NHS HULL

‘EXPLORING THE CASE FOR A TOP TIER MEMBERSHIP’

Service Improvement Element of the Organisational Development Project

Final Report: February 2009

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Exploring the Case for a Top Tier Membership - Service Improvement Element of the Organisational Development Project

SECTION 1: INTRODUCTION

Background

Within the Organisational Development demonstration projects supported by the NHS Centre for Involvement (NCI) there are two parallel work programmes. One is the diagnostic element, which gives organisations an externally validated baseline assessment of Patient and Public Involvement (PPI) within their organisations; the other is the service improvement project element.

Organisations who work with the NCI benefit from 50 days of supported time. The service improvement project element comprises 20 days of support.

Within reason, NCI is happy to support any service improvement project, as long as it can be demonstrated that the project will be of value to Patient and Public Involvement within the organisation and to the wider NHS in terms of learning.

NHS Hull (Hull Teaching Primary Care Trust [PCT]) is testing out a membership model to maximise engagement of its local population with its commissioning function. One of the areas being debated within the PCT is the need for academic rigour to support decision-making around proposed membership models – particularly the need for a 'top tier'. Linked to this is whether structures and processes within the PCT are robust enough to support the involvement generated through such a model.

The notion of a membership model in commissioning is extremely innovative and draws on examples from Foundation Trusts. Foundation Trusts, which are public benefit corporations that place public, patients and stakeholder involvement at the heart of governance, under the Health and Social Care Community Health and Standards Act 2003 have to adopt a membership model in order to succeed the demanding authorisation process (Slipman, 2007; Ham and Hunt 2008) by 'Monitor' - the independent regular. They do have some flexibility around what the model looks like, as long as the 'legal minimum' is met.

Foundation Trusts are provider organisations (such as acute trusts, specialist trusts, mental health trusts or ambulance trusts) and not commissioning organisations. Just as there were concerns about the respective roles of the elected Board of Governors and the Corporate Board when the Foundation Trust legislation was making its way through the parliamentary process, so too

there are similar questions being asked about what the most effective ‘top-tier’ of the membership model would look like within a commissioning PCT.

The Aims of the Service Improvement Project

Following discussion with the PCT, the decision was taken that the Service Improvement element of the project would involve:

- a detailed review of evidence around what are the possible ‘top-tier’ models for a membership organisation;
- an analysis of the strengths and weaknesses of each of the identified models within the context of the World Class Commissioning (WCC) competencies (DH, 2007a), the assurance framework (DH, 2008), the draft national PPI organisation standards (NHS Centre for Involvement, 2008) and other key documents (Dr Foster Intelligence, 2008); and
- production of a report and possible tools such as an assessment framework.

The work would take place in three stages:

1. The service improvement team will undertake a detailed review of available evidence drawing on Foundation Trust documentation (DH, 2006a: DH, 2007b: DH and Monitor, 2007: 2008), documents from other organisations such as various social enterprise models (www.socialenterprise.org.uk) and co-operatives (www.cooperative-uk.coop/live/cme0.htm) in order to identify possible models for the top-tier.
2. The various emergent models will be tested against the WCC competencies and other measures and a SWOT analysis undertaken (strengths/weaknesses/opportunities/threats).
3. A stand alone report will be produced for this element of the work which can be used as the basis of consultation if appropriate.

Evidence for a Possible ‘Top Tier’

Starting point
From the outset of the Service Improvement Project, NHS Hull identified two possible options for a ‘top tier’ and these formed the starting point for the collation of the evidence about possible structures. The two possible options were:

- a shadow *Board of Governors* elected from a middle tier membership currently referred to as NHS Hull Champions. The Board of Governors and the PCT Board would have a common chair; and
- a *Health Congress* that would sit alongside the PCT. The chair of the Health Congress would not be the chair of the PCT Board, but would meet regularly with the PCT chair and chief executive.

Our remit was not, however, to look only at the two identified options. Indeed, a third option emerged during early discussions, which was not to have a 'top tier' at all. We therefore undertook a detailed review of the literature to identify what different alternatives might look like and whether there were further options.

We were specifically charged with undertaking this project for the city of Hull and within the context of NHS Hull. The PCT clearly stated its aspiration to be the Hull people's NHS. There was an awareness of the need to avoid taking an approach that produced something too rigid in terms of a top tier structure that might not be what the people of Hull actually wanted once a system was in place to gather their views. This was something of a 'chicken and egg' phenomenon similar in nature to the dilemma faced by host organisations in relation to the newly emerging Local Involvement Networks (LINks). A LINk should decide its own form but it cannot do this until it is established and its establishment means making at least some rudimentary *a priori* decisions about form.

We were also aware of three other contextual issues that we needed to take account of:

1. We came across references to the 'apathy of Hull'. This refers to previous experiences of trying to motivate people in a city to become interested enough in health issues to become involved. A city-wide 'listening exercise' has been procured and we recognised the need to ensure that the results of this exercise should inform our work.
2. The PCT membership proposals are 'hitting the streets' at the same time as the mental health trust membership scheme and the acute trust membership scheme. Although the City Council has proposed a city-wide membership scheme, this is not planned for the immediate future and both the mental health and acute trusts are seeking Foundation Trust status and therefore, as required by the process, are actively recruiting members. The three Trusts are working closely together but awareness and sensitivity is needed to ensure synergy between the emergent models.
3. The new Local Involvement Networks (LINks) which have replaced and expanded the functions of the Patient and Public Involvement Forums (PPIFs) were launched from April 2008. Their remit is to help local people and organisations to have a voice in their local health and social care services. They too are recruiting to a membership.

Methodology

Identification of evidence for the review included scoping electronic databases for a five year period for evidence sources in the English Language. Data

were then further scrutinised for further relevant references, and these were collated and included if appropriate.

After collating the evidence, data were analysed and relevant sections were allocated to the themes for the report, which were:

- the rationale for a membership approach;
- possible membership models; and
- the strengths, weaknesses, opportunities and threats of emergent models with reference to the World Class Commissioning competences.

SECTION 2: RATIONALE FOR THE MEMBERSHIP APPROACH

Introduction

NHS Hull had already launched its membership scheme when we commenced this project. The membership model to date includes a **Core** comprising three constituencies of:

- individual members;
- staff members; and
- voluntary and community sector organisation members.

The **individual** constituency is itself made up of two types of members: **public** (people who live within the PCT boundaries) and **patients** (people who have accessed healthcare within the PCT boundaries, but who are not resident there). This approach was adopted by the PCT to help ensure that those often classified as ‘seldom heard' or ‘frequently overlooked' would have an opportunity to give their views.

The aim of the core membership is that a minimum of 1% of the population should be ‘signed up' by the end of March 2009, which equates to about 2500 people.

The proposed second level of membership is the **NHS Hull Champions**. These are people who would be prepared to take a more active role in the work of NHS Hull. They will be expected to register as volunteers with the PCT. The option of having a shadow Board of Governors would probably mean electing a Board from this level of membership i.e. the NHS Hull Champions.

In addition to the patient versus public involvement debate, the governance structure of Foundation Trusts includes a compulsory staff membership category and the PCT has taken the decision to include a staff member constituency within its membership scheme.

Although the decision to develop a membership scheme (including a staff membership) had already been taken, the first part of our review explores the rationale for membership.

Principles of Involving People

Initiatives that enable people to have a greater say in all aspects of healthcare have been gathering pace over the last decade. The Community Health Councils (CHCs) which were part of the health landscape for nearly 30 years were abolished in 2003 and Patient. Under the *NHS Reform and Healthcare Professions Act* 2002 Public Involvement Forums (PPIFs) were established in each NHS organisation in England and performance managed by the Commission for Patient and Public Involvement in Health (CPPIH). However,

one of the main criticisms of both the CHCs and PPIFs was that the voices being heard were few in number and they were the same voices as were being heard throughout public services (Hogg, 2008). This is not intended to be a criticism of those people who gave their time and energy to involvement and participation - it is a more a statement about the need for organisations to consider what representation really means and how to ensure that involvement mechanisms are both seen to and actually do make an impact.

Skidmore *et al* (2006) discuss the notion of social capital and how those who are already well-connected become better-connected through participation. The same people who put themselves forward as, for example, school governors are the same group who are likely to sit on patient panels and on other public service Boards. This group become known for being willing volunteers, they develop an expertise and consequently they become the people that are invited to participate and take up governance roles in organisations. Skidmore *et al* argue that the way these governance arrangements work creates barriers for those who are traditionally outside of the system.

In 2006 the Department of Health published *Our Health, Our Care, Our Say* (DH, 2006b) which forcefully stated that the *status quo* had to change and that public services that commissioned and/or provided services had a duty to 'systematically and rigorously' find out what people both wanted and needed from their health services. The onus of responsibility to carry out this duty was firmly placed on the organisations and included a requirement to 'reach out to those whose needs are greatest but whose voices are often least heard'.

The abolition of the PPIFs and CPPIH in 2008 and the replacement with Local Involvement Networks (LINks) was one of a number of significant measures introduced by the Local Government and Public Involvement in Health Act to change the previous system and expand the number of people who would have a say in how local health and social care systems work. There remains scepticism about how LINks will work and views range from 'nothing will change' and LINks will 'change nothing', to hopes that LINks will provide a vehicle for more local people to have a say about local services.

It is not our role within this review to provide a detailed assessment of LINks and in any case it is too early to make such an assessment. However, an area of LINks that is causing great concern for acute, mental health and ambulance trusts is how LINks will work with the membership schemes that have been, and are being, established as part of the continued expansion of Foundation Trusts. For PCTs, a particular concern is that they are being assessed under World Class Commissioning in terms of their ability to engage with local people **now.** Many PCTs feel they have to find ways in advance of LINks being fully established to meet the requirements outlined in the World Class Commissioning competencies (DH, 2007a).

Leaving aside whether LINks will or will not be a successful vehicle for local voices to be heard, the involvement of local people in commissioning is a new challenge that PCTs are facing. The opportunities for local people to have a

say in how tax payers' money is spent is admirable, but the reality of getting people involved is less easy to fathom. Lawless and Knowles (2006) discuss work in this area undertaken by the National Primary Care Development Team (NPDT). One of their programmes of work is the Healthy Communities Collaborative which aims to put community members at the forefront of service change and to develop deprived communities. Lawless and Knowles discuss, in particular, the role of Practice-Based Commissioners and how local people are able to influence locally-based commissioning to improve health. Their work includes useful examples that have relevance to our current work. In particular, they discuss a number of commissioning roles for community members including contributing to needs assessment and feeding through the results of successful community approaches to delivering preventative services.

Commissioners must, however, be aware of the need to balance input into commissioning from those who currently use services and those who may use services in the future, i.e. the patient and the public perspective (Coulter, 2006). Walker (2006) discusses that those in governance roles, such as members of the Board of Governors, should be patients and that there is a strong argument that commissioners must make sure that services are responsive to the views of those immediately affected by provision. However, there is also a need, according to Walker, for commissioners to consider using aggregated information gathered by organisations that seek to represent the views of people using services. This is also the patient perspective, but this is broader and arguably avoids the possible pitfall of patients using governance roles to bring attention to their own personal agendas. Walker also cautions that carers' perspectives can differ from patient perspectives and, whilst these perspectives are valuable, they may be different.

This does not, however, give the **public** a say in commissioning services as well as patients. This does need to shift fundamentally if the NHS is to give true weight to the public health agenda and fully engage people with commissioning services that prevent ill health. In Hull this is such an important distinction if the city's population is to improve its demographic profile.

Involving Staff

Involving and engaging staff in the NHS was the subject of an NHS Taskforce in 1999. Subsequently the NHS has developed a resource pack *Staff Involvement – Better decisions, better care* (DH, 2003) which brings together evidence of the benefits of involvement to NHS organisations, including better patient satisfaction, better outcomes from patients, better morale and better retention of staff. The *Improving Working Lives Standard* (DH, 2000) sets out a model of Human Resource practice to help organisations to implement engagement and involvement practices.

These three initiatives were given a great deal of emphasis in the years following the publication of the NHS Plan, but during the challenging financial climate more recently and the major upheavals resulting from PCT mergers,

the emphasis has shifted away from these initiatives. What has now emerged as one of the key initiatives in terms of staff engagement and involvement is the membership model spearheaded by Foundation Trusts and, in particular, the introduction of the staff governor - a new role within the NHS[1].

As part of the application process for Foundation Trust status, Monitor (the independent regulator for Foundation Trusts) expects to see (DH and Monitor, 2008):

How has the organisation developed its HR 'strategy', by involving and engaging staff (and other partners/stakeholders) and where has this involvement informed and influenced the business plan, e.g. use of volunteers to assist in service delivery. How … the organisation responded to the feedback it has received from these parties to improve or change service provision.

The staff constituency should reflect the diversity of local staff, and there should be a stated minimum number of staff members. Organisations have the ability to select an opt-in membership (staff have to actually become members) or an opt-out membership (staff are automatically members unless they express the wish not to be).

There is evidence, however, that the involvement and engagement of staff has some way to go before it really does what it aspires to do. The way in which staff membership functions in Foundation Trusts is emerging and developing. The Foundation Trust Network in 'New Voices, new accountabilities', which was a review of the first wave of Foundation Trusts published in 2005, described the influence of staff membership as evolving and the role of a staff governor as 'challenging'. Ham and Hunt (2008) further conclude, "staff governors are often an under-used resource. Their contribution should be a higher priority for NHS Foundation Trusts and HR departments should make use of their experience and credibility." (p.38). There is a widely-held view that further work is needed and we should bear in mind that the evidence to date (or lack of it) is, of course, drawn from the acute Trusts rather than from community settings and is from provider rather than commissioning organisations.

World Class Commissioning

Involvement and engagement of patients, members of the public and staff has not been given a high profile in the NHS, in spite of the duties outlined in

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[1] The basis of the staff membership model is rooted in the success of staff engagement within the retail sector, and in particular, from the John Lewis Partnership (JLP) where the ultimate aim is the happiness of its staff (members), through their worthwhile and satisfying employment in a successful business. JLP aims to employ people of ability and integrity who are committed to working together to support the principles of the organisation. It also recognises the success of the model from within the education sector where each school, for example, has staff governors who sit alongside parent, community and Local Authority governors.

Section 11 of the Health and Social Care Act 2001 which placed a duty on NHS organisations (Strategic Health Authorities, Primary Care Trusts and NHS Trusts) to make active arrangements to ensure that the views and preferences of local people influence decisions in a systematic and ongoing way.

The duty to involve has subsequently been strengthened in the NHS Act 2006 (specifically Section 242) and in the Local Government and Public Involvement in Health Act 2007.

How organisations should go about involvement and engagement and the level to which this should take place has, arguably, been a somewhat subjective process. In terms of commissioning, this has now been further-clarified with the publication of the World Class Commissioning competencies (DH, 2007a). Competences 1 - 4, but particularly competency 3, outlines a set of indicators against which PCTs as the commissioners of services are being judged through the assurance framework (DH, 2008b).

PCTs went through the first year of panel and self-assessments in 2008 and will be expected to show year-on-year improvements in their commissioning competence, which included involvement and engagement of patients, the public and staff. Engagement is also one of the NHS top five priorities outlined in the NHS operating framework for 2009/10 (DH, 2008c).

There are conflicting views on the way the policy agenda has been evolving and whether it will lead to real involvement of patients, the public or both. Florin and Dixon (2004), for example, argued that the desirability of public involvement is based on a number of assumptions that by their very nature are not testable. These assumptions include that greater public involvement will lead to more democratic decision making and in turn better accountability; that public involvement is an intrinsic good; that increasing involvement will make services more responsive to the individuals and communities that use them which will lead to improved health. They write (p160) that *Current policies to increase public involvement are piecemeal and disparate … the difference in the methods used to involve the public in foundation trusts and primary care trusts has no basis in evidence.*

Whether the most recent policy changes will address these issues is something that will be tested out over time.

Summary

In summary, there are many reasons why a membership model as part of a broader aspiration to involve and engage with patients, the public and staff is seen as a positive way forward within the NHS, although the policy initiatives are not without their critics. For commissioners, a clear benefit will be to enable them to move towards being ‘world class’ as outlined by the Department of Health in its World Class Commissioning programme.

NHS Hull is without doubt ahead of the game in terms of recruiting a membership, and it is doing so in tangent with other significant health organisations in Hull.

Deciding how the membership model should be structured is, however, potentially different for a commissioning organisation and in the following section we explore different top tier options, followed by an analysis of each option.

SECTION 3: POSSIBLE MEMBERSHIP MODELS

In this section we explore a range of options for the top tier of a membership followed by a SWOT Analysis (Strengths, Weaknesses, Opportunities, Threats) for each option. We briefly discuss how each option would help NHS Hull to meet the World Class Commissioning competences.

Option 1: The Board of Governors

One of the options proposed by NHS Hull is to have a 'top tier' that is modelled on, and reflective of, the Foundation Trust model.

Foundation Trusts were first set up in 2004 as Public Benefit organisations placing public, patient and stakeholder involvement at the heart of their governance arrangements. In order to achieve Foundation Trust status organisations have to meet strict financial and governance criteria. The benefits of gaining Foundation Trust status is that organisations gain a level of independence from the NHS and cease to be under the direction of the Secretary of State. They are no longer performance-managed by the Strategic Health Authorities, but do still have to meet the requirements of the Healthcare Commission. Foundation Trusts have legally binding contracts with commissioners and are regulated by Monitor. They can make financial surpluses but must reinvest surplus in health improvement.

In terms of the way that Foundation Trusts engage with the Patient and Public Involvement agenda, they are based on the traditions of 'mutual' organisations. They have a Board of Governors elected by the membership which sits alongside and interacts with the NHS Trust Board of Directors (which includes non-executive Directors appointed through the NHS Appointments Commission). Foundation Trusts aspire to be locally-owned organisations driven by local priorities.

Whilst there is no single standard model for Foundation Trust membership (but they must have a minimum staff constituency and a public constituency), a key role for the Board of Governors is to feed into the NHS Trust Board of Directors the views of stakeholders so that strategic decisions can be based on local views. Arguably the traditional 'guardian of community interest' passes from the non executive Directors who sit on the NHS Trust Board to the members of the Board of Governors.

There is limited evidence as yet from Foundation Trusts about the success of the membership. Ham and Hunt (2008) in a review of five Foundation Trusts concluded (p2):

…that the hybrid governance model adopted for NHS Foundation Trusts is working increasingly effectively. As the model has developed, there is greater clarity about the role of the board of governors and how the knowledge and skills of governors can be used to best advantage. The statutory powers of

governors have helped to ensure that they are taken seriously and are not treated as rubber stamps.

There is less clarity on the role of the membership community and the most effective way of governors relating to members. NHS Foundation Trusts are communicating with members in various ways but recognise that more needs to be done to become membership organisations. The experience of the mutual sector needs to be drawn on to enable NHS Foundation Trusts to make further progress in this area.

Looking at the experience from the mutual sector shows however that there is what Cornforth (2004) describes as an under-developed literature base. In his paper, *The governance of co-operatives and mutual associations: a paradox perspective* he discusses the concerns and many challenges faced by Boards of lay representatives. These challenges include:

- supervising senior managers;
- ensuring probity;
- protecting the needs of members and other stakeholders;
- conflicting demands and pressures: acting as representatives for particular interest groups and 'experts' charged with driving forwards the organisation's performance;
- tension between driving performance forwards and ensuring conformance;
- tension between controlling and supporting managers;
- elected members not having the expertise required to make the Board effective; and
- resolving the potential conflicts of interest of different stakeholders.

Cornforth goes on to discuss how Boards face not just one or two of these challenges but paradoxical issues meaning that whilst they might be able to resolve one issue they will then be faced with other challenges as a result.

Strengths

The strengths of adopting a Foundation Trust-type model with an elected Board of Governors are many:

- The Foundation Trust model is familiar and already has generated twomillion members in England.
- The acute and mental health sector are already 'spreading the word' about how Foundation Trusts operate and what a Board of Governors does.
- If at some time in the future the government supported commissioning organisations to seek Foundation Trust status the PCT would be well-placed to meet this requirement.

Weaknesses

- NHS Hull is a commissioning organisation and is becoming increasingly separate from its provider arm. The Foundation Trust model is closely aligned to provision of services.
- NHS Hull has a real opportunity to do something innovative and different. The Foundation Trust model is not without its problems, e.g. lack of understanding of the respective roles of the Board of Governors and the Board of Directors; lack of clarity around the role of staff governors. The PCT would actually be creating a body that is known to have tensions.
- Evidence from the mutual and co-operative sectors shows what Cornforth (2004) describes as *serious concerns about the democratic legitimacy of [lay] Boards, because of low levels of membership participation and their effectiveness…*
- A significant weakness of the Board of Governors is that they 'belong' to the organisation and may be seen as being part of the establishment by the outside world. This is particularly the case if the organisation reimburses individuals for their time as well as for out of pocket expenses. By doing this there is arguably a contract between the organisation and the individual and objectivity and independence is threatened.
- Foundation Trust Governors have, in practice, very limited powers and there influence on strategic decisions is mediated and indirect.

Threats

A key point to note is that the Board of Governors, like PPIFs, tends to be made up of a small group of insiders. Foundation Trusts have tried to address this through the allocation of Governor roles to different segments of the population but in a system of fair election it is a difficult area to control. Skidmore *et al* (2006) maintain that pushing harder in the same direction will not change this but what needs to happen is that organisations should seek to 'find the points where stronger and more effective connection can be made between formal participation by a smaller group of insiders and the more formal, everyday social networks in which a much bigger group of citizens spend a significant part of their lives'. Skidmore *et* al describe this as linking the elite with what already exists in terms of capitalising on where discussion about health typically happens e.g. the school gate, the book club and so on.

Opportunities

One way of minimising the problems of the elite group of insiders is to develop an approach based on matrices and segmentation.

Matrices

The Institute of Public Care (cited by Walker, 2006) has drawn on a range of material to further the idea of a spectrum of service user involvement – a kind of matrix. This is based on a four point involvement scale which builds on the work of Arnstein (1969). At the very basic level, the matrix includes activities involved in providing information (**communication**). The next level of the matrix is **consultation,** which includes activities around securing ideas, suggestions and feedback. The third level is **negotiation** which involves activities involved in securing agreement to commissioning decisions; and the final level is **participation,** which includes activities involved in working together to make commissioning decisions.

By considering different aspects of a membership model it is possible to align them to the levels in the matrix of involvement. In the Foundation Trust model the elite insider group (the Board of Governors) are probably those who will be involved in the participation level. The core members (e.g. the public and staff constituency) are likely to be involved in communication and possibly consultation. The proposed NHS Hull Champions are an interesting group and are most likely to be involved in consultation and negotiation. It is, however, interesting that the division between negotiation and participation is a grey area and if the champions get involved in negotiation it would make sense to involve them in participation. The argument must then play out as to if champions get involved in participation, why do you need a group of elite governors? The answer must lie in whom the Champions are – that is, are they elite or are they able to represent the views of the population who currently use or may use health services? This is where segmentation comes to the fore.

Segmentation

Healthy Foundations: a segmentation model (DH, 2008) identified three overarching dimensions that had greatest significance when specifying the population segments most likely to adopt at-risk behaviours. It is then logical to make sure that you involve people from these segments in planning, commissioning and monitoring services. The three dimensions are:

- age/life stage;
- circumstances/environments; and
- attitudes/beliefs towards health and health issues.

This type of approach to ensuring that organisations are including the right people in the right decisions is a feature of *Reaching out: community engagement and health* (IDeA, 2008), which discusses communities of 'interest' as well as communities of place. In an area such as Hull there will clearly be both and there will be interdependencies between the two types of communities. Therefore even in a small geographical area (place) there will be people at different life stages that will form a community of interest; or

people with different beliefs about health who will form a community of interest and so on.

The three localities of NHS Hull may form a natural segmentation in terms of communities of place and this approach would certainly integrate with other Patient and Public Involvement plans within the PCT.

Where this discussion is leading is that it is possible within a membership model (such as in a Foundation Trust) to use a matrix approach with segmentation to gain a better degree of representation of the local population. If NHS Hull went down the route of having an elected Board of Governors, it could align its public constituency Board seats to communities of place (e.g. Practice-Based Commissioning consortia/localities) and/or interest to maximise representation and better mirror the local population.

How Option 1 would contribute to World Class Commissioning

Having a top tier might enable NHS Hull to demonstrate directly that it is skilled in a variety of public, community and patient engagement and involvement (competency 1 and competency 3), although it could equally demonstrate this through working with the Champions and its members.

The model has no demonstrable advantages in terms of working with community partners (competency 2).

Option 2: Health Congress

The idea of a health congress is innovative and consequently there is little by way of empirical or even grey literature to draw upon. Our understanding from discussion with the PPI team in Hull is that the health congress model is similar to the model outlined in *Getting ready for LINks: planning your local involvement network* (DH, 2007c). This model requires NHS Hull to facilitate periodic citizens' meetings where priority issues are identified, discussed and decisions are taken. Task groups are then established to review, consult and consider the priority issues. The PCT would use its existing membership as a means of communicating to and from the local community and the Champions would become engaged in the operational work of the PCT – e.g. they might provide a lay voice on various structures and committees but would not be elected or representative.

Strengths

- The model would enable people to 'dip in and out' and get involved in issues that have meaning for them personally.
- The model avoids the professionalism of involvement where a few individuals become professional meeting attendees and involvement 'experts'.

Weaknesses

- Training and support for volunteers participating in the task groups would be resource heavy (assuming that different people would be involved in groups depending on the nature of the issue).
- Building relationships with individual patients and members of the public for the PPI team would be challenging.
- Care would need to be taken in order for the congress to be seen as independent from NHS Hull.
- There would be no democratically-appointed representatives who could directly influence strategic decision-making e.g. through having a place on a voting Board with explicit powers.

Opportunities

- The model would have synergy with the principles of LINks and, if carefully planned, could work alongside the LINk to maximise involvement.
- It builds capacity and interest across a broader population of people.
- Experience of being involved in one way is likely to lead to further involvement.
- The development of a track record of identifying priority issues raised by the community, responding to them constructively through task groups and seeking and taking action as a result of task group recommendations will build momentum and generate excitement.

Threats

- People may not feel motivated to participate.
- Not following up on priority issues or responding to the recommendations of the task groups would undermine the willingness of people to get involved in further activities, not just the Health Congress.

How Option 2 would contribute to World Class Commissioning

The Health Congress model if carefully constituted to engage with a broad range of community members and groups (with the Champions and membership in place) would enable NHS Hull to demonstrate directly that it is skilled in a variety of public, community and patient engagement and involvement (competency 1 and competency 3).

The model has advantages in terms of working with community partners (competency 2), particularly if the congress work is done in tangent with the local authority and other health and social care organisations and third sector partners.

Option 3: Practice-Based Commissioning Membership Model

A third option would be to pitch membership and governance at a locality level and align the membership to Practice-Based Commissioning (PBC) consortia. The existing public membership could be aligned by locality and the proposed NHS Hull Champions could be locally based (this would also provide more in depth involvement and engagement at PBC level). Members of the locality groups could then meet with PCT commissioners within a defined governance arrangement to ensure that communication channels are in place between localities and the PCT Board of Directors. The top tier effectively becomes the representatives (however selected or elected) from each locality. These representatives would probably be drawn from the Champions.

Strengths

- Decision-making would be at a very local level and would maximise clinical involvement of GPs and practice staff.
- Input into service redesign in line with the 'care closer to home' agenda would be maximised.

Weaknesses

- There is a limited track record of surgery-based involvement and people may find the distinction between practices as providers and PBC confusing.
- People may not wish to be involved in issues that are PCT-wide rather than PBC-wide.
- People may feel constrained because of ongoing relationships with GPs and surgeries.
- Voluntary and community organisations are less likely to be organised along PBC consortia boundaries.
- This approach may reinforce differences between people rather than commonalities within communities.

Opportunities

- Builds on existing relationships and loyalties between patients and GPs.
- Reinforces identity of PCT with GP surgeries.
- May create opportunities to respond to issues particular to very local groups.

Threats

- Consortia may seek to promote agendas that are particular and not in the interest of the whole PCT.

How Option 3 would contribute to World Class Commissioning

The PBC model would enable the PCT to demonstrate (with the Champions and membership in place) achievement of competency 1 and competency 3 and would have certain advantages in terms of ensuring geographic engagement. It may also facilitate achievement of competency 4 (clinician engagement).

The model has no real demonstrable advantages in meeting competency 2.

Option 4: Health Systems-Wide Model

A fourth option is to draw on the Board of Governors of the acute and mental health trusts (and possibly the Practice-Based Commissioning groups and any other commissioned service providers) and build a core group made up of each of these key stakeholders to inform commissioning decisions. The top tier is comprised of those who hold, and have probably been elected to, positions in services that are commissioned by the PCT.

Strengths

- This model could potentially be the foundation of a city-wide membership model.
- As the commissioner this would allow greater access to more people with diverse interests, channelled through a central group, and would thus help in demonstrating achievement of Level 4, competency 3 and in influencing and understanding the agendas of the other organisations.
- Communication and information pathways would be through the central group back to the appropriate Board of Governors of the Foundation Trusts.
- The group would have greater objectivity as the members of the group would 'belong' to other organisations.

Weaknesses

- The membership for NHS Hull is already being recruited to. The membership could be 'handed over' to the provider arm however if the decision is for them to become a Community Foundation Trust.

- The PCT would be relying on others to support and manage the membership, although it could still retain a membership for communication purposes.

Opportunities

- There are synergies in developing and supporting people to be involved.
- Expertise that people develop as governors in other organisations will have relevance to serving on the core group.
- The other health organisations are developing their models so there is opportunity to shape these potentially before they become too 'fixed'.
- It would help establish NHS Hull as the local leader of the NHS.

Threats

- Members would not be primarily associated or oriented with the PCT.
- There is a significant difference between the agenda around service delivery in an acute and mental health trust and the broader wellbeing and public health agenda of a PCT.
- Acute and mental health trusts are less situated within a community and locality than a PCT.
- In terms of achieving the World Class Commissioning competencies, the PCT would have less 'control' over the involvement agenda as it would be involving by proxy.

How Option 4 would contribute to World Class Commissioning

The Health Systems-wide model would enable the PCT to demonstrate (with the Champions and membership in place) achievement of competency 1 and competency 3 and would have certain advantages in terms of ensuring engagement of people with a range of health needs e.g. mental health needs, long term conditions and so on.

This model has clear advantages in demonstrating achievement of competency 2.

Option 5: Social Enterprise principles e.g. co-operative, mutual or public benefit organisations

Drawing on the principles of social enterprise and basing the top tier around models of social enterprise, mutuals, co-operatives or public benefit organisations in many ways crosses the other options in that social enterprises have developed many different forms of governance as we discuss below.

Hewitt (2006) argues that social enterprise can play a ‘crucial role’ in giving local communities a stronger voice in how health and social care services are developed. This relies on commissioners understanding better the local market including third sector provision from which it can procure services.

In terms of learning from social enterprise principles, this is less simple than originally thought. Social enterprise organisations are configured and structured in a number of different ways – what makes them social enterprises (or not) is the way in which trading surpluses are used rather than their accountability and governance arrangements. Marks and Hunter (2007) discuss different types of social enterprise, different business models, legal options and ownership structures. Our analysis of the various models they outline shows that a typical model has many similarities with the Foundation Trust model of a top tier Board, elected from and by the members, working alongside an operation/executive group who put into place the decisions made by the top tier.

The work of Marks and Hunter also points to the difficulties in defining what social enterprise is (they discuss for example whether Foundation Trusts and BUPA qualify as social enterprises).

In conclusion, there is no one governance or accountability model (in terms of a top tier structure) that defines a social enterprise. Social enterprises are not differentiated by their governance and accountability but by the way that they use surplus. We did not therefore carry out a SWOT Analysis or pursue this option further.

Option 6: LINk

The sixth option is to work with the developing LINk to establish a mechanism by which all Patient and Public Involvement from the membership is channelled through the LINk in terms of the commissioning cycle and World Class Commissioning. This would require clear protocols for communication and the PCT would need to ensure that it resources the LINk to do this work on its behalf. The way it might work is that the PCT authorises or charges the LINk with establishing its top tier.

Strengths

- The LINk is developing and shaping its functions to include taking on the involvement agenda of the membership.
- This model would avoid duplication.

Weaknesses

- The remit of LINks is wider than health and not focused on primary care.

- LINks are not well established or mature and are finding their own way.
- LINKs are more likely to engage with patients than the public.
- It could compromise the objectivity of the LINk.

Opportunities

- Working with the PCT would be a very practical function for the LINk and might serve to attract people to the activity.
- Profile, identification and recruitment would be undertaken by the LINk.
- It would help establish NHS Hull as the local leader of the NHS.

Threats

- Members would not be primarily associated or oriented with the PCT.
- There is a significant difference between the agenda of the LINk and the agenda of a PCT.
- Tangential or broader issues may be translated from the LINk to the PCT.
- The LINk is an emerging entity and little is known about how successful it will be.

How Option 6 would contribute to World Class Commissioning

Working closely with the LINk (with the Champions and membership in place) would demonstrate achievement of competency 1 and competency 3 as long as the LINk is able to motivate the city of Hull to get involved in its work and manage its members' engagement with the PCT.

This model has clear advantages in demonstrating achievement of competency 2.

Option 7: No top tier

The final option that we have considered is that there should be no top tier or elected board or hub. In many ways the basis of this option and the SWOT is the mirror image of the case for the option for a Board of Governors. It should also be clear that if the Hull champions are formed as a second tier they will effectively then potentially become, by default, the top tier. It therefore becomes essential that just as clarity would be needed for any of the options so too would there need to be absolute clarity about purpose and what respective players and people (including the champions and the central PPI team) will be doing.

There are two main reasons for not having a top tier. First, it avoids the conflicts that are apparent between the Board of Directors and the Board of Governors. The Board of Directors has direct links with the Patient and Public Involvement agenda and does not 'rely' on the Board of Governors to represent the members. It is important, however, that information pathways are clearly defined so that members (and the champions) can influence the Board and its decisions.

The second reason actually addresses, in part, these challenges and is based on the premise that there are many existing forms of public involvement already, including citizen juries, direct forms of participatory democracy, representative democracy, local involvement networks, public polling and a wealth of patient experience metrics in place or under development. As long as NHS Hull can build a matrix of activity based around existing involvement activities **and** there are clear information pathways into decision making processes then the argument for not having a top tier gains increasingly strong resonance.

Strengths

- This model avoids all of the pitfalls of having a 'second' Board and the consequential need for clarification about the respective roles.
- There is no conflict with existing legislation i.e. if there are plans for commissioners to gain Foundation status this is probably years away.
- The model does not rely on people needing to 'represent' constituencies and the communication challenges that brings.

Weaknesses

- People might feel they have no voice at a senior level.

Opportunities

- Scope to revisit the decision later on based on a changed context and/or further consultation

Threats

- Limited, but people might have an expectation of a voice in the PCT.

How Option 7 would contribute to World Class Commissioning

The no top tier model would have no evident disadvantages in terms of enabling the PCT to demonstrate achievement of competency 1 and competency 3 (given that the Champions and membership are in place).

This model has no clear advantages in demonstrating achievement of competency 2.

SECTION 4: CONCLUSION AND NEXT STEPS

We have defined six options for a top tier membership but have discounted one of them (option 5). Option one is a traditional Foundation Trust model and we have discussed in some detail the need to look at issues such as market segmentation if the option is to avoid some of the challenges that Foundation Trusts experience in developing their membership. The option of convening a health congress periodically has been discussed and is, in our view, a viable option as long as there is a clearly defined protocol for how the congress would work with the Hull Champions group and the wider membership. The option of working through Practice-Based Commissioning groups is also a viable option and has a number of advantages including local engagement and prioritisation and potential clinician engagement.

Two other options of working through the commissioned services schemes of governance or working with the LINk are possibilities, although these groups are emergent which, on the one hand, creates opportunity, but, on the other, requires careful handling. These two options should not, in our view, be discounted completely, but it might be that the time is not right to pursue these. Option seven is a no top tier option which again, in our opinion, is feasible. There is also a possibility of combining one or more options. We have also, as part of this work, started to explore a debate about strengths, weaknesses, opportunities and threats. We have looked at the World Class Commissioning competencies and looked at which options would be most beneficial in supporting progression to level 4 of the commissioning competencies.

This piece of work has been designed to look at the evidence for different models and aims to start a debate about the top tier. We would encourage NHS Hull to continue this debate as it moves forward with developing its vision for its membership.

References

Coulter, A. (2006) ‘Patient engagement: Why is it so important?’, in Andersson, E., Tritter, J. and Wilson, R. *Healthy Democracy*. 27-35.

Day, P. and Klein, R. (2005) *Governance of Foundation Trusts: Dilemmas of Diversity*. London: The Nuffield Trust.

Department of Health 1999 *NHS taskforce on staff involvement.* London.

Department of Health 2000 *Improving Working Lives Standard*. London.

Department of Health 2003 *Staff involvement – better decisions, better care*. London.

Department of Health 2006a *NHS Foundation Trusts: a sourcebook for developing governance arrangements.* London.

Department of Health 2006b *Our Health, Our Care, Our Say*. London

Department of Health 2007a *World Class Commissioning: competencies.* London.

Department of Health 2007b *The whole health community diagnostic programme*. London.

Department of Health 2007c *Getting ready for LINks: planning your local involvement network*. London

Department of Health 2008a *World Class Commissioning: competency measures*. London.

Department of Health 2008b *Commissioning Assurance Handbook*. London.

Department of Health and Monitor 2007 *Applying for NHS Foundation Trust Status: guide for applicants*. London.

Department of Health and Monitor 2008 *Applying for Foundation Trust Status: guide for applicants*. London.

Dr Foster Intelligence 2008 *Patient Insight: harnessing the power of public opinion*. London.

Florin D and Dixon J 2004 Public Involvement in health care *BMJ* 328:159-61

Foundation Trust Network 2005 *New voices; new accountabilities*

Foundation Trust Network 2007 *NHS Foundation Trusts: the story so far*

Ham, C. and Hunt, P. (2008) *Membership Governance in NHS Foundation Trusts: A Review for the Department of Health*. London: Department of Health.

Hewitt P. 2006 *Social Enterprise in Primary and Community Care*. Social Enterprise Coalition.

Hogg, C. 2008 *Citizens, Consumers and the NHS: Capturing Voices*. London: Palgrave Macmillan.

Lawless M. and Knowles S. 2006 *Community participation in the commissioning process – work of the health communities collaborative.*

London Borough of Bexley *Role descriptions school governors* accessed via www.bexley.gov.uk/service/schools/governors/govroles.html

Luton Governor Service *The role of the staff governor* accessed via www.learning.luton.gov.uk/l2g/custom/files _uploaded/uploaded_resources/

Marks L. and Hunter D.J. 2007 *Social Enterprise and the NHS*. Unison.

NHS Centre for Involvement 2008 *PPI competency alignment project (draft).*Unpublished. Warwick.

Skidmore P., Bound K. and Lownsbrough H. 2006 *Community Participation: Who benefits?* Joseph Rowntree Foundation.

Slipman, S. 2007 'Foundation Trusts and Patient and Public Involvement'. In Andersson, E., Tritter, J. and Wilson, R. (Eds) *Healthy Democracy: the future of involvement in health and social care*. Involve and the NHS Centre for Involvement. London.

Thurrock Council *The role of the staff governor* accessed via www.thurrock.gov.uk/education/governors/content.php?page=misc_role_staff

Various information about the John Lewis Partnership accessed via www.johnlewispartnership.co.uk

Various information from the Foundation Trust Network accessed via www.nhsconfed.org.ftn

Walker N. 2006 *Involving people who use services in the commissioning process* CSIP.

www.cooperative-uk.coop/live/cme0.htm accessed 13 July 2008
www.socialenterprise.org.uk/Page.aspx?SP=1878 accessed 13 July 2008.

Jayne Taylor
Victoria Taylor
NHS Centre for Involvement