



"Democracy and Governance"

Written Submission on Foundation Trusts to the Health Committee, House
of Commons, London

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4 January 2003

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1. *Summary*

2. The submission addresses how Foundation Trusts will be governed, and makes recommendations for improvements.
3. Stewardship, and how the public interest is protected, involves how the public interest is protected when it is delegated, such as to Foundation Trusts. The notion of stewardship is absent from the proposed approach and its importance is crucial to defining the proper role of governors.
4. The appropriate separation of Trust management from Trust governance is necessary and the proposed approach is found to be confusing. A variety of risks are identified which can undermine proper Trust governance and which in turn offer ways to improve the proposed roles for the Board of Governors and the Management Board.
5. Board governors need to have a clear duty to their Foundation Trust. The proposed approach, involving a wide variety of community groups in Trust membership from which governors would be elected, is risky. It should not be assumed that a Trust's democratic legitimacy could emerge from undemocratic constituencies, since this would only raise the legitimacy of representation itself as an issue. Steps are needed to ensure that representation is in the Trust's interests, too.
6. Recommendations for improvements are made in the areas of public scrutiny, management/governance relations and the duties of governors.

7. I welcome the development of Foundation Trusts and commend the Department of Health in this respect. My submission is intended to reinforce the focus on democratic accountability, good governance and public stewardship.
8. *INTRODUCTORY REMARK: Democracy in the 21st Century*
9. The proposed Foundation Trusts are in my view evidence that the health service is prepared to embrace a wider, pluralistic and fundamentally more democratically satisfying approach to health service delivery.
10. I have been critical [1] of the lack of integration of public and private providers within a single regulated health system, arguing that a fixation on public ownership and control has blinded policy makers to the benefits of a mixed economy of service provision, responsive to individual needs and expectations. But these outcomes can be achieved without sacrificing the critical importance of well-structured and coordinated service specification, through either monopsony purchasers, or appropriate regulation.
11. To a great extent, the democratic accountability of the NHS has depended on the relation between the Secretary of State for Health and Parliament, an interesting level at which to position a public service that is required to meet the individual healthcare needs of over 48 million people in a complex, dynamic and effective manner on a daily basis. New thinking is needed to meet the democratic standards of the 21st Century, thinking which leads to organisational innovations like Foundation Trusts.
12. *INTRODUCTORY REMARK: Good policy making; even better implementation*
13. Governments face a dilemma when trying to balance good policy making with effective policy implementation – the more highly specified the means for implementation the greater is the risk of failure. The way forward calls for flexibility and innovation on the one hand by providers and forbearance and restraint on the other hand by policy makers.
14. But better policy making will also need to step outside the bounds of what is known and embrace experimentation, and that takes not just courage but the creation of what one might call "public service laboratories" where new forms of service delivery can be developed. Can Foundation Trusts be evidence that service pluralism and an experimental and innovative culture are about to appear?
15. The need for flexibility, change and experimentation in hospital development is actually more important than is realised. Many (perhaps the majority) of our ideas of how hospitals should be organised and what they should do are now dated. As well, there are many constraints on how NHS providers organise themselves to meet their clinical and other service priorities – many of these constraints may be self-imposed and may in the end prove dysfunctional. The ability of Foundation Trusts to deliver to the very top of the policy agenda could ultimately depend on their freedom to innovate – in effect their ability to shape themselves to the these times and to meet public expectations, a clear challenge to conceptions of a uniform national health service.

16. The concern about "two-tierism" in the NHS reflects a preference for this uniformity, which unfortunately has restricted innovation and fostered an inability for people to meet the health care needs of the public through novel approaches to the delivery of care. I would suggest that it is clearly in the public interest for greater experimentation in organisational form within the NHS, and this cannot be done with *a priori* assumptions about what particular structures are acceptable. Flexible organisations are central for effective governance since that will enable the Trust's ability to meet its public service remit.
17. *REMARKS ON GOVERNANCE [2]*
18. *Stewardship, and how the public interest is protected*
19. Foundation Trusts will be delegated the responsibility to act in the public interest by the government, which at present protects that responsibility in the form of the accountabilities of the Secretary of State for Health. Acting on behalf of the public interest in a delegated manner is 'stewardship', the key attribute of governance in Foundation Trusts.
20. It should be expected that different interpretations of the public interest will emerge, between the Department of Health and Foundation Trusts and community stakeholders.
21. The public interest in the UK is not generally determined in a Darwinian contest between competing stakeholder interests and claims ("winner takes all") but has been embodied within the accountability of Parliament to the public; this has been particularly so in health since the founding of the NHS. However, with Foundation Trusts there will be another interpreter of this public interest. In itself this is not a bad thing, as it will impose on government a greater opportunity to engage with the public not as the sole determiner of the public interest, but as one of the key stakeholders participating within a wider forum of debate and discussion – representing a clear challenge to the members of this Committee, for instance.
22. But, it must be said, government does have a duty to ensure that it does not undermine the ability of Foundation Trusts to do what they have been licensed to do.
23. In light of that, I would suggest the Committee consider whether a wider forum of policy-making and decision-making in health is needed (other than Parliament, of course), since the existing ways will I suggest be less effective than in the past, as fault lines are likely to form in the determination between the public interest and health priorities.
24. I think the proposed Commission for Health Inspection and Audit is not the appropriate body to undertake this as it would have a conflict of interest between what it identifies as its priorities vis-à-vis inspection and audit, and what may in fact be in the wider public interest; adherence to a programme of measurement and performance in itself is not an embodiment of the public interest. The specification of the proposed Independent Regulator for Foundation Trusts is for similar reasons not the right body. Something else is needed, and warrants further consideration.
25. *The appropriate separation of management and governance*

26. It is important to keep the management and governance systems separate. In the case of Foundation Trusts this will be even more important given the high degree of independence that the Trust will have and the obligation to act in the public interest. The Trust governing board will be charged with considerable responsibilities and duties under the Trust's license and must be able to attract governors of the highest quality.
27. It is in this context that I find the different responsibilities of the Board of Governors and Management Board confusing.
28. My concern is that prudential matters involve a managerial accountability to the Board of Governors by the Management Board, which in turn demands expertise at the governing level to form an independent opinion of management.
29. For this to be workable, the relationship between the Board of Governors and the Management Board must have a degree of independence and autonomy on both sides. The tensions that this will engender and therefore need to be taken into account are at least these:
 - 29.1. The risk that an ineffective Management Board will 'delegate management decision-making upwards' to the Board of Governors;
 - 29.2. The risk that the Management Board will fail to respect weakly defined authority of the Board of Governors and seek to 'keep it in the dark';
 - 29.3. The risk that a hyper-active Board of Governors will become involved in operational matters;
 - 29.4. The possibility that some members of the Board of Governors will view their involvement in governance affairs as merely a form of public philanthropy and not take their responsibilities seriously enough or fail to intervene when confronted with poor management;
 - 29.5. The risk that the Board of Governors will not be expert enough in the various issues facing the Trust and that they will be unable to assess managerial performance and thus become 'captives' of the management;
 - 29.6. The risk of collusion between the chief executive and board chair;
 - 29.7. The risk that the Board of Governors will become self-engrossed with its own representational relationships and interpersonal dynamics and fail to assume wider Trust responsibilities.
30. I suggest that alterations in the proposed minimal standards for both management and governing boards be considered with respect to addressing these potential risks.
31. *Forms of public representation and governance*
32. Representation on the governing board by stakeholders drawn from the Trust's membership could militate against the Trust ever actually being able to undertake the necessary strategic developments that would lead to them being successful.

33. Special interest groups may seek to dominate governing boards which can lead to organisational chaos if not failure, particularly where doctrinaire elements conspire to undermine what is potentially sound strategic direction. Without arguing against the importance of public involvement and representation, and acknowledging the broader context of public accountability, members of governing boards should be committed to the Trust's flexibilities and freedoms within the context of its license. The responsibility for stewardship described above should also be a responsibility of individual members of the governing board. Boards need the freedom to ensure that its members are committed to the Trust's constitution and license.
34. This raises concerns for how governors are elected or selected, and I would advise greater consideration be given to the process by which Trust membership is achieved, particularly by representatives of non-governmental organisations and special interests groups who generally themselves often lack a formal democratic accountability in virtue of their special interest status, as they appear to form a major component of the general pool from which governors are to be drawn.
35. Wider participation by members of the public should be more actively solicited, even if it means altering the proposed system of membership and elections to the governing board. In particular, people who are not involved in the health service (professionally or otherwise) should be particularly sought.
36. It should not be assumed, therefore, that a Trust's democratic legitimacy can emerge from undemocratic constituencies, since this would only raise the legitimacy of representation itself, an area which needs to be considered in more detail as it is a major source of democratic deficit. Further consideration needs to be given to the forms of democratic procedure to be followed to identify potential governors.
37. *Recommendations for improvements*
38. I would recommend the following to enhance public scrutiny:
 - 38.1. Integral to the Trust's license could be a 'promise of performance' imposing a generalised framework of accountability to act in the public interest, and which includes an explicit 'public interest override', which will permit the Trust to address unspecified areas or issues but which may not sit comfortably with existing policy and direction and protect it if does. The Chief Executive and Chair would undertake this promise as a matter of personal accountability. The notion of promises is compelling because they carry the element of moral obligation and involve language that is broadly accessible to the public at large. The risk otherwise is an inscrutable regulatory regime that the public cannot understand, and which would further disenfranchise the public from the NHS.
39. I would recommend the following as an alternative specification of the respective roles of the two boards:
 - 39.1. The Management Board should comprise the Chief Executive and the senior management team (however defined), with the Chief Executive serving at the pleasure of the Board of Governors. If the Board of Governors has questions of operational interest, then it is best undertaken in the context of their governance responsibilities, not as parties to daily management as non-executive directors. This is a departure from current NHS practice, which I

think is necessary in light of the greater autonomy of Foundation Trusts. A known weakness of boards involves due diligence over management.

39.2. The Board of Governors should involve a wider level of representation beyond that of the more obvious social stakeholders, to include financial, organisational, technology (information and clinical) and human resource expertise at least, with the Chief Executive, Medical Director, and other senior clinical staff holding ex-officio, non-voting/advisory seats on the Board. A known weakness of governance systems is a lack of access to operational expertise.

40. I would recommend the following to clarify the role of governors:

40.1. All members of a Board of Governors should be as a matter of duty appointed to ensure that the Trust acts within its licence, and should therefore be appointed to further these aims and objectives, in keeping with the stewardship duty to the public interest. It is a known risk that members of governing boards may not always reveal sources of conflicts of interest which in the case of widely representational boards is exacerbated and often leads to serious breaches of trust or conflict. Trusts need to have some expectation that governors will act to further the aims and objectives of the Foundation Trust.

41. Concluding Remark

42. I see Foundation Trusts as a move toward creating the necessary structural differentiation that encourages excellence in health service delivery through more responsive local accountability, and increasingly personalised service to meet demanding and evolving public expectations.

43. The evolution of a mixed economy hospital sector is slowly taking shape. Scrutiny of Foundation Trusts should not detract from also taking account of the wider benefits to the public to be gained from a more integrated system of provision reflecting a diversity of organisational providers and systems of ownership.

44. While the present focus on Foundation Trusts and new forms of regulating providers is timely, the regulation on the commissioning side is still a weakness and should be priority for similar consideration.

45. I hope these remarks are helpful to work of the Health Committee, and I thank them for receiving this submission. Should any of these issues be of further interest to the members of the Committee, I would be pleased to provide oral evidence.

References

[1] q.v. Tremblay, *Exploding health care myths – the real threats to public health*. British Journal of Healthcare Management, 5(3-1999)89-91.

[2] q.v. Tremblay, *Balancing Accountability and Authority: the new governance*, British Journal of Healthcare Management, 2(12, 1996)669-673.

Note on the author

Dr Tremblay, partner in Tremblay Consulting, advises clients on issues that link business strategy and public policy in health. His career has involved health policy, service delivery, education, research, administration and management in many countries including his native Canada. His PhD is from the University of Toronto. He is a specialist in policy development, implementation and evaluation, and has developed specific ways to help clients assess and improve their strategic role in health and related markets.

Formerly, he led the UK healthcare consulting practice for EDS, and was a Principal at A.T. Kearney, EDS's management consultancy division.

He has also held appointments at the Health Services Management Centre, University of Birmingham, UK, where he was Senior Lecturer, Director of the Masters in Quality, Deputy Director of the Public Service MBA and an Associate Dean.

He was Director of Education at Chedoke-McMaster Hospitals (now Hamilton Health Sciences Corporation), and McMaster University, Canada.

Dr Tremblay is an expert advisor on health to the *Council of Europe*, Strasbourg, an Associate of the *Woodrow Wilson Center*, Washington, D.C and a member of the *Strategic Planning Society*. He is on the editorial board of the journal *Disease Management and Health Outcomes*.

He is a member of the UK's *National Forum on the Internet and Democracy*, hosted by the Hansard Society.

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