

Annual East of England Regional Health Scrutiny Conference

20 November 2009

**'Effective Health Scrutiny and working with
local and regional NHS bodies'**

Summary Report of the Conference

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This report is a summary of the 2009 Annual East of England Regional Health Scrutiny Conference, produced by Mike Cooper on behalf of the East of England Regional Health Overview and Scrutiny Chairs' Forum.

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1 Introduction

- 1.1 The Annual East of England Regional Health Scrutiny Conference – 'Effective Health Scrutiny and working with local and regional NHS bodies' – was held on 20 November 2009 at Newmarket.
- 1.2 The Conference was attended by 55 people, including representatives from the majority of the region's social services local authorities, along with representatives of a range of NHS bodies and Local Involvement Networks.
- 1.3 The aim of the conference was to look at:
 - the roles and responsibilities of health bodies in the East of England; and
 - how they work together and how they determine priorities;and to consider ways in which to develop healthy scrutiny's relationships with NHS bodies and its engagement in NHS commissioning on a regional and sub regional level.
- 1.4 The conference was chaired by Mike Cooper, a member of the expert advisory team of the Centre for Public Scrutiny (CfPS), an independent consultant and former councillor.

2 Presentations

The conference started with a set of three presentations.

- 2.1 The first, on **The Role of the Strategic Health Authority (SHA)**, was given by Simon Wood, the Programme Director for NHS East of England's Clinical Vision *Towards the best, together*.

Simon explained that the SHA performance manages Trusts (except Foundation Trusts); is accountable to the Department of Health; and is responsible for strategic direction of the NHS in the region and for improving health. He said that the focus for health scrutiny should be the Primary Care Trusts (PCTs), as they commission services; and that health scrutiny committees need to consider carefully what they want to get involved in. It was noted that over half the Trusts in the region are Foundation Trusts; and that the NHS expected a 'flat cash' budget – a cut in real terms. He reported that a forthcoming issue for joint scrutiny is a review of health services for people with learning disability.

- 2.2 The second presentation, **Primary Care Trusts moving toward world class commissioning**, was given by Andrew Pike, Chief Executive Officer of South East Essex Primary Care Trust.

Andrew described the Primary Care Trust (PCT) as the local leader of the NHS, whose role is to secure the services required to meet the health needs of its population, by commissioning services – often jointly with local authorities – in a way that secures the best outcomes for the available resources. This is a continual process in the face of changes in health technologies and demographics – in particular the ageing population; and requires new skills of NHS managers in managing change and public expectations. He said that PCTs welcome the engagement of scrutiny committees in needs assessment, service design and planning, joint commissioning, NHS consultations on service variation; and also the involvement of public and patients and of Local Involvement networks. He recommended that scrutiny committees should 'follow the patient' and focus on pathways of care.

- 2.3 The third presentation, **Priorities and Role of the Specialised Commissioning Group**, was given by Trevor Myers, Chief Operating Officer of the East of England Specialised Commissioning Group.

Trevor explained that the Specialised Commissioning Group (SCG) is a collective of the region's PCTs – it is not part of the SHA. Its role is to secure services for relatively small cohorts of patients, which are generally of high cost, and cannot be commissioned effectively by individual PCTs. He said that some specialised services require centralisation; but some can be provided locally and at home; and that the threshold between local and specialised services is not fixed: better local services and earlier intervention can mean less need for specialised services. He advocated greater integration and collaboration between services and a rationalisation of specialist providers, as currently many providers offer similar services. He emphasised the importance of assessing need, and welcomed engagement by scrutiny committees, which he said would usually require joint scrutiny and should take place as early as possible.

- 2.4 Copies of the presentations are attached as appendix C to this report.

3 Panel session

- 3.1 After a short break, the presentations were followed up by a panel session, which considered how health scrutiny can make a difference; its role and how it can add value to the processes described in the presentations; how to develop the role of health scrutiny; and how it can effectively engage with NHS organisations and influence NHS strategies and commissioning decisions across the region. Questions and comments were taken from delegates, and the panel responded and discussed the issues raised.
- 3.2 On the panel were the three speakers, Simon Wood, Andrew Pike and Trevor Myers, plus:
- Richard Henry, who is Chair of East & North Herts Primary Care Trust and a Stevenage Borough Councillor; and
 - Sally Newton, who is Chair of Hertfordshire County Council's Health Scrutiny Committee, and has also been a town and district councillor.

The following is a summary of the issues and suggestions raised by delegates and the panel.

3.3 *The role of health scrutiny*

Health scrutiny should be a critical friend of the health service. It should get involved in developing strategies and plans and scrutinise changes – how they are implemented, what impact they have and are they achieving planned outcomes? (But detailed implementation should be left to the NHS.)

Health scrutiny can make a difference: capture patient and staff experience; involve local public and clinicians' perspectives; identify better ways of delivering service.

Members have a role as elected representatives and community leaders; and bring an element of democratic accountability to health services. The value of health scrutiny is in its external viewpoint and lay perspective.

We are all stakeholders in the NHS, as users and tax-payers.

Questions were raised about health scrutiny and inspection; it was noted that:

- Health scrutiny does not have a direct role in inspection; inspection is a role of the Care Quality Commission (CQC).
- Local Involvement Networks (LINKs) have statutory powers to carry out visits; health scrutiny members do not have a right to carry out visits, but can, and often do, visit services by agreement with the provider – such visits are not 'inspections'.

3.4 *Relationships with partners and stakeholders*

NHS Trust Non-executive directors (NEDs):

- NEDs do have a scrutiny role, but they are jointly responsible with other directors for the performance of their Trust and have to act in the interest of the Trust.
- Both health scrutiny and NEDs act as a critical friend to the NHS.
- There is potential for the roles of health scrutiny and NEDs to complement each other and for a constructive relationship.

Foundation Trusts (FTs) are subject to new forms of governance:

- PCTs keep FTs to their vision and strategy through their contracts.
- In theory, an FT's membership and its 'elected' Board of Governors makes it more accountable to its local communities.
- FTs must still engage with democratically elected councillors and with PCTs.
- FT Governors' do have a form of scrutiny role, but they have a responsibility to act in the interests of their Trust.
- FTs are 'local NHS Bodies', and in terms of its role and powers, health scrutiny should treat FTs the same as other Trusts.
- Health scrutiny retains its role as independent external scrutiny, representing the community.
- There is the potential for effective relationships, sharing tasks, information etc.

Other bodies that health scrutiny could work with:

- Regulators – Care Quality Commission (CQC) and Monitor (the Independent Regulator for Foundation Trusts).
- Local strategic partnerships and Local Area Agreement.
- Professional Executive Committee (of the PCT).

3.5 Challenges

A major challenge to the NHS - and to scrutiny - is the pace of change in the health service:

- There is a need for both to face up to difficult decisions.
- Health scrutiny cannot look at everything; it will need to prioritise.

There is an increased focus on **commissioning** as the driver of service provision and a separation of provider functions from the commissioning role of PCTs.

- This could be a problem for scrutiny, as it is forced to focus on commissioning and contracting, and could become 'remote' from front line service delivery and the users' experience.
- There is a need to consider the impact of commissioning / decommissioning proposals on other services; how do you avoid unintended consequences?
- Scrutiny needs to prioritise and balance its attention to commissioning and to frontline service delivery / user experience, so it can have greatest effect.
- Specialised commissioning is not subject to different rules from other commissioning.
- Creating commissioner and provider organisations requires different skills in the NHS.

There is a greater focus on evidence and good practice (in the NHS).

There is a common view that there needs to be greater focus on **patient experience**.

- How do we ensure the health service delivers in terms of outcome for the patient?
- Concerns: staff too focused on their job, not the patient's experience.
- Need to address variability of patient experience.
- How do we ensure the health service delivers in terms of outcome for the patient?

There is a move in the NHS to contracting for the patient pathway as a whole and to create seamless patient pathways. But care pathways cut across commissioners and patient pathways for long term conditions are more complicated.

Integration of health and social care:

- There is likely to be closer relationship between local government and NHS.
- There is increasing use of joint commissioning and joint teams.
- Some PCTs have combined with each other and with their local authority.
- There is the possibility of different models developing locally.

Concerns were raised that **'management'** in the NHS detracts from patient care, and there was too much effort put into monitoring and measuring unnecessary targets. It was suggested that the real issue is the type of management, not how much – managers need the right skills to develop services in the current environment.

There is currently some duplication of performance management capacity between Monitor (the Independent Regulator for Foundation Trusts) and SHAs, but when all Trusts are Foundation Trusts, SHA costs should reduce.

3.6 Good practice

Examples of good practice from health scrutiny activity across the region:

- Devolving local scrutiny activity to local forums, that can then be reported back to a main scrutiny committee.
- Spreading good practice, promoting and sharing examples of things that have saved money and/or improved care, across different services.
- Developing a concordat between health scrutiny and NHS to help prioritise the scrutiny / consultation work programme.
- Revisiting health scrutiny recommendations to check on their effect and any changes to services.

3.7 How to make health scrutiny more effective:

To make health scrutiny more effective it needs to:

- consider carefully what issues it should get involved in;
- focus on where it can be most effective, and at what time; and
- prioritise, choose, be selective, not try to do everything.

Health scrutiny should have a greater focus on patient experience:

- 'follow the patient' not examine the service;
- focus on 'total place' spending (rather than individual services); and
- identify good and bad practice and the variability of patient experience.

A suggestion is to use mystery shoppers to test front line delivery.

There needs to be a close relationship between the health scrutiny committee and the local PCT; this should be continuous engagement not just formal scrutiny; with good dialogue and information, well in advance; and include planning how health scrutiny should engage with the NHS and how it can be most effective.

Consultation:

- Need to be clear about role of consultation – it is not a referendum.
- Should avoid drowning public in consultation.
- Health scrutiny committees should engage with NHS partners to consider the form of consultation and assess if it is appropriate.

Health scrutiny and elected members should engage with Trust Boards, practice based commissioning etc to represent their residents and act as 'community leaders', and help address the democratic deficit in the NHS.

Health scrutiny should understand the roles of and develop its relationship with key partners and stakeholders:

- Non-executive directors on trust boards (see briefing paper at appendix A).
- Foundation Trusts (see briefing paper at appendix B).
- Care Quality Commission (subject of report to Regional Chairs Forum).

Many developments in the health service will require engagement on a regional or sub regional basis, i.e. beyond a single health scrutiny committee. This will require health scrutiny committees to engage with each other and develop effective relationships with NHS partners regionally, in particular with the Specialised Commissioning Group.

4 Summing up

- 4.1 In bringing the conference to a close, Mike Cooper summed up what had been an informative and wide-ranging event, and explained that the points made throughout the conference will be recorded and summarised and reported to the East of England Regional Health Overview and Scrutiny Chairs' Forum; and that a summary report will be made available to delegates electronically through local authority officers.

5 Follow up

- 5.1 The questions, comments and suggestions made during the panel session, and those placed on the ideas wall, were recorded and summarised. A report of the issues raised, drawing out key points and making proposals for development, was presented to the East of England Regional Health Overview and Scrutiny Chairs' Forum, which considered how to develop health scrutiny engagement with NHS partners and with regional and specialised commissioning.
- 5.2 There was also an 'ideas wall', where delegates could place questions and comments on post it notes; where these were not addressed in the panel session, they will be forwarded to the appropriate body for their consideration,
- 5.3 The East of England Regional Health Overview and Scrutiny Chairs' Forum at its meeting on 10 December 2009 considered a report of the key conclusions of the conference and proposals for development.
- 5.4 The Forum agreed the following:
- i. Health scrutiny should understand the roles of key partners and stakeholders and how they relate to health scrutiny, and should consider how they can develop their relationships with them, in particular:
 - Non-executive directors (NEDs) on Trust Boards (the Forum received the briefing paper at appendix A).
 - Foundation Trusts (the Forum received the briefing paper at appendix B).
 - Care Quality Commission (the Forum received a report from a representative of CQC).

- ii. The Forum should seek to develop an effective relationship with the SCG.
- iii. The Forum adopted a draft framework for establishing joint health scrutiny committees to address regional and specialised commissioning proposals.

The Forum will progress these issues further.

- 5.5 The Forum is made up of the Chairmen of all social services authority health overview and scrutiny committees within the region or their representatives, and acts as a contact point for regional health bodies for health scrutiny issues affecting more than a single social services authority.
- 5.6 The Forum confirmed that it is an 'informal', strategic body; and that it is not a health overview and scrutiny committee and is not decision-making.

The role of the Forum includes:

- Mechanism for establishing joint scrutiny arrangements.
- Focus for communication between health overview and scrutiny committees, and with NHS regional partners.
- Channel for the sharing of good practice and provision of advice and guidance to individual health overview and scrutiny committees.
- Forum to enable more openness and early engagement from the SCG.

6 Glossary and further information

6.1 Glossary of terms and abbreviations

- CQC: Care Quality Commission.
- DH: Department of Health.
- Health scrutiny committee: The overview and scrutiny committee, sub committee or panel responsible for scrutiny of health services (also described as health overview and scrutiny committee or HOSC).
- FT: NHS Foundation Trust.
- LINK: Local Involvement Network.
- NED: Non-executive director (of an NHS Trust).
- NHS: The National Health Service (in England).
- PCT: NHS Primary Care Trust or teaching Primary Care Trust.
- SCG: Specialised Commissioning Group (of the PCTs in the region).
- SHA: Strategic Health Authority.
- SofS: Secretary of State (for health).

6.2 Sources of further information

- Care Quality Commission (CQC) www.cqc.org.uk
- Centre for Public Scrutiny www.cfps.org.uk
- East of England Regional Assembly www.eera.gov.uk
- East of England Specialised Commissioning Group www.escg.nhs.uk
- Local Government Association www.lga.gov.uk
- NHS East of England (East of England SHA) www.eoe.nhs.uk

Appendix A: The Scrutiny Role of the Non-Executive Director (NED)

The NED on an NHS Trust Board

Typical NHS Trust Board comprises five executive directors, paid employees, including the CE and finance director; and equal or larger number of non-executive directors, including the chair. The Board is accountable to Department of Health (DH). Board has a responsibility for taking forward DH / Government strategy and policy, and to follow guidance of NHS Plan.

All directors, executive and non-executive:

- share responsibility for Board decisions;
- are required to act in the best interest of the NHS; and
- have a role in ensuring the probity of the organisation's activities and contributing to the achievement of its objectives in the best interest of patients and the wider public.

To fulfil their role, all Board members need effective relationships with key stakeholders, including elected councillors and the local authority. (*DH Guide to NHS Boards*)

Role of NED:

1. **Strategy:** 'to *constructively challenge* and contribute to the development of strategy'.
2. **Performance:** 'to *scrutinise* the performance of management in meeting agreed goals and objectives and monitor the reporting of performance'.
3. **Risk:** 'to *satisfy themselves* that financial information is accurate and that controls and systems of risk management are robust and defensible'.
4. **People:** role in appointment and remuneration of executive directors.
5. Plus **Accountability:** to ensure the Board acts in the best interests of the public and is accountable to the public for the services provided and the public funds it uses.

(From 'Governing the NHS' 2004, 1 to 4 taken from the Higgs Report, DTI, 2003)

The **SAGE** criteria – NEDs act as:

1. Steward – includes *independent scrutiny* and financial stewardship;
2. Ambassador – ensuring patients come first, local partnerships;
3. Guardian – providing leadership and strategic direction;
4. Experience – draw from own, external experience.

NEDS should:

1. *Challenge* the executive team as plans are developed.
2. Maintain objectivity, and not get distracted into operational detail or cross the line into management responsibilities.
3. *Question and probe* the executive team on its performance; monitor against planned objectives.
4. Be constructive and guiding so their *scrutiny* leads to better outcomes and strategies.
5. Be assured of controls and standards of governance, finance and risk management.
6. Be a source of support for chair – constructive, not uncritical.
7. Add value – should not substitute for or supplement executive effort.

They are NOT external policing. Their role is to assist in governance, not be 'representative'.
(From 'Governing the NHS' DH 2004)

Responsibility of NED includes:

- To 'help the board work in the public interest'. (*NHS Appointments Commission*)
- To provide reassurance that standards of governance are observed. (*DH Guide for NHS Boards*)
- NEDs need to be able to work as a team, challenging yet supportive, independent yet involved, to maintain independence yet not be aloof, uninformed or peripheral. Need to take the wider view and establish their credibility. (*HSJ Nov 2006*)
- NEDs need to gain the 'trust and respect of other board members'. (*Higgs*)
- They should question intelligently, debate constructively, challenge rigorously and decide dispassionately. (*Higgs*)

Foundation Trust – as above except:

Two-tier governance:

1 – Board of Directors (corporate leadership); and 2 – Board of Governors (oversight).

Board of Directors: responsible for the performance of, and exercising the powers of, the FT; accountable to FT members through Board of Governors (not to SHA, DH or SofS). Also accountable to Monitor. Board has duty to consult and involve Board of Governors.

NEDs:

- are appointed by the Board of Governors;
- provide independence, balance and challenge to the executive directors (*Monitor*); and
- take full and equal responsibility and accountability for the function and success of the trust .

Board of Governors: Also called Council of Governors, Membership Council, member's council, governing body. Proportion of governors elected by the members and accountable to members. Guidance says that Governors:

- *challenge and collectively hold to account* the board of directors;
- *scrutinise* the trust's annual plan; and
- must act in best interest of the FT.

Strengths and weaknesses of the Non-Executive scrutiny role**Benefits of Non-Executive Scrutiny:**

- External expertise.
- Varied experience and perspective.
- Community focus?

Limitations of Non-Executive Scrutiny:

- Their shared responsibility for: a) setting policy and objectives; and b) organisational performance; limits the independence they can bring to scrutiny.

(*Benefits & Limitations: Dr Roger Moore, CE, NHS Appointments Commission, 2006*)

Tensions within the Non-Executive role (*From Audit Commission*):

Part of corporate team and therefore supportive of the Chair and C.E.	vs	Acting as a counterbalance to the power of the Chair and Chief Executive
Good team spirit is essential to the operation of the Board	vs	Monitoring the performance of executive directors
Contribute to development of strategy	vs	Monitoring the implementation of strategy, they may be drawn into operational issues

Further issues with FTs:

- FT NEDs, being closer to the management of the trust, compromise their independence and ability to scrutinise the executive; so the 'internal' scrutiny role and holding the executive to account falls to the Board of Governors.
- FT NEDs appointed more as 'experts', so community accountability is a role of Governors.
- But governors also have a responsibility to act in the interests of the Trust, so their 'scrutiny' is not independent.

Summary by Dr Roger Moore:

- We are all scrutineers of the public services we use.
- NEDs have a key role in shaping organisational objectives and scrutinising performance.
- But *external scrutiny* can provide further safeguards.

ie There is a distinctive and necessary role for local authority health scrutiny; the roles of health scrutiny and the Non-Executive Director can be complementary.

Appendix B: NHS Foundation Trusts – key features for health scrutiny

NHS Foundation Trusts (FTs) were established under the Health and Social Care (Community Health and Standards) Act 2003. They remain part of the NHS, but with new governance arrangements and greater freedoms, intended 'to devolve decision-making from central government control to local organisations and communities, to make Trusts more responsive to the needs and wishes of local people' (*Department of Health*).

The key differences from other NHS Trusts are that FTs are:

- legally independent bodies under new form of public ownership as independent 'Public Benefit Corporations';
- accountable to local people, through their membership and Governing Board;
- not accountable to or performance managed by the Strategic Health Authority (SHA), Department of Health (DH) or Secretary of State (SofS);
- responsible to Monitor (see below) not Secretary of State.

FTs have greater freedom (than other NHS Trusts) to develop their services and direct their resources to meet local needs and priorities. FTs:

- are free of central government control and not performance managed by SHAs;
- can retain financial surpluses and retain proceeds of asset sales;
- decide their own capital investment needs; and
- can raise capital from the public and private sectors (within limits set by Monitor).

FTs (similar to other Trusts):

- are subject to national standards and targets, and to inspection by the Care Quality Commission (CQC) (same as other NHS Trusts);
- provide NHS services under legal contract to Primary Care Trusts (PCTs) (as commissioner).

'Terms of Authorisation' set out the conditions under which the FT operates, including: the services it can provide, the services it is required to provide to the NHS – 'protected' services, and a list of assets that are 'protected' (ie are required for the provision of 'protected' services).

In relation to the role and power of health scrutiny, they are 'local NHS bodies' and should be treated the same way as other NHS Trusts; however scrutiny committees should note that:

- Officers of an FT are required to provide information and attend health scrutiny committees, the same as other Trusts, but they are likely to see their primary accountability as being to their governing body.
- If an NHS Foundation Trust wants to change 'protected' NHS services, it must consult the local health scrutiny committee, and obtain the agreement of Monitor (similar to consultation on substantial variation and health scrutiny right of referral to SofS).

FTs are accountable to:

- members through Board of Governors;
- PCTs through contracts;
- Monitor.

FTs can tailor their governance arrangements to suit their community and health economy.

Membership: FTs have a duty to engage with their local community, and encourage local people to become members. The way that its membership is structured and recruited is up to each FT.

Membership is open to:

- residents and patients in areas served by the FT;
- staff of the FT; and
- optionally – patients who do not live locally, and their carers.

Members:

- receive regular information about their Trust;
- are consulted on plans for future development;
- can vote in elections to the Board of Governors; and
- can stand for election as Governors.

And public members are eligible to be appointed as non-executive directors (NEDs) on the Board of Directors.

Governance. Two-tier governance:

Board of Governors (oversight) and Board of Directors (corporate leadership).

Chair of FT is Chair of Board of Directors and Chair of Board of Governors.

Board of Governors. Also called Council of Governors, Membership Council, member's council, governing body.

The exact size and shape of its Board of Governors is determined by each FT in the light of its local circumstances, within minimum parameters set out in legislation:

- a majority of places must be representatives elected from public and patient membership;
- at least three staff governors elected from the staff membership; and
- at least one local authority governor, one primary care trust governor and where applicable at least one university governor, nominated by the relevant organisation.

Role of Board of Governors:

- represent the interests of the members and partner organisations in the local health economy in the governance of the Trust;
- share information about key decisions with their membership community;
- work with the Board of Directors to set the strategic direction of the Trust and ensure it acts in a way that is consistent with its terms of authorisation;
- advise the Board of Directors and 'influence' decisions about spending and service development; and
- collectively hold the Board of Directors to account.

Plus the Board of Governors:

- appoints Chair and NEDs of Board of Directors (and can remove on 75% vote);
- approves appointment of Trust Chief Executive;
- agrees terms and remuneration of NEDs and Chair; and
- receives annual report and accounts.

Governors are not responsible for the day-to-day management of the FT.

Governors must act in the best interests of the FT (same as Directors).

Governors have a 'scrutiny' role and are separate from the 'executive' function of the Board of Directors, but they are not 'independent' as they are required to act in the interests of the FT.

Board of Directors. Made up of executive directors, paid employees, including the CE and finance director; and equal or larger number of non-executive directors, including the chair.

Role of Board of Directors:

- responsible for performance of Trust, exercises powers of FT;
- responsible for the day-to-day management of the organisation e.g. setting budgets, staff pay and other operational matters (like other NHS Trusts); and
- must consult and involve Board of Governors in strategic planning of Trust, and in preparing the Trust's forward plan must have regard to the views of the Board of Governors.

Monitor, the Independent Regulator of Foundation Trusts: approves applications for Foundation Trust status, issues Terms of Authorisation, monitors performance, and can intervene in the event of serious non-compliance with the terms of authorization – can require the FT to take certain action, and can suspend or remove members of the Board of Governors or Board of Directors. Monitor is accountable directly to Parliament (not Secretary of State).