role (Healthcare Commission, 2005; Day & Klein, 2005; Chester, 2005). Priority areas in which training was needed included: developing an understanding of the governor role, help in setting work

objectives and strategies for engaging and communicating with the public and other constituencies (Chester, 2005).

- There is consistent evidence to suggest that Governors need more resources in order to fulfil their roles and responsibilities, particularly in communicating with their constituents (Chester, 2005, Lewis, 2005, Day & Klein, 2005).
- The number of meetings of Board of Governors that take place would appear to be important, not only for democratic accountability, but also in helping to shape and define the roles of Governors (particularly in its early formation). A study at the Homerton Hospital FT indicated that Governors felt that 6 meetings per year were insufficient to help understand their role and develop a programme of work relating to this (Lewis, 205).
- Survey data among Governors suggests that there is future optimism for the role and effectiveness of the Board of Governors (given further time and experience in the role). National survey data among FT Governors found that 70% believed that they would become more effective in their role in the future (Chester, 2005). The downside of Governors developing experience and a greater ability to contribute to the executive operation of the FT, is that the propensity for 'informal co-option' increases. This may precipitate a conflict of interest as Governors aim to balance the role as representatives of the Membership with their 'executive' role.

3.5 Governors - NMUH Proposals

- The consultation document indicates that NMUH currently plans to have 36 Governors: 18 public Governors, 3 staff Governors and 15 nominated Governors from partner organisations (i.e. LA's, PCTs). This would appear to contravene current FT regulations that state public Governors must form a majority on the Board of Governors.
- The NMUH has indicated that it will continue to hold all Board meetings, both Board of Governors and Board of Directors, in public.
- Whilst the NMUH has developed an outline of the anticipated responsibilities of its Governors, as yet, there are no published proposals as to how frequently the Board of Governors will meet, the level of funding available to support its work or details on the nature or level of training that will be available for potential FT Governors.

- **Are there sufficient numbers of patient Governors on the Board of Governors?**
- **Will the composition of the Board of Governors reflect the diversity of the local community?**
- **What training will be available for Governors to help Governors fulfil their role and duties, particularly in engaging with their respective constituents?**
- **Will there be an indicative budget for the Board of Governors?**

3.6 Directors

- The Board of Directors is made of Executive Directors, Non Executive Directors, the Chief Executive and the Chairman. The responsibilities of the Board of Directors Trust include:
  - Day to day (operational) management
  - Service performance
  - Financial planning and performance
  - Overseeing long term (strategic) planning
- Executive Directors must include the Chief Executive and Director of Finance and must also include a registered doctor and nurse. There is no prescribed limit on the size of the Board of Directors though the range is generally between 10 and16 (average 12). FT's are expected to appoint a balance of Executive and Non Executive Directors.
- The Non executive director role has become of increasing importance so as to ensure that FT's have the necessary skills and expertise to help manage and direct such a complex organisation. In FT's, Directors have reported that there is now more local control over appointments has been found to beneficial in helping to select the right skill base for their executive needs.
- FT's Boards are required to self certificate their projected performance in relation to finance, governance and mandatory provision of goods and services. Monitor has indicated its concern at the level of over optimistic expectations and inaccurate predictions within the sector, given the number of FT's failing to meet set objectives. Monitor has indicated that independent reviews of self certification will be undertaken if this pattern continues in 2007/8.
- The Board of Governors may appoint Non Executive Directors: Non Executive Directors have to be members of the public or patient constituency, but cannot also be Governors (DoH, 2006).

3.7 Relationship between the Board of Governors & Board of Directors

- There is strong evidence to suggest that the operational role of the Board of Directors is clearly set out and understood by all parties. The role of the Board of Governors in strategic planning however has proved more contentious and evidently been a source of tension in the relationship between the two FT boards (Day & Klein, 2005; Lewis, 2005; Chester, 2005).
- Analysis of the operation of both Board of Directors and the Board of Governors suggest that the Chairman (who Chairs both) and the Chief Executive play a significant in driving the agenda of the Boards. Governors also reported that the dual role lead to conflict as they lacked their own Chair through which to hold the Board to account. In its audit of FT's, the Healthcare Commission (2005) has questioned the ability of the Board of Governors in its role to influence the decisions of the Board of Directors.

3.8 Relationship between the Board of Governors & Board of Directors – NMUH proposals

- No details are provided within the NMUH FT consultation document as to how both boards will interrelate. It is not clear if there will be any joint meetings of the two boards, though it has been indicated that the Chairman of the FT will continue to chair both.
- Other evidence provided by NMUH indicates that Non Executive Directors will be 'expected to bring independent judgement and question the Executive Directors so that the Board can come to well informed judgements as a corporate team'.
- Transitional arrangements for the management of NMUH are as set out in statutory regulations: the Chair, Chief Executive and Non Executive Directors are appointed to the Board of Directors for the remainder of their existing term or 12 months (whichever is longer).

- **How will an effective relationship between the two Boards be forged at the NMUH Hospital?**
- **How will the Board of Governors have meaningful influence with the decisions of the Board of Directors?**
- **What will be the Board of Governors role in strategic planning for the Trust?**

4. Partnerships and the local health economy

4.1 Partnerships – national perspective

- In order for FT's application to proceed beyond the consultation stage, it must be able to 'demonstrate that they have the support and involvement of staff and other local stakeholders for their vision for reform' (DoH, 2007)
- Although FT's will be independent of NHS control, it is obligatory to operate a 'duty of partnership' with other health and social care institutions in the locality which under the terms of their licence.
- New financial freedoms available to FT's may be likely to place them at a considerable competitive advantage over other NHS trusts in the local health economy. How this may relate with 'Duty of partnership' is undefined, thus there may be need to ensure that FT's do not act in an uncompetitive manner.

4.2 New contractual relationship with PCTs

- PCTs will be required to enter new legally binding three year contracts with FT's. Evidence from other scrutiny reviews (Camden, Birmingham) indicate that there should be a careful evaluation of the local PCTs capability and capacity to manage the new relationship with the FT's, particularly in relation to commissioning, contract monitoring and performance management.
- Concerns have been noted in respect of the (3 year) legally binding contracts that PCTs will enter in to with FT's and the flexibility that the TPCT will have to develop more primary care based models of service provision (as set out in the review of London NHS services). This is particularly important at this juncture as Haringey TPCT is developing its Primary Care Strategy.

- As FT's are likely to have contracts with a number of PCTs and operate from a position of greater strength than individual PCTs, there is a danger that services may become provider led (i.e. set by the FT). This is particularly pertinent given the development of Practice Based Commissioning, as services are commissioned from smaller purchasing units (groups of GPs). Consortia or joint commissioning arrangements (already developed for specialised services) may increase the ability of PCTs to direct the nature and level of service provision at FT's.
- PCTs may need to develop more robust monitoring systems to ensure that 'case mix drift' does not occur: where FT's 'select' patients on the basis that certain interventions attract a higher tariff or that certain conditions are associated with higher costs. This situation may be particularly prevalent where there is a high for demand services and where patients are prioritised.
- It is noted that disputes between FT's and PCTs have occurred. In such disputes the regulator (Monitor) has been reluctant to become involved encouraging parties to seek local resolutions to problems that occur. A number of these disputes have been facilitated by local Overview and Scrutiny Committees.

4.3 Partnerships – NMUH proposals

- All acute sector hospitals in the locality are in the process of applying for FT status. If all local applications are successful, the impact of an 'unequal playing field' among acute trusts may be limited.
- Local partner agencies (Enfield PCT, Haringey PCT, Barnet, Enfield & Haringey MHT, Haringey Council & Enfield Council) will all be able to nominate Governor representatives to the Board of Governors of the NMUH FT.
- Haringey PCT has indicated that it has met with the NMUH to discuss the impact of changes that will result with the latter acquiring FT status. It has indicated that it is satisfied with NMUH proposals and supports the trusts application for FT status (written confirmation is awaited).
- Although the NMUH is independent of NHS control, it has indicated that the London wide NHS consultation will inform developments at the trust and it will work in conjunction with other partners in the local health economy.

- **Does Haringey TPCT have the capacity, skills, expertise and infrastructure to commission, monitor and performance manage contracts with the NMUH?**
- **What steps will Haringey TPCT take to ensure that the commissioning process is truly commissioning lead?**
- **Will there be sufficient flexibility within the contracts to allow Haringey PCT to develop its primary care based models of service provision?**
- **What will be the role of Practice Based Commissioners be with the FT?**

- **Will the NMUH continue to attend local strategic health partnership boards?**

5. Impact on local people

5.1 Current service position of NMUH

- The current performance (2006/7) of the NMUH Hospital would appear to be mixed where the quality of services provided by the trust are rated as 'fair', though the management and use of resources was rated as poor (Healthcare Commission, 2007).
- In the annual patient satisfaction survey where patients are asked to rate services according to admissions procedures, the hospital ward, treatment received and interaction with doctors and nurses, the NMH came in the bottom 20% of trusts for 44 of the 66 assessed variables (Healthcare Commission, 2007a).
- The NMUH is however compliant with all core standards in the annual self-assessed health check report (Healthcare Commission, 2007).

5.2 Impact of FT on local people – improved accountability

- New governance arrangements may ensure that the FT's are more accountable to the local community (i.e. patients and public on Board of Governors);
- Operation of the FT Membership may enable local people to become more involved in the operation of the trust and help to bring closer links to the community;
- Services may be more responsive to community needs through more localised control over finances (i.e. the reinvestment of operating surpluses in local services) and improved arrangements for patient and public feedback (i.e. through the Membership);

5.3 Impact on local people – plan & develop services more quickly

- Speedier access to capital may allow the trust to provide improved facilities and equipment to maintain high levels of patient care;
- FT's more likely to have business strategies that focussed on growth and the development of new services for patients (Healthcare Commission, 2005);
- Had greater ability to focus on patient priorities, particularly access to services and patients environmental concerns (Healthcare Commission, 2005);

5.4 Impact on local people – patient experience

- The NMUH has indicated that apart from improved communication, patients may not experience an immediate difference in services once FT's status is approved. Improvements in the hospital environment and all round patient experience can be expected however in the short to medium term, as new governance arrangements and new financial freedoms begin to take effect.

- Improved accountability of FT's to their patients and the public is anticipated to bring positive developments for the patient experience. The operation of the FT Membership and Board of Governors may ensure that the interests of the local community are prioritised.
- Research undertaken by the Healthcare Commission (2005) indicates that there has been no real change in clinical networks or the pathways of care experienced by patients since the inception of FT's.
- The NMUH Patient and Public Involvement Forum have indicated that they have been consulted on the plans for FT status and are satisfied with the FT proposals.

How will the acquisition of FT status help to meet local health inequalities targets?
How will the trust determine what the priorities will be for service improvement once FT status has been achieved?

6. Finance

6.1 Financial position of FT's – national picture

- Overall the FT Sector is financially stable with a predicted operating surplus of £198 million predicted for 2007/8. 57 of the 59 FT's are predicting an operating surplus in 2007/8. Projected operating surplus across the sector varies from £10,000 to £14.45 million (median £1.81million). There is evidence that the FT sector is reducing operating costs, where £344million (3%) of cost savings have been achieved in 2006/7.
- All FT's are prescribed a borrowing limit set by the regulator based on an individual assessment of their finances. Increases in capital expenditure (2005/6) would appear to be financed predominantly financed through public sector loans (£137m), though other sources were used such as private sector loans (£74m) and disposal of assets (£63). There is a however a concern that there is an under development of capital in the FT sector: total long term borrowing in the sector is £129m against a prudential borrowing limit of £2,183m (6%).
- There is evidence to suggest that there is a strong financial monitoring system in place to support FT's. Those FT's that fail to meet standards set by the regulatory authority are required to submit monthly recovery plans.
- Monitor has an 'Asset Protection' process to ensure that there is due process in the disposal of key capital assets of FT's. Those assets which are essential to the provision of core services are declared in the application and granting

6.2 Financial position of NMUH

- The NMUH currently has a cumulative deficit of £13m. The NMUH aims to improve on the small operating surplus 2006/7: a projected surplus of £3m is forecast for 2007/8.
- Approval for the LIFT hospital developments was granted in August 2007. This allows for an investment of £111m payable over 35 years.
- Income will continue to be predominantly derived from local NHS commissioning agencies (PCTs). Income from private patients is capped at 2002/3 levels, which for the NMUH is approximately £200,000-£300,000.
- More challenging financial position for the NMUH lay ahead given that the tariffs for Payment by Results (price set for medical interventions and procedures) would be declining in future years.

- **How will the NMUH use new financial freedoms available under FT status?**
- **What are the consultation processes for any plans to dispose of capital assets?**
- **What are the investment priorities for any operating surpluses?**

7. Relationship with Overview and Scrutiny

Relationship with Overview & Scrutiny

- The relationship of the FT with Overview & Scrutiny Committee should continue as before, with one exception, that appeals should now be directed to Monitor (the FT regulator) instead of the Secretary of State. There is no public evidence of any appeals being lodged to date with Monitor.
- Patient and Public Involvement Forums will be dissolved in April 2008 and be replaced by Local Involvement Networks (LINks).

- **What will be the implications of the establishment of Local Involvement Networks (LINks) for the FT?**
- **How will the Membership of the FT interrelate with LINks?**

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