Investigating the governance of NHS Foundation Trusts

Executive Summary
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Background

NHS Foundation Trusts (FTs) are a new form of NHS organisation set up in 2004. They were conceived as a new kind of organisational form, still part of the NHS, but modelled on ‘co-operative and mutual traditions’. FTs are different from other NHS Trusts in two distinct ways: First, they have greater autonomy, and less accountability to the central NHS. They have greater scope to decide how they organise themselves internally, in order to deliver high quality services and control costs. They are able to retain financial surpluses, and do not need permission from an external body such as a primary care trust (PCT) or strategic health authority (SHA) to make internal investments in new services or in buildings. Financial accountability to Parliament is via a new regulator, Monitor, rather than via the ‘traditional bureaucratic route’ through PCTs and SHAs. Secondly, FTs are required to have members and governors, new classes of stakeholders for NHS hospitals. These new roles are designed to increase local accountability.

There have been very few studies of the governance of FTs to date – only one academic study (by Day and Klein) in 2005 – so the SDO took the view that the operation of the new forms of external and internal governance of FTs should be investigated.

Aims

The objectives of the study were:

1. to assess the effect of the new external governance arrangements on FTs’ decision making and behaviour, in respect of patients and carers, staff, and in relation to partner organisations;
2. to assess the effect of the new internal governance arrangements on FTs’ decision making and behaviour, in respect of patients and carers, staff and in relation to partner organisations;
3. to analyse whether the nature of the FTs’ governance regime (compared to that of other NHS trusts) has made any difference to the effectiveness of the governance of FTs;
4. to identify and disseminate the lessons learnt for improving the governance of all NHS trusts (whether FTs or not)

Methods

We used a multi-site case study design, studying four FT hospitals in detail. Two were in London and the Home Counties and two in the north of England. The study sought to examine the new governance arrangements in the FTs over a two year period (2007 to 2009). The results of the case
study research were put in context by using quantitative data about all FTs and all other NHS Trusts, to see how our four case studies compared.

**Results**

The FTs in the study had developed a self reliant ethos in which they were aware of themselves as autonomous agents within the larger structure of the National Health Service. The self reliant ethos found expression largely at board level, but efforts were being made to devolve this attitude to clinical directorates as well. This exercise of greater freedom to make decisions was tempered by varied dealings with the FT regulator, Monitor, depending on the situation in the individual FT. It was particularly when Monitor picked up problems in the FT’s performance that it was felt to be intrusive.

Elevation to FT status had brought a cultural change in the study sites. The FTs had become more business focused. They recognised a more acute need to cut cost of services, to grow their surplus and to re-invest in order to expand and develop services and produce more income.

At the same time, the autonomy of the FTs in the study should not be overstated. A wide range of national policies apply to the NHS as a whole, and not specifically to FTs. These policies had a very large effect on the FTs in our study. In the case of the national targets, such as the 18 week patient pathway and infection control targets, it is clear that the centralised command and control aspects of the NHS were very powerful influences on the FTs in the study.

Elevation to FT status did affect the FTs’ relationships with other health care agencies in the local health economy. The fact that FTs had developed a stronger sense of their own identity and of the need to protect their services and future income streams against other trusts, and to expand services to increase income, meant that they were competing more strongly with other local hospitals. But the FTs’ greater sense of themselves as separate entities did not always lead to deterioration in relationships with other local organisations. The FTs continued to see themselves as part of the local health economy.

Turning to the changes in internal governance, we found that the representative structures of the FTs in the study involved significant costs. These structures provided the FTs with alternative sources of knowledge that could be useful in organising their services to the satisfaction of the community, and thus conveyed a sense of local legitimacy to the FT. In joining the FTs’ representative structures, governors felt a sense of duty to the hospital. The relationships between the governors and the FTs’ executives were still developing, and not all of the governors felt they were able to carry out their role of holding the FT to account.

Our study design entailed four FTs being studied in depth, in order to obtain detailed information about their governance. The comparative quantitative data demonstrate that our four case study FTs were generally similar to
other FTs in the country in respect of issues such as financial performance, use of resources and quality of care. The quantitative data also demonstrate that, on the whole, FTs are performing better than other NHS hospitals. This is due to the fact that only better performing hospitals have been allowed to become FTs. Finally, the quantitative data show that in their local areas, the case study FTs were performing a little better than their competitors in some respects, but not all. There was clearly real competition for the FTs in each case study area in terms of performance.

**Conclusions**

The view of FTs as being akin to mutual organisations is not accurate in the sense that they are not owned by their members. FTs are part of the NHS system, albeit with a greater degree of autonomy. The process of integrating new stakeholders into the fabric of FTs and understanding how best to use their different experience, knowledge and skills is a slow one. The costly patient, staff and public involvement aspects of FTs’ governance structures require further development if they are to demonstrate their value.

Autonomy has allowed FTs to adopt a more business like approach. This greater focus on performance (both financial and in the delivery of services) may well be useful for all NHS organisations, in order to improve efficiency and service quality.

One of the important lessons from the study is the salience of the NHS context within which FTs are operating. The period during which the field work was undertaken was one of financial expansion for the NHS. In this environment, the PbR payment system allowed FTs to increase their incomes and grow their surpluses. The financial outlook for the NHS for the next few years is much less good. There is likely to be less income available for all hospitals, including FTs. FTs should be well placed to take account of these changes in future years, as their financial systems are better developed than other NHS trusts, and they should be able to rise to the challenge of increasing their technical efficiency. On the other hand, one of the great advantages perceived by the FTs in the study was the ability to make investments and improve services using the surpluses they had accrued. If it becomes more difficult to make a surplus, one of the advantages of being an FT, greater local decision making power, could be vitiated.

**Recommendations**

**Internal governance and use of stakeholders**

The issues of which we suggest that the new governance structures and policies need to take account are the following:

- Staff participation. There are two levels of staff participation to be considered. One is at operational level: in clinical directorates staff
participation appears to be developing relatively well. The other is at strategic level, where less staff participation is currently occurring. If it is thought desirable for staff to participate using FT structures (rather than, for example, through their trade union representatives), it will be necessary to invest significant time and effort in training staff to understand how the FT is governed and what their contributions could achieve.

- Public and patient participation. In order to improve the quality of participation, it is necessary for FTs to achieve a greater degree of clarity about what participation is for. Specifically, there is a need for clarity nationally about the scope and extent of governors’ role in local accountability. There needs to be a common understanding about of the role of governors in their relationship with the membership of the FT, the public generally and also other public participation arrangements, such as LINks (to be renamed local Healthwatch).

**Improved financial management**

Our study noted that FTs were becoming more business like, and that these characteristics were likely to enable them to deal effectively with the coming financial stringency. The aspects of FT behaviour which enable them to run their financial affairs in a business like way should be extended speedily to other NHS Trusts, as they prepare to become FTs.

**Further research**

Given that the financial context for FTs will be radically different in the next few years, and that the regulatory environment, (and possibly the actual governance structures of FTs themselves) will change. These factors indicate that it would be very useful to continue to study the governance of FTs for some years to come, in order to understand the effects of these changes on how FTs operate at local level. This will require continued detailed case study research into a small number of FTs and their local healthcare communities.

As it appears that there are problems with the current regulatory framework for FTs, there is also a need for specific research on how the regulatory bodies carry out their tasks in relation to FTs, as well as other NHS organisations. In particular, independent research on Monitor’s role, philosophy and performance would be very useful. This is particularly salient as the role of Monitor is to be expanded in the near future. The research would need to include how Monitor’s role relates to that of other regulators, such as the Care Quality Commission.
Addendum

This document is an output from a research project that was commissioned by the Service Delivery and Organisation (SDO) programme, and managed by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO), based at the London School of Hygiene & Tropical Medicine.

The management of the SDO programme has now transferred to the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton. Although NETSCC, SDO has conducted the editorial review of this document, we had no involvement in the commissioning, and therefore may not be able to comment on the background of this document. Should you have any queries please contact sdo@southampton.ac.uk.