King's Fund

Seminar
PAPER

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Date
MAY 2005

Governing Foundation Trusts
A new era for public accountability
This paper

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A new era for public accountability

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Published in the UK by the King's Fund

Charity registration number: 207401

First published 2005

Available from:

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Edited by Caroline Pook
Typeset by Andrew Haig & Associates
Printed in Great Britain by the King's Fund

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Summary

- Foundation trusts, which were first set up in 2004, represent a radical departure from the way in which health services are held to account.
- The traditional accountability of NHS hospitals to the Department of Health and the Secretary of State for Health has been replaced by a new accountability of foundation trusts to their members and their elected governors, and to an independent regulator called Monitor.
- Foundation trusts enjoy new freedoms to control their own affairs so it is important that the new governance arrangements work well – if not, NHS hospitals will cease to be accountable.
- The views and rights of members are represented by the board of governors of a foundation trust. The majority of governors are elected by the membership, which is drawn from the community, patients and staff of the trust. In addition, foundation trusts appoint unelected governors representing stakeholders' organisations such as the local primary care trust.
- The governor role is new and there is, as yet, little consensus as to its appropriate roles and responsibilities.
- The King's Fund held the first national networking event for elected foundation trust governors in January 2005. A straw poll at the event found that most governors are unclear about their role and few feel that they can currently communicate effectively with their membership. However, a large majority (70 per cent) are confident that they will make a difference to their trust in the near future.
- This paper sets out different roles that foundation trust governors might usefully play – these roles are intended to provide a framework for debate between boards of governors and boards of directors. It is vital that a clear agreement over respective roles is reached within each foundation trust.
- Our network of governors identified several important developments that are needed nationally including:
  - an ongoing network for governors from all foundation trusts
  - training for governors together with a national framework setting out their expected roles
  - greater independence of governors from their board of directors
  - more resources to do their job well.

Introduction

Foundation trusts represent a radical departure from the traditional means by which the NHS has been held to account. Traditional NHS hospitals are directly accountable to the Department of Health and the Secretary of State for Health for the day-to-day management of the health service; however, foundation trusts enjoy unprecedented freedom from political control, and are accountable, through (mainly elected) governors, to their members, who are drawn from local residents, patients and staff.

The first ten foundation trusts 'went live' in April 2004, joined by a further ten trusts in July of that year. There are currently 31 operational foundation trusts in England (Monitor 2005a). These trusts are drawn from the top-performing hospitals, as judged by the Healthcare Commission. The Government has proposed that, over time, all NHS hospitals should adopt foundation status.

Since their introduction, foundation trusts have been developing these new governance arrangements. But they have done so largely independently, guided only by the basic requirements of the enabling legislation – the Health and Social Care (Community Health and Standards) Act 2003. Defining what local governance arrangements will – and should – look like as they evolve and become established is crucial if the public is to be reassured that their community's hospitals have not simply been handed over to the managers and professionals who run them.

The importance of foundation trust governors is underlined by the increasing trend among foundation trusts to appoint non-executive directors for their highly specialist skills (such as commercial law or finance) rather than for their links with local communities. Foundation trusts will increasingly be reliant on an effective board of governors if they are to be publicly accountable.

There is ambiguity over the roles that governors might legitimately play. To bring greater clarity, the King's Fund hosted an event in January 2005 for more than 60 elected foundation governors from 14 of the first 20 foundation trusts. This was the first time that such a large group of governors had come together to discuss their emerging role.

This paper looks at the early experiences of foundation trust governors and considers how they might best deliver their accountability role.

Accountability at local level

The advent of NHS foundation trusts has cut the direct ties of accountability to the Secretary of State for Health over the day-to-day management of services. In theory, this means that no politician has to stand in front of Parliament defending the actions of health care professionals and managers – the resonance of a dropped bedpan in Peterborough will no longer be heard in Whitehall.

Whether politicians will be able to distance themselves in this way in practice remains to be seen. However, John Reid, the current Secretary of State for Health, recently informed the House of Commons that ministers will no longer answer questions about the operational management of individual foundation trusts, and will instead refer questions to the chair of the institution concerned (Secretary of State for Health 2004).

This separation of foundation hospitals from national politics has only been possible because of new governance arrangements that are at the heart of a 'localist' approach to public sector

accountability. Foundation hospitals are 'owned' by their members, who are drawn from local residents, patients and staff. This model draws on notions of 'mutuality' – where organisations are ultimately controlled by the people that rely upon their services.

Members of foundation trusts:

- can elect governors to represent them
- can stand for election as a governor
- can put themselves forward as the chair or a non-executive director of the trust
- have the right to be consulted on the foundation trust's plans for the future.

The expected benefits of this 'localist' approach are a greater sense of ownership and engagement of patients, the community and staff in the running of public services and, consequently, an improvement in the quality and responsiveness of services (Blears 2003). Localism aims to replace a largely theoretical sense of public ownership – through accountability to national government departments – with something more tangible to service users and local communities.

In practice, foundation trusts will have multiple sources of accountability. They will be accountable to:

- **members**, through their board of directors and board of governors
- **local primary care trusts**, through legally binding service agreements
- **Monitor,** an independent public body responsible for authorising, monitoring and regulating NHS foundation trusts. Monitor issues successful trust applicants with a licence to operate and oversees their compliance with the terms of this licence.

At this early stage of foundation trusts, it is uncertain which form of accountability will have most weight. However, it is already clear that where foundation trusts experience financial difficulties, Monitor has significant power to intervene; for example, at Bradford Teaching Hospitals NHS Foundation Trust, the chairman was replaced by Monitor within its first year of operation.

How do foundation trusts attract members?

Within the first six months of operation, the first 20 foundation trusts had attracted more than a quarter of a million members with an average of 12,843 each (Monitor 2004).

Unsurprisingly, a great deal of variance exists between these trusts, with the largest membership recorded at the University Hospital, Birmingham (96,174 at 1 August 2004), and the smallest membership at the Royal Marsden Hospital, London (1,506 at 1 August 2004).

There is no obvious way of determining what a satisfactory membership should be (assuming that a membership rate of 100 per cent of eligible members is unrealistic). Foundation trusts have adopted different methods for attracting members. Some, such as University Hospital, Birmingham, have adopted an 'opt-out' scheme – where membership among patients and staff is assumed unless they actively decide not to join. Others, such as the Homerton University Hospital, London have adopted an 'opt-in' approach, relying on a positive decision by members to join.

TABLE 1: MEMBERSHIP AND GOVERNOR ELECTIONS IN FIRST-WAVE FOUNDATION TRUSTS		
Total membership (at elections March/April 2004)	185,038	
Total membership (at 1 August 2004)	256,860	
Elections (March 2004)		
Overall turnout	**36%**	
Highest	67%	Royal Marsden Hospital, London
Lowest	19%	University College, London and University Hospital, Birmingham
Public constituency (drawn from local residents)	**53%**	
Highest	70%	Royal Marsden Hospital, London
Lowest	31%	Basildon and Thurrock University Hospital
Patient constituency (drawn from patients that may not live locally)	**27%**	
Highest	85%	Royal Marsden Hospital, London
Lowest	16%	University Hospital, Birmingham
Staff constituency	**26%***	
Highest	64%	Gloucester Hospitals
Lowest	16%	University College, London

Source: Monitor (2004a).
* Basildon staff return not available

These two models offer different benefits and drawbacks (Table 1). The large membership associated with the 'opt-out' approach provides a mechanism for communication and engagement with a broad sweep of the community. However, this engagement may be weak as members have made little commitment to the organisation: for example, University Hospital, Birmingham had the lowest voting return (19 per cent of eligible members voted for their governors). By contrast, the highly specialist Royal Marsden Hospital in London attracted the smallest number of members (1,506) but had the highest percentage of voters in governor elections (67 per cent). Arguably, a small but highly active membership is just as capable (if not more so) of articulating patient, staff and public views to influence the management of foundation trusts.

Overall, 36 per cent of first-wave foundation trust members turned out to vote for their governors in the initial foundation trust elections. This compares well with voting rates in local elections. However, it is clear that the membership rate among the eligible population is very low. Nevertheless, it appears that foundation trusts have continued to attract members even after the initial publicity associated with their inauguration. According to Monitor, foundation trusts increased their memberships overall by 39 per cent in their first few months of operation (Monitor 2004).

What formal powers do foundation trust governors have?

The interests of members are secured by elected governors who sit as a board with a set of defined powers that they can discharge (*see* Box 1). The majority of governors are elected by the members, who are grouped into different constituencies:

- **staff** – those employed by the foundation trust
- **public** – those living within the area of the foundation trust
- **patients** – patients using or having used the hospital and who may not live locally (foundation trusts can choose whether or not to have this constituency).

In addition, foundation trusts appoint unelected governors representing stakeholder organisations such as the local primary care trust, the relevant local authority and a university if the trust is a teaching hospital. Governors from the public and patient constituencies must form a majority on the board of governors (Department of Health 2004).

BOX 1: FORMAL POWERS OF FOUNDATION TRUST GOVERNORS

- To appoint the foundation trust chair.
- To appoint the foundation trust non-executive directors.
- To approve appointment of the chief executive.
- To remove the chair and non-executive directors (subject to approval by 75 per cent of governors in a vote).
- To agree remuneration of non-executive directors.
- To appoint or remove trust auditors.
- To receive the annual report and accounts.
- To advise the trust and be consulted on strategic direction.

Governors do not have the right to veto individual decisions of the board of directors. Nor does the Department of Health expect governors to take an active role in the day-to-day management of the trust – this is the role of the management team and the board of directors (Department of Health 2003). The influence of governors is therefore more summative: the council of governors must ultimately make an overall judgement about the management of the trust in deciding whether or not to re-appoint (or not to remove) existing non-executive directors and chairs.

However, governors are not simply reactive: they can articulate priorities and future developments through their right to be consulted on strategic direction and to offer advice to the trust. The legislation (Health and Social Care (Community Health and Standards) Act 2003) and accompanying guidance (Department of Health 2003) do not elaborate on methods for offering this advice, nor provide any framework for judging whether a foundation's board of directors has listened to it carefully enough.

Monitor will gauge the adequacy of the governance arrangements of foundation trusts as part of its compliance regime (Monitor 2005). However, Monitor's expectations in relation to the power of governors is, as yet, only lightly sketched, leaving room for local discretion.

The first wave of foundation trusts has embarked on an important journey – one intended to set a future course for all NHS providers – without a highly developed sense of what the appropriate role of their governors should be.

How powerful are governors in practice?

The King's Fund conducted a straw poll among elected governors who attended the first national network meeting, to gauge their opinion of their role and power to date (*see* Box 2). Less than half of our respondents thought that there was a clear understanding of their role within the trust and fewer than a third felt that they had already made a difference to the trust in their role. Governors also expressed difficulties in communicating with the members who elected them: only 32 per cent felt that they had an effective communication route. However, these difficulties may have reflected temporary problems rather than a more serious problem with the governance approach itself; an overwhelming majority (70 per cent) felt confident that they would make a difference to their trust in the near future.

BOX 2: STRAW POLL OF FOUNDATION TRUST GOVERNORS

Q1 **In my foundation trust there is a clear understanding about the role of governors.**
Yes 48% No 20% Not sure 33%

Q2 **I am confident that I have already made a difference to the running of my trust through my work as a foundation trust governor.**
Yes 29% No 29% Not sure 41%

Q3 **I am confident that, in the near future, I will make a difference to the running of my trust through my work as a foundation trust governor.**
Yes 70% No 5% Not sure 25%

Q4 **I have an effective route to communicate with the members who have elected me.**
Yes 32% No 49% Not sure 20%

Straw poll carried out for King's Fund Foundation Governors' Network Day (January 2005). 40 replies for Qs 1 and 3, 41 replies for Qs 2 and 4.

What is the role of a governor?

The Department of Health refers to three types of role for the board of governors: advisory, guardianship and strategic. However, these terms are ambiguous and open to multiple interpretations. At our network event we tested out a range of potential roles that governors might want to take on within their foundation trusts. The result was that a majority felt that almost all of the roles we suggested were valid (*see* Table 2).

Only a small minority of governors (14 per cent) thought that they should be involved in the operational management of their foundation trust. This is unsurprising, given that national guidance (Department of Health 2003) makes it clear that the board of directors, rather than the board of governors, is responsible for the operational management of foundation trusts. Governors who nominated their top priority role for a foundation governor were more divided in their choices. The most popular role (identified by one third of governors) was that of the 'select committee member', suggesting that scrutiny of the work of the trust by governors is seen as important (Table 3).

TABLE 2: SUPPORT FOR POTENTIAL DIFFERENT ROLES FOR GOVERNORS

	% that agree (57 respondents)
Community barometer *Providing ready source of community views to inform the work of the board*	91
Strategic player *Taking active role in shaping the corporate strategy of the hospital*	91
Select committee member *Providing independent scrutiny of the work of the board and hospital*	89
Conscience *Ensuring that the board acts in accordance with NHS values*	84
Ambassador *Promoting the work of the hospital to the community and other stakeholders*	81
Elected constituency representative *Handling, monitoring and promoting individual members' concerns*	63
Operational manager *Taking an active role in the management of day-to-day issues and concerns*	14

TABLE 3: TOP PRIORITY ROLE

	% that identify as top priority (40 respondents)
Select committee member	33
Strategic player	20
Community barometer	15
Ambassador	13
Elected constituency representative	10
Conscience	10
Operational manager	0

Clarifying the role of a foundation governor is difficult. They are unlikely to play a single, easily defined role. Nor will governors themselves, or their colleagues on boards of directors, all agree as to the best and most legitimate way in which they can make a difference. Our discussion with current governors attending the network meeting also emphasised that boards of directors of foundation trusts appeared unclear about the role of governors. Some governors felt that their role and their independence were cherished and supported by the board of directors. However, other members of the network felt that they were some way away from a meaningful partnership with their boards.

The description of potential roles that we have produced is intended to offer a framework for debate between members, governors and directors of foundation trusts. There are no right or wrong answers – each foundation trust must develop its own unique approach to governance within the broad parameters of the legislation. What is important, however, is that there is

consensus between the board of governors and the board of directors as to their respective roles. Anything less than consensus is likely to lead to dysfunctional management and poor accountability.

What needs to be done?

Our network event clarified that foundation trusts are dealing with governance issues very differently and that governors experience varied levels of support in their role. It is not surprising that such new governance arrangements should face teething troubles. However, there is a significant development agenda for foundation trust governors and, by extension, for boards of directors if they are to get their governance arrangements right. Our event identified a number of key messages that the NHS must address if this new venture is to be a success:

- better communication between governors and members
- ongoing networking opportunities for governors from different trusts
- a national training programme for governors
- a national framework to set out more detail about the respective roles of governors and directors, and to work to develop productive relationships
- independence of governors from their boards of directors and a clearly defined right to be involved in strategic planning and scrutiny
- more resources (time, support and funds) to enable governors to do their job well
- benchmarking across trusts to see how well governors' roles are developing
- strong levels of active membership that are representative of the diverse communities.

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