# Public involvement among first wave applicants for Foundation Trust status

**Ros Levenson,**
**November 2003**

**© The Sainsbury Centre for Mental Health, 2003**

**CONTENTS**

**1. Introduction**

**2. What they have said to local people will be the benefits to local people of foundation status**
General
Modernisation
Flexibility / new freedoms
*Freedom from central control / Local ownership and control*
*Financial freedoms*
*Freedom to reward staff differently*
Greater patient, public and partner involvement
Greater staff involvement
Contribution to regeneration
Contribution to research
Benefits of membership

**3. How they have tacked the potential disadvantages of foundation status**
Explicitness about public concerns about foundation trust status
Meeting expectations
Financial burden of the new arrangements
Administrative burden
Expected benefits may not fully materialise
Local apathy

**4. Membership eligibility**
Public membership
Staff membership

**5. Governance arrangements**
Different levels of involvement for public members
Clarity about governance criteria
Representatives of the public membership
Representatives of the staff constituency
Election process
Appointed Governors
Board composition
Exclusions to becoming a governor

**6. How they have sought local support for their application**

**7. How they have worked with PCTs, community and voluntary groups, local authorities and other 'influencers'**

**8. To what extent, and how, have they reached out to excluded groups?**

**9. Evidence of the success of their efforts to date**

**10. Conclusions**

**© The Sainsbury Centre for Mental Health, 2003**

**Public involvement among first wave applicants for Foundation Trust status**

## 1. Introduction

The future for foundation trusts remains the focus of intense political debate, both inside and outside Parliament. Meanwhile, a first wave of applications for foundation trust status has been submitted by acute hospital trusts, the outcome being subject to the necessary legislative framework being in place. It is clear that (subject to the legislation being passed) mental health trusts will also be able to apply to become foundation trusts. The Sainsbury Centre for Mental Health has indicated its intention to work with mental health trusts to build their capacity to become foundation trusts. As part of this, it is hoped to look at examples of good practice in creating a broad membership base and in making the case to local people for foundation status.

In order to inform the Sainsbury Centre for Mental Health, a short piece of work was commissioned to examine and evaluate the literature produced by a small sample of first-wave applicants for foundation status to determine:

- What they have said to local people will be the benefits of foundation status;
- How they have tackled the potential disadvantages of foundation status;
- How they have sought local support for their application;
- How they propose to build their public membership constituency, should they be successful;
- How they have worked with PCTs, community and voluntary groups, local authorities, MPs and other local ‘influencers’;
- To what extent, and how, they have reached out to excluded groups;
- Whether there is any evidence their efforts have been successful to date.

It was suggested that the literature of six trusts should be examined for these purposes. In fact, literature from seven trusts was examined. These Trusts are as follows, with the abbreviated name used in this report given in brackets:

Addenbrooke’s NHS Trust (Addenbrooke’s);
Bradford Hospitals NHS Trust (Bradford);
Homerton Hospital University Hospital NHS Trust (Homerton);
King’s College Hospital NHS Trust (King’s);
Stockport NHS Trust (Stockport);
University College London Hospitals NHS Trust (UCLH);
University Hospital Birmingham NHS Trust (Birmingham).

The documents used are listed in Appendix 1.

The Trusts were selected in order to include, as far as possible:

- London and non-London Trusts;
- Trusts covering urban and mixed rural-urban areas;
- Trusts with and without a national reputation for teaching and research.

**© The Sainsbury Centre for Mental Health, 2003**

This report addresses the questions posed above, with the exception of the final question; it was not possible to ascertain from the current literature whether the efforts of the Trusts have been successful to date.

**2. What they have said to local people will be the benefits to local people of foundation status**

General

The most striking aspect of how the trusts set out the benefits of foundation trust status was the similarity of what they each said. They were clearly drawing on the suggested wording of official documents and templates to set out the main ways in which NHS Foundation Trusts differ from existing NHS trusts, including:

- They will be directly accountable to local people through an elected Board of governors;
- They will be approved by an Independent Regulator, who will issue an authorisation under which they will operate;
- They will be accountable to NHS Commissioners through legally binding contracts;
- They will be allowed new freedoms to reflect local needs and priorities.

In addition, each applicant outlines a range of specific benefits, summarised below.

Modernisation

All Trusts located the identified benefits of foundation trust status within the government's wider ambitions to modernise the NHS. This point was particularly emphasised by Stockport, Bradford and UCLH. For example:

> *NHS Foundation Trusts will play a significant role in delivering the reform necessary to achieve a fully patient-centred NHS. However, it is only one of a number of initiatives, such as the development of primary care and cutting waiting lists, which taken together will reform the patient experience during this decade.*
>
> (UCLH)

The consultation documents generally explained that foundation status was about modernisation, rather than a fundamental change. For example:

> *Becoming an NHS Foundation Trust is not about changing our purposes. It is about changing the way we are run, making us more efficient and locally accountable.*
>
> (Addenbrooke's)

Flexibility / new freedoms

All of the Trusts laid heavy emphasis on the flexibility and freedoms associated with foundation trust status, especially the freedom to improve services and focus on local priorities and communities served. This point was made, in some form, by each of the trusts, though particular emphasis was given to this point by King's, Birmingham, Homerton and Stockport. Trusts varied in how much detail they gave of their 'vision' or plans for service improvements and in whether and how they linked their vision to achieving foundation trust

**© The Sainsbury Centre for Mental Health, 2003**

status. For example, Bradford outlined short term and medium term visions, detailing plans for service improvement but the links between the vision and the application for foundation status were not fully made explicit, except in general terms as:

> *…[becoming a foundation trust] could provide significant freedoms and momentum to help achieve the ambitions for developing clinical services…*

However, the Bradford document then goes on to say that a key test for foundation trust policy is how it assists the Trust in pursuing priorities for redevelopment at the Bradford Royal Infirmary and St Luke's Hospital.

Birmingham listed its desired service improvements and said:

> *We believe we can do this better and quicker as an NHS Foundation Trust.*

King's welcomed the opportunity to negotiate contracts on longer term basis with PCTs, enabling them to plan ahead with more certainty.

UCLH expected to become faster and more responsive to patient and local healthcare needs.

***Freedom from central control / Local ownership and control***

This common theme was expressed differently by the applicants, and the nature of foundation trusts was described in subtly different ways. Bradford referred to "social ownership" which was seen as enabling foundation hospitals to develop new ways of working with community groups, local businesses, statutory and non-statutory organisations. It was also said to provide a transparent and democratic process, replacing top-down bureaucratic control. Birmingham likened foundation trusts to "mutual organisations such as co-operative societies and housing associations".

King's pointed to a reduced level of central direction in the shape of targets and binding central guidance, giving more freedom to respond quickly and effectively to local and specialist needs.

Non-London trusts appeared to have a particular perspective on freedom from central control Birmingham states that currently many decisions about local health care are made in London, whereas foundation status would bring the chance to make the decisions more locally. Addenbrooke's states:

> *Rather than hospitals being directed from Whitehall by central government, they will become accountable to their membership and the Board of Governors.*

The corollary of freedom from central control was a perceived increase in local ownership and control, giving more power to local communities. For example, Stockport saw foundation status as:

> *a way of ensuring that the people of Stockport and High Peak can contribute to the running and success of our hospital services.*

Stockport describes the benefits of foundation status under two headings: Local Voice and Local Choice. Local Voice is explained in terms of increased local ownership and

**© The Sainsbury Centre for Mental Health, 2003**

accountability and more responsive services. Local Choice emphasises the relevance of increasing patient choice, and changes in how providers will be paid for the care they provide.

Actual ownership of the assets was also seen as a benefit and explicitly mentioned by several trusts.

***Financial freedoms***

This too was a universal point, and in some instances (Bradford and Addenbrooke's) it was linked with freedoms in how a hospital is managed. The greatest advantage was said to be the freedom to access much needed additional capital more quickly. King's stated these freedoms would allow implementation of capital improvements (e.g. building and refurbishment) earlier than would otherwise be possible. Likewise, Bradford stated:

> *The major freedoms will include changing the way hospitals can borrow money and retain surpluses and help increase investment in local facilities.*

Birmingham made a similar point and outlined plans for more facilities for patient care, more beds, more operating theatres and more diagnostic capability, better patient facilities, improved car parking, better use of technology and a new Centre for Defence Medicine in partnership with the Ministry of Defence. Stockport discussed plans to provide a new cardiac and surgical unit.

UCLH pointed out that greater financial freedom would enable them to retain the proceeds of redundant assets for local use. They also saw the financial freedoms as an opportunity to replace key equipment over a 5 year period and to proceed on hospital infrastructure and IT.

Only one Trust – Addenbrooke's – outlines more ambitious plans to utilise financial freedoms. They say that there is scope for development of "unregulated services" i.e:

> *…enterprises or services that may generate money to enable us to invest in the NHS. They would not be funded by the NHS, nor would they be a substitute for NHS income. Our aim would be to generate income to help us improve our NHS services.*

***Freedom to reward staff differently***

This was highlighted as an explicit benefit of foundation trust status by all Trusts with the exception of King's. Birmingham set out the benefits to the workforce in detail (including revised pay arrangements, major expansion in staff numbers, development of new roles and support for lifelong learning) though it failed to explain how these benefits related to foundation status. However, their excitement at the benefits of these freedoms was tempered by assurances that they will not poach staff from other trusts or enter into salary bidding wars.

Greater patient, public and partner involvement

This is seen as a major benefit in all the documents examined. Several trusts aspire to build on what they already see as excellent relationships with patients, the public and partner organisations. Foundation status is said to be a chance to:

**© The Sainsbury Centre for Mental Health, 2003**

*… put in place new governance arrangements enabling local people, patients, staff and partner organisations to have more of a say in shaping the direction of the hospital*

(King's)

The Homerton document asserts:

*NHS Foundation Trust status has the potential to provide us with an important avenue to better the health, well being and social standing of the local community and to continue to raise the profile of the hospital.*

And:

*The public, patients and staff need to believe in and identify with their hospital. Foundation status is an important aid to achieving our vision.*

All the applicants explain that foundation trusts will be accountable to local people who can become governors; this is seen as a major aspect of involvement and accountability. The Homerton document also gives weight to more involvement with local partner organisations through their place on the governors, and UCLH talks of a strengthening of connections between local hospitals and their communities.

Greater staff involvement

Some of the applicants emphasise the benefits of staff involvement and say that staff will be able to influence key decisions and have their voices heard (Stockport, Homerton)

Contribution to regeneration

Bradford, Birmingham, UCLH and Addenbrooke's hope that foundation status will strengthen their contribution to local economic regeneration (though they fail to explain what freedoms they will have to do this that are not currently in place). For example:

*As a major local employer and large, complex business, a foundation hospital could play a part in local economic regeneration.*

(Bradford)

Birmingham intends to create and promote employment for local people, create a "medipark" as a base for healthcare and related industries, employing increasing amounts of local labour. Addenbrooke's hopes that the foundation trust will contribute to economic growth, sustainable communities and a good quality of life for those they serve.

Contribution to research

Addenbrooke's hopes that foundation status will enhance its alliance with research bodies. Birmingham sets out its research and teaching plans and the public is asked what the research priorities should be. However, the research agenda is not explicitly linked with the Foundation Trust issue.

**© The Sainsbury Centre for Mental Health, 2003**

Benefits of membership

Several trusts mentioned benefits to those who became members of the foundation trust. Although all emphasise that being a member would not confer any rights to special treatment, most do offer some special access to information, or to events such as seminars on 'wellness', smoking cessation and general health topics.

UCLH goes further than any of the others in referring to access to a discounted health check service, the ability to apply for an affinity card (a credit card, use of which supports the Trust financially, similar to those promoted by national charities) and tangible benefits such as cheaper telephone bills, or access to shopping discounts along the same lines as NHS staff.

**3. How they have tacked the potential disadvantages of foundation status**

Explicitness about public concerns about foundation trust status

For the most part, the documents examined are careful to make both the benefits and risks of foundation status explicit, and they frankly acknowledge some of the most common fears about foundation trusts. UCLH is an outlier on this, and tackles the risks only superficially, saying:

> *Some people regard [foundation trusts] as a highly controversial policy and a national debate is continuing as the legislation progresses through the House of Lords. However, it is for the politicians to argue national policy. Our remit is to implement government policy rather than discuss its merits.*

The Bradford document deals with concerns about elitism and back-door privatisation in short order and swiftly offers reassurance but, unlike most of the other documents, it does not have a separate section on risks or disadvantages.

Other documents set out a number of risks, advantages and disadvantages of foundation trust status in an even-handed way, though inevitably concluding that the risks and disadvantages are no higher for foundation trusts than for the rest of the NHS and possibly lower. Some of the perceived risks were thought to be present, with or without foundation trust status. Becoming a foundation trust at an early stage was seen as the least risky option.

Stockport recognises common fears of privatisation of the NHS, elitism and competition. These are dealt with by offering reassurance that the government intends that all hospitals will have an opportunity to apply for foundation status within five years. They also refer to restrictions on the powers of foundation trusts, their income and their use of assets to ensure they remain fully within the NHS.

Homerton states:

> *We are aware of the concerns that some people have about Foundation Trusts*

It then goes on to say that they will use a number of principles to guide the application, which will minimise the risks and disadvantages, e.g.:

- Keeping business as usual during the application;

**© The Sainsbury Centre for Mental Health, 2003**

- Keeping work manageable;
- Not raising expectations that cannot be met;
- Seeking benefits for the population served, not just for the hospital;
- Increasing involvement of local community and staff in the planning and running of the hospital;
- NHS Foundation Trust status should be seen as an important aid to achieving established aims and objectives;
- Work with local PCT;
- Contribute to social and economic welfare of Hackney;
- Cooperation not competition with health partners in North East London.

Birmingham's document has on its first page a reassurance that foundation trusts will not be privatised organisations, nor a way of poaching the best staff and will not be about services developing in a multi-tiered fashion. On the latter point they say that it will not happen as, in time, all trusts will become foundation trusts.

All trusts clearly state that there will be a 'legal lock' on assets to prevent privatisation.

In addition to the fundamental political concerns about the concept of foundation trusts, the following potential risks and disadvantages are noted in the documents under review. (It should be noted that a number of issues made explicitly by Stockport and King's are alluded to in a less direct way in some of the other documents).

Meeting expectations

Stockport, among others, notes the risk of the expectations of the public and others being unrealistically high.

> *The challenges include engaging with patients with differing needs, and satisfying everyone's expectations…. Expectations of members may be unrealistically high.*

Financial burden of the new arrangements

Trusts also acknowledge that there are costs in reaching out to the community. Some recognise the risk that the cost of running a membership scheme may divert resources from patient care, although they offer reassurance that their own particular arrangements minimise this risk.

Administrative burden

King's and Stockport both acknowledge the fear that the move to foundation trusts status may distract staff and take too much time, taking the minds of staff off their primary jobs. In particular, King's recognises the worry that senior management will be distracted by the focus and time in setting up the new governance arrangements, and that the new governance arrangements may be quite costly. King's had it in mind to discuss with the Department of Health the possibility of seeking financial support to cover the costs of administering the new arrangements.

**© The Sainsbury Centre for Mental Health, 2003**

Expected benefits may not fully materialise

Given the uncertainty that prevailed at the time the consultation documents were issued, it is not surprising that some trusts – particularly King's and Stockport – were aware that final legislation may not deliver the hoped-for benefits. Public concerns about financial instability were also noted. The solution of King's to this issue was to monitor the progress of the legislation and contribute to the debate.

Local apathy

Several trusts recognise the risk of local apathy, or insufficient engagement with the local community, leading to the organisation becoming dominated by one section of the public at the expense of others. At worst, the Board of Governors could fail to develop into a really effective representative forum, or could be dominated by a single interest group. Trusts intend to address these risks by having the membership of the foundation trusts as broadly based and representative of patients and the public as possible. Elections for Governors from the public constituency were also seen as safeguards, so long as the membership was large.

King's hoped to use ideas and feedback from consultation to ensure that the governance arrangements are as robust as possible.

Birmingham stated:

> *UHB wants to encourage as wide a membership as possible. We recognise many people will prefer to join if they feel they can actively make a difference or see some benefit in joining.*

They outline the benefits of becoming a member as:

- Having a genuine voice and influence on how the Trust and its services develop;
- Participating and providing regular feedback and opinions about services and possible developments;
- Receiving regular information on the Trust and healthcare in general;
- Being consulted on plans for future development;
- Attending special functions such as open days, tours and seminars;
- Participating in seminars on subjects such as wellness, smoking cessation, heart disease and other clinical conditions;
- Opportunity to be elected to Board of Governors;
- Access to a members only section on the Trust's website.

Other applications also gave very similar explanations of the benefits of membership in order to encourage the public to become involved (see also section 2).

The Bradford document has a section on how Bradford would develop a large and representative public membership community. They propose to:

- Meet many local groups and associations to explain what is happening and why people should become members;

**© The Sainsbury Centre for Mental Health, 2003**

- Ask for the views of people as we meet them about Bradford Teaching Hospitals and how they wish to be represented on the Board of Governors;
- Work with local and other media;
- Build a database to enable comparison of the Trust's membership with the Census and hospital data, to enable monitoring of geographical coverage, age, sex, ethnicity and socio-economic grouping.

Birmingham expects that existing members of their Patient Councils may wish to become members of the foundation trust, and therefore eligible to stand as governors. The Trust will ensure that there is cross representation between these established mechanisms and the Board of Governors and Directors.

Proposed arrangements in the documents reviewed for membership and governance that are intended to address the risks attendant on low membership and participation are outlined in the two successive sections on membership eligibility and governance arrangements.

## 4. Membership eligibility

The variations in membership eligibility are, for the most part, subtle, as all are working within the national framework which requires a public constituency and a staff constituency, each electing some of the Governors, with the representatives of the public making up a majority of the Board of Governors.

Public membership

The main variations relate to:

- The lower age limit for membership (age 16 or 18);
- The definition of a patient (including whether a time limit is suggested for 'recent' patients);
- The eligibility, or otherwise, of carers;
- Eligibility for membership for local residents (who may or may not be patients), i.e how 'local' is construed.

The membership criteria for each of the applicants are summarised below:

*Addenbrooke's*

- All members of the public aged 16 and over who live within the proposed membership community are eligible to become members (i.e. all electoral wards within Cambridge City Council, South Cambridgeshire District Council, East Cambridgeshire District Council; selected wards from Uttlesford, East Herts and North Herts District Councils; selected wards from St. Edmundsbury Borough Council; selected wards from Forest Heath District Council and one ward from Braintree)
- In addition, current and former patients of Addenbrooke's are eligible, wherever they live. This extends to carers, parents and guardians for patients who are under 16, or not able to represent their own views for reasons of incapacity or disability

**© The Sainsbury Centre for Mental Health, 2003**

*Birmingham*

- Should live in the City of Birmingham

OR

- Have been a patient at the Trust within the last 3 years (no mention of carers)

*Bradford*

- Anyone over the age of 16 and
- Resident within Bradford Metropolitan District Council boundary; or
- Has been an in-patient, out-patient or day patient – *whether private or NHS* – at the Trust's hospitals within the previous 3 years; or
- Is a carer of such a patient

It should be noted that Bradford is the only one to mention the eligibility of private patients.

*Homerton*

- All members of the public aged 16 and over who live within the proposed membership community (it is inferred from the document that this is the London Borough of Hackney and the Corporation of London, i.e. the City of London)
- Current and former patients, wherever they live; this extends to carers, parents and guardians for patients who are under 16, or not able to represent their own views for reasons of incapacity or disability
- The document refers to patients and carers who have 'recently' received care in the hospital, but 'recently' is not defined.

*King's*

- Residents of Lambeth and Southwark (who account for 2/3 of workload) – age 18 and above
- Non-local patients ( 1/3 of workload) – having been patients or their carer within the last 3 years
- Eligibility will not be limited to those on electoral register – the aim being to be as inclusive as possible, embracing people who do not traditionally get involved with the NHS.
- Parents of local children and carers of local patients living locally eligible for membership as local residents.

It should be noted that King's is the only one to specifically say that it is not necessary to be on the electoral register.

*Stockport*

- Over 16 years of age

AND

- Live within boundaries of Stockport and the High Peak

OR

**© The Sainsbury Centre for Mental Health, 2003**

- Have been a patient in the last 3 years (a patient can transfer his/her membership rights to a named carer)

OR

- Be a member of staff

*UCLH*

Offers 4 options for catchment area of the public constituency, with catchment areas as follows:

Option A. Continuous area within which large clusters of local people live who use UCLH as their local hospital or have used UCLH for secondary services (preferred option)
Option B. A geographic, loosely based concentric circle of approximately 1 mile radius from the centre of the UCLH campus and taking into account the need to run along electoral ward boundaries
Option C. London Boroughs of Camden and Islington
Option D. Whole of North London Strategic Health Authority.

Staff membership

There are subtle variations in eligibility for staff membership of foundation trusts, and a detailed analysis of differential rules for proposed staff membership is not part of the remit of this report. For the most part, it is intended that all staff – full time and part time – will be eligible for membership if they are permanent staff, hold temporary contracts of 12 months duration or honorary contracts. Staff working in a foundation trust for contractors were often mentioned as eligible for membership, and in most cases registered volunteers were also eligible. Precise terms for staff eligibility will be set out in the constitution of each foundation trust.

## 5. Governance arrangements

This section looks at proposed arrangements for the Boards of Governors. It is, however, outside the remit of this document to look at the role of non-executive directors within foundation trusts.

In short, every board must have:

- A majority of governors elected by members of the public constituency
- At least 1 governor representing local NHS PCTs
- At least 1 governor representing local authorities in the area
- At least 1 governor representing staff
- A Chair
- At least 1 governor appointed from the local university (if the Trust's hospitals include a medical or dental school)

(A short guide to NHS Foundation trusts. Department of Health, August 2003)

All the applicants set out this broad framework for governance of foundation trusts, explaining the public and staff membership and the planned roles of boards of governors and boards of directors, and the role of the independent regulator, drawing on the Department of Health Guide. They all explain that there are to be 3 types of governor:

**© The Sainsbury Centre for Mental Health, 2003**

- Public governor (elected by the public constituency)
- Staff governors (elected by staff members of the foundation trust)
- Partnership organisation governors (appointed to represent the interests of local partner organisations)

Within this framework, the consultation documents make a few points that differentiate them and these are discussed below.

<u>Different levels of involvement for public members</u>

The documents generally recognise that members may wish for different levels of involvement, ranging from minimal (receiving information only) to extensive (standing for and serving on the board of Governors). Homerton and King's are at the forefront of acknowledging this potential for different levels of involvement, with King's stating that those choosing just to receive information would get newsletters, voting rights, invitations to formal meetings of governors, information via members' section of website and access to staff in the membership department to deal with queries or information requests. Members seeking more active involvement could:

- Receive more detailed information about specific services
- Be invited to join specific interest groups e.g. for planning, developing or monitoring services
- Have the opportunity to stand for Board of Governors (and, if elected, participate in sub-groups of the Board)
- Have the opportunity to become a volunteer.

<u>Clarity about governance criteria</u>

The King's document is an example of explicitness about the criteria used for developing proposed governance arrangements:

- Practical, not placing unmanageable burdens on the organisation
- Need to create a Board of Governors which can function effectively
- Equitable balance between local people, non local patients, staff and local partners on Board of Governors
- Need to involve a genuinely representative mix within each of these stakeholder categories and to be inclusive and involve as broad a base of stakeholders in each category as possible.

King's also makes the distinctive claim that new arrangements deal with the problem of ambiguity in the role of NEDs on non-foundation trusts, who currently fulfil a 'representational' role as well as 'bringing specific business or other skills' to the Board.

UCLH is also quite explicit, emphasising the workability of their proposed arrangements as much as inclusivity. They are unusual, also, in that they propose that members will have to renew their membership positively after 3 years.

**© The Sainsbury Centre for Mental Health, 2003**

Representatives of the public membership

Many of the suggested arrangements are common to all, e.g. staggering initial terms of office as Governor, to ensure some continuity. In addition, each trust has outlined its own proposals for the election of Governors from the public constituency. These are as follows:

*Addenbrooke's*

- Not proposed to segment the public constituency on a geographical or any other basis – this reflects that the membership community is not very diverse, compared to national standards.
- The Trust's approach to ensuring the Board of Governors is representative is to build a large, active membership. This will 'involve alliances with representative forums for groups who may be at risk of exclusion'.

*Birmingham*

2 options are given for the public governors:

*Option 1*

- 9 members of the public living in South Birmingham PCT area
- 2 members of the public living in the Heart of Birmingham PCT area
- 2 members of the public living in North or East Birmingham area
- 5 members of the public living outside of Birmingham who have recently been patients, 3 of whom are current / former patients of the Trust's regional specialist services

*Option 2*

- 9 members of the public living in the South Birmingham PCT area of which at least 2 will be male, 2 will be female, 2 will be over 65, 3 will be from ethnic minority groups
- 2 members of the public living in the Heart of Birmingham PCT area
- 2 members of the public living in North or East Birmingham area
- 5 members of the public living outside of Birmingham who have recently been patients, 3 of whom are current / former patients of the Trust's regional specialist services

*Bradford*

- 14 of the 16 Governors elected by the public constituency will represent geographical areas in Bradford, relating to the area panels and local neighbourhood forums. The remaining 2 would be elected by patients and carers who live outside Bradford MDC.
- Areas will be grouped, with 4 areas each electing 3 governors and 1 area electing 2 governors (reflecting hospital usage)

*Homerton*

- Emphasises the need to think about balancing the membership for age, gender, ethnicity, geographical area and different types of patient.

**© The Sainsbury Centre for Mental Health, 2003**

- There are no plans to segment the public constituency, but they do propose to encourage involvement right across the community. “A well developed membership strategy will ensure that no one group is over represented.”
- Attracting a diverse and representative membership will be a challenge, not achievable overnight. Building interest in membership will need to be ongoing.
- It will be possible to co-opt members on to the Board of Governors, although they will not be able to vote

*King’s*

- Public / patient constituency will consist of 3 equal groups – Lambeth (6), Southwark (6) and non-local patients (6)
- Sub-dividing Lambeth and Southwark into 6 areas, based on groups of electoral wards, varied to reflect density of patients from the different areas.
- Public members may vote and stand within own area; 2 governors will represent each area.
- Keen to ensure representation of ethnically diverse community

*Stockport*

- There should be 20 elected Governors
- Constituencies for voting and standing for election to be based on Local Authority Area Committee Sectors - currently 8 sectors, and each will elect 2 Governors; plus one sector covering High Peak and Dales, for which there will be 3 members
- Plus one Governor for members living outside these areas (i.e. covering the wider geographic area).

*UCLH*

Minimal details are given. It is suggested that while it is important to be inclusive, the Members’ Council needs to be workable. It is suggested that members should reflect the numbers of patients attending UCLH from:

- Its catchment area (for which it provides options)
- Regional patients or carers
- National patients or carers (from outside London).

Representatives of the staff constituency

The proposals for staff Governors elected by staff vary slightly from Trust to Trust.

*Addenbrooke’s*

Addenbrooke’s 3 staff Governors will be drawn from those who:

- Hold a substantive contact of employment with the Trust
- Hold a fixed term contract likely to last or which has lasted in excess of 12 months – successive contact will count toward the 12 months, if no break in service
- Hold honorary contacts in excess of 12 months

**© The Sainsbury Centre for Mental Health, 2003**

- Registered with Addenbrooke's staff bank
- Employed by another organisation that is providing services to the Trust under an ongoing service contact in excess of 12 months.

Only one electoral college is proposed for all staff members, i.e. there is no segmentation of the staff constituency.

Birmingham

2 options are proposed for Birmingham's 4 staff Governors:

*Option 1*:
All staff vote for all candidates with the top 4 being elected irrespective of professional background or discipline

*Option 2*:
- 1 governor will be medically qualified
- 1 governor will be a registered or auxiliary nurse
- 2 governor will be an AHP / pharmacist or scientist
- 1 governor will be ancillary, technical, administrative or clerical
- Staff to vote only for members from their own professional group or discipline.

*Bradford*

5 staff Governors proposed to be drawn from:

- 1 doctor
- 2 nurses / midwives
- 1 allied health professional or scientist
- 1 for all other health groups
- Staff with contracts of less than 12 months would not be eligible for membership
- Governors representing staff would not be managers of the Trust (at level 3 or above).

*Homerton*

Homerton's 6 staff Governors will be drawn from those who:

- Hold a substantive contact of employment with the Trust
- Hold a fixed term contract likely to last or which has lasted in excess of 12 months
- Hold honorary contacts
- Work for partner organisations but are based at the Homerton
- Registered with Homerton staff bank
- Employed by another organisation that is providing services to the Trust under an ongoing service contact in excess of 12 months
- Registered volunteers.

*King's*

6 staff governors to be drawn from:

**© The Sainsbury Centre for Mental Health, 2003**

- All employees with substantive Trust contracts
- All employees with fixed term contracts of 12 months or more
- Staff with honorary contracts who hold substantive contracts with organisations working in partnership with the Trust
- Staff registered on King's Bank who have worked at the Trust for a total of 12 months or longer
- Staff employed by a contractor based at the Trust who fulfil the minimum 12 month requirement
- Registered volunteers who fulfil the minimum 12 month requirement.

1 governor will be from medical and dental staff (including honorary contract holders), 2 from nursing and midwifery, 1 from allied health professional and scientific and technical staff, 1 from support workers (volunteers, contractors etc).

*Stockport*
5 staff Governors

- to be elected to represent staff constituency, i.e. 2 doctors on a permanent contact, 2 nurses / midwives, 1 Allied Health Professional / Scientist, 1 for all other staff groups including health care assistants.
- Candidates will need to be nominated and seconded by 2 other members and would have to state which category of membership they are standing for. They would provide a statement of their reasons for standing, skills and attributes.

*UCLH*

Scant details are given. The document simply states that staff will be elected from those who have become NHS Foundation Trust staff members.

Election process

The election process is interesting in so far as it helps or hinders active public participation. It is, however, difficult to get a rounded view of trusts' intentions as apart from stating their intention to hold secret ballots, there is little comparable material in the applications reviewed. It is, however, interesting to compare these two approaches to nominations:

In Stockport, candidates for election to the Board of Governors will need to be nominated and seconded by 2 other members and will need to state which category of membership they are standing for. They would provide a statement of their reasons for standing, skills and attributes.

By contrast, at King's any member of the foundation trust can put themselves forward for election – no supporting nominations or sponsors will be required. Each candidate would be invited to produce a short personal manifesto explaining why they wish to stand. The Trust would offer support to candidates in preparing this and would take responsibility for distributing manifestos to members as part of the overall election process.

UCLH is the most explicit about the possibility of entryism and dominance by a single interest group. They state:

**© The Sainsbury Centre for Mental Health, 2003**

> *The Trust wishes to ensure diversity and to avoid 'capture' by a vocal minority. It therefore is considering using the singe transferable vote for elections, in preference to the traditional 'first past the post'.*

The other documents yield little information. Addenbrooke's favours a non-transferable vote. Homerton is working closely with the Electoral Reform Society on voting systems. Birmingham, Stockport and King's do not specify their preferred voting system, while Bradford simply says that a detailed election process would be set out in the foundation trust's constitution

Appointed Governors

The consultation documents show a number of variations relating to appointed Governors. Among the main variations is the size of the body of appointed Governors and the extent of patient and voluntary sector representation. Only one of the trusts has plans for a young person's Governor. Trusts all make it clear that Governors from partner organisations will be representing the interests of a certain sector, rather than their specific organisations.

*Addenbrooke's*

Addenbrooke's proposes to have 10 appointed Governors. They will be drawn from:

- PCTs – 2 (host / lead PCT)
- Local specialist services commissioning group – 1
- Cambridge University – 1
- University of Cambridge School of Clinical Medicine – 1
- Higher education institutions involved in the education of nursing and AHPs - 1
- Research Councils and Research Funding Charities – 1
- Local authority 2
- Regional Development Agency - 1

*Birmingham*

Birmingham proposes to have 13 appointed Governors. In addition to the legally required representation from:

- S. Birmingham PCT, as host PCT
- Birmingham City Council
- University of Birmingham.

They also propose stakeholder governors drawn from a range of key partner organisations, namely:

- University of Central England
- Birmingham and Solihull Learning and Skills Council
- Advantage West Midlands (the Regional Development Agency)
- Birmingham Chamber of Commerce
- Birmingham Council for Voluntary Service
- The Royal Centre for Defence Medicine.

**© The Sainsbury Centre for Mental Health, 2003**

And they would seek views on what other organisations might be represented e.g.:

- Higher education
- Further education
- Secondary education
- NHS Patients Forums
- Business groups such as the CBI
- Hospital volunteer services
- MPs
- Other local authorities
- Philanthropic groups.

*Bradford*

Bradford proposes to have 10 appointed Governors. The following organisations would each be invited to nominate Governors:

- Bradford MDC – 3
- PCTs – 4 (1 from each of 4)
- Bradford Care Trust – 1
- Leeds and Bradford Universities – 2 (1 from each).

*Homerton*

Homerton proposes to have 5-7 appointed Governors, drawn from:

- City and Hackney PCT –at least 1
- LB Hackney 1
- Corporation of London 1
- NELStHA 1
- University 1.

*King's*

King's proposes to have 10-11 appointed Governors. The following organisations would each be invited to nominate a governor:

- KCL / Guy's / St Thomas's school of medicine and dentistry
- University of the South Bank
- Lambeth PCT
- Southwark PCT
- Lambeth Patients Forum
- Southwark Patients Forum
- SE London WDC
- SEL StHA
- Lambeth Council
- Southwark Council

**© The Sainsbury Centre for Mental Health, 2003**

- King's Joint Staff Committee.

*Stockport*

Stockport proposes there should be 12 appointed Governors. The following organisations would each be invited to nominate:

- PCTs (3, i.e. 2 from Stockport PCT and 1 from High Peak and dales PCT). Preference expressed for clinical representation through the PECs. PCT Governors not to be appointed to represent their specific PCT, but to provide a perspective for the wider health community.
- Local authority – 2, to provide perspective of wider community and environment in which Trust operates)
- Educational Governors – 2
- Enterprise Governors – 2 (1 from Stockport Chamber of Commerce and 1 from local media)
- Voluntary Sector Governor – 1 through the Council for Voluntary Service (CVS)
- Young People's Governor (identified by working with the Local Education Authority)
- Patient Forum Governor.

Board composition (in addition to Chair)

In summary, the proposed composition of the Boards of Governors of the potential foundation trusts that were studied is as follows:

| | Public / patient | Staff | Partner organisations |
|---|---|---|---|
| Stockport | 20 | 5 | 12 |
| King's | 18 | 6 | 10-11 |
| Bradford | 16 (min) | 5 | 10 |
| Birmingham | 18 | 4 | 13 |
| Homerton | 13-15 | 6 | 5-7 |
| Addenbrooke's | 14 | 3 | 10 |
| UCLH | Not clear | 3 | Not clear |

Exclusions to becoming a governor

All foundation trusts will be subject to the same basic criteria for excluding people from becoming a Governor, for example, undischarged bankrupts and individuals who have in the last 5 years committed an offence and served a term of three months or more in prison. The exclusions are made explicit by Stockport, and UCLH.

It is interesting that someone who has served a recent prison sentence is not eligible to become a foundation trust Governor. (This is in line with rules about serving on other bodies, such as Parish Councils, although recent ex-prisoners could serve as a Member of Parliament.) There are some inner city areas where a substantial proportion of young men may be excluded from becoming Governors of foundation trusts because they have recently been in prison. This issue has a particular dimension for the population of areas where crime and imprisonment are more common. Since the inmate population of prisons in England and Wales contains five times the number of black people found in the population at large and

**© The Sainsbury Centre for Mental Health, 2003**

black people found guilty of offences are sentenced to custody sooner and for longer than white people (see NACRO website), it is also an issue that black people may be unfairly excluded from the governance of foundation trusts.

Stockport is also clear that:

> *The Trust may, with the agreement of a majority of the Board of Governors, disqualify an individual from seeking election or, if elected, require his/her resignation if, in the judgment of the Board of Directors, the individual's actions are damaging to the Trust's ability to discharge its role.*

**6. How they have sought local support for their application**

The main ways in which the trusts have sought support for their application is by:

- A consultation period of at least 10 weeks
- Public meetings (often publicised in the local media)
- Offering to go out to speak at local meetings
- Clear formulation of specific questions that need to be addressed as part of the consultation.

Other ways that were mentioned include:

- Trust AGM will focus on foundation issue (Bradford)
- Special insert in Bradford Telegraph and Argus (Bradford)
- Information about the application sent to every household, as well as using the local authority press, Hackney Today and City View.
- Presentation to Overview and Scrutiny (Bradford)
- Met with local MPs and senior staff within partner organisations (Bradford)
- Trust will use local authority's 5 area panels and 97 neighbourhood forums to consult on the foundation trust initiative (Bradford)
- Availability of consultation document in languages other than English, and in other formats than standard print:
    - Available in Urdu, Punjabi and Bengali (on request by telephone) (Birmingham)
    - Information available in Albanian, Cantonese, Arabic, Somali, Bengali and French on request; and in large print, Braille, audio tape or diskette. (UCLH)
    - Free interpreting service available, and Braille and large print available. Brief information in 5 languages on back cover (Stockport).

It is, of course, quite possible that trusts have engaged with partners in a number of ways that are not evident from the consultation documents. There are also several statements of intent about reaching out to local communities, of which these two are the most eloquent:

> *Some people may need more support and encouragement than others, so as well as using adverts and leaflets, we will use a more direct approach. We will use different points of contact including health centres, dental surgeries, voluntary organisations, local authority offices, post offices, housing associations, neighbourhood teams and*

**© The Sainsbury Centre for Mental Health, 2003**

*the free press will be used to help us reach people who would not otherwise get involved...*

(Homerton)

*It will be our intention … to strengthen our links with our local communities. We will aim to extend involvement beyond the current arrangements and extend the sense of ownership that people feel towards their local NHS hospitals. There is a long history of community involvement … and it will be our intention to build upon that.*

(Stockport)

There is some slight variation in how responses to consultation have been sought.

- By telephone, email, letter or via the Internet (Stockport, Homerton).
- By email and in writing (Addenbrooke's). They also invite comments on "how we are engaging with patients and the public on this issue".

**7. How they have worked with PCTs, community and voluntary groups, local authorities and other 'influencers'**

This is more often described in general than specific terms, although several trusts refer to existing good relationships with local partner organisations and patients and the public. Some specific examples are:

- Locally agreed plan with PCT on establishment of cardiac and surgical unit (Stockport)
- Reference is made to continuing to work closely with social service and primary care partners, especially in developing services for children and older people. (Stockport)
- As a major employer with a turnover of £135 million, the trust intends to strengthen the contribution to the local economy by working closely with the Chamber of Commerce and investigating how more supplies and services can be bought from local businesses. (Stockport).
- "The Trust enjoys excellent relationships with the Bradford health community, which frequently makes it an obvious choice for piloting national initiatives (examples include *Pursuing Perfection* and *Action-on Cataracts*). We are committed to partnership working and to develop strategic alliances with partners to improve services for patients" (Bradford).

**8. To what extent, and how, have they reached out to excluded groups?**

All would-be foundation trusts claim success in forging links with their local communities, including those groups who have often been excluded, but there is little to differentiate one from another on this, and little that points towards the relevance of their past efforts to their future intentions for foundation status. However, in addition to the methods used for seeking support for the foundation trust consultation, outlined above, several approaches are evident from the consultation documents.

- Self nomination and support in preparing manifesto - apparently aimed at including people who might be deterred by formal nomination processes (King's)
- Department of Health short guide to NHS Foundation Trusts sent out with consultation document (King's – and possibly others) - some documents were

**© The Sainsbury Centre for Mental Health, 2003**

obtained from the Internet, rather than by post, for this review, so it is not clear what additional documents may have been dispatched with postal enquiries.

- Membership Relations Office proposed to ensure interaction between members and governors e.g. regular updates through newsletters and electronic means. (Bradford)
- Availability of material in community languages and a variety of formats.

Finally, it should be noted that there were differences in style and accessibility that may assist or impede the trusts in reaching out to excluded groups. For example, UCLH, which is clearly worried about entryism, has produced a consultation document that is rather forbidding. They stress that they expect members standing for election or appointed to sign up, not only to support core NHS principles, but also to the vision statement and values of the Trust.

The Birmingham document possibly has more jargon than other documents, for example, it refers to "ambulatory care", "redesign processes" and "emulate the best human resource practices". However, Birmingham does offer a glossary that picks up on some, though not all, of the complex terms used. And only Birmingham appears to have thought about the possibility that the word 'governance' may be obscure and off-putting and it heads its chapter on governance "How the foundation trust would be run".

**9. Evidence of the success of their efforts to date**

It has not been possible to address this question as it is too early in the process, and too difficult to discern from the sources available. However, this question would merit further research at a later stage, using interviews with a range of people to complement documentary evidence.

**10. Conclusions**

While the documents reviewed have a great deal in common, there are significant differences in:

- The style and readability of the documents
- The amount of detail given in consultations
- Detail of efforts made to reach local communities
- Criteria for membership
- Safeguards proposed to minimise risks of local apathy and consequent dominance by a small minority
- How members may stand for election as a Governor, and the help available to do so
- Size and composition of Board of Governors.

If mental health trusts apply, in due course, to become foundation trusts, they will wish to learn lessons from the first wave applicants and to construct their own applications with these factors in mind.

**© The Sainsbury Centre for Mental Health, 2003**

**Appendix 1 - Documents used**

Seeking your views on our application for NHS Foundation Trust status. Consultation Document. September 2003. Stockport NHS Trust.

Delivering excellence as a Foundation Trust – Consultation document. Sept 2003. King's College Hospital NHS Trust

Consultation document on becoming an NHS Foundation Trust – Bradford Teaching Hospitals NHS Trust

Your hospitals in your hands – consultation document on becoming an NHS Foundation Trust – University Hospital Birmingham, September 2003.

Foundation Trust -Our Foundation for the Future, Consultation document. Homerton University Hospital. September 2003.

Your Hospital – Your chance to be involved. Our NHS Foundation Trust application – consultation. Addenbrooke's NHS Trust. August 2003.

Consultation document – supporting our application to become a NHS Foundation Trust. University College London Hospitals. September 2003.

A short guide to NHS Foundation trusts. Department of Health, August 2003

**© The Sainsbury Centre for Mental Health, 2003**