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Investigating the governance of NHS Foundation Trusts

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Glossary of terms/abbreviations

CQC   Care Quality Commission

FT   Foundation Trust

HCC   Healthcare Commission

ISTC   Independent Sector Treatment Centre

LINks   Local Involvement Networks

Monitor   Foundation Trust regulator

OSC   Local Authority Overview and Scrutiny Committees

PALS   Patient Liaison and Advice Service

PBC   Practice based commissioning

PC   Patient Choice

PCT   Primary Care Trust

PPI   Forum Patient and Public Involvement Forum

PbR   Payment by Results

Acknowledgements

Executive Summary

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 over stated. 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.

1 Introduction

1.1 Study background and objectives

The National Institute of Health Research Service Delivery and Organisation Research and Development Programme funded a research team, based at the London School of Hygiene and the Universities of Leeds and York, to undertake a three year study of the governance of Foundation Trust hospitals (FTs) between 2007 and 2010.

In the eyes of those who developed early policies, FTs were conceived as a new kind of organisational form, still part of the NHS, but modelled on 'co-operative and mutual traditions' (DH 2005). 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.

FT are a new organisational form operating in a complex policy environment in the NHS characterised by three main aspects. The first structural characteristic is the increasing use of market like mechanisms, such as a national tariff (Payment by Results), the encouragement of an increased diversity of provider types (including FTs, as well as non NHS for profit providers), and Patient Choice. The second is the marked increase in the numbers of regulatory bodies (such as the Care Quality Commission, formerly the Healthcare Commission, during the study period). The third is the continuing use of 'command and control' from the centre. The policy context is discussed in detail in chapter two.

In the study reported here, we were interested in understanding how Foundation Trusts interpreted the legislation and the policies emanating from Whitehall, whether they were able to implement the changes envisaged by policy makers, and the effects of any changes on their own governance arrangements. With regard to governance, we were interested in the effects on both the internal workings of Trusts and on their relationships with other organisations PCTs.

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).

We used a multi-site case study design, studying four FTs in detail. Two were in London and the Home Counties and two in the north of England. The study sought to capture changes that occurred over a two year period within the FTs, focusing particularly on the new governance arrangements at the top of the FTs, on financial management, and on two 'tracer' services (orthopaedics and diabetes). It also sought to understand the effects of the new regulatory environment on the internal governance of the Trusts. The results of the case study research were put in context by using quantitative data about all FTs and all other NHS Trusts, so see how our four case studies compared. The study methodology is described in detail in Chapter three.

1.2 Structure of this report

Chapter two reviews the policy context for the study. First, it focuses on the general structure of the NHS, being the internal market and enduring central control elements which affect FTs, especially national targets. Public participation mechanisms in the NHS are discussed, as these interact with the new stakeholders, being FT members and governors. Then chapter two discusses the policy and legislation applying specifically to FTs and sets out their formal ownership, decision making and regulatory structures. Chapter two then discusses what was known about the governance of FTs when the study started and, finally, what the expectations and concerns about the new policy were at the time. Chapter three presents our study design and methods. Chapter four sets out the results of the study. It is structured as follows: the first part reports on the quantitative data which puts the four study sites in context; the second part reports on issues specific to FTs (namely autonomy, responsiveness to local needs using the new mechanisms of members and governors, and the effect of FT status on local relationships); and the third part reports on the issues which affect FTs as well as other NHS Trusts (such as central targets and the Payment by Results regime). Chapter five gives our conclusions.

2 Policy context

This chapter will examine the context within which all FTs are operating, in order to enable readers of our findings to understand the experience of the FTs in the study. The first part deals with national policies in respect of the organisational and institutional structures of the NHS in which the FT policy is situated. Then the policies motivating FTs themselves are described, followed by a detailed analysis of the formal and legal governance of FTs. A brief indication of what is known about FTs is given, and finally, the concerns voiced about the FT policy are set out.

2.1 Structure of the NHS

In order to understand the context within which FTs are operating, it is necessary to explain the broader organisational structures of the NHS. This requires initially a brief description of the salient aspects of the organisational history of the NHS of the past two decades, followed by a description of the position pertaining during the period of the study of FTs reported here.

2.1.1 The NHS internal market

The NHS was established initially in 1948 as a hierarchical public organisation. However, by the late 1980s an internal market was seen by the government as the best form of governance structure for the NHS. An internal market for community, secondary and tertiary health care was introduced by means of a split between the purchasers of care and its providers. The providers of health care were constituted into 'self governing Trusts' (still publicly owned), who were supposed to compete with each other, thereby enhancing technical efficiency (Department of Health, 1989). The system of annual budget allocations was to be replaced with one based on negotiated contracts between purchasers and providers. The government's reasons for the introduction of the internal market into the NHS were made explicit in *Working for Patients* (Department of Health, 1989). They were value for money (i.e. efficiency), responsiveness to patients and greater choice. Research concerning the internal market does not provide any convincing evidence that efficiency was, in fact, improved by the introduction of the new structures (Le Grand et al 1998). Responsiveness and choice for patients were not significantly improved. One of the reasons researchers have identified for this lack of success was that the incentives to behave in market like ways were not strong enough, and the hierarchical elements of the NHS continued to exercise control (Enthoven, 1999; Touhy, 1999; Allen, 2002b).

The early indications following New Labour's election victory in May 1997 were that, despite a softening of the rhetoric about competition and markets, there would be a continuing commitment to the purchaser/provider split (Allen, 2002b). After an initial period when the New Labour government emphasised the need for purchasers and providers to co-operate within a re-integrated public service, a series of new policy initiatives now moved towards a more overtly marketised system. Attempts to focus on standards and modernisation coupled with the use of centrally defined targets and performance management were tried out, but, especially since the election in 2001, these were being supplemented by an increased emphasis on markets and choice (Allen and Riemer Hommel, 2005; Hughes and Vincent-Jones 2008).

These developments can be seen as a response to what is perceived as the failure of the hierarchical model, combined with learning from the deficiencies of the Conservatives' internal market of the 1990s. The objectives of the internal market of the 1990s were re-articulated through a set of more radical reforms. The government is trying to take account of the failures of the internal market structures, particularly in relation to motivation and incentives on the supply side. The re-emphasis on markets as a motor for improvement is encapsulated in 'four inter-related pillars of reform' which 'are designed to embed incentives for continuous and self sustaining improvement' and produce 'better quality, better patient experience, better value for money and reduced inequality' (DH 2005b). These policies are summarised here, as they are the structural context in which FTs are operating. Fuller accounts can be found elsewhere (e.g. Hughes and Vincent-Jones 2008; Allen, 2006; Allen, 2009).

(1) 'Demand side reform - more choice and a stronger voice for patients' (DH 2005b).

Enhanced patient choice is a key feature. It strengthens the demand side of the market by allowing individual patients to decide where to obtain hospital treatment. Instead of being told where to go by their family doctor, patients can choose from a large menu of approved providers, both within the NHS and independent. (DH, 2002, 2003, 2004a, and 2005b). The role of PCTs is not to direct patients to particular providers, but to offer a choice amongst a range of providers who may be owned by the state or not. Patient choice is designed to empower individuals and to act as a mechanism to improve services, as patients are thought likely to avoid under-performing hospitals, and the prospect of losing funding under Payment by Results (see below) should create incentives to improve quality and access times.

Another feature on the demand side is *practice based commissioning*, which is being introduced to GPs or groups of GPs. Practices are being given a

budget with which to commission care for their patients. This means that there are other demand side entities of which all NHS Trusts may need to take account.

(2) 'Transactional reform - money following patients, rewarding the best and most efficient providers, giving others the incentive to improve' (DH, 2005b)

A national tariff of fixed prices for procedures, based on health resource groups (HRGs) to pay both public and independent providers is being introduced (DH 2005b). It is called 'payment-by-results' (PbR), which is a misnomer, as it is actually payment by activity. The idea is to shift the emphasis to competition based on quality and to sharpen incentives, as each episode of care reimbursed (or lost to another provider) is charged at national tariff rates, which are average costs. This is meant to improve provider efficiency by driving down the costs of providers whose costs are currently above average costs. PbR in England is also designed to support the operation of patient choice, as each episode undertaken at the hospital chosen by the patient attracts additional revenue. PbR is being introduced gradually in England, with differential speed between different types of providers: FTs have had 550 of 600 possible HRGs using PbR since 2004/5, while non FT NHS trusts did not get to this point until 2008/9. PbR was expected to cover about 90% of NHS inpatient, day-case and outpatient work in England by 2008.

(3) 'System management and regulation - a framework of system management, regulation and decision making which guarantees safety and quality, fairness and equity' (DH, 2005b)

In addition to the continuing role of the hierarchical system run from the Department of Health through performance management, the regulation of this system is increasingly carried out by a series of arms length agencies. From the perspective of the current reforms, the most important agencies include Monitor, which licenses and regulates Foundation Trusts (see below for further details) and the Care Quality Commission (formerly the Healthcare Commission, and prior to that, the Commission for Health Improvement), which has a broad range of responsibilities concerning the quality of care. Since 2009, there has also been a market regulator, the Cooperation and Competition Panel, but, as this is so recently established, it has not had a significant effect during the life of the FT research project reported here.

(4) 'Supply side reform – more diverse providers, with more freedom to innovate and improve services.' (DH 2005b).

A range of new (or revamped) providers is being encouraged to contract with NHS purchasers to supply services to NHS patients. These include FTs,

for profit suppliers of care (mainly cold surgery centres known as independent sector treatment centres; ISTCs), and not for profit providers of health care (ranging widely to include community nursing, mental health and learning difficulty services, for example.) FTs were first proposed in *Delivering the NHS Plan* (Secretary of State for Health 2002).

2.1.2 Centralised command and control in the NHS

In addition to the structural factors discussed above, which provide a 'market like' environment in which FTs operate, it should also be noted that large elements of central hierarchical control are also still in existence. The targets introduced in the early New Labour period from 1997 have continued. FTs are not operating in a free market.

The most salient of these hierarchical policies is the fact that each year an operating framework issued to the NHS by the Department of Health setting out annual priorities for the whole system to follow (e.g. Department of Health, 2004b). Most notably, the operating frameworks during the period of the research included the imposition of national targets for issues such as reducing hospital acquired infections and reducing inpatient waiting times. All NHS hospitals including FTs were (and are now) required to return data to the centre about the extent to which they have met national targets. There were three notable targets during the period of the research reported here: First, the eighteen week pathway (DH, 2004a): 'By 2008 no one will wait longer than 18 weeks from GP referral to hospital treatment.' Second, the healthcare associated infection targets. This started with *Planning and Priorities Framework: national standards local action* (DH, 2004b), which set a target to 'Achieve year on year reductions in MRSA levels, expanding to cover other health care associated infections as data from mandatory surveillance becomes available'. In successive years, more specific infection targets were set (e.g. *The NHS in England: the operating framework for 2007/08* DH, 2006, in respect of C.Difficile*)*. Third, the four hour wait in accident and emergency departments (DH, 2000). This stated that by December 2004 all A and E patients should be discharged, admitted or transferred within four hours of arrival).

Moreover, the Healthcare Commission carried out inspections of hospitals and issued annual reports for the public to be able to see and compare the performance of hospitals in respect of the national targets (e.g. HCC, 2007).

Central control includes wage regulation. There is a national pay framework ('Agenda for Change', DH, 2004c) which applies to all NHS staff (except doctors and dentists) whether they are in FTs or not. In addition to pay rates, **there are the restrictions on FTs - as on all NHS trusts — in respect of the conditions of employment and working practices at**

all levels of both clinical and ancillary staff. These conditions of working have existed over a long time and have been exacerbated by the European work and employment regulations. Further examples of central control include the introduction of a standard form of contract to be used in the market regime (thus somewhat undermining the notion of a market as involving the devolution of power from the centre) and actual direct planning of services, such as the reconfiguration of health services in London (Healthcare for London, 2007).

2.1.3 Public and patient participation in the NHS

In addition to the quasi market structure and continuing central control exercised in the NHS, the policy context in which FTs operate also includes another important element. There are many mechanisms for public participation which already exist, in addition to those introduced by FTs themselves (see below). This section will outline some of the more important mechanisms at local level which may relate to (and possibly conflict with) the FT member and governor structures. (For a full discussion of public participation in the NHS at national, local and individual levels, see Allen, 2010).

PCTs – involvement in commissioning: The NHS policy of 'World Class Commissioning' puts the commissioning of services at heart of NHS system (DH, 2007). This is a key policy for making the market reforms referred to above work well. It includes a statutory duty for PCTs to demonstrate that views of patients and public are effectively represented in their decisions about commissioning (National Health Service Act 2006).

NHS organisations' duty to consult: All local NHS organisations, including both PCTs and provider organisations such as NHS Trusts, have a continuing statutory duty to consult the public on changes which are 'significant' i.e. which have a 'substantial' impact on the manner in which services are delivered and/or the range of health services available (Local Government and Public Involvement in Health Act 2007, 'the 2007 Act').

LINks: For many years, this took the form of the Community Health Council (CHCs). These were controversially abolished in 2003 and replaced by Patient and Public Involvement Fora (PPI Fora), which, unlike CHCs, did not cover a local area, but were tied to particular NHS organisations. As from 2008, LINks have replaced PPI Fora in the NHS. (For a detailed discussion of the difference between PPI Fora and LINks, and the operation of LINks, see Hughes et al, 2008).) These new bodies are slowly being established under the 2007 Act to promote and support the involvement of people in the commissioning, provision, and scrutiny of local care services, and to obtain views of people about their needs for, and their experiences of local care services. LINks are charged with making views known, and making

reports and recommendations about how local care services could or ought to be improved, to persons responsible for commissioning, providing, managing or scrutinising local care services (2007 Act).

Local authority Overview and Scrutiny Committees (OSCs): These Local Government Committees were set up by the Local Government Act 2000 (amended by section 7 of the Health and Social Care Act 2001, now section 244 of the NHS Act 2006).Unlike other NHS public involvement mechanisms, they are based in local government structures and are constituted by elected members of local authorities. Their role is to review local health and social care. They must be consulted in the event of proposed major changes to NHS services. They can investigate matters referred by LINks (formerly PPI Fora) and can refer some matters to Secretary of State for Health.

In addition to choice for individual patients, there are two mechanisms which allow individual patients to express concern about services they have received*. The first is Patient Advice and Liaison Services (PALs):* These organisations provide a service based in each NHS trust. Their role is to provide information, advice and support to individual patients and carers concerning their own experiences of services at that trust. The second is the *NHS Complaints System.*

2.2 NHS Foundation Trusts

2.2.1 Policy goals for FTs

Having described the overall structural context in which FTs are operating, we will now turn to the policies affecting FTs directly, starting with the policy goals which they are meant to achieve.

'NHS Foundation Trusts are a new type of NHS Hospital tailored to the needs of local populations and run by local managers, staff and members of the public. The Health and Social Care Act 2003 establishes NHS foundation trusts as independent public benefit corporations modelled on co-operative and mutual traditions.'

   (DH, 2005a)

We can see two clear strands of thought in this statement: First, that FTs are designed to be NHS organisations with greater autonomy from central control; and secondly, that local people, including staff, patients and members of the public should be involved in running these hospitals. The aim of the governance regime for FTs is to change the balance between the competing goals of autonomy and accountability (Davies, 2004) to tip it further in favour of autonomy, although the membership structure is meant to increase local accountability to make up for lower levels of accountability upwards. The goal of increased autonomy for NHS providers fits into the market like structures in the NHS discussed above – this autonomy is

thought to be a method of enhancing the efficiency and responsiveness of providers, which are two of the main aims of the internal market. The idea of local accountability is part of a different, but related strand of thought, in which central control should be diminished but accountability for public money continue, and, again, that responsiveness to local people be enhanced. This is partly a response to the continued central control of the NHS outlined above. These themes of increased autonomy and local participation are what are meant to differentiate FTs from ordinary NHS Trusts, and are the focus of our study.

Autonomy is one of the main interests of policy makers. Concern had been expressed at governmental level (e.g. Reid, 2004) and inside the NHS that the NHS was over centralised, and the healthcare system would produce better results if more power were given to the people delivering the services. The implicit assumption of the government is that all aspects of performance of more autonomous providers of public services will be better than those under closer central control. As stated in our proposal to carry out this research, the current evidence about increasing autonomy at local level indicates that not all of these assumptions are warranted (Peckham et al, 2005). In general, the literature on organisational performance indicates that there is no consistent relationship between matters such as the internal and external governance structures of an organisation, its ownership; and its performance (Sheaff et al, 2004). As Howell (2004) points out, the institutional design challenges posed by continued public ownership, but divested control are complex. The environment in which an organisation operates can be as important as its own governance arrangements, especially its ownership structure (Ballou and Weisbrod, 2003). As will be seen in later chapters of this report, the environment in which FTs are operating, in addition to their own governance structures, is very important to their performance.

Closely related to the notion of autonomy from the centre is the idea that FTs will enhance public and staff participation and will therefore be more responsive to local needs. FTs are characterised by government as modern exemplars of the co-operative and mutualist tradition and as an alternative to centralised control. It is argued that a kind of social ownership exists in the form of the empowerment of local communities to become involved in the stewardship of their local hospitals (Vincent-Jones, 2005). Mutuals are supposed to 'combine business efficiency with member benefits' and offer a clearer customer focus (Mutuo, 2005, quoted in Vincent-Jones, 2005). But, as stated in our proposal, the evidence about mutual organisations is not so clear. Although there is some evidence to support this (Saltman et al 2003; Levaggi and Smith 2004), this may result in services only increasing their responsiveness to certain groups, not to all users (Blomquist, 2004). Hansmann (1986) also points out that not for profits may have difficulty in

responding flexibly to changes in what their consumers what because they are constrained in their access to capital (compared to for profits). Hansmann (1986) also has doubts about the efficiency of not for profit organisations, as there is less incentive on managers to minimise costs where there are no ownership claims to residual earnings.

2.2.2 Formal governance structures of FTs

The internal and external governance of FTs varies from that of NHS Trusts (Health and Social Care Act 'HSCA' 2003).

Ownership

FTs are separately constituted companies, in a new category known as public benefit corporations. Section 1 (1) of the HSCA states that

'An NHS foundation trust is a public benefit corporation which is authorised… to provide goods and services for the purposes of the health service in England'.

A public benefit corporation is

'a body corporate which, in pursuance of an application under this Part, is constituted in accordance with Schedule 1 [of HSCA]'.

Schedule 1 starts with a statement that a public benefit corporation must have a constitution, and then continues to deal with matters such as eligibility for membership of the trust, board of governors, board of directors, auditors, accounts and annual reports. There are no specific provisions in the Schedule concerning the ownership of the FT, which implies that their ownership is the same as ordinary NHS Trusts.

In order to avoid the risk of NHS assets being used for other purposes, they are protected by the provision that an FT is not at liberty to dispose of its key assets (section 16 HCSA). When an FT is authorised by the regulator (Monitor, see below), the authorisation will designate some of its property as 'protected property', which cannot be disposed of without the approval of the regulator. Protected property is that which the FT needs in order to meet its authorised obligation to provide health services in England. In other words, the FT cannot dispose of the assets needed to provide the amount of healthcare the regulator initially mandates it to provide to the NHS. However, any property surplus to this requirement can be disposed of.

The rest of HSCA gives clues as to the ownership of the FT. Although section 7(7) of HCSA states that 'the trust's property is not to be regarded as property of, or property held on behalf of, the Crown', section 13 of HCSA states that the initial public dividend capital (PDC) of an FT is an asset of the Consolidated Fund (i.e. the government). Subsequently, guidance was issued by the DH in April 2005 stating that no further PDC

will be issued and that interest bearing debt will be issued instead. It could be argued that FTs can be characterised as non profit state owned firms.

Although at first sight it looks like the non-distribution constraint embodied in the FT legislation indicates that FTs are analogous to non-profit mutual organisations, this is misleading. The HSCA stipulates that in the event of dissolution of an FT, the Secretary of State can order its assets to be transferred another FT, an NHS Trust or the Secretary of State. Assets cannot be distributed to the members. This view is supported by a later consultation document ('Consultation on a regime for unsustainable NHS providers', DH 2008) issued by the Department of Health which suggests that the insolvency regime for FTs should not be that used by the courts for insolvent privately owned companies. Instead, the regulator would 'de-authorise' the FT, and it would revert to NHS Trust status (without members), at which point the proposed 'unsustainable provider regime' for NHS Trusts would apply (and thus a special administrator of the NHS Trust would be appointed). All this suggests that FT ownership is structured somewhat along the lines of 'social ownership' with remaining aspects of traditional state-managed public ownership and not really resembling independent non-profit ownership.

Decision making and local involvement

FT staff, and people living locally, have the right to become members and vote for a board of governors. The local authority and the local PCTs are also represented. The governors appoint the chair of the board of directors and non executive directors. The majority of the board of governors must be elected by the public members, and there must be at least three governors representing members of staff of the FT and one representing any local university medical school. The board of governors is meant to work with the board of directors in setting the strategic goals of the FT. They are required to pass information about FT performance to their constituency, and to inform the regulator (see below) if they have serious concerns about the board of directors which cannot be resolved at local level.

Unlike ordinary NHS trusts, FTs are no longer directly accountable to the Secretary of State for Health and are not performance managed by Strategic Health Authorities. (Nevertheless, the national priorities in the annual guidance referred to above do apply to FTs, and they are inspected by the Care Quality Commission in respect of these.) Compared to NHS Trusts, FTs have greater freedom to determine the level and type of investment in new capacity. Also, they do not need to break even, year on year, and can retain any surpluses which they accrue. FTs can borrow money from whom they wish, within a borrowing limit set by the regulator.

Not all assets may be used as security, as protected property may not be charged without the regulator's permission. FTs are allowed to make independent investments by forming companies or acquiring membership in corporate bodies (HSCA, s17). FTs have a small degree of increased freedom in setting rates of pay (NHS Employers, 2005). But they are still subject to the national NHS pay regime of *Agenda for Change*.

Regulation

FTs are still regulated by the state: to come into being, they have to be licensed (in an 'authorisation') by an independent regulator (Monitor). FTs' financial affairs are monitored over the years by Monitor, which can demand large amounts of financial information and give directions. Monitor has said that it will operate a risk based approach to regulation, allowing a lighter touch for FTs which are performing well (Monitor, 2005). Moreover, the provision of services by FTs are inspected by the Healthcare Commission (now the Care Quality Commission), in the same way as all NHS Trusts. There is a legal obligation for FTs to work in partnership with other health and social care partners (HSCA 2003, s29). All other statutory requirements (such as health and safety legislation and the European Working Time Directive) still apply to FTs.

2.3 What is known about FTs

There has been a small amount of academic research and official evaluation of FTs since their inception.

An early study by the Health Care Commission (2005) looked at the first 20 FTs. In addition to the quantitative analysis, the review included a qualitative component involving a large number of interviews across the country. The quantitative component compared FTs and non FTs using analysis of routine data. The analysis found that FTs and non FTs showed an improvement on a number of the indicators such as waiting times, but there was no significant difference between them. The qualitative component of the review found that FTs had business strategies focused on growth and development of services; an increased ability to plan and develop services; and made use of their ability to gain access more quickly to capital investment to improve and develop services. There was a lack of clarity as to the role of governors and some areas of duplication between the Board of Governors and Patient and Public involvement forums. There was low engagement of staff. The review examined relationships with other organisations in local health communities. It found that current relationships were determined by the history of local relationships.

Another early study of the first 20 FTs (Day and Klein, 2005) focused on the degree of local accountability which the new regime has so far

engendered. They found that small numbers of people volunteered to become members of FTs, but that the voting turnout among those members when they were given the opportunity to vote for the board of governors varied from relatively high to below 20%. Not all FTs kept detailed records about the characteristics of their members. Those that have done, have found an under-representation among young people and ethnic minorities.

A quantitative academic study has looked at FTs' financial performance compared to other NHS hospitals which have not yet obtained FT status (Marini et al, 2008). This study focused on two financial measures which would indicate the extent to which FTs are benefiting from their more autonomous status inside the NHS. The first was retained surplus, measured as a proportion of total expenditure. The surplus is regarded as a proxy for good quality financial management, and is encouraged by Monitor. If having FT status were to be seen as beneficial to performance, one would expect the retained surplus to increase on hospitals obtaining FT status. The second measure is the Reference Cost Index which allows one to measure FTs' costs of production in comparison to all NHS hospitals' costs. This can be seen as a measure of relative efficiency. One would expect FTs to be more efficient, as they are subject to greater incentives to retain surpluses. The results of the study did not show that obtaining FT status affected either of these two measures as one might predict. FT hospitals do perform better than non FT hospitals, but the better performance predates the change of status. In other words, there were long standing differential trends in performance between hospitals which are not significantly affected by becoming an FT.

During the course of our study, the Healthcare Commission and Audit Commission (2008) produced a joint report on the whole NHS system reform programme. The report was based both qualitative work in various NHS regions and analysis of routine data. This showed that although FTs tended to be higher performers in the quality of services ratings from the HCC, there was no evidence that this was as a result of their status. There was a clear link between income growth and FT status, but again, FTs were chosen on the basis of financial viability, so the growth may not be attributable to FT status per se. The report found FTs have been successful in generating surpluses, although expressed some concern at the size of unused funds (this is a concern later echoed by the House of Commons Health Select Committee in 2008). The FT application process was seen to have made a significant difference to the internal processes of both successful and unsuccessful applicants, encouraging them to function in a more 'business-like' way. Some instances of confusion of roles between governors and boards of FTs were found.

Three further studies of the governance of FTs were published in 2008, after this research project was under way (Lewis and Hinton, 2008; Ipsos MORI, 2008; and Ham and Hunt, 2008). Lewis and Hinton undertook a study of the governance of one FT (Homerton Hospital in London), where they observed that both governors and directors found the new role of FT governor ambiguous and difficult to define. Governors felt they had little impact on decisions made by their FT during the first year (2004/5).

Ham and Hunt studied the governance of five established FTs, and one NHS trust preparing to become an FT in late 2007. They found that, over time, the governance model for FTs was working increasingly effectively: greater clarity about the role of governors was developing and better use of their skills and knowledge was being made. They took the view that 'governance arrangements of NHS Foundation Trusts take 2-3 years to bed in' (Ham and Hunt, 2008, page 13). On the other hand, they found that staff governors were still an under used resource, and also that there was still little clarity about the role of the members and the way in which governors could effectively relate to the members. The FTs in the sample showed wide variation in the emphasis they put on recruiting large numbers of members (range of under 4,000 to over 47,000).

Ipsos MORI undertook a survey of all FT governors in late 2007 on behalf of Monitor. The response rate was 55%. They found that responding governors had mixed views about the productivity of governors' meetings. They were generally satisfied with their relationships with the executive directors, but there was room for more engagement. Generally, the responding governors said they were clear about their roles and responsibilities, but they were not entirely confident that they were in fact able to represent the public, patients and FT membership. More than half of responding governors did not report how their achievements had benefited local people, the FT or patients, and a large minority did not even state what their main achievements were. The responding governors indicated that they wanted a more proactive role in the FT, with better links to the executive directors.

2.4 Expectations and concerns about FTs

When the establishment of the new status of FT for NHS hospitals was initially debated in 2003, the contributions to the debate both in parliament and from outside (by organisations such as the British Medical Association) illustrated both the claims and counterclaims about what the new governance structures of FTs would be able to achieve.

Proponents of FTs saw the new status as offering more rapid creation of new services, greater patient involvement in decision-making about services and a more business-like and efficient approach.

Conversely, opponents (including Mohan, 2003; BMA , 2003 and the House of Commons Health Select Committee, 2008) raised concerns about a range of issues. First, there was possible creation of a two-tier system in healthcare where FTs were performing much better than ordinary NHS Trusts, and not all of the public would have access to the former, thus affecting equity of provision. FTs might poach staff from non FTs and cause wage inflation by paying them more. Secondly, the acute sector of healthcare, which is where most FTs operate, would be expanded at the expense of other elements such as community and primary care. Thirdly, powerful FTs would have an adverse effect on PCT commissioning, making it difficult for the pivotal role of commissioning in the NHS internal market to be carried out well. Fourthly, related to this, FTs would not be cooperative with other NHS bodies and thus would form a barrier to developing integrated care and better patient pathways. Finally, there were fears that specific interest groups might exert undue influence on the new public governance structures. Some of these concerns were touched on in the completed work on FTs discussed above. They were also investigated in our study, and our findings about them will be reported in subsequent chapters.

2.5 Concluding remarks

This chapter indicates that FTs are operating in a very complex policy environment, and that they cannot be viewed in isolation. Great hopes have been placed on the policy of FTs, but it should be borne in mind that they are just one policy mechanism in a system with inherent contradictions between strengthened market mechanisms and continuing command and control. Before this study, little was known about how FTs are dealing with their new governance structures and the policy environment – the subsequent chapters of this report will increase that knowledge considerably.

3 Methods

3.1 Methods

This chapter will describe the study design, methods used and way in which the analysis was undertaken.

3.1.1 Study design

The study used a case study design, complemented with an analysis of a national dataset covering all NHS hospitals.

3.1.2 Case studies

We used a case study design to investigate the governance of FTs. Some aspects of the study design were largely determined at the start of the study, notably the novelty of the organisational form of FTs and the diffuse nature of governance. There were few precedents for FTs in the NHS or elsewhere in the UK public sector. The fact that FTs themselves were new - at the start of this study the first wave of Trusts were just two years old – meant that there was little recorded experience to draw upon. Furthermore, tariffs were new to the NHS. Proposals for engaging patients and the public, while appearing to contain elements of previous arrangements, appeared novel. The only realistic option was a prospective study.

Governance arrangements, by their nature, permeate organisations. In the case of FTs, we were interested in the development of governance arrangements both within Trusts and beyond them: activities inside FTs were likely to be influenced by relationships with PCTs, SHAs and national regulators. The main practical result here was that we would have to study Trusts qualitatively. Moreover, there was no single place where we could observe developments. Governance arrangements were likely develop in several places in any one FT in the course of a two year period. We therefore had to observe developments within FTs, and in their local and national regulatory contexts, where those observations would be made in a number of different places at any one site.

Three decisions substantially determined the design of the study, which concerned internal, external and construct validity. In order to maximise internal validity we adopted a strategy of multiple comparisons. We used a multi-site case study design, making our observations in a number of different places within each site (see below for more details). This allowed us to compare and contrast evidence gathered in different places within a site, and from the same places within different sites, so as to maximise confidence in our findings and their interpretation. This is a form of analytical generalisation (as opposed to 'statistical generalisation' used in quantitative research). Analytical generalisation uses the previously

developed theory as a template with which to compare the empirical results of the case study (Yin, 2003). The aim is to expand and generalise theories, rather than to enumerate frequencies. This placed our study in a long line of studies of policy implementation, stretching back to classic studies by Pressman and Wildavsky (1973) and Perrow (1999).

Moving on to external validity, study design decisions are often presented as a choice between producing the most accurate possible account of events in a particular setting (prioritising internal validity) or producing insights that can be applied in other, similar settings (prioritising external validity). In practice we decided to try to balance the two, and produce accurate accounts of events which can be applied more generally. If an account does not 'ring true' it will not be credible. Equally, it would be odd to produce a report on a major policy initiative if nobody could draw any lessons from it. In this study, the main focus of our analysis was on developments in governance arrangements. Our aim, therefore, was to produce insights which could be applied – with the usual cautions with interpretative findings – to other initiatives focused on the development of governance arrangements.

The third decision concerned construct validity. In any study the investigators have to make some assumptions about what matters for that study.

The technical problem here is that these assumptions inevitably influence thinking about the way that things work in any given setting. This is the problem of construct validity (eg Shadish, Cook and Campbell 2002). Investigators have to take steps to ensure that their starting assumptions are helping to produce an accurate account of events, and not leading them to miss important insights.

A common strategy is to identify a conceptual framework, and use it to work out which aspects of a development to study – and then review the value of the framework during the course of the study, revising it as necessary. In policy implementation studies one obvious source is the set of policy documents, and the discussions and debates that typically follow in the wake of any major policy initiative. In practice, early policy documents on FTs contained a mix of ideas and aspirations, including autonomy, efficiency, local accountability and competition. FTs seemed to reflect an amalgam of ideas emanating from several different academic stables.

Another source is academic theories about – in this case - the way that organisations work. We concluded that it was possible to make some broad decisions about the approach we should take, but that we would need to refine our thinking during the course of the study. Political science based theories about governance, concerning such issues as decentralisation, marketisation and the role of regulation are central to our understanding of the operation of FTs as part of the English NHS (e.g. Majone, 1994; Clarke and Newman, 1997; Power, 1997; Moran, 2003; Saltman et al, 2003;

Allen, 2006). These theories are concerned with how institutional structures, especially those of the State, relate with the actual implementation of policy. They are concerned with the inter-relationship between structure and agency. That meant that in this study, we were interested in both the new institutional arrangements in which FTs operate (such as reduced interaction with SHAs, and having to be answerable to Monitor) and how senior managers, key clinicians and other FT staff responded to those institutions.

The study also draws on the theory of 'contextualism' which takes account of the content, process and context of change (Pettigrew, 1985). This approach is particularly useful when comparing different organisations (such as FTs and NHS Trusts and FTs with each other), as in this study. This approach emphasises that the effects of organisational change are multi-layered and complex. To address these complexities, multiple levels of analysis were utilised to study these process phenomena which are fluid in character and 'spread out over both time and space' (Langley, 1999). These complexities were best addressed using in-depth methods in a number of case studies so that patterns may be recognised (Ferlie, 2001).

As with any study design, there are threats to validity. The main threat to internal validity was that we would produce uneven or incomplete accounts, for example because we could not negotiate equal access to all areas of all of our sites. In the event this did happen, and some of our findings reflect more work at some sites than others. We do not believe, though, that this had a major effect on our overall findings. The volume, and diversity of data collected meant that we were confident about our findings and their interpretation: but we have indicated below places where we were unable to collect the material we would ideally have liked.

On external validity, the main danger is typically over-confidence – the attempt to push the general application of findings further than they really stretch. In this study we focused on the development of governance arrangements in FTs, and believe that the findings should apply to current or future acute hospital FTs. The results might, if used with care, shed useful light on the development of governance arrangements in other NHS organisations. To repeat a point made earlier, our approach was based on analytical generalisation: we are not claiming that our sites are statistically representative of FTs, but the data about NHS trusts allows us to situate the FTs studied in the general run of all FTs and NHS trusts, showing how they resemble or differ from these.

The principal challenge in this study concerned construct validity. FTs are both novel and complicated, and there was no single body of evidence or theoretical tradition which helped us to understand them. In the event we used two broad theoretical frameworks, both to guide our approach to our research and our analysis, but recognise that we could have used others, eg democratic network governance. All we – or anyone else – can do here is to make our assumptions and working explicit, so that others can make their own judgements.

3.1.3 Case study sites

The four acute hospitals included in the study each had a Board of Directors, a Board or Council of Governors or Members (the name varied between sites), and a membership body. According to hospital size and clinical speciality, they were each divided into various clinical directorates and support services. In all the FTs, the Board of Directors consisted of a Chairman, Non-Executive and a series of Executive Directors, including, a Chief Executive Officer and a Finance Director. The Council of Governors (or equivalent) consisted of patient, staff, public and stakeholder representatives. Hospital support services included, among others, pharmacy, diagnostic, therapy services, and facilities management. Clinical directorates varied, but all included specialities of orthopaedics and general medicine (which includes diabetes). Each directorate was led by a General Manager and a Clinical Director, and comprised of a number of consultants, junior doctors and nursing and other staff. Within the clinical directorates, consultants and nursing staff reported to general manager and clinical director, who had responsibility for managing the budget, quality control and the provision of services. In turn, the general manager and clinical director report to the Board of Directors, who had overall responsibility for the performance of the Directorates and the FT. The Board of Directors consulted with the Council of Governors (or equivalent) on the FT's performance and its future strategies. Governors reported consultations to their various member constituencies.

FT1 is a teaching hospital and became an FT in 2004. It provides a wide range of services from two main locations in the North of England serving a population of over half a million. In 2008-9 FT 1 retained a surplus of around £ 4.2 million. As far as its market position is concerned, we have obtained Herfindahl-Hirschmann competition indices (HHI) at the NHS trust level for the fiscal years 2003/04 and 2007/08 from Professor Carol Propper of Imperial College, London, who has calculated them for a study of competition in the NHS. These HHIs have been constructed using actual patient flows to the trust in a given year, for all elective services. For each year, there is one observation per trust. HHIs vary from 0 (trusts facing the most competition) to 10,000 (monopoly). FT1 had an HHI index of 7788 in 2003/4 and 7602 in 2007/8. This indicates that FT1 has been subject to more competition over the period, but that it was not in a very competitive market at the beginning of our study.

FT2 gained Foundation Trust Status in 2005. It is a district general hospital that provides a full range of services for a population in the Home Counties. In 2008-9, FT2 retained a surplus of almost £8.5 million. As far as its market position is concerned, FT2 had an HHI index of 6077 in 2003/4 and 5515 in 2007/8. This indicates that FT2 has been subject to considerably more competition over the period, and that it was in relatively competitive market for healthcare at the beginning of our study.

FT3 gained Foundation Trust status in 2006. It is a district general hospital serving two large towns and a wide rural population in the north of

England. In 2008/9 FT 3 retained a surplus of about £2.4 million. As far as its market position is concerned, FT3 had an HHI index of 7267 in 2003/4 and 7119 in 2007/8. This indicates that FT3 has been subject to more competition over the period, but that it was in a not very competitive market for healthcare at the beginning of our study.

FT4 gained Foundation Trust status in 2006 and is located in London. In the financial year ended 31 March 2009, FT4 retained a surplus of over £9.5 million. As far as its market position is concerned, being in London, FT4 is positioned within close proximity of a number of other large NHS Trusts and NHS Foundation Trusts. FT4 had an HHI index of 4283 in 2003/4 and 4092 in 2007/8. This indicates that FT4 has always been subject to considerably more competition than the other three FTs. It has also been subject to increased competition over the period, and that it was in quite a competitive market for healthcare at the beginning of our study.

3.1.4 Sources of data

The following sources of data were used in the case study research.

It should be noted that the extent to which internal documents and access to internal meetings were made available varied between the four FTs. Two of the FTs did not agree to any members of our research team attending any internal meetings, nor having access to internal documents.

Documents

The documents examined included external documents on the Monitor website setting out the terms of operation in respect of the FT; internal documents dealing with membership, strategic planning, financial matters, service delivery and developments; and documents produced by or about each FT's performance (such as Health Care Commission reports).

These documents were examined to find information relating to the main themes of the research: autonomy, staff and patient responsiveness and relationships with the local health economy. As subthemes were raised in the interviews (see below), evidence in relation to these were also sought in the documents. These included NHS national targets and service developments.

Observation of meetings

In all the case study sites, several public governors' meetings were observed to understand aspects of the roles of the FT governors, as well as the issues of importance to the respective FTs.

In two of the case studies, the FTs declined to allow the research team access to internal meetings, such as clinical directorate meetings.

It was not possible to arrange the observation of contractual meetings, but interviews were conducted with those responsible for contracting, both in the FTs and the commissioning PCTs (see below).

Interviews

Two rounds of semi structured interviews were undertaken in each case study site in the following time periods: the first round was between December 2007 to July 2008; the second round between March 2009 and Sept 2009.

(The original proposal envisaged three rounds of interviews. In practice, the team felt that this was not necessary,. In the event, very rich data were obtained from two rounds of interviews and other interactions with FT staff and members of the public.)

A range of representative personnel were selected to reflect a range of roles within the organisation. The aim was to solicit a range of views and experiences from people involved from executive level right down to the 'coal face' i.e. those engaged with providing services, i.e. clinical staff. Two other main sample groups included one external and one internal to the hospital. The external group included commissioners the relevant local PCT; and the internal one a range of members and governors.

A series of interview schedules were developed, tailored to the different roles of the interviewees. For the first round of interviews, the schedules were based closely on the three themes of the research project. The schedules for the second round of interviews were developed by considering the data collected to date, and working out what areas required further investigation. (These latter included both original issues about which insufficient data had been collected in the first round, such as the interrelationship of different forms of public participation, and also issues which had become more prominent during the course of the research project, such as the role of the relevant Strategic Health Authorities.)

The following types of people were interviewed:

1. PCT commissioning staff.

2. Senior Trust managers, including the Chair, CEO, Finance Director and Medical Director.

3. Clinical and managerial staff in respect of orthopaedic and diabetes services.

4. Members and governors of the FT.

5. Non executive directors in some of the FTs.

6. Staff in relevant Strategic Health authorities

7. Members of other public representative bodies, such as Local authority overview and scrutiny committees, Patient Advice and Liaison Services, Local Involvement Networks.

Detailed schedules of who was interviewed in each case study site are set out in Appendix 2.

The interviews were all recorded digitally and typed up verbatim.

Despite extensive efforts to recruit patients in some sites, it was not possible to undertake any focus groups. In any event, observation of locally organised meetings with members and governors supplied a large amount of data about members' views.

National quantitative data

Quantitative routine data were extracted from the York database in order to place the four case study sites in context. Data were selected to include measures of size (elective and non-elective admissions, staffing levels), efficiency (staffing ratios, day case rates, length of stay), quality (waiting times and targets, MRSA infections), and overall financial performance (retained surplus.) for the years 2004/5 to 2007/8. Additional data on admissions for the two tracer conditions in 2006/7 were derived from Hospital Episode Statistics.

Data on all measures were extracted for each of the four case study sites. It is important to understand how the case study sites compare with FTs more generally. To do this an average value for each of the measures and for each year was calculated for the 68 FTs in existence at the end of 2007/8. A similar exercise was performed for the remaining NHS trusts that had not become FTs by this date.

Finally, a list of local competitor trusts (both FTs and NHS trusts) was compiled for each case study site. Data on the measures was extracted for each of these trusts.

The purpose of the quantitative data analysis was to describe the differences and similarities in the four case study sites both cross-sectionally and over time. Comparisons are made between the four sites, with national averages for FTs and NHS trusts, and with the case study sites' local competitor trusts.

3.1.5 Analysis of case studies data

The quantitative data about numbers and types of members and governors was recorded in a series of tables (see Appendix 3). The analysis of the mainly qualitative data collected required some sophistication. The notion that interviews with people or observation of their activities give a version of the 'truth' about the phenomena of interest is a problematic one. For example, Hammersley and Atkinson (1995) point out that rather than asking whether an informant is telling the truth, we need to consider what

the informant's statements reveal about her feelings and perceptions and what inferences can be made from these about the environment itself. Triangulation of data (i.e. the use of multiple sources of evidence, in this case formal and informal interviews, observation and documents) may help, as a mixture of approaches may allow data from each to illuminate the other. The positivist view is that triangulation increases the validity of the data; namely the degree to which a measurement actually measures or detects the phenomenon that it is designed to measure. But, when one triangulates by using different data sources, the researcher has to remain mindful of the context bound and skilful character of social interaction. In fact, triangulation can serve as a reminder of the situated character of action (Silverman, 2001). But it should not, therefore, be expected that each source will produce the same data.

Qualitative observational and interview data were analysed in the following manner. Interviews were taped and transcribed. Observational field notes were transcribed. The research questions for the study were used to generate an initial set of categories, which were used to code the data. An iterative process was used, under which the categories will be applied to the data and amendments to them made in accordance with what the data reveal. This is a modified form (Miles, 1979), of grounded theory (Glaser and Strauss, 1967). Careful notice was taken of deviant cases, as they can be particularly helpful in testing a hypothesis (Silverman, 2001). In order to ensure validity, at least three members of the research team read all the data and contributed to production of themes for the analysis, using an agreed framework. A similar process was used to analyse the documents (other than purely financial documents) collected.

In order to improve validity, a study advisory group was convened. This consisted of approximately 10 people, with a range of expertise including an FT executive director, an FT chair, the chair of the FT network, members of patient representative groups, and researchers with relevant expertise. The advisory group commented on the interim findings in November 2008, and later on the draft of the final report.

3.2 Ethical approval and research governance approval

Ethical approval was granted for the study by London - Surrey Borders Research Ethics Committee on 11 April 2007, under reference number 07/Q0806/32.

Research governance approval was granted by each of the four FTs and the other NHS bodies included in the study.

4 Results

4.1 Contextual quantitative data

4.1.1 Introduction

A brief description of the characteristics of the four case study sites in relation to other FTs was provided in the previous chapter. The purpose of presenting the analyses in this chapter is to facilitate generalisation from the four case study sites. We will show the extent to which our four FTs were typical of FTs in general. We will also show the extent to which all FTs vary from non FT hospitals.

In the first section of this chapter a more detailed comparison is made between the case study FTs and other FTs and NHS trusts. The analysis presented here draws on routine data from the period 2004/5 to 2007/8.

One important factor to consider in the analysis of these data is that many differences between FTs and NHS trusts arise because of the criteria that must be met in order to obtain foundation trust status. FTs will therefore tend to be the better performing trusts. Furthermore, the number of FTs has increased over time. The comparison group of FTs in these analyses comprises the 68 FTs that were in existence by the end of 2007/8. The comparison group of NHS trusts (or non-FTs) therefore comprises the remaining acute hospital trusts that had not achieved FT status by the end of 2007/8 (although some have subsequently become FTs).

These results describe the similarities and differences in the four case study FTs with respect to each other and in comparison with the average FT and NHS trust. The variables considered range from measures of activity and staffing, together with indicators of efficiency and quality. The results additionally consider broad trends over time in each of the FTs in comparison with each other and national trends, and the performance of each case study FT with their local 'competitor' trusts.

4.1.2 Hospital activity

First, the size of the four FTs in the study will be examined. The first measure is numbers of admissions. In 2004/5 the average FT and NHS trust had around 42 thousand elective admissions and 23-25 thousand emergency (non-elective) admissions (Tables 1, 2). Two of the case study sites (FT1 and FT3) had activity levels around 40-50% greater for both elective and emergency admissions. The activity level at FT2 was similar to

the national average whereas activity at FT4 was about 20% lower than the national average.

Over the period 2004/5 to 2007/8 all FTs experienced on average increases in elective and emergency activity of 14% and 10% respectively. Over the same period NHS trusts experienced, on average, larger increases of 19% and 16% in elective and emergency activity respectively. The only case study site that experienced a similar rise in activity was FT4 where elective admissions increased by 26%. The other three sites all had increases in elective admissions but these were smaller than the national averages. In particular, elective activity at FT1 fell in 2005/6 and 2006/7 before rising again in 2007/8 to return to a level similar to that in 2004/5.

Table 1. Number of elective admissions (000)

	2004/5	2005/6	2006/7	2007/8	2004/5-2007/8
FT1	66	66	64	67	+1%
FT2	43	46	47	47	+9%
FT3	58	59	58	64	+10%
FT4	34	36	41	43	+26%
FTs	42	43	45	48	+14%
non-FTs	42	44	47	51	+19%

Table 2. Number of emergency admissions

	2004/5	2005/6	2006/7	2007/8	2004/5-2007/8
FT1	36	36	38	38	+5%
FT2	19	21	21	22	+14%
FT3	33	32	31	34	+5%
FT4	17	17	19	20	+16%
FTs	23	24	24	25	+10%
non-FTs	25	27	28	29	+16%

Thus, three of the case study FTs had rises in admissions similar to all FTs, and one had a significantly larger increase.

4.1.3 Staffing

Another measure of the size of the FTs was their staffing levels.

Overall staff levels

Table 3. Total staff numbers (full-time equivalent (000))

	2004/5	2005/6	2006/7	2007/8
FT1	4.5	4.1	4.2	4.2
FT2	2.4	2.6	2.7	2.8
FT3	4.6	4.7	4.6	4.6
FT4	2.4	2.5	2.6	2.6
FTs	3.3	3.4	3.4	3.5
non-FTs	3.5	3.6	3.6	3.7

Table 3 reports total staff numbers, measured as full time equivalents, for each of the four years. Both FT1 and FT3 employ more staff than other FTs while the opposite is the case for FT2 and FT4. On average, FTs tend to employ slightly fewer staff than non-FTs. Overall, staffing levels have increased over time in both FTs and non-FTs. However, there has been no clear trend in staffing levels at the four case study sites, with FT1 reducing its staffing complement over time, while there have been increases at FT2 and FT4. The staffing levels at FT3 in 2007/8 are much as they were in 2004/5.

Over the four years the percentage of all staff who were categorised as administrative staff was 17% for all FTs on average and 16% for NHS trusts, falling to 15% for this group of Trusts in 2007/8 (Table 4). FT1, FT2, and FT3 all reported levels of administrative staff at levels similar to or below the national average for FTs whereas FT4's percentage has been substantially lower in all years.

Table 4. Administrative staff numbers as proportion of total staff numbers

	2004/5	2005/6	2006/7	2007/8
FT1	0.19	0.17	0.17	0.17
FT2	0.16	0.16	0.16	0.15
FT3	0.17	0.14	0.15	0.15
FT4	0.09	0.09	0.09	0.07
FTs	0.17	0.17	0.17	0.17
non-FTs	0.16	0.16	0.16	0.15

Thus, three of the case study FTs had similar staffing profiles to all FTs and one had lower levels of administrative staff.

4.1.4 Measures of efficiency

Next, we considered how efficient our four case study FTs were, compared to other hospitals. One indicator of efficiency is the proportion of elective care performed as day cases rather than inpatient admissions. In 2004/5 the day case rate for the average FT was just over one third (0.34) and was slightly lower in NHS trusts (0.31). There was also evidence that there was a trend towards higher day case rates such that by 2007/8 the average FT was had a rate of 0.37 and the average NHS trust a rate of 0.35.

FT2 had the highest rate of the four case study FTs and it also experienced the largest increase to 0.41 in 2007/8. In contrast, FT4 had a lower rate than the average FT and saw no increase in the period 2004/5 to 2007/8. FT1 and FT4 were similar to the average FT at the start of the period but saw little increase over time such that by 2007/8 their rates were slightly below average.

Table 5.   Day case rate for elective spells

	2004/5	2005/6	2006/7	2007/8
FT1	0.33	0.34	0.35	0.35
FT2	0.38	0.41	0.44	0.41
FT3	0.34	0.35	0.34	0.34
FT4	0.30	0.31	0.30	0.29
FTs	0.34	0.34	0.35	0.37
non-FTs	0.31	0.31	0.32	0.35

A second measure that may indicate differences and improvements in efficiency is the average length of stay for patients. At the national level FTs appear to have a slightly shorter average stay in comparison with NHS trusts. Both FTs and NHS trusts experienced a consistent decline in average length of stay over the years with FTs maintaining their slight advantage.

The national pattern of a trend for shorter stays was repeated in the four case study FTs. In 2004/5 the average length of stay at FT3 was the same as the national average for all FTs (at 3.5 days) whereas FT1 had much shorter stays (average 2.8 days). FT2 and FT4 were both marginally below the FT average at 3.3 days. There do seem to be differences in how length of stay has changed in the four case study FTs. FT1, FT2 and FT3 have all seen a smaller reduction in length of stay than FTs have in general (by 0.3 to 0.5 days over four years compared with 0.6 days for all FTs). However, the reduction at FT4 was much larger (by 1.0 days over four years) such that by 2007/8 it had achieved a shorter length of stay than FT1.

Table 6.   Average inpatient length of stay in days

	2004/5	2005/6	2006/7	2007/8
FT1	2.8	2.6	2.4	2.4
FT2	3.3	3.0	2.8	3.0
FT3	3.5	3.4	3.2	3.0
FT4	3.3	3.1	2.5	2.3
FTs	3.5	3.3	3.1	2.9
non-FTs	3.7	3.4	3.2	3.0

4.1.5 Indicators of quality

We also examined indicators of quality to see how our case study FTs compared with other hospitals. Data is collected nationally about those aspects of quality which are national targets.

Data have been collected since 2004/5 on the percentage of patients seen in accident and emergency department within the four hour target. In 2004/5 the percentage of patients who were not seen within four hours was, on average, 1.8% in FTs and 2.7% in NHS trusts. Nationally, there was a substantial improvement in 2005/6 although this was not subsequently maintained and by 2007/8 the percentage missing the target was 1.5% in FTs and 2.2% in NHS trusts.

All case study FTs reported their figures as good as or better than non-FTs throughout the period 2004/5 to 2007/8. There was some fluctuation over time but in all four FTs the 2007/8 figure did not differ substantially from the 2004/5 figure. FT1 and FT3's performance is close to the average for all FTs whilst the performance of FT2 and FT4 was generally better than the average FT.

Table 7.   Percentage missing four hour wait target in Accident & Emergency

	2004/5	2005/6	2006/7	2007/8
FT1	1.9	1.5	1.6	1.7
FT2	1.1	0.8	0.9	1.3
FT3	1.8	1.4	1.8	1.7
FT4	1.4	1.7	1.4	1.3
FTs	1.8	1.3	1.4	1.5
non-FTs	2.7	1.8	1.8	2.2

Data on the 13 week outpatient wait target were available for all four years. FTs in general performed better than NHS trusts although the differences were very small. In 2004/5 the average FT failed the target in less than 0.01% (or 1 in 10,000) of outpatient attendances. For NHS trusts the target was missed, on average, in 0.04% (or 1 in 2,500) of attendances. By 2007/8 both FTs and NHS trusts in general were reporting that only 0.01% of outpatients failed to be seen within the 13 week target period.

FT4 was the only case study FT to report their missed target percentage as 0.01% or above and this was only in two years (2004/5 and 2005/6). Even the percentage reported in 2004/5 (0.02%) represents a rate of 1 in 5000. The other three FTs reported that no outpatients were seen later than demanded by the 13 week waiting time target.

Table 8.   Percentage of patients missing 13 week outpatient wait target

	2004/5	2005/6	2006/7	2007/8
FT1	0.00	0.00	0.00	0.00
FT2	0.00	0.00	0.00	0.00
FT3	0.00	0.00	0.00	0.00
FT4	0.02	0.01	0.00	0.00
FTs	0.00	0.01	0.01	0.00
non-FTs	0.04	0.02	0.04	0.00

Another indicator of quality is the length of time it takes for admission as an elective inpatient. In 2004/5 the median wait at the average FT was 48 days and by 2007/8 this figure had declined to 38 days. Waits at NHS trusts were slightly longer. The median wait was 57 days in 2004/5 and fell to 50 days in 2007/8.

The case study FTs varied widely in their waiting times. At FT1 median waits were nearly half that of the average FT (23 days in 2006/7, no data for 2007/8). The picture was very different at FT4 where the median wait was 50-100% larger than for the average FT, peaking in 2006/7 at 92 days (compared with 45 days for all FTs.) Waits at FT3 were similar to the average FT whereas FT2 achieved a steady decline from 2004/5 so that by 2007/8 its median wait was similar to the average FT.

Table 9. Median wait in days for elective admission

	2004/5	2005/6	2006/7	2007/8
FT1	28	26	23	-
FT2	61	55	49	41
FT3	43	45	50	41
FT4	72	89	92	58
FTs	48	47	45	38
non-FTs	57	57	58	50

Data on the number of MRSA bacteraemia cases has been reported since 2006/7. Nationally, FTs reported an average of 30 cases and NHS trusts an average of 40 cases in 2006/07. By 2007/8 these averages had fallen to 22 and 29 respectively. Data for the four case study FTs indicated an excess of cases at FT1 and a lower number of cases at FT4.

Table 10. Number of MRSA bacteraemia cases

	2006/7	2007/8
FT1	55-59	45-49
FT2	20-24	20-24
FT3	25-29	30-34
FT4	20-24	15-19
FTs	29.6	21.8
non-FTs	39.6	29.2

4.1.6 Financial performance

We examined the financial performance of the four case study FTs compared to other FTs and to hospitals which were not FTs. The four FTs varied in their financial performance over the period 2004/5 to 2007/8 as measured by the financial surplus retained by each FT annually. All four experienced year-on-year improvements, as did FTs nationally. FT3's overall financial performance could be described as typical of the average FT. FT2 and FT4 consistently outperformed the average FT - their retained surpluses were 2-3 times that of the average FT in 2007/8. FT1 underperformed in comparison with the typical FT but did manage to turn its large deficit in 2004/5 into a surplus by 2006/7.

In 2004/05 the average FT reported a retained deficit of £0.5 million with the average NHS trust reporting a deficit of £2.2 million. At this time three

of the four case study FTs reported small retained surpluses whereas FT1 experienced a large deficit.(Table 11) Over the period 2004/5 to 2007/8 there was an improvement in financial performance nationally. The average FT was in surplus by 2006/7 and in 2007/8 the average surplus was even higher at £5.6m. The average NHS trust did not return to surplus until 2007/8 and the average retained surplus (£1.9 million) was lower than for FTs.

All four case study FTs experienced year-on-year increases in their retained surpluses in the period 2004/5 to 2007/8. FT1 managed to cut its 2004/5 deficit by almost two-thirds in 2005/6 and returned to surplus in 2006/7 and 2007/8. However, its retained surplus in 2007/8 was the smallest of the four sites and less than half that of the average FT. FT2 and FT4 were similar in their patterns of financial performance. Both produced small surpluses in 2004/5 at a time when the average FT was in deficit. Both experienced growth in their annual retained surplus to 2007/8 and consistently outperformed FTs in general such that in 2007/8 their surpluses were 2-3 times that of the average FT. FT3 is the case study site that is most typical of the average FT with respect to financial performance.

Table 11. Retained surplus by year (£million)

	2004/5	2005/6	2006/7	2007/8
FT1	-5 to -10	-1 to -5	+0.5 to +1	+1 to +5
FT2	0	+1 to +5	+1 to +5	+5 to +10
FT3	0	+0.1 to +0.5	+0.5 to +1	+1 to +5
FT4	0	+1 to +5	+1 to +5	+10 to +15
FTs	-0.5	-0.3	0.3	5.6
non-FTs	-2.2	-4.3	-1.2	1.9

4.1.7 Analysis of tracer conditions (diabetes and orthopaedics)

As we used the provision of services for two tracer conditions as a way of focussing our study of the governance of FTs, we examined the routine data about diabetes and orthopaedics to see how typical the four case study FTs were in this respect.

There were 449 inpatient admissions in total for diabetes in the four case study sites. The majority (88%) of these were non-elective admission.

There were almost 24 thousand inpatient orthopaedic admissions in total in the case study sites which were evenly divided between elective and non-elective admission.

4.1.8 Diabetes admissions 2006/7

The small number of admissions at each FT makes it difficult to draw conclusions from the analysis of non-elective admissions for diabetes. Average age and the percentage of female admissions were similar to national averages with the possible exception of FT4, where the percentage of females was lower. Mean length of stay was lower than the national average in FT1 and FT3 and slightly higher in FT2 and FT4. This differs from the overall analysis of non-elective admissions above that found all case study FTs had mean lengths of stay substantially lower than the national average. In addition to the small numbers involved, these analyses do not account for differences in the severity of admissions.

Table 12. Non-elective admissions for diabetes in 2006/7

	n	Mean age (years)	Female (%)	Mean length of stay (days)
FT1	129	53.6	44	3.7
FT2	99	51.2	47	4.8
FT3	93	48.2	43	3.3
FT4	76	51.5	33	4.7
England	20,952	53.1	45	4.4

4.1.9 Orthopaedic admissions 2006/7

Nationally there were almost 600 thousand inpatient elective admissions for orthopaedic procedures in 2006/7. The average age of patients was 54 years and just over half (56%) were female. The average waiting time before admission was just under three months (87 days) and the average length of stay was just over two days.

The average age of admissions at the case study FTs was similar or lower and sex distributions were similar. However, three of the FTs had longer average waiting times than the national average. The one exception was FT1 which had an average waiting time of 71 days. The average length of stay was similar to the national average in FT1 and FT2 and lower in FT3 and FT4.

Table 13. Elective admissions for orthopaedics in 2006/7

	n ('000)	Mean age (years)	Female (%)	Mean waiting time (days)	Mean length of stay (days)
FT1	3.3	49.7	52	71	2.0
FT2	3.3	54.5	52	113	2.1
FT3	4.6	52.3	54	102	1.6
FT4	2.4	49.2	55	95	1.6
England	593.6	54.0	56	87	2.1

There were 450 thousand non-elective admissions for orthopaedic procedures in 2006/7, representing around 43% of all orthopaedic admissions. Among the four FTs both FT1 and FT4 reported that just over half of their orthopaedic admissions were non-elective. The ratio of non-elective to elective admissions was similar to the national average in FT2. This ratio was smaller in FT3 where less than 30% of orthopaedic admissions were non-elective.

Non-elective admissions at FT1 and FT4 were younger on average and a lower proportion were female whereas FT2 and FT3 were more typical of the average trust. Nationally, average length of stay for non-elective admissions was longer than for elective admissions (5.5 days versus 2.1 days). Two case study FTs (FT2 and FT3) reported average length of stays similar to the national figure. At 4.1 and 3.6 days respectively, both FT1 and FT4 reported mean lengths of stay below the national average.

Table 14. Non-elective admissions for orthopaedics in 2006/7

	n ('000)	Mean age (years)	Female (%)	Mean length of stay (days)
FT1	3.5	47.0	44	4.1
FT2	2.6	53.7	51	5.4
FT3	1.8	51.7	49	5.1
FT4	2.5	45.9	42	3.6
England	449.5	53.9	51	5.5

Thus, the case study FTs varied in their performance in respect of orthopaedics. Three had longer waiting times than average. (This might go some way to explain why, at interview, they were so concerned with how to meet the 18 week patient pathway target.)

4.1.10 Comparison with local competitor trusts

In order to have some idea about their local environment, we identified a group of competitor trusts (both foundation trusts and NHS trusts) for each FT (Table 15). The number of competitor trusts varied from four at FT1 up to nine at FT3. All the case study FTs included at least one other FT amongst its competitors.

Table 15. Number and type of competitor trusts

	FT1	FT2	FT3	FT4
non-FTs*	3	3	4	2
FTs*	1	2	5	3
Total	4	5	9	5

at 31/3/2008

FT1 is large in comparison with the other case study FTs in terms of activity (Table 16). However, its local competitor trusts also have higher than average activity and FT1 is third largest of the five. However, FT1 has experienced the smallest growth in activity. FT1 performs comparatively well on length of stay - this was the shortest among all five trusts in all years. FT1 also performed relatively well on the 4-hour A&E wait target. FT1 is the weakest of the case study trusts on financial performance but was not the worst in its locality. Indeed, in 2006/7 FT1 actually had the largest surplus of the five trusts.

Table 16. FT1 and its competitor trusts

	2004/5	2005/6	2006/7	2007/8	2004/5-2007/8
Activity (elective admissions 000s)					
FT1	**65.9**	**65.7**	**64.4**	**66.7**	**+1%**
C1	30.2	31.6	32.1	31.1	+3%
C2	118.0	118.1	123.5	125.3	+6%
C3	58.2	59.0	58.2	63.8	+9%
C4	69.2	68.2	71.4	79.6	+13%
Inpatient Length of stay (days)					
FT1	**2.8**	**2.6**	**2.4**	**2.4**	**-15%**
C1	3.0	2.6	2.5	2.6	-17%
C2	4.1	3.8	3.6	3.4	-20%
C3	3.5	3.4	3.2	3.0	-16%
C4	3.4	3.3	3.1	2.9	-18%

Missed 4 hour A&E target (%)

FT1	**1.9**	**1.5**	**1.6**	**1.7**
C1	3.1	1.6	1.3	1.4
C2	5.7	3.4	3.3	5.9
C3	1.8	1.4	1.8	1.7
C4	4.8	2.2	0.9	2.4

Retained surplus (£million)

FT1	**-5 to -10**	**-1 to -5**	**+0.5 to +1**	**+1 to +5**
C1	-1 to -5	+1 to +5	+0.1 to +0.5	+0.5 to +1
C2	+0.1 to +0.5	+0.1 to +0.5	+0.1 to +0.5	+5 to +10
C3	0	+0.1 to +0.5	+0.5 to +1	+1 to +5
C4	-10 to -20	-10 to -20	-10 to -20	0

FT2 was unexceptional with respect to volume of activity amongst its local competition. There was some variation in growth in activity among the six trusts with FT2 experiencing the third largest increase in elective activity. There was little difference in the average length of stay among the trusts in 2004/5 and FT2 was near the upper end. However, FT2 failed to reduce length of stay at the same rate as all except one of its competitors, leading to a larger gap in 2007/8.

Data on the missed 4-hour A&E wait target showed FT2 lying in the middle compared with its competitors. FT2's financial performance was better than its competitors and it made the largest surplus of the six in 2007/8.

Table 17. FT2 and its competitor trusts

	2004/5	2005/6	2006/7	2007/8	2004/5-2007/8
Activity (elective admissions 000)					
FT2	**43.2**	**46.2**	**47.0**	**47.2**	**9%**
C1	33.2	34.7	39.7	42.1	21%
C2	48.6	52.6	50.8	51.9	6%
C3	39.1	38.8	38.1	41.9	7%
C4	n/a	20.7	22.4	20.4	-1%
C5	55.9	57.6	59.2	66.2	16%
Inpatient Length of stay (days)					
FT2	**3.3**	**3.0**	**2.8**	**3.0**	**-10%**
C1	3.2	3.0	2.7	2.7	-18%

C2	2.9	2.6	2.6	2.5	-16%
C3	3.4	3.4	3.1	2.7	-23%
C4	n/a	3.3	3.1	3.1	-6%
C5	2.9	2.7	2.7	2.6	-11%

Missed 4 hour A&E target (%)

FT2	**1.1**	**0.8**	**0.9**	**1.3**
C1	0.3	0.4	0.4	0.7
C2	1.6	2.3	1.6	1.5
C3	1.6	1.4	1.3	2.3
C4	2.0	1.1	0.9	1.5
C5	1.3	0.5	0.5	0.4

Retained surplus (£million)

FT2	**0**	**+1 to +5**	**+1 to +5**	**+5 to +10**
C1	+0.1 to +0.5	+0.1 to +0.5	0	0
C2	-5 to -10	-1 to -5	+1 to +5	+1 to +5
C3	0	-5 to -10	+1 to +5	+1 to +5
C4	0	0	+0.5 to +1	+1 to +5
C5	0	0	+5 to +10	+5 to +10

FT3 had largest number of competitor trusts. It was fairly average with respect to size and growth in elective activity. Its length of stay and reduction in length of stay also lie in the middle of the competitor trusts' figures. Financial performance was quite erratic amongst the nine trusts with FT3 being one of four trusts producing consistent growth in their retained surplus. Even in 2006/7, a year when most trusts were in surplus, two of the competitor trusts reported large deficits.

Table 18. FT3 and its competitor trusts

	2004/5	2005/6	2006/7	2007/8	2004/5-2007/8
Activity (elective admissions 000)					
FT3	**58.2**	**59.0**	**58.2**	**63.8**	**9%**
C1	65.9	65.7	64.4	66.7	1%
C2	118.0	118.1	123.5	125.3	6%
C3	114.6	118.4	124.9	130.7	12%
C4	69.2	68.2	71.4	79.6	13%
C5	76.0	68.7	78.9	81.1	6%

C6	10.6	11.9	12.7	13.2	20%
C7	26.7	30.7	33.0	34.4	22%
C8	123.9	132.8	132.2	128.5	4%
C9	22.3	23.6	23.0	25.3	12%

Inpatient Length of stay (days)

FT3	**3.5**	**3.4**	**3.2**	**3.0**	**-16%**
C1	2.8	2.6	2.4	2.4	-15%
C2	4.1	3.8	3.6	3.4	-20%
C3	3.6	3.7	3.2	2.9	-25%
C4	3.4	3.3	3.1	2.9	-18%
C5	3.3	3.2	2.6	2.3	-42%
C6	1.7	1.7	1.6	1.6	-8%
C7	3.0	2.8	2.7	2.6	-17%
C8	3.8	3.6	3.5	3.7	-4%
C9	4.8	4.3	3.8	3.5	-38%

Missed 4 hour A&E target (%)

FT3	**1.8**	**1.4**	**1.8**	**1.7**
C1	1.9	1.5	1.6	1.7
C2	5.7	3.4	3.3	5.9
C3	1.2	1.7	2.0	1.9
C4	4.8	2.2	0.9	2.4
C5	1.6	1.3	1.9	2.1
C6	1.0	1.7	1.7	1.4
C7	1.6	1.6	2.0	1.7
C8	2.0	1.8	2.0	2.2
C9	1.2	0.9	1.1	1.5

Retained surplus (£000)

FT3	**0**	**+0.1 to +0.5**	**+0.5 to +1**	**+1 to +5**
C1	-5 to -10	-1 to -5	+0.5 to +1	+1 to +5
C2	+0.1 to +0.5	+0.1 to +0.5	+0.1 to +0.5	+5 to +10
C3	+1 to +5	0	-5 to -10	0
C4	-10 to -20	-10 to -20	-10 to -20	0

C5	-1 to -5	+0.1 to +0.5	+0.1 to +0.5	0
C6	0	+1 to +5	+1 to +5	+5 to +10
C7	0	0	0	+1 to +5
C8	+0.1 to +0.5	+0.5 to +1	+1 to +5	+5 to +10
C9	0	0	+0.1 to +0.5	+0.1 to +0.5

FT4 was the smallest of the four case study trusts but the strongest in terms of financial performance. It was also the smallest in comparison with its six competitor trusts and growth in activity was third highest. However, it did have by far the shortest average length of stay and it achieved the second largest reduction in length of stay. Financial performance amongst the competitor trusts showed some dramatic differences across the years. In earlier years several trusts reported very large deficits and in later years there were some very large surpluses such that the financial performance of FT4 was far from exceptional among this group of trusts, although FT4 had the most steady increase in surplus over the years.

Table 19. FT4 and its competitor trusts

	2004/5	2005/6	2006/7	2007/8	2004/5-2007/8
Activity (elective admissions)					
FT4	**34.3**	**36.3**	**41.2**	**43.1**	**20%**
C1	66.6	71.2	74.2	77.2	14%
C2	52.6	56.6	61.6	61.4	14%
C3	55.2	61.4	63.2	73.5	25%
C4	50.4	54.3	64.0	72.7	31%
C5	35.2	39.5	40.1	n/a	n/a
C6	62.1	67.7	70.3	110.1	13%
Inpatient Length of stay (days)					
FT4	**3.3**	**3.1**	**2.5**	**2.3**	**-43%**
C1	3.7	3.4	3.1	2.9	-27%
C2	4.0	3.5	3.4	3.3	-20%
C3	4.2	3.7	3.6	3.2	-30%
C4	4.5	3.9	3.1	2.9	-56%
C5	4.0	3.6	2.8	3.0	-34%
C6	4.0	3.4	3.1		
Missed 4 hour A&E target (%)					
FT4	**1.4**	**1.7**	**1.4**	**1.3**	

C1	1.7	2.0	1.8	1.6
C2	1.7	1.8	2.3	2.7
C3	1.5	1.5	1.5	1.6
C4	0.8	1.1	1.7	1.8
C5	1.1	1.2	1.5	1.8
C6	1.7	2.0	1.6	

Retained surplus (£000)

FT4	**+0.1 to +0.5**	**+1 to +5**	**+1 to +5**	**+10 to +20**
C1	+10 to +20	+0.1 to +0.5	>+20	>+20
C2	<-20	<-20	-1 to -5	0
C3	-1 to -5	+0.1 to +0.5	+1 to +5	+10 to +20
C4	-10 to -20	<-20	+10 to +20	+10 to +20
C5	-1 to -5	+1 to +5	+5 to +10	0
C6	-10 to -20	-10 to -20	+5 to +10	

4.1.11   Characteristics of the four case study FTs

The analysis in this section enables the four case study FTs to be characterised with respect to (i) each other; (ii) FTs and NHS trusts nationally; and (iii) local competitor trusts both cross-sectionally and over the period 2004/5 to 2007/8.

FT1 is a larger than average FT in a local area with several larger than average trusts. Unlike most FTs it has not seen growth in elective activity. It performs well on measures such as waiting time for elective admission and average length of stay but has performed less well on target indicators such as four hour A&E waits and MRSA infections. It struggled with a financial deficit, though it wasn't unique among local trusts, and has subsequently returned to surplus.

FT2 is average in size both nationally and among its local competitor trusts. It has experienced some growth in activity and performs well on targets such as the four hour A&E wait. It is financially sound but other local trusts are now in a similar financial position and also performing well on measures of quality and efficiency.

FT3 is larger than the average FT but has several competitor trusts of similar size or even larger. Like FT2 it has experienced some growth in activity but so have many of its local competitors. Its performance on efficiency and quality indicators is similar to FTs nationally and average amongst its competitors. It has had a modest and steadily improving financial performance whilst that of its competitors has been more erratic.

FT4 is a small but successful FT, particularly in comparison with the other case study FTs. It has seen the largest growth in activity. It performs well on efficiency measures such as length of stay and continues to improve. It performs well on targets but has the longest waiting times for elective admissions. It is financially very strong but it is also located in a highly competitive area where other much larger trusts are also performing strongly.

4.1.12 Conclusion

There were, as expected, some clear differences between the average FT and the average NHS trust. In particular, differences were seen in indicators of quality and financial performance, two of the criteria used to determine if a NHS trust is eligible for foundation status, with FTs outperforming NHS trusts.

Analysis of the four case study FTs indicates that they vary in terms of key factors such as their level of activity, measures of efficiency, indicators of quality, and financial performance. The figures suggest that the case study FTs are generally typical of FTs rather than non-foundation status NHS trusts. However, the variation between the four individual FTs ensured a mix of performance both above and below the average for all FTs when assessed cross-sectionally and over time.

The analysis of the four case study FTs in comparison with their local competitor trusts puts the differences between the four FTs in context. What appears on first examination to be a major difference between the four case study FTs needs to be considered in the context of the local health economies. For example, the case study FTs are fairly typical among their competitors in terms of financial performance - what differs is the typical financial performance in each local health economy. Therefore the four case study FTs represent a mix of characteristics typically seen in FTs operating in a range of local circumstances.

4.2 Issues specific to FTs - autonomy

4.2.1 Introduction

Having reported on how the characteristics and performance of the four FTs in the study relate to other FTs, and to other NHS Trusts in the previous section, in order to put them in context, this part of the results chapter will now report on the core questions posed by the study concerning the governance of FTs.

The first of these is about autonomy. Here, autonomy can be understood as autonomy from oversight in the form of goal setting or supervision over operational decisions and therefore denotes greater discretion in tasks and functions (McGrath, 2001, quoted in Exworthy et al, 2010). One of the main

aims of the changes in governance contained in the FT policy is to increase the degree of autonomy of the hospitals who are FTs from central NHS control. This section will report on the cultural changes and activities which have been prompted by this autonomy, looking at themes of increasing self reliance, room for manoeuvre and greater business focus. The section will also report on the limits of autonomy, as the FTs in the study have had varied experiences of regulation from Monitor, and all noted the continuing effects of other forms of national regulation. (It should also be noted that a later section of this chapter, on issues affecting all NHS organisations, will report in more detail on the important effects of centrally set performance targets on the FTs in the study.) Moreover, the effects of organisational autonomy can be overestimated if solely the experiences of senior management in the FTs are examined. The section will also present results concerning the much less marked changes in some clinical attitudes and behaviour.

This section will demonstrate that the FTs in the study had developed a self reliant ethos, which made them concerned about their financial viability. They became more business focused, and aware of the effects of their activities on their financial position. They used their autonomy to make more decisions at local level, exercising more 'room for manoeuvre'. But these changes were not uniformly popular with clinicians.

4.2.2 Mixed experience of regulation

The experience of the four FTs in the study has varied in relation to Monitor, the FT regulator. In general, the FTs which performed according to all targets were not 'bothered' by Monitor. They reported that it was other aspects of regulation (from the quality regulator and from parts of the NHS hierarchy) which they found more intrusive. It was the FTs whose performance did not reach expected standards which experienced much greater intervention from Monitor. Nevertheless, in some of the FTs, there was clearly a strong awareness at all times of the possibility of Monitor's intervention if targets were missed. Some of the FTs in the study were more concerned about the power of Monitor than that of their local PCT (see later part of this chapter concerning relationships with local organisations), as Monitor could remove their license to operate as an FT. Although some in the FTs complained about the conflicting demands from different regulators, it was also clear that the national regulators and local partners did try to work together in relation to the FTs.

Monitor was reported by the FTs has having a policy of keeping at a distance when everything was running smoothly. Several of the FTs in the study reported a good relationship with Monitor, and that they did not feel overly scrutinised by it.

[the chair of monitor said to an executive], 'if you're honest with me…in your self declarations… that you're not in self denial or anything, you know, if you've a problem, an issue, raise it, and in return I won't go running off and causing problems for your Trust, we'll deal with it in a very professional and managed and measured way'.

(Executive)

"their line [Monitor] is, "Are you delivering against the key targets?" "Are you in financial surplus?" And if the answer to both of those is, "Yes," you don't hear from them."

(Executive)

But, at the same time, some of the FTs feared that they might have their powers eroded as other agencies attempted to enforce national guidelines.

"the way the contracting and quality and operating framework and all this sort of agenda is going, we're actually being pulled gradually back in"

(Executive)

These FTs saw that centralisation continued. In fact, during the course of the study, these FTs observed that national scandals about the quality of care delivered in FTs (especially at Mid Staffordshire NHS Foundation Trust) had made ministers more concerned about being given reassurance about FTs' performance, and that this national mood meant that it was possible that there would be an erosion of FTs' autonomy. Changes in policy at the Department of Health, through the issue of guidelines and other instructions, could be the principal threat to the autonomy of FTs.

"I have the impression that…the latest team at the Department are wanting to harness things back together again"

(Executive)

One example of a national policy was the new model contract that the FTs were required to use.

"if you sign up to it, you're stuck with a lot of things that ….you're nervous about having to supply"

(Executive)

Some of the middle managers were also very aware of the regulators.

"I just feel that we are more heavily regulated now than any time in the past and we are regulated by a number of regulators, all who seem to have tremendous powers to shut you down or cause you a lot of problems if you are not at standard"

(Service Manger).

But it was thought by some that at ward level, this awareness was less intense.

"I think if you asked the, everybody else sat in the department, "Who's Monitor and what do they do?", most of them wouldn't know"

(Clinician)

On the other hand, there was also some evidence of staff being very conscious of Monitor. For example, at routine division and directorate

meetings, as well as at meetings mainly attended by ward-based nurses, Monitor would be mentioned, mainly in relation to infection control and other quality measures.

At one of the FTs, inspections by the Healthcare Commission (later the Care Quality Commission) highlighted several hygiene issues and provided negative feedback, and thereafter, there remained a constant threat that they would be coming back to inspect.

"the staff are very conscious of things like the Care Quality Commission and the importance of the feedback, if only because that fact that the Trust really prioritises that"

> (Clinician)

But this was not seen as an entirely negative thing for the hospital. At least one clinician recognised that the hospital should improve, and that the attentions of Monitor and the Healthcare Commission (later the Care Quality Commission) had been an impetus to do so.

"That sort of information is useful".

> (Clinician)

Monitor required detailed specific information which this FT did not produce routinely. They started to do so in response to Monitor's requests, with the result that, over the period of the study some of the FTs paid closer attention to routine collection of key data items, and became more systematic in their data collection. Thus, Monitor's intervention had led to improvements in the FT which were clearly needed.

The local Strategic Health Authority (SHA) and Department of Health were also perceived by managers in several of the FTs as demanding and time-consuming in seeking to verify and clarify statistics relating to key targets, especially when they required data in a different format from other reports which had been prepared. The picture presented by interviewees was of considerable impact at the grassroots of regulatory systems, although the staff there had less personal exposure to the actual regulators than the trust wide strategic managers.

The FTs noted that at all times, the relationship with Monitor was businesslike.

"Monitor are very good...they have a very good approach to regulation. They're immensely helpful."

> (Executive)

Models from business were adopted and this did not always sit well with staff at some of the FTs. Some executives stated that they were not used to having to justify their finances or show how they would meet targets in such detail.

"Monitor have I think worked very hard at being a regulator, and I think they've made the difference between performance management that we had previously and regulation really quite stark."

(Executive)

On the other hand, some of the FTs experienced Monitor more like a performance manager at times, especially in relation to failures to meet quality targets, such as infection control.

For example, if there were problems in terms of meeting targets then the relationship changed quickly and the level of scrutiny from Monitor could become quite intrusive. This happened to two of the FTs in the study.

"…if you're in their vision, you know they're like dogs with bones you know…they were on the phone every day over something and it was little and this was a bit picky and that was a bit picky and "we don't think we've seen the infection control action plan from the last visit" so we said "well that's because we've had a re-visit and we've had a clean bill of health, you know the action plan was… it was shared with you at the time". "We don't think we've seen an action plan from the recent visit" and we said "well that's because there were no actions required" and it's those kind of conversations."

(Executive)

The hospitals were not prepared for a regulator that would act as fast and as decisively as Monitor

"…with Monitor… the hammer dropped very quickly on us and you know, we lost half the Board, … so there was a significant, you know, downside to being a Foundation Trust. The clinicians were very supportive about being a Foundation Trust when it came about, they could see all the benefits as well, they didn't feel that way six or nine months later when the Chief Exec had gone, their Chairman had gone and half their Board had gone."

(Manager)

"I think in hindsight and being fair to everybody, if we had understood the sort of relationships that we should have either encouraged or developed with Monitor, then perhaps we wouldn't have run into quite as many problems as we did. But we were being….we were used to being fairly autonomous. But you know, Monitor can intervene and intervene very quickly, which he did [referring to the chair Bill Moyes]."

(Executive)

4.2.3 More autonomy: room for manoeuvre

Despite the continuing experience of regulation described in the previous section, the FTs in our study all reported having a heightened sense of autonomy and room for manoeuvre inside the NHS since they had become FTs. Freed from direct accountability to the SHA, they were able to make more decisions about the future of their organisation. It should be noted that, although the FTs were conscious that their autonomy differentiated them from other NHS agencies, they still considered themselves to be working with the larger umbrella of the NHS.

As one executive reported,

"the biggest advantage has been the headroom– we shouldn't underestimate the amount of…. time that this has taken up in…..reporting constantly to the centre….about every little thing"

(Executive)

At another FT in the study, it was confirmed

"there is a lot less…accounting …to the centre… several senior people…are now…freed up to focus on developing the way in which we want to manage……the organisation"

(Executive)

"I'm not compelled to do all the other things that other Trusts actually have to report on"

(Executive)

The FTs reported that the chief executive (CEO) of the hospital did not have to report upwards to the SHA. He or she was responsible only to the FT Board.

"The relative importance of the Chief Executive and the Chairman has changed in an FT….the Chief Executive reports to the Board, full stop"

(Executive)

The benefits of not having to report to the SHA and to make their own forward plans were seen as significant by the FTs in the study. Staff were able to provide directors with information that allowed the FTs to plan on significantly longer timescales. FTs could develop three year strategies.

"we are now…able to plan three years out….for the first time, we're… getting some…real information, so that we can think about scenarios…in future, and actually, support that thinking…whereas I don't think that thinking actually happened…too much in the previous status"

(Executive)

Decisions could be made and implemented more quickly as there was no longer a large management super structure above the FTs. The FTs did not have to take business cases beyond their own boardroom.

"Once the local Board approves something, off you run with it..making decisions and making things happen on the ground are a lot faster…. you've got total autonomy…and no-one else is accountable...for what happens"

(Executive)

The FTs reported making decisions about where their surplus should be invested without needing the approval of any other NHS organisation. Perhaps the most significant dimension of the FTs' autonomy reported in the study was their power to make investments using the surplus generated. They reported that this compared favourably to their experience as a NHS Trusts. In former times, even where the hospital had the money to invest in a capital project, there was still a significant number of approvals to obtain. They reported that these had included other NHS organisations amending even minute design details of projects.

"We had a big capital project…which took…many years to get approved through the usual processes, even though the money was approved…. there was a lot of hoops that had to be jumped through with strategic health authorities and people needing to tick boxes on. Now…that's certainly been reduced"

(Executive)

This feeling of greater control over their own affairs included employee relations.

"On the HR side, and we ought to be able to, if we decide to sack somebody on a compromise agreement or whatever, we should be able to do that without having to…report it back up the line to the SHA or whoever"

(Executive)

But the FTs recognised that they were still bound by national employee terms and conditions, which they would have liked to alter.

"There were lots of things in Agenda for Change that are just nonsense… like you could be paid as a boss on exactly the same salary scale as your….subordinate….there was also no facility for recognition of extra responsibilities….these things are just…nonsense"

(Executive)

"We contract out our cleaning and catering, and we spent a lot of time debating on whether we should pay them the Agenda for Change rates or not"

(Executive)

At middle management level in one of the FTs, a service manager also noted that the effect of the hospital having FT status affected his/her work.

"We develop a Performance Plan that goes up to the Chief Exec. I report in to the Chief Exec, and we develop more strategic direction of our own Directorates within the context of the hospital. Before, as a Trust, we were constrained by national policy"

(Service Manager)

"You're much more in charge of your own destiny really"

(Service Manager)

But the FTs in the study still saw themselves as part of the NHS and subject to many aspects of central control. The increased autonomy is a question of degree.

"We get all these missives from the Department of Health and we have to remind them occasionally that we don't have to listen to them, but we will be happy to co-operate and all the rest of it. There's no point in pretending that we're an island"

(Executive)

"You obviously still have to follow national standards and targets and so on, but the internal workings of the Trust, how you conduct business, is entirely down to you as a Trust"

(Executive)

"For example, when guidance came out on – from the Department of Health ….that there would be a Modern Matron per two wards. I said to the Board, 'This is what the guidance says, this is what we've got, this is what we suggest'… …and we had one extra. We don't agree with having one to every two wards"

And the re-imposed powers of the central control might have to be accepted in return for some sorts of additional investment.

"If there's any national money for initiatives we are still able to apply, but, of course, once you do, the SHA expect to performance manage you on it"

During the study period, their local SHAs became more important to the FTs in the study because a greater emphasis on regional plans occurred. This was partly due to the changes suggested by the Darzi report (2008), such as introduction of polyclinics in each area, and partly due to the swine flu emergency of the summer and autumn of 2009. The FTs were obliged to participate in more activities with the SHAs, and be subject to their direction on some issues (such as emergency planning). Moreover, it became clear that the SHAs were still involved in many aspects of the FTs' operation. For example, SHAs were responsible for the allocation of medical training posts and so retained a measure of control over a key part of the workforce.

It should also be noted that because the SHAs performance managed the PCTs, their influence could be felt indirectly by the FTs, through their relationships with the PCTs. For example, the pressure to deliver on the 18 weeks waiting time target (discussed in detail later in this chapter) came from the national level via the SHAs to the PCTs, who related directly with the FTs. In addition, one FT reported having to attend a regional meeting about the waiting time target, chaired by the SHA.

4.2.4 Self reliance and business focus

One of the aspects of becoming an FT which the hospitals in the study all noted was that, while they had more 'room for manoeuvre' (i.e. more autonomy inside the NHS), they also had concomitantly more responsibility for their own affairs, in both positive and negative ways. The positive ways included making longer term strategic business plans and detailed decisions about how to run their own organisations; the less comfortable aspect was having to be more financially responsible – not having the rest of the NHS system to fall back on if they were in financial difficulties. A combination of these factors made all the FTs in the study business focused. The senior staff were very concerned to understand better how the business of the hospital ran – what the income and costs were – and to take advantage of any opportunities to expand and strengthen that business. They wanted to grow their surpluses and achieve financial security. One notable aspect of this was the conscious marketing of the hospitals to local GPs and patients. This was regarded as a good investment.

The FT executives saw self reliance as personal responsibility, which was not an entirely negative experience. But one FT executive voiced clearly the concern of them all about the negative aspects of self reliance. The FTs in the study felt a responsibility to make good business decisions within the wider context of meeting patient need.

" You can't hide behind the skirt tails of [SHA]… I feel more vulnerable. I feel more like a Director of a company rather than a Director or a large Public Body, lost in the quagmire of the NHS [laughs]"

(Executive)

Strategic planning

The first positive aspect of business focus to note is the ability of the FTs in the study to carry out longer term strategic planning. As quoted in the preceding section, one FT felt able to plan for at least three years ahead. In one of the other FTs, an even longer term timescale was invoked:

"Longer term strategic health of the organisation, where we're going to be in ten years' time? What sort of investments do we need to be making now? What kind of partnerships do we need to be developing with others"

(Executive)

The cultural change for these FTs involved a longer term vision of the future and a strategy for achieving the vision. By contrast, NHS Trusts had a much more short-sighted approach.

"FTs needs a much greater vision of the future, and a much clearer strategy… historically, the NHS has gone from year to year… short-termism"

(Executive)

Making a surplus

One of the key aspects of this business planning was the aim to make a surplus, which could be retained.

"Managing like a business I'm not sure exactly what I'd mean by that… business…doesn't necessarily have a profit motive…it means we've got to serve our customers well, and make a surplus which we can reinvest"

(Executive)

This was regarded as a change from running an NHS Trust, where financial control meant ending the year with neither a profit nor a loss, if at all possible. As another Executive described,

"You always had to land, you know, on a postage stamp"

(Executive)

NHS Trusts were seen as having no incentive to make savings because any money not spent at the end of the financial year would be clawed back.

"Before it would just be moving money around the system…. traditionally NHS people…were never very good at making savings"

> (PCT Executive)

Some of the FTs in the study had exercised their powers to make cash investments. Some of the cash was being invested in institutions with safe credit ratings, and some was being reinvested into services. Under the old NHS Trust system, cash balances were rare. As one executive mentioned,

"we've got more cash in the bank now than we used to have as a Foundation Trust – as an NHS Trust…. cash balances were quite rare in NHS Trusts because at the end of the year you all had to balance down to a very small number"

> (Executive)

During the period of the research, all the FTs in the study were making healthy financial surpluses (see the description of the case study sites in the methods chapter). This was mainly achieved due to growth in incomes, rather than increasingly efficient use of assets (although they did also try to achieve this).

"Well in our particular environment, over the past four or five years, you know, we've been experiencing, predominately, growth. So whilst everybody in the NHS has to make efficiency savings, we've made those more through growth at the margin if you like, rather than cutting costs per se. You know, we've tried to get – we have efficiency programmes all the time and we push, you know, we've changed, for example, the theatres to be, you know, extended sessions that work longer into the evenings that don't, you know, sweat the assets a bit more. You know, there's various other bits and pieces, but predominately, it's been more about growth than saving money"

> (Executive)

Business development

But the FTs in the study did not simply want to make a surplus and bank it for 'a rainy day'. They wanted to use money accumulated to make investments in their services. There were two main reasons for making these investments. First, to allow the business of the hospital to expand, and to attract (or retain) work, and thus income (and thus increase the surplus). Secondly, the aim of improving patient care was a clear driver. These aims were seen as mutually reinforcing by managerial staff. They did not voice concerns which opponents of the FT policy as a whole had raised about the pursuit of profit by FTs having the effect of damaging patient care. (The later section about the attitude of clinicians to the new FT status will demonstrate that the views of clinical staff about the effects of pursuing profits were more mixed.)

As one senior manager explained, customer service, making a surplus and improving the service were inter-related,

"Managing like a business I'm not sure exactly what I'd mean by that… business…doesn't necessarily have a profit motive…it means we've got to serve our customers well, and make a surplus which we can reinvest"

(Executive)

All service improvements in the FTs studied had to be justified on the basis of 'business planning'. The FTs had various committees that analysed their investment policies. The surpluses generated from the re-organisation of clinical directorates was sometimes re-invested into the hospital in order to further improve and expand services. This involved changing the wider culture of the Trust from that of a government organisation with a budget to a financially accountable business. In that context, the expansion of services was justified by the potential for a service to deliver a return and contribute to the FT's surplus.

"When they come and say to us, 'We want investment to do x,' and we sit and look at they and say, 'At the moment you're not even breaking even, go away and work out why,' they understand why because I sit and say to them, 'We're running a business, we can't invest in everything that loses money or we won't be here,' you know, 'Get a grip'."

(Executive)

This requirement for cultural change to a financially responsible organisation was felt at the level of the individual medical directorates in the study FTs.

"We can sit down and make a case for…let's expand our theatre capacity because of the demands, let's invest some money in some equipment. Before that, we used to be constrained with not always having enough money"

(Service Manager)

The cultural shift to a business focus could be observed at the level of clinical teams within Directorates. A Directorate that wished to expand its services had to make a financial case to the Executive demonstrating how the expansion would contribute to the FT's surplus. This placed new 'cultural' pressure on clinicians to give acceptable reasons for expanding their services. As one service manager explained,

"If we were to do a business case now, we would show what the contribution of the service was, and if it was making anything under a 10.7% contribution, unless there was a fantastic reason to expand, we wouldn't."

(Service Manager)

The planning process within the FTs required communication between individual directorates and the Executive. Proposals required business cases to be approved at Executive level if they needed new consultant appointments or major capital funding, but not all decisions required approval at FT level. Executives became more stringent about the financial viability of their own decisions.

"If I wanted to put in a nurse specialist into renal, we would make that decision inside the directorate, and there'd be no going to the executive for a decision like that"

> (Clinician)

Orthopaedics departments in two of the FTs had successfully appointed two new staff recently, with business cases showing that the additional funding was through waiting list initiative money. (This relates to the 18 weeks patient pathway, which is discussed in part c of this chapter.) They had also benefited from substantial investment in new equipment.

"It's up to the directorate to put together a cost effective business case that stacks up and as long as you do that you will get the support, and it'll work and you'll get the approvals"

> (Service Manager)

But it should be noted that the FTs gave several examples of investments which had been made primarily to improve the quality of services provided, not to increase income directly. (These included better consultant cover for accident and emergency services and improving maternity services.) In the favourable financial environment during the period of the study, there was money available to the FTs to undertake these types of investments.

"Well, touch wood, we've been in a very fortunate position in that we're, at the moment, very financially sound, we get rated as "excellent" by Monitor. The trust has been able to use its financial security as a cushion to do different things. We have, for example, invested a lot of money on our Maternity services, and we've just got another rating of "excellent" for Maternity, but we were probably doing that almost as a loss leader, because we were investing the time and the money in that service because we could see it was something there was a need for, and but the national tariff didn't cover that service"

> (Executive)

Overall, the FTs gave several examples each of new or expanding services, infrastructural investments (such as better information technology) or capital developments which they had been able to fund out of their surpluses.

Entrepreneurial behaviour

We also found evidence of one of the FTs in the study making different kinds of investments in services than it might have done prior to obtaining FT status. It was involved in commercial partnerships and joint ventures with profit making independent organisations from outside the NHS. In some cases, it had lent its NHS 'brand name' to the commercial organisation in return for remuneration. All the FTs in the study were interested in expanding into wider areas of service, but not all of them had the opportunity to do so in such a directly commercial way. The change to FT status had given one FT more autonomy to make more commercial decisions.

"It enables us to go into joint ventures with independent providers…..and from the voluntary sector"

(Executive)

One FT was also starting completely new service (bariatric surgery), which it thought would be profitable. And another FT in the study was making major investments into new specialist cardiac services.

One of the FTs in the study was trying to find a way to make more money from private patients. Each hospital was given a 'private patient cap' on becoming an FT, which allowed it to make the same income from private patients as in the last year before being converted to an FT. In the case of this FT, it was clear that there was more demand for private care than the cap allowed. It was actively seeking ways to circumvent the cap.

Some of the FTs in the study had planned to use redundant buildings to make property developments and thus increase income. But the national banking and general financial situation deteriorated before they were able to do so.

Another example of entrepreneurial behaviour was that two of the FTs were opening additional NHS outpatient clinics in a wider geographical area round the hospital buildings in order to 'capture' the inpatient work for their FT. (Competition with other NHS organisations is discussed in the later section of this chapter dealing with local relationships.)

The interest in marketing their services to potential patients and to GPs also demonstrated entrepreneurial behaviour. The degree to which conspicuous marketing of services occurred varied between the FTs in the study. One FT had actually appointed a marketing director, whose job was to build relationships with GPs and PCTs. This FT was also using dedicated staff to analyse referral patterns to the hospital, so that any GPs who were not referring to them could be targeted. The FT had also developed 'new branding'.

The FTs which had not appointed a specific person to a marketing role were also showing interest in improving relationships with GPs and PCTs locally to ensure that referrals were made to them. For example, another FT used a survey of GP practices in a five mile radius of the hospital to find out how to appeal to them. This was followed up by liaison visits by teams of managers and consultants. These are designed to protect market share, to promote new services already being offered at the FT and to find out if there was demand for any new services. Although the FTs in the study acknowledged that GP liaison visits had occurred prior to FT status, they reported that the focus of these visits had changed to being more about promoting the FT to the primary care team.

The FTs in the study noted that their members and governors could also be drawn in and used for marketing the FT (this will be discussed in the later section in this chapter concerning responsiveness to local communities).

Patient centred care

The aim of providing good quality patient care (whether for its own sake, or because it would enhance the reputation of the FT and attract further patients), was clearly articulated along with the desire to make a surplus to become financially secure. This created the need for the FTs to be seen as 'customer focused'.

"We're providing a service here .. we're trying to get people customer focused..and the NHS isn't always.. ...customer focused."

(Executive)

Not having to report to the SHA, the FTs had the ability to look more deeply at how they delivered care to patients without having to consider how any other organisation might impact upon their business. They had the incentive and the autonomy to focus on patients.

"The key challenge was to become – to be truly patient focused as an organisation... as an FT, it's much easier to do that"

(Executive)

Focus on efficiency and profitability

In order to run the FTs on more business focused lines, all of the FTs in our study had made significant efforts to understand their costs and income streams in more detail. They were concerned to understand what aspects of their services were profitable. This also led to the redesign of services in some cases, so that they could become more efficient. The FTs saw the wider NHS environment as subject to change. In this environment they thought that understanding their costs, via the introduction of accounting techniques such as the Patient level costing system, would enable them better to understand where they could accumulate a surplus with the NHS changeable environment. In order to make savings and increase profits, FTs required clinical directorates to examine the patient pathway, produce routine financial data in terms of costs and income, and thus establishing the 'true' costs of treatment. The individual clinical directorates in each FT in the study were striving to make their directorate profitable. One example of a management tool used was the so called 'blobagram', which compared directorates. It pictorially represented which of the directorates was making a profit at any one time. Internally, clinical directorates were becoming more competitive, and largely upon a financial basis. For example, Medical and Surgical Directorates treated markedly different conditions and they

could not compete on the basis of patient care. They could, however, compete on the basis of relative profitability.

"There can be that perceived competition because you want to do well and not look to be failing in front of an Executive Team who can be very questioning"

(Service Manager)

By remapping the patient pathway and by reassessing the use of the asset base (e.g. theatre time), that FTs were able to reduce costs and increase profits, thus growing their surplus.

"As a result of doing the process mapping, they've been able to cut out a number of steps, significantly shorten the Care Pathway, and thereby you generate more surplus, because it costs you less"

(Executive)

Business focus required the extensive collection of financial data. FTs needed to know the costs associated with the treatment of each patient.

"There needs to be much more use of the data in a financial –Foundation Trust…clinical outcomes data, clinical throughput data, analysis of the profit"

(Executive)

These savings could be re-invested into the FT in order to generate more income.

"Let's grow this business. How can we be creative in terms of finding new ways to get income?" It's…more buoyant, more exciting than saying, "Oh, we've just got to cut costs"

(Executive)

Business focused FT directors recognised the potential for tension in applying profit and loss methods of accounting to the delivery of services in clinical directorates. Business focus was sometimes used to halt clinicians' desire to expand services.

"The Clinicians said, "Oh, you've got to do that, we're going to lose it." I said "Well…the reality is, it's not good use of the public purse, and tell them "no."

(Executive)

However, the focus on the profitability of individual directorates should not be overstated. The FTs in the study were well aware that the different parts of the hospital were interdependent: while not all of the services would necessarily make a profit in their own right, most might need to be continued in order to provide the full range of services needed in a hospital of their type (such as a district general hospital), and some services would continue to cross subsidise others.

"It makes people a bit nervous. You suddenly start saying, "You know, we're going to run this like a business." If you've truly run it like a business, we'd stop doing obstetrics tomorrow because it loses us money hand over fist, you know, we'd probably stop doing ENT or do – but we're not, we're a district general hospital here to provide a service. So yeah, you know,

Orthopaedics is a good old cash cow, if you like, it brings in a lot of income, but that's to be shared out amongst the Trust"

> (Service Manager)

We found very little evidence of the FTs in the study deciding to stop providing a service because it was not profitable. In any event, the license to operate from Monitor stipulated which services each FT had to provide. One rare example was that one of the FTs did decide to stop providing a specific service, primarily because the department was not large enough to offer sufficiently high quality.

"We don't do – we gave up our [x] Service a few years ago. You know things where you just think we shouldn't be in that business; that's not sensible for [FT name], but we will compete on things where we think we are the best. So we're trying to find the right balance between quality, clinical quality, patient centred approach, but with a business head…"

> (Executive)

An additional effect of collecting more data for the purposes of efficiency in the FTs was that, in some departments certainly, the staff delivering the services had more information about many aspects of clinical activity, even at the level of individual wards and staff members. The co-operation of clinical staff was required to collect these data, and the data were shared at team level. This helped increase clinical engagement in some areas and allowed more decisions to be made a lower levels in the organisation.

4.2.5 Attitude of clinical staff to FT status

In the four FTs in the study, it appeared that becoming an FT had mainly affected the hospital at board and senior management level. It had had less effect on the day-to-day running of clinical directorates, although service managers were more acutely aware of the need to have a business like focus on their service when planning developments. On the other hand, the effect of FT status on clinicians (both medical and otherwise) was less marked, and varied considerably between individuals and directorates. While some clinicians had 'bought in' to FT status, many were more ambivalent about the elevation of their Trusts to FT status.

In all the FTs and across both tracer groups, many clinicians were keen to point out that their own values and motivation had not been changed by the hospital gaining FT status.

"It hasn't altered my decision making process, which is patient focused and, if you like, trainee doctor focused…and I don't see at the moment any difference in my attitude to that role, having become a Foundation Trust"

> (Clinician)

"I don't think it alters my clinical approach, or my ability or reluctance to spend money"

> (Clinician)

The senior clinicians in the study were divided about whether or not to engage with the greater with business focus of their FT.

"Some clinicians have really taken it on board" but, *"Some don't get it"*

(Executive)

Not only were some clinicians averse to such a shift, they were actually hostile. They stated that they were not trained to base the delivery of medical services on a business focus. They were trained to be patient focused.

"Making money or saving money? I don't see health as making – I don't see the Health Service as a business for making money"

(Clinician)

Requiring them to become business focused, in many ways, cut into the core of their professional identity.

"We're not competing, we don't want to compete. We want to develop a service that's appropriate to our own abilities and what we perceive as the needs of our unit to deliver a rounded healthcare service for the region"

(Clinician)

"I've always thought competition with other Trusts was completely barking mad because if patients need treating, they need treating and we're not…running a business"

(Clinician)

While some of the clinicians felt the presence of the business focused Executive and the demands for expanding and developing, it did not interest them.

"My colleagues are not interested in money. My colleagues…. what drives them is treating patients to the best of their ability with a sense of excellence"

(Clinician)

Some clinicians were aware that being an FT required increased marketing of the hospital's services to patients and those referring.

"I think it's really clarity of what service we're going to provide, who we're going to provide it to, what are the advantages that we can have over perhaps GP care, for which patients, you know, and how often we would see them"

(Clinician)

But not all were prepared to participate in these activities.

"I don't see it as my job to go out and make a relationship with the GPs…. I personally see that as a job for the management to sort out"

(Clinician)

The clinicians were aware that there had been some managerial changes due to the hospital becoming an FT. They could see the effects on the managers working with them.

"I don't think there's been a huge change apart from, you know, a feeling of immediacy from the management"

(Clinician)

The FTs were starting to use different accounting techniques that were focused on quarterly profits and losses. These methods of collecting information were used for the basis of their strategic investment decisions. FT directors were starting to engage with clinicians to help them understand the new logic driving the expansion and development of their particular clinical directorate. But not all clinicians knew exactly what these changes were, despite the fact that managers were trying to engage them in the more rigorous financial processes.

"There is Service Line Reporting, which I'm not quite sure what that is. It's mentioned in meetings and it seems to be something to do with achieving certain in house processes or targets, and I'm not quite sure"

(Clinician)

The clinicians were aware of any problems affecting patient care within their directorates and were interested in resolving them, but they were not convinced that FT status would make any difference to this. It did not seem to have affected their involvement (or otherwise) in decisions about making new investments in their directorates. Although they felt that if they really wanted to make some form of investment they could approach their service manager, they did not report feeling any increased ownership of the strategic direction of the clinical directorate since FT status was achieved.

"We never see any of the money anyway, so as a unit, it makes no difference"

(Clinician)

Some were not convinced that internal decision making inside the hospital had changed, and that their concerns would be taken into account any more than before.

"Higher echelons of the management ….are pushing for changes in the business case, changes in the service, it's the same as it ever was before. Whether we will get listened to more or not, I've no idea, you know, but we're not pushing any more or any less than we historically were"

(Clinician)

A few of the senior clinicians interviewed wanted to have greater power in respect of financial matters, but this did not seem to be the main concern of most. Some felt they were held responsible for the medical failures in the directorate, but that they were not able to influence how the directorate was organised and how it spent its money.

"The problem is the clinicians don't have the power because they don't control the devolution and the use of the money"

(Clinician)

From the senior managers' perspective, things were seen differently, however,

"In the past, doctors and Consultants ran the thing…so they may not have been financially, but they were all powerful, and that was wrong"

(Executive)

As far as national targets were concerned, some Service Managers felt that they were held to account for these targets, but at the same time were not able sufficiently to influence the organisation of way work was carried out in their directorates. They suggested that they, rather than clinicians, were held responsible for meeting targets.

"It's very easy to hold a General Manager to account. It's much harder to hold a clinician to account…it's really annoying"

(Service Manager)

On the other hand, in some of the FTs, in some directorates, the Clinical Directors and service managers worked in close partnership, with clinical directors bringing both their own clinical expertise and carrying weight with their colleagues; the managers bridging and implementing the requirements of the Executive and providing knowledge of and support for their directorates. Several of the managers felt that they were afforded a high level of autonomy over operational decision-making. As one clinician explained

"He's probably one of the two best general managers in the Trust…he'll just make the decisions…and in many ways what he's doing he's keeping me up to date."

(Clinician)

In the orthopaedic departments in some of the FTs in the study in particular, there was a growing understanding among clinical staff about the business requirements of their FT. A sense of genuine team work across the directorate existed, with clinicians and managers working together. The clinicians did not express themselves as being hostile to concepts of efficiency and having a business like approach, but they mainly confined this view to their own directorate. They were concerned that any savings made be spend in their area. Nevertheless, as time went on, some clinicians who attended FT wide meetings were beginning to develop a more FT wide, strategic view.

Where extra funds were required to undertake new work, a detailed plan was worked up and presented to the Executive as part of the schedule of meetings. The manager's team was responsible for briefing the Executive and providing figures to back up statements. Some of the service developments were initiated by the managers, without the engagement of clinicians, in some cases the clinicians had come up with the ideas, and sought help from managers to develop and present them. In some cases,

managers also dealt directly with the issues that come from the board. For example implementation of hygiene standards might come as an 'edict' and it would be the job of the manager to develop a plan alongside the clinician to show how this was being carried out within the directorate.

"A lot of the edicts that come down from the executive will go down through [the managers] route and between us we'll create a plan .... But I think we work well"

(Clinician)

One issue we investigated in the study sites was whether the FTs had used their increased room for manoeuvre to change pay to clinicians (or others). We found that actual pay scales had not changed for clinical staff since FT status was obtained, as none of the FTs in the study had decided to deviate from Agenda for Change nor altered doctors' salaries. (One FT did pay a one off, across the board bonus of £100 to all staff, irrespective of their role or status.) But some of the FTs had offered incentives and rewards of other kinds.

"gives us a little more freedom as Managers to reward Consultants for bringing patients here, for enhancing the service that they offer, because if you can give them better facilities, or additional training or whatever, then they will attract more patients"

(Executive)

And some of the FTs in the study had actually rewarded productive staff members. They used financial incentives to help them achieve national targets and standards.

"We do pay Consultants extra bonuses for doing waiting list work. We've got a huge heap of work, and we pay them a very generous bonus to come in on Saturdays and do that, and that is about access targets"

(Executive)

The FTs were also interested in finding more flexible ways to deploy staff within the hospital, although this was difficult to achieve.

"Staff obviously like to work in areas that they know, but in most organisations, if you've got a quiet time in one area you can move staff over from one area to another area. I'm not quite sure in the hospital that there is that level of flexibility"

(Executive)

The main benefit of elevation to FT status was the removal of some of the management above the Directors of FTs, as the FTs were no longer directly responsible to the SHA. Thus, it was primarily the directors that felt the difference between Trust and FT status. This feeling of increased autonomy did not seem to have been passed on to Clinicians, on the whole. Rather, they were patchily aware of the increased business focus, and many were uneasy about it.

4.2.6 Conclusion

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. FTs were receiving a range of instructions from DH, some of which had to be followed, but some of which they considered as 'guidance'. Senior staff were keenly aware of having more room to manoeuvre. The self reliant ethos found expression largely at board level, but efforts were being made to devolve down to clinical directorates as well. Some directorates reported being much more involved in the strategic planning of the trust. 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. (This feeling of autonomy should not be exaggerated, however. The effect of other parts of the NHS and other regulators on the FTs in the study will be discussed in the section of this chapter concerning issues affecting all NHS organisations.)

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. Improvements had been made in the type and quality of financial information collected and used. The cultural shift to business focus had penetrated the management level of individual hospital directorates, but inconsistently in clinical circles. Some clinicians were actually averse to this business focus. Many clinicians did not recognise many of the key freedoms FTs had been awarded as influencing service delivery within their directorates. While the relationships between some clinicians and managers were good and produced fruitful results, others were less easy. Where clinicians were unsympathetic to this approach, the increasing business focus may not have helped improve these relationships.

4.3 Issues specific to FTs - responsiveness to local need

4.3.1 Introduction

The main features which differentiate the governance of FTs from that of NHS Trusts are the increase in autonomy from central NHS structures, and the introduction of additional local accountability mechanisms. The previous section of this chapter has discussed autonomy and its limits for FTs in our study. This section will discuss how these local accountability mechanisms were used and understood in our four case study sites.

One of the defining features of FTs is the concept of a membership. People who become members of FTs are entitled to vote for governors, who form a supervisory board (sometimes called a 'board of governors' or 'members' council'), which exists in addition to the executive board of the FT. Despite

the rhetoric of mutuality, it should be remembered that members do not own the FT, as it is still a public asset. (The legal status of this membership was discussed in chapter 2.) Monitor's guidance (Monitor 2009a) on the role of governors outlined three key areas of activity for governors. *First*, statutory duties. These consist of appointing and removing the chair of the members' council and main board (who is the same person), the non executive directors ('NEDs') and auditors; approving the appointment of the chief executive of the FT (the 'CEO'); deciding the remuneration of the chair and NEDs; and receiving the FT's annual report and accounts. *Secondly*, the board of governors' role is to hold the board of directors collectively to account for the performance of the FT. *Thirdly*, the governors are expected to engage in a range of other activities, such as constituency meetings with members, liaison with patients regarding their experience; and developing a membership strategy.

This section will report on how the FTs in our study dealt with these issues, in the context of the other public and patient involvement mechanisms which were also operating the same time. These were PALS, PPI fora (now LINks) and OSCs (whose main features were discussed in chapter 2 above). The section will also report on the motivation of members and governors and the numbers and composition of members in each of the FTs in the study. We found that, although the FTs put considerable resources and effort into their membership and governors, it was not clear that commensurate benefits were enjoyed by all the hospitals: some aspects of the new structures proved useful, but there was concern from some governors that they were not able adequately to fulfil their role of holding the FT to account; and from others that the new mechanisms over lapped with other public and patient involvement structures. Despite the FTs in the study having been FTs for different periods of time (the earliest being since 2004), they all reported that they were still in the process of evolving their representative structures.

4.3.2 Data on membership provided by each FT

Details of the memberships of each of the four FTs in the study are set out in Appendix 3. Unfortunately, each FT reports these data in different ways, so that not all issues can be compared.

We can see that all four FTs have increased their membership over the past few years. FT1, in particular, has made a very large increase in membership in 2007-8 (from about 9,000 in the previous year to over 44,000). The FT reported that they had decided that increasing the number of members was a very high priority, and they were able to obtain expert marketing and data handling advice from a commercial organisation which was acting as a partner to the FT. This allowed the FT to launch a

membership drive. Former patients were contacted and asked to opt out of membership, rather than opt in. Governors were also responsible for undertaking recruitment activities in their local area. They were encouraged to attract people from black and minority ethnic communities at particular cultural events and also went to the local university to recruit students.

By 2007-8, the other three FTs had memberships of approximately 10,000 (FT2); 9,000 (FT3) and 13,000 (FT4) respectively. FT2 has analysed the proportions of the eligible public population who had become members by March 2009. For each constituency, this was less than 4% of the population.

Each FT has provided an analysis of the number of staff members who have become members of the FT. By 2008-9, these were approximately 4,500 (FT1); 2,000 (FT2); 1,600 (FT3) and 3,000 (FT4).

Some of the FTs have analysed the ages of their public members, and compared these to the numbers of people in those age groups in the local population.

In the case of FT 1, by 2009, the membership was skewed towards people over 65 years old and under 35 years, and other people of working age were under represented. FT 3, similar data were available for 2007. These showed that there were proportionately fewer members under 34 years old than the eligible catchment area indicated were appropriate. The membership was skewed towards people over 50 years old. This is not surprising, as those who use the hospital most are likely to be more interested in becoming members, and these are likely to be older people.

As for ethnicity, FT3 and FT4 provided analyses. FT3's analysis showed that in 2009, the considerable Asian population was under represented. In FT4, however, from the figures available about ethnicity of members, ethnic minority groups were not under represented.

FT3 also reported that in 2009, the socio economic profile of the public membership was roughly proportionate to the numbers of each socio economic group in the local population.

4.3.3 Public members

Although having members of the public as members of the FT was a key feature of becoming an FT, in order better to engage local people with their local NHS, the hospitals in our study took some time to work out the best way of interacting with these people, and how to channel their energies to best effect. In all the FTs, there was much talk about large 'investments' of time and energy to develop and engage with the membership. The hope was that this would pay dividends in terms of public involvement.

Early thinking in the FTs was mainly about how to recruit and engage local people. There was a clear desire on the part of the executive boards in all four FTs to engage with the community in which the hospitals provided services and to grow the membership. As in all forms of public involvement, it was recognised that some members would be much easier to reach than others, but there was a desire in all the FTs to reach a good cross section of their local populations. Some FTs invested in sophisticated market research tools to identify the socio-economic breakdown of their membership, as well as geographical analysis. Some other FTs undertook similar analyses and recognised the need to focus on the black and minority ethnic populations and the poorer communities in their area.

The FTs found that people with certain illnesses or other interests were more motivated to participate. This is especially so with chronic diseases and maternity. Thus engagement was not uniform.

"you tend to get the people that have either got real issues or you never really tend to get just the mid range patient, they're either one extreme or the other and the bulk of the patients are in the middle"

(Governor)

During the course of the study, although starting from different numerical bases, the concern in the FTs was about improving the engagement of the members that they had, rather than just driving up numbers of members. One director wanted to have some kind of debate with the membership,

"Surely the point is , we just don't want a nice even number to shout [about], you actually want some form of interaction with that [membership]"

(Executive)

Where it occurred, a feeling of taking part by members was valued by the FT.

But, not all of the FTs wanted to impose a minimum level of activity on their members. Some of the FTs had a very positive view of membership, at whatever level people wish to engage with them.

"I think the worst thing that we could do about membership and governors, but particularly membership, is getting to a kind of very introverted debate about how active members should be"

(Governor)

The act of joining was seen as enough in these FTs. That was regarded as engagement with the organisation. A larger pool of members from whom to draw was not seen as decreasing involvement, but opening up opportunities to more people who could then interact in an active way with the organisation at some point.

One example of the role highlighted was simply for members to be 'proud' of their hospital. Indeed one executive describe the board of governors as a

'supporters' club'. It was thought by some FT executives that membership could encourage strong affiliations. Bearing in mind that the NHS was a very large bureaucratic organisation, being a member of an FT could give the NHS 'a face' and the people could be in partnership with the hospital gaining a much needed 'voice'.

On a routine basis, the delivery of care by clinical staff in the hospitals was largely unaffected by the new membership status. One clinician's telling comments summarised this feeling that it was business as usual at the hospital

"On a day to day basis that doesn't impact upon me in the slightest, the fact that there are 10,000, whatever they're called"

(Clinician)

However, in each of the FTs in the study, the membership was relating with the governors and board of directors in a range of ways. In one of the FTs, a newsletter was posted three or four times a year providing information on areas of success and also about forthcoming events. In another, a letter was sent from four times a year and a 'magazine' twice a year. It should be noted that the FTs were concerned about the high costs of this mode of mass communication with members. But the FTs were highly committed to expansion and communication, and were looking for resources to support this.

The membership of each FT provided a large group which could be approached for intelligence and information. One of the FTs used its extensive membership to achieve over one thousand responses from public members to their long term strategic plan. In additions, the FTs were becoming more sophisticated in obtaining information from members by breaking the memberships down into areas of 'interest'. One FT had developed a 'sophisticated database' which could extract members' interests and align them with particular areas of hospital work or activities. For example the one hospital used its database to advertise 'medicine for members'. These sessions were open to the public and were an opportunity for clinical staff to give talks directly to members.

"Medicine for members' session may focus on a particular group (or illness);…there's an open day coming up very shortly and some of my previous areas have had [these]… my new area is also participating either in show casing what they do or having an open afternoon so there's a bit of mixture there to welcome them [members] into the areas…These are in general information giving sessions but enable people to raise the questions they wish with informed clinicians."

(Executive)

The members were also being used as teaching supports. By exploring patient experience when listening to members, staff were able to achieve two things: a better understanding of what it was like to be a patient and

also direct engagement with membership. This training helped doctors with their day to day work.

The way in which some of the FTs consulted with members and others changed during the course of our study. In the later part of the study, some of the FTs were putting more effort into consulting patients, whether they were members or not. The emphasis on hearing the experiences of patients increased.

4.3.4 Staff as members and governors of the FTs

Initially, some staff believed that simply by working at the hospital they were automatically members once the hospital gained FT status. This was not the case. Later on during the study, some of the FTs changed the system so that all staff were given the option to opt out instead of opt-in, and new starters were automatically made members.

Some of the staff in management positions in the directorates, whom we interviewed, had become members but others, quite senior in their professional roles, saw no advantage in doing so. Those who were members, often along with their families, joined as a way of supporting the FT but also because the information in the members' newspaper offered them a broader view of what was going on in their hospital. However, there appeared to be general apathy among staff about membership of the FT, let alone becoming a governor. We interviewed one staff member who represented ancillary staff, who was passionate about communicating with her constituency – porters, catering assistants, laundry services, domestics, who she felt were often excluded from information. She had pressed the Trust to ensure that they received newsletters and written material since they often did not have access to computer- based information. She believed that these efforts had at least opened up opportunities for engagement for these staff, while conceding that some still did not take a positive interest. Those who wished to be involved in activities continued to do so, though there are difficulties for some staff members to attend some meetings of the council/ board as they could not get time off work.

Some staff governors commented that staff were generally reluctant to contribute a full day's work and then also attend meetings in the evening. One nurse manager summed up this problem by pointing out that there were mechanisms to get information to the 'grass roots' in her FT, but this was not always taken up.

"The mechanisms are there, you will always get that element of come do the job and go home, and if you were to ask them what were going on it would probably be, no we never get told. But I would dispute that, I think they just choose not to listen"

(Governor)

The Staff governors had a difficult role to fulfill as governors and employees of the FT simultaneously. Being employees of the FT appeared to have an inhibiting effect on what they were prepared to say in their roles as members or governors. This was noted by some of the other governors.

"What we are concerned about, I think, is the extent to which our staff Governors are able to express their views through the, sort of through the Council of Governors mechanism really. I think they sometimes – we have five staff Governors, and I think they sometimes feel constrained by virtue of being employees of the Trust. Perhaps in expressing, you know views. I think they find it in a forum such as the Council of Governors meeting to express views that might be seen as challenging their the Board, you know. Some of them, you know, it's not an issue for all of them, but I think some of them find you know, find it a little bit inhibiting. …But my sense is that, you know, they have – the staff have a separate channel of communication with the management through the, you know, through their Trade Union representatives and so on, if they have any concerns. But whereas the Governors, the staff Governors, although they – I'm not sure how they – how representative of the staff they are seen by the people who elect them, you know. …but I think they have some concerns about their effectiveness …as representatives of the staff."

<div align="center">(Governor, member of the public)</div>

This was echoed by one of the union representatives in one of the FTs, who did not see that FT status had made any difference to the way in which staff were involved in the hospital.

"Okay, I don't think it's that different really. We've… I mean, it's nearly, as I say, a couple of years since we went over to Trust status. And we meet monthly with the management and I get – as a… I'm the staff side chair – so I get involved in quite a lot of stuff. So I don't feel that it's really changed that much in respect of how we communicate with each other. For me, nothing's really changed that much."

<div align="center">(FT staff union representative)</div>

But the FTs in the study were making efforts to involve staff as members and governors, nevertheless. All the FTs held staff forums to offer opportunities for staff and their representatives to communicate with the executives about FT issues. In one FT, a staff governor gave an example where, during a busy session of 'information giving' the Chair was keen to get feedback from Staff Governors.

"The Chairman did actually…say…don't you think we're giving them too much information, don't we want something back, How are our staff. What's the morale like? What is happening out there in the Trust? I think he does realise that, and I think that's why they've set up now these meetings with Staff Governors to try and find out exactly what's going on"

<div align="center">(Governor)</div>

In some FTs, the Executive and Chair made an effort to make the position personally comfortable for the new staff members.

"I was sat with the Chair and the Vice-Chair and I'm thinking, and I said you know to the Chair "do I have to say anything" and they said "not unless you want to", but you know like I say it then takes you a year to get into it you know and I've got involved with some sub-committees and things which is very good as well you know."

<div align="center">(Governor)</div>

One Staff Governor was able to add an extra dimension to medicine for members meetings. These are sessions organised on subjects of interest for members, for example MRSA, alcoholism and diabetes. Here, a Staff Governor was able to 'take on issues' presented at these meetings (on behalf of members) and make sure they are dealt with. She reported herself as slowly becoming a further face to the organisation.

"If people have got any problems or any issues I talk to them one to one afterwards, and then I can actually, if it's an issue where they've been in hospital and they've had a bad experience"

(Governor)

It should be noted, however, that even if staff were not notable in their involvement as governors, staff were increasingly involved in the operational level of the FTs by participating in the running of directorates and at the level of individual clinical services. Some staff were involved in their directorates' business planning and service developments, especially in relation to orthopaedic services in some FTs.

4.3.5 Motivation to become a governor

In all the FTs in the study, governors seemed motivated to join the FTs representative bodies by a personal sense of responsibility to the hospital.

"I'm a very strong believer that it's our hospital and therefore ...we have a responsibility to do something about it"

(Governor)

Some governors interviewed placed a high value in representing the public voice in the NHS, and saw their role as part of furthering democracy.

Some governors also believed that they had a duty to support the hospital given the high standards of care they had received as patients.

"I've been an outpatient here and an inpatient here...I've spent an awful lot of time, and a very large part of my last year....I felt I'd better get involved"

(Governor)

Often, they felt that the owed the hospital a debt of gratitude.

"My son has utilised the services of the Hospital in great depth over the last few years and... wanted to be able to give something back to the hospital"

(Governor)

Some governors felt that their professional careers have something to offer the hospital.

"I've been in industry, I knew reasonably well, so I wasn't frightened or afraid of what the industry was about."

(Governor)

"I have a certain amount of knowledge of business generally and how things operate and should operate and what's it for in terms of health, safety, targets, all those sorts of things, so I suppose I can bring my knowledge to bear and ask the necessary questions of the Board"

(Governor)

One felt that he or she worked in a related industry.

"I thought there were parallels between running [name of industry] and running hospitals. I don't know anything particular about the National Health, but they're both 24 hour operations and have similar sorts of issues"

(Governor)

Some governors had already been involved with the hospital and had a history of volunteering and involvement in the community.

"I have worked at the hospital here as a volunteer"

(Governor)

Governors often stated that they took pride in being associated with the hospital.

"I feel very proud of the hospital and very pleased to be part of it and part of its management structure and I get a terrific personal buzz out of sitting on the Council"

(Governor)

4.3.6 Relationship between governors and members

In the FTs in the study, public governors were elected by geographical constituencies of members. But it was not clear the extent to which they were able to carry out their roles in a similar manner to local authority councillors, who represent the people of their area. The Code of Governance for FTs states that governors are responsible for regularly feeding back about the FT to their constituencies; a potentially challenging task without a substantial infrastructure.

"I think there is a degree of confusion as to what is the role of governors and membership council because membership council is in our Trust they are people who are subject to an electoral process, do they represent their constituency, do they represent their own views?"

(Governor)

The FTs in fact took the line of collective representation; although governors were elected on a geographical basis, they did not perceive that the governors' role to be representative of constituents but of the community as a whole. One reason for adopting this line in one of the FTs was to prevent sectional geographical interests from dominating debates. As one executive expressed,

"As a collective you are representative of our populations. Therefore, yes you are accountable to them, but to them again collectively rather than to individual constituencies"

(Executive)

Some governors tried to link into other local democratic forums such as the area forums, but these were often poorly attended themselves. In one FT, in recognition of the need to relate to local communities, the Chair had suggested that some of the meetings will be held in local areas, chaired by the local Governors.

Some governors saw the link with local members as the least developed part of their role.

"I think that the other bit is – and this is one that's not yet fully developed in my own mind, and probably isn't in the minds of other people, it's associated with exploring ways of working... Better ways of working, so instead of just simply recruited membership......which is a central part of how Trusts are meant to facilitate this communication. It's not simply having members and, like, groups of members, it's about engaging those members in forms of discussion, which enable it to feel – the local population to feel that it's their local hospital and that they've got a local stake in it. You have to allow the Trust Board to do its job, and Executives to work with that Trust Board, but equally you have to find ways of engaging the public so that they can play a part and reduce risks. Enable the Trust to avoid problems, but also to conduct work which really does fit with the nature of the local population."

(Governor)

Nevertheless, we observed many types of informal links between governors and the local community. These included attending community days, fairs, stalls at bus stations, visits to local government community fora, a university open day and a specific youth project in one FT. In another FT, strong links had been developed between the governors and the local churches.

Legitimacy: representing the hospital to outsiders

All the FTs in the study could see the potential for using the membership and governors to enhance their local reputations and power base.

"We see the Governors as a very, very positive force for the hospital"

(Executive)

Governors could also counter negative allegations made by hostile local press.

The closer links between the FT and the community caused by having members and governors could also be helpful in supporting the hospital against other local NHS organisations. Some of the FTs considered their new representative structure was useful as a strategic weapon. It served to legitimate the activities of the board and the trust.

"They are seen as a very important strategic weapon...the governors and their influence into the community, is really, really key"

(Executive)

The FTs in the study reported that having a membership gave them more confidence in their negotiations with other health care agencies.

"It's kind of odd because you're having these discussions with the PCTs about… we're the ones who have patient and public representatives"

(Executive)

PCTs also acknowledged the potential for a 'representative' FT to get the better of a PCT without members. As one commissioner reported,

"If the PCTs decide to decommission certain services for what might be very good clinical reasons and the Foundation Trusts use their membership as a sort of cohort of people to argue strongly against that, it will be interesting to see that tested"

(PCT Executive)

The governors themselves also saw this part of their role as important.

"I think the second bit though is to be a translator sometimes of what the Trust is trying to do. And Trusts are very keen to involve Governors in that, almost could be too keen on occasions, because whilst there are ways in which the Trust promulgate their initiatives and their plans and their efforts and their excellence, in the case of [X] Hospital, it's felt that if you have people who are closely connected to the lay members of the public, they too can interpret or translate some of the work that's been done, designed to help the local population. But there is definitely, I think, a translator, interpreter, facilitator type function for the Governor."

(Governor)

Interestingly, some of the PCTs were also interested in the local accountability role of the FTs' governors. Having reported his/her concerns about FTs becoming too focused on financial success and insufficiently focused on the adequate provision of services within the local area, one senior PCT official pointed out that the governors could do more to hold the FT to account to the local community.

"I think they could do an awful lot more. I don't think they make the most of it"

(PCT Executive)

The governors could more aggressively represent the health needs of the community to the FT.

"I would be saying…this is our hospital, it's got a lot of money…why aren't we doing much more in a, kind of, health and wellbeing way, as opposed to just, sort of, treating and generating surplus way?"

(PCT Executive)

This comment by the PCT Executive can be seen as illustrating the lack of clarity in government policy concerning the respective purposes of the several organs of public representation currently in existence.

4.3.7 Holding the hospital to account

At all the FTs in the study, relationships between the governors and the boards of directors were still developing and maturing. The executives were tending to use the governors as consultative bodies to check the validity of their strategic plans for the hospital, rather than let the governors direct the affairs of the board. Governors considered themselves as 'having

something to offer' the FTs and were also 'feeling their way' with regard to their roles. Some were more content than others about the roles they were playing.

One of the key roles of the governors of an FT is meant to be holding the hospital board of directors to account on behalf of local people. As one governor explained,

"To be a critical friend of the hospital...so that they will reflect on the processes of the organisation and what it's doing, not an assessment on this occasion, but in the delivery of healthcare, and offer wise counsel about that. Now, there are clearly other people who do that. There are people who are non-Executive Governors [sic] who are on the Trust Board, who have a financial and legal liability about this, but I'm being a critical friend about processes as seen from how I imagine the local population, if you like, my constituents' experience, the hospital and its initiatives and projects. In a sense I think that's what Monitor requires so, if you like, we're checking the balance, and the critical friendship role has – you've got to be honest enough and robust enough with the Trust Board and its team to conduct that role properly... You do have to try and find ways of asking questions which are constructive, and which I think Monitor expect us to interrogate in a constructive way that work with the Trust, so that's bit one."

(Governor)

And indeed, some of the executives of the FTs in the study stated that they did receive this sort of scrutiny from their councils of governors.

"It means I'm accountable to another set of stakeholders"

(Executive)

In two of the FTs, the governors were developing a strong voice and were becoming more active in understanding what was being presented to them. They were keen to explore a more independent approach and were becoming more confident in questioning directors at meetings, using the material provided.

FT Directors saw the responsibility to governors as an important reminder of their wider responsibility to patients and members. The addition of governors and their connection with FT Directors was thought to be a sign of a good organisation, one in which directors were aware of what their members, and patients were thinking.

"That has been a really big change, so we're much more aware of the membership of the local community. That has been a really positive thing. I think it's probably one of the best things that's come out of it"

(Executive)

The Directors felt more confident about what they were planning to do after consulting the members

"If we have consulted members at the constituency meetings and asked them what they think about things and we've got the answer, it does ...give us more confidence"

(Executive)

There were very mixed views from the governors themselves about the extent to which they are actually able to hold the board of directors of their FT to account, however.

Some governors were impressed with the amount of power they were given in the role:

"I had the impression that the Members' Council was probably a... body with... very limited and vague powers... It's a bit more than that"

(Governor)

And another stated that,

"It's a more important and powerful body than I imagined before I got involved"

(Governor)

One governor was keen to point out how the members' council could operate.

"You can act as a sounding board I suppose for the Board, and you can also ask some questions and make sure that things are being attended to"

(Governor)

Many governors we interviewed recognised the knowledge gap between themselves and the FT's directors which limited to the direct role that governors could play in the FT.

"If we feel that the hospital is making an unwise investment...[we] ask a few questions and make them...reconsider or whatever, but I don't think we are knowledgeable enough to know what is going on elsewhere"

(Governor)

Several governors whom we interviewed were concerned that they were not able to hold the board to account properly.

One issue raised in several of the FTs in the study was that the governors were excluded from board meetings, and did not get access to board papers. One interviewee was very concerned about this.

"But because members of the public and governors are excluded from Board meetings you can't possibly judge whether a Non-Exec is doing his job and they only have half a view of how well the Chairman is doing and I do think he's doing a good job but it is a very poor governance structure and I really, really think that the governors themselves are being presented with a sanitized view of decisions and effectively don't have much of a role in running the hospital.

Interviewer: So, what – would giving the Governors access to more meetings, would that help their role or, what would you – how would you make the – how would you beef up the Governors?

Well, how? I would, at a stroke, ensure that they had the right to attend the Board meeting and see the documentation that supports because in PPI days that's what I used to do and that meant that anything that the hospital said you were actually prepared; you had information to express a view. I mean, at the moment [laughs] the Council of Governors – the Governors just have to accept what the hospital say 'cause they have no information history,

haven't seen or heard the debate so how can they possibly be involved and too easily, if any of them express a view, it's dismissed as being, "Well, that's interesting, but actually that's not what our research has shown."

(Links representative)

Secondly, several governors stated that items were not presented to or discussed in sufficient detail at members' council meetings for governors to feel that they were actually contributing to decision making. All initiatives came from the directors.

"Pretty much my own experience thus far has been to seek our approval for what appear to be decisions that have mainly been taken"

(Governor)

One governor noted that she/he was allowed to participate, in private, in some discussions about how the surplus of the FT was to be used, but that s/he felt that the decision had already been made by the directors.

Several governors stated that they were disappointed by the lack of influence they had over the FT.

"But of course we are not involved in the day-to-day administration of a hospital and that was specifically stated in our role …for those – because a lot of people, I think, who stood for election thought that they were going to be able to influence things in a far greater way than they were."

(Governor)

The staff in the study FTs also had mixed views of the influence of members and governors.

"It's certainly made a difference being in an FT…We've got responsibilities to our community, to the members…extra things that we never had before

(Service Manager)

Some staff saw governors as able to provide alternative forms of knowledge and as useful source of contacts in the community. As one Executive reported,

"It's a mixture of their knowledges, their experiences, their links with other communities. So there's one person on the Members' Council who I found particularly helpful who's had a career in nursing and so she understands the area, and she now works a lot with voluntary bodies."

(Executive)

Some staff were unaware of the council of member's relative strength or relationship to the Executive.

"I have no sense of how influential they are… I just genuinely don't know"

(Service Manager)

4.3.8 Developing roles for governors

The FTs in the study were aware of the difficulties in finding the appropriate role for governors, and were trying to improve matters. The FTs in the study gave considerable thought to how to use their governors appropriately. In some of the FTs, this was working well. At trusts that have been FTs for some years, governors have been engaged in various tasks: they were used on interview panels to appoint individual non-executive members of the board; they attended professional networking bodies; and they had the opportunity to 'shadow' clinical staff around the hospital. At all the FTs, however, the governors were discouraged from championing the causes of individual patients.

The national organisation, the Foundation Trust Network was an effective way of bringing together governors from the FTs in the study with a wider group of governors to allow them learn from each other. This was particularly useful as neither Monitor nor the DH gave any detailed guidance about how local representative structures should develop.

The chair of one of the FTs explained his approach involved discussing fewer items at council meetings.

"Well, I think that when I first came here, there was still quite a lot of apprehension, you know, on both sides and a relative lack of understanding, in fact, actually of what the respective roles and responsibilities were.... We're in the process of evolving a much more specific modus vivendi, in fact, actually for the Council of Governors and I think in the future we will have a number of things which they will find will make life much more satisfactory. So, for example, I have recommended that we have a small group of the governing council, which is responsible for setting the agenda. ....I think that there's been a sort of feeling that if you don't do that, that they are very much being preached at... i.e. they are the ending of the line, so to speak, so we had better just tell them that, you know, and usually produce major paper overload, in fact. And I think that that's inappropriate. So we're trying to, you know, get better agendas. Have meetings where the focus, in fact, is much clearer, on specific issues."

(Chair)

One way of improving the use of governors was to devolve more responsibility to them.

"One of the most successful groups they've set up is the Membership Development and Communication Strategies Sub Group, which, up until now, I have chaired, but we've now agreed that one of the Members' Council will chair it, which is fantastic"

(Executive)

The FTs had all noted the large amount of resources and administrative work necessary to the support of the governors' council and the membership. One of the FTs estimated a cost of £4 per member per year. The governors themselves recognised that they placed a strain upon the administrative resources of the FT.

"I think it's just a question of getting the right balance between how much the Governors get involved with the hospital... and is that time worth spending"

At some of the FTs in the study, there was some concern that the Governors councils might be large. The size might dilute its effectiveness and increase administrative and management burdens in accommodating its needs.

"You can never actually get down to the nitty gritty, awful word, of what's going on at a Governors' meeting, 'cause there are so many people there"

(Governor)

A smaller council might enable the governors to achieve consensus and consider the issues in more detail. The role of the Chairman is also important in gaining the confidence of the Governors and ensuring their ability to contribute in a satisfying way.

"We've got an excellent Chairman, who I'm very impressed that he seems to know everybody's name already and he's only been in the chair since November"

(Governor)

4.3.9 Relationship with other PPI mechanisms

As discussed in chapter two, there are several other ways in which patients' and the public's views are represented at local level, in addition to the membership and governors of FTs. In our study sites, some aspects of patient and public representation were dovetailed together well. But there also seemed to be some lack of coordination between the different organisations, partly due to a lack of mutual knowledge.

In one of the FTs in the study, some of the governors were also members of the local LINk. They had a long history of involvement locally. Here, the report from the PALS was also presented to the governors' meeting. At another of the study FTs, the same person was running the PALS and also looking at recruitment of members. One of the FTs also pointed out that using FT members for consultation was far wider ranging than using the former user group at the hospital – there were 12 people in the user group, and nine thousand members.

But not all the governors were so well informed about the other local mechanisms. In one FT, several governors were only vaguely aware of the LINk, but this was not entirely surprising, as it was in the early stages of development. Of more concern was that the governor of that FT who chaired the patient experience committee was not sure of the role of the LINk, and was only being given a short version of its report. Some of the FTs had taken steps to make links with their local LINk and run workshops to try to agree the boundaries between the LINK and the membership council, but the relationships were at a very tentative stage, probably due to the recent establishment of the LINks. For their part, the LINks appeared

to be more focused on their relationships with the PCT, in an attempt to influence commissioning decisions, rather than the local FT.

One of the local authority officers involved with the LINk was concerned that there could be duplication between the LINk and the membership structures of the FT.

"It's a difficult one 'cause I think, in some ways, the LINK does duplicate. I mean, and certainly our elected members would say, "Excuse me, you know, we represent local community and we hear from our residents about services that are happening locally, so what could the LINK tell us that's different to that?" And, you know, and again, as I said earlier, you know, the Health Service and Social Care have both had – and increased their user involvement tremendously in recent years so they're saying "Well, we're already talking to users so what"

(LINk representative)

A clinician in one of the FTs reported that he had better ways of getting into contact with patient representatives. He had direct contact with his local Diabetes UK group.

"The other patient that we have, which I don't know if that counts, but the voluntary organisation that looks at diabetes is Diabetes UK, so I go and talk to the Diabetes UK local group once or twice a year, so I hear what they want. it's not the LINks Group. But that's talking to patients themselves, getting their view. But PALS I am reactive to, rather than proactive with.

Interviewer: What about LINks, you...?

I've heard of it, but don't get involved with it. I don't know what it is."

(Clinician)

In one of the study sites, an Overview and Scrutiny committee member was not impressed by the FT governors' role, compared to the role of an elected local authority committee.

"And since the Council of Members is only – is not an actually a decision-making body, it is a body to influence as opposed to have real power it's – it doesn't bring democratic accountability to the FT."

This person was also concerned that s/he had no access to board papers since the hospital had become an FT.

4.3.10   Conclusion

While in three of the four FTs, there were memberships of under 13,000 each, the representative structures of the FTs in the study still involved significant costs to run. 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. The FTs' directors reported feeling more confident in 'acting strategically and tactically' with the addition of the membership. In joining the FTs' representative structures, governors felt a sense of duty to the hospital along with pride in it. Having an 'axe to grind' or desire to represent part of the community aggressively was not a primary

motivation. The relationships between the governors and the FTs were still developing, and not all of the governors felt they were able to carry out their role of holding the FT to account, while in other locations they felt they had a direct relationship with the board.

4.4 Issues specific to FTs – relationship with local organisations

4.4.1 Introduction

Having discussed in the previous section of this chapter how the FTs in the study used the new FT mechanisms to be responsive to their local populations, this section will discuss how becoming an FT affected their relationships with local NHS organisations, including other providers and PCTs.

This section will show that elevation to FT status did affect the FTs' relationships with other health care agencies. As reported earlier in this chapter, 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. They were also more likely to want to expand the services they provided, to the detriment of other trusts. But this section will demonstrate that 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. They were aware that they needed to maintain good relationships with local organisations both for the sake of achieving good patient care and in order to make sure they were on good terms with the PCT, which was the main source of their income.

4.4.2 Relationships with other providers

Other hospitals

It was pointed out to us that local hospitals were in competition with each other irrespective of whether they were FTs or not. (The discussion of the effects of Payment by Results on all NHS hospitals in the following section of this chapter will enlarge on this.) Nevertheless, elevation to FT status had made FTs more conscious of their identity and more concerned to compete as individual agencies. There was some fear that competition would become intensified as more NHS Trusts became FTs. But there was also evidence in our case studies that the FTs were still co-operating with other hospitals in respect of issues which would improve patient care.

It was clear that FTs did not want to lose any income.

"there's a very real sense of… trying to hold onto that activity"

(PCT Executive)

One PCT executive felt that the delivery of health care within the local area had become much more competitive.

"no doubt about it…the feeling is much more competitive"

(PCT Executive)

Some of the FTs were acutely conscious of local competitors seeking to acquire elements of their business.

"[name of trust] wants to cherry pick bits of our services"

(Executive)

It was reported to us that other Trusts were actively attempting to poach their services. This practice could involve treating an FT's clinicians to dinner, and quite crudely, attempting to convince them they would be better off elsewhere and that they should move to another Trust. This could be a serious source of friction in relations between Trusts.

Some of the FTs reported that their local competitors were keen to trumpet the quality of their staff, to the detriment of the FT's reputation.

"They think they're the only people who are excellent and tell everybody"

(Executive)

On the other hand, one of the FTs reported a strong collegial sense between clinicians across organisational boundaries.

Some of the FTs had also shown an interest in 'acquiring' smaller and managerially vulnerable NHS Trusts in the local area. But these mergers required much negotiation and it had to be clear that mutual advantage would result from the merger. Thus, the FTs were not prepared to go ahead unless circumstances were right. Referring to one prospective takeover, which had taken up a large amount of effort to investigate, but had ultimately not gone ahead, an Executive said,

"both Boards reached the conclusion that now was not the right time."

(Executive)

Some of the other FTs in the study also referred to occasions when the local hospitals were planning to divide up specialist services in such a way that each hospital could focus on their particular area of expertise, rather than providing a small amount of each service. Thus, mergers and collaboration were also occurring, as well as clear examples of competition.

The FTs' behaviour in relation to other local hospitals demonstrates how they were thinking strategically about service developments, and what work was worth taking on. One of the FTs pointed out that it was not

always advantageous to them to take on work, in which case a partnership with other hospitals would be preferable.

"So, we're flexible in that we can go one of two ways, we can be very competitive if we feel there's something in that for us, but we can also be more passive if you like in terms of developing that partnership. And so, what we don't do is we don't try to crush the competition or run them out of town, but also, we're not in the business of giving away some of the services that we deliver."

(Chair of FT)

This tension between competing and collaborating was also seen in another example of developing pathways of care between hospitals.

"But again we've said we're not in competition if you like with [X hospital], we work very collaboratively with them and we do have a strategic alliance in the way we deliver services between ourselves, so at the end of the day we wouldn't necessarily see ourselves going to [local area] to do that if its natural constituency for [X hospital. But if it's a service that they're not delivering then, after discussions with them, then we'd be prepared to go out and deliver that."

(Executive)

Another theme which came up in interviews with the FTs in the study was that their relations with other NHS Trusts locally were sometimes characterised by 'envy' because the non FTs in the area did not have the same degree of autonomy. The FTs saw this as stemming from the fact that they were better performers in any event.

"I would say 'envy' is probably the word....The fact of the matter is they haven't got the same status and the same freedoms, 'cause they're not as good a hospital.... they have not performed to the level that you need to be to get there"

(Executive)

Some of the executives in the FTs believed that other organisations did not like to see the FTs succeed.

"no-one likes success in the NHS...if you make a surplus....people view you with some degree of suspicion....we're ripping people off somehow"

(Executive)

On the other hand, not everything was better for FTs. One clinical director reflected on the fact that his FT was not able to refuse referrals, even when the hospital struggled to meet demand. In contrast, the local NHS Trust had been allowed by the SHA to turn away referrals.

Primary Care

In the same way that factors other than FT status affected the relationships between local hospitals, there were general NHS wide factors that affected the relationships between the FTs in the study and primary care providers. But it is likely that the increased focus on maintaining and increasing income for the FTs had exacerbated the tensions with primary care in some

respects. But it should be noted that, as reported earlier in this chapter, at the same time there were commercial factors encouraging the FTs to market their services to GPs and to maintain good relationships with them.

In addition to the effects of Payment by Results, one of the factors affecting the relationship between FTs and GPs was the Quality and Outcomes Framework (QOF). QOF is the contractual framework under which GPs are remunerated. It was reported to us that the incentives in QOF made GPs more interested in providing some of the care for people with diabetes themselves. While clinicians did not necessarily think this was a bad idea, FT managers were concerned not to lose income for the FT. One clinician explained how the dynamics worked for diabetes.

"Yes, I think that there are huge issues around Payment by Results, and I think that it, kind of, sets one group up against another. I think generally in terms of diabetes, which is a very good example of this, the numbers of people with diabetes are increasing hugely and we cannot possibly continue in the way that we are providing care at the moment. So we've got to be quite organised and structured, and I think that GPs will and do take on a lot of diabetes care, and screening, and monitoring, particularly as they get paid for it through their QOF points...I think a great amount of care can happen in the community for diabetes, but I think that there will always be patients who will be admitted to our wards, who are very, very ill, who are very, very complicated, that will need to be seen by a specialist team of people. So I don't – I think that we have to be careful that we don't dismantle what we've got, but we enhance what we've got so we provide a better service, and obviously most of that service will be in Primary Care, but I don't see it as a threat to me because I quite happily work in Primary Care; it doesn't matter to me, but I do think that the needs for inpatients will be assessed more than they have been, because we will be more focused. So I see it as an opportunity rather than a loss, but I think some people do see it the other way.

(Clinician)

The other issue which was raised was the possibly unhelpful effect of practice based commissioning (PBC) on relationships between FTs and their local GPs. (PBC will be discussed in the next section of this chapter.) One PCT executive was concerned that the FTs had become less eager to co-operate with GPs because they were concerned that the GPs would use PBC to reduce the amount of work done by the hospital, thus reducing its income. S/he also pointed out the difficulty of managing the tensions in the system caused by policies creating opposing incentives.

"Practice based commissioning is a nightmare. One, is that we're a bit behind with it and, secondly, because the governance structures actually run counter to some of the governance structures which are in the hospital Trust arena, particularly the FT arena and there's no real incentive for FT Trusts to engage with GPs. In fact, there tends to be a bit of a wall between GPs and FT Trusts just because GPs as they encroach, as practice based commissioning would encourage them to do so on some of the minor operational stuff, which, normally speaking, you would expect hospitals to want to get rid of, then the hospitals tend to start getting a bit precious about their use of their consultants' time to attend these sort of GP clinics and, in fact, in our case, have specifically said, under... over my dead body will these consultants help these GPs.

"Interviewer: I see. So, it... I get the impression that it's not working in a direction that... Well, it was intended to work in is...

No. Well, it won't. At the one end of the system you've got FTs and so forth driven by PBR and supply led demand but the other end of the scale which I know encouraged GPs to manage demand locally and reduce the entrance to acute Trusts. Those two things are completely opposite and immediate tension in the system. We're trying to do… we're trying to reconcile two completely opposite things."

(PCT executive)

4.4.3 Relationships with PCTs

The FTs and other participants in our study did not report that becoming an FT had made their relationship with the local PCT or PCTs much worse. On the whole, the tenor of the relationship prior to elevation to FT status was maintained. But some changes had been noted. These concerned the effects mentioned earlier in this chapter of the FTs being more conscious of the need to maintain and increase their incomes.

One of the commissioners noted that change in status to FT had not made it more difficult for the PCT to carry out its plans.

"Interviewer: Have you noticed any changes in the way hospital services are delivered, say, in relation to things like Diabetes and Orthopaedics since the arrival of FTs? Has more care been pushed out into the community sector or is more work being retained within hospitals?

I don't think I can answer that. I mean, we certainly – I've not really noticed any – I don't think FTs had any influence or change on that to be honest. I think where we have wanted to move services out into the community we've been able to do so. You know, we've been able to – we've had no problem negotiating contracts with the Foundation Trusts which are certainly along the lines of any other Non-Foundation Trust that we negotiate contracts with. You know, I just – I don't think the FT status has had any impact on that kind of thing."

(PCT Executive)

Interestingly, this person went on to say that the reason for the lack of change in the relationship with the FT was due to the fact that it had many competitors locally, so that it could not afford to damage its relationship with the PCT. So it was market factors, rather than FT status which had an effect on the relationships locally.

One of the FT executives pointed out that they had to maintain a good relationship with the local PCT not only to ensure income for the FT, but also because the FT understood itself as part of the local health system. They did not want to undermine the local NHS

"I mean, there's clearly ways we could make more money if we didn't have to work collaboratively with Primary Care but I'm not sure that that would be in the best interests of the Health Service or of the nation….So I think it's reasonable that, you know, there should be balance. Commissioners have commissioning tools and I, you know, I think that's a good thing. I think having a strong Commissioner is really important because you can then have good robust challenge where you should but you can also have really good collaborative working and good support for, kind of, agreed shared priorities and I think we've built a good relationship with [X PCT]. Certainly around commissioning, I think they're – in general, they are very supportive…. I think in terms of our corporate responsibility yes, we're an FT, but our job is providing healthcare and actually that can't be and that shouldn't be, you know, at the

expense of everybody else. It's got – we've got a responsibility, a moral responsibility to be part of the health system."

(Executive)

In general, FTs reported that they engaged with their local PCTs to plan improvements to local services.

"We are talking to our local commissioner, [name], about developing a care of the elderly model, which will have community based geriatricians from either our trust or another trust."

(Executive)

But this collaborative type of relationship with commissioners could go wrong. One of the FTs told us about an occasion when the PCT had drawn on their expertise to develop and plan a new clinical pathway, but that the delivery of that pathway had not then been awarded to the FT. The work was put out to tender and another group of providers were awarded the contract.

In general, the fact that national policy was promoting a greater diversity of types of provider organisation during the period of the research meant that commissioners in some areas were keen to promote competition, rather than simply maintain existing contractual relationships with established local providers.

"From a commissioning point of view part of the work that we are doing is about market management and how we actually encourage there to be a multiplicity of high quality providers so that we have got positive competition, and that patients really do get the very best services. So as a commissioner you would welcome any provider who would be able to provide high quality services. That may be a Foundation Trust, that may be a social enterprise organisation, that may be a private sector organisation or whatever, so the market, managing the market and market development is very much in the foothills at the moment for the NHS."

(PCT Executive)

The other side of this is that FTs saw the relationship with the commissioners differently. The relationship with commissioners could be improved by becoming an FT, as the new sphere of autonomy with respect to other entities within the local healthcare economy could provide appropriate distance. The increase in autonomy allowed the FTs to restructure their relationships with the PCTs to some extent.

"It leads to a more mature relationship….commissioning…is a relatively underdeveloped process, and it stops it being a cosy chat. When they demand that we sign a contract we're going to say, "Well actually no, you know, we're not going to sign up to that, sorry"

(Executive)

Over the period of the study, relationships between those FTs whose the local PCT personnel had changed had improved, as the two sides got to know each other better. But all the FTs and PCTs were still learning how to manage the complex relationship. It proved difficult to link commissioning,

contracting and demand management. What was noticeable was that, by the end of the study period, the national focus on improving quality of care using contractual mechanisms inter alia (Darzi, 2008) had had an effect on the relationships between the FTs and their PCTs. In addition to needing to make the contract work concerning financial issues, there was an increased interest in how the contractual relationship could be used to improve quality.

The FTs reported taking a self interested view of the model NHS contract. They were reluctant to consent to NHS agreements that did not benefit them adequately.

"I think we are more cognisant of our independence. Probably, I think we're more cognisant of it than the PCTs necessarily, so they tend to want us to work to the same timescales and rules as non-Foundation Trusts a lot of the time. So, for instance, recently as part of annual planning they want us to sign up to the Model Contract the Department of Health has published. but we're quite, you know, we know that we are in a slightly different position, so we've been looking at options trying to weigh up whether or not we sign. You know, thinking about taking legal advice about the pros and cons of signing up to the contract and I think we're quite aware that that's different to how NHS Trusts are approaching it, but I'm not sure the PCTs quite yet – they know it, but they don't really act like they know it"

(Executive)

Some FTs reported experiencing frustration when negotiating with the PCT, as it did not have as much autonomy as the FT. In particular, one FT wanted to renegotiate elements of the national contract, but the PCT lacked the authority to negotiate. As one Executive reported,

"Can we just change it?" They look it up in the Guidance, "No, that's red." We're not allowed to change any of that. So you're, kind of, sit there going, this isn't really a negotiation"

(Executive)

As one of the FT executives pointed out,

"In a proper commercial relationships you'd have a real option about whether you sign the contract or not, here you don't."

(Executive)

Some of the FTs expressed the view that the form of the national contract was weighted in favour of commissioners. It laid them open to serious financial penalties if they underperformed, and the PCTs were not able to negotiate changes to these aspects.

The dual nature of the relationship between the FTs and the PCTs is illustrated by the following comments from an FT manager. While collaborative work concerning planning of services locally was still very important, the question of FT income and what the PCT could afford to pay often became difficult.

"You know, on a clinical day to day basis if I'm working with my colleagues in the PCT, I get on with them very well… we've done loads of work with them on developing cardiac services

across primary and secondary care, we're doing the same in diabetes, ... and I think at that level relationships work well, and I actually think overall they work well in terms of there's a healthy discussion and debate... ...But you'll always get into issues about what they pay for and what we charge for so once you get into finance I think the thing becomes more challenging, because it's bound to do, you know, so you know we might say you should be paying for this, and they might say well no it's already in your baseline, you know, so you'll always get a discussion about finance that is challenging."

(Manager)

There were tensions in the relationships between the FTs and PCTs in the study.

The incentive on FTs to increase their income, coupled with autonomy in decision making, had meant that they were not always acting co-operatively with their local PCTs about service developments.

"So, our experience of dealing with our current FT is sometimes contentious. One of the things that they have done is made a large number of service improvements which we haven't actually wanted them to do and that's sort of partly disrupted the local health economy so they've invested, for example, in cardiac techniques so... Which we didn't really want them to do. So, they initiate improvements sometimes without asking us whether that's part of our commissioning intentions."

(PCT Executive)

In circumstances where some PCTs were trying to reduce activity due to projected overspends in the local budget, having an FT as one of the providers was reported as making this task more difficult.

"Well, we've had some very, very strong conversations over the last four months and that's become very transactional and of course because... You know, that there is the issue within FTs of supply driven demand and, you know... We... And this is a sort of constant tension because they are always looking to make money; they are... they are really businesses and it's ludicrous in a cash limited system to have people who are driving businesses for surplus and profit when you've got a cash limited system.

But, they often do that to the detriment of the rest of the health economy and, you know, this is public money, so it's a cash limited system and they're drawing resources out of it in... in a... inequitable manner."

(PCT Executive)

There may not be sufficient demand in a local area for more hospitals to become FTs, but other hospitals might still be trying to achieve this status. This had the effect of driving up the volumes of activity beyond the budget of the local PCT.

"There is a finite number of Foundation Trusts that you can have, which will operate successfully, certainly the size of ours, I don't think that you could support more than two Foundation Trusts. Because there's just not enough catchment area"

(Executive)

Another commissioner attributed the difficulties in keeping activity to affordable levels to the capacity of the FT to retain a surplus. S/he thought

this power would not be able to continue in increasingly straightened financial circumstances.

"I think, this is again just a very personal view, I don't think that's a tenable proposition after the next election. I just don't think it's going to be acceptable to have large scale reductions in public services and ask the public services sitting on quite big surpluses. So, I think we, yes, we would certainly feel unhappy, uncomfortable about that. But, I just don't think it can exist as we go forward."

(PCT Executive)

One of the FT executives acknowledged that there were concerns at national level about FTs' surpluses.

"There's a constant debate in the Department about whether they pull that back 'cause it's a cash strapped NHS"

(Executive)

The drive for FTs to produce and retain surpluses was making it harder for the PCTs to plan services locally. The fact of becoming an FT made each hospital unwilling to lose income, so that services continued to be duplicated in a small area. As the financial situation becomes worse in the NHS, commissioners feared that as work diminished, they would not be able to get FTs to give up services. One PCT executive feared that in the more competitive healthcare environment, there was a risk that smaller PCTs could be dominated by larger FTs.

"Some of the problems have been is that you had the very small PCTs before big dominant Acute Trusts people, and much more capacity to live and breathe the detail of contract in Acute Trusts than you have in the relatively small PCTs."

(PCT Executive)

And some PCTs reported that FTs can be less transparent than other NHS organisations, indicating a concern that the FTs could be taking advantage of their superior information about services they delivered.

"There is much more transparency with non-FTs around that sort of stuff"

(PCT Executive)

4.4.4 Conclusion

The responses of the commissioners and the FTs themselves indicate that being an FT had made a difference to local relationships. The FTs in the study were acutely aware of their need to retain and increase referrals, in order to maintain and hopefully increase their income. Although this imperative applied to other NHS hospitals too, the FTs were made more competitive and less co-operative by their new requirement to be self reliant. The effect of Payment by Results on the FTs will be discussed in some detail in the next section of this chapter.

On the other hand, one should not over state the changes in local relationships. The FTs still saw themselves as part of the local health economy and recognised that they had obligations to help this work well, not just to pursue their own interests.

4.5 Issues affecting NHS organisations

4.5.1 Introduction

Having discussed issues specific to FTs in the previous section, this section of the results chapter will report on the aspects of NHS wide policies which were found to be important in understanding the behaviour of the FTs in our study. These policies apply to all NHS organisations, not just FTs, and are a vital part of the context in which FTs operate. Chapter two described these policies. This section will report our findings about how these policies affected the four FTs in the study.

The key policy issues affecting all NHS organisations including FTs are national targets (notably the 18 Weeks patient pathway and infection control for MRSA and C.Difficile). Moreover, the market related mechanisms of Payment by Results and Patient Choice (especially the former) have been very influential on the FTs in our study. We also investigated the effects of another market related policy, namely Practice Based Commissioning, but this had not been taken up widely in our study sites and did not seem to have affected FT behaviour.

To recap about the targets, the 18 Weeks patient pathway stipulates that patients must be admitted for treatment within a maximum of 18 weeks from referral by their GP, and those with urgent conditions will be treated much faster. By December 2007, 18 week waiting periods had been successfully achieved across the NHS (DH, 2006b). The infection reduction targets stipulate that both MRSA and C.difficile infections in hospitals must be reduced.

To recap about the market mechanisms, Payment by Results (PbR) is a prospective payment system that provides a national tariff for individual procedures for all acute providers across the NHS. By 2006-07, it covered all elective, all accident and emergency, and all outpatient and emergency admissions, effectively £22 billion worth of services (2007b). Patient Choice gives patients the opportunity to choose where they are referred for hospital treatment. By 2008 patients were able to book outpatient and elective treatment with any provider that met NHS eligibility criteria. Practice Based Commissioning gives GPs an increased role in commissioning local services (DH, 2005). Introduced in April 2005, PBC allows groups of GPs and other community health professionals (such as

nurses) to commission local services for their local communities. At present, however, the policy has not been widely taken up. In any event, whether Practice Based Commissioning was operating or not, GPs are vital to all NHS hospitals (including FTs) because they are the source of patient referrals. Thus the relationship between the hospitals and the GPs is crucial.

This section will demonstrate the important influence that these policies had on the FTs in our study. PbR afforded the FTs the opportunity to increase their income if they increased volumes of patients treated. Depending on their cost structures (which FTs can alter to ensure that their costs are below the national tariff), PbR also provided the opportunity to increase surpluses. It is clear that the FTs were heavily influenced by this incentive. Moreover, the 18 Weeks patient pathway was a target that the FTs were very concerned to meet. In conjunction with PbR, it also gave them the opportunity increase the volume of patients treated and thus to increase their income. Patient Choice offered the FTs the chance to build an additional source of income outside the direct control of PCTs, as patients could choose their hospital. The FTs were concerned to market their services to patients and to take account of their capacity to choose. In principle Practice Based Commissioning (PBC) should have given the FTs the chance to engage with primary care providers and market services with a view to increasing referrals or having new services commissioned, but PBC *per se* was not influential for the FTs in the study. In practice, the FTs understood that their relationship GPs as referrers was very important in any event, and needed to be cultivated to ensure referrals were made.

4.5.2 National targets

The first part of this section will report on the effect of NHS national targets on the FTs in our study.

4.5.3 The 18 Week Patient Pathway

Main issues for the 18 weeks pathway

This national target had a very important influence on the internal organisation and operation of all four FTs. Arguably, this policy has had a greater operational affect on clinical directorates within the FTs than elevation to FT status itself. FT status allows trusts to engage in autonomous business planning and service improvements for the purpose of retaining a surplus. However, so great has been the influence of 18 weeks that clinical directorates have largely suspended business planning and the pursuit of wider service improvements in the interests of meeting the 18 weeks target, which has proved an exacting target.

As a result, while FT Executives were supportive of achieving the18 weeks target, those in clinical directorates were ambivalent about its value. In all the FTs, clinical staff were broadly receptive to a policy that offered a reduction in waiting times, but they also pointed to the anomalies the target produces. Essentially, 18 weeks is an arbitrary target with no relation to the clinical needs of patients. However, it forces clinical decisions to be made on the basis of an 18 week pathway. Thus, 18 weeks was seen by some as a clinical decision made by government. Accordingly, clinicians resented this intrusion into the delivery of care. A patient's condition could not always be treated properly within the specified time window. Sometimes patients were seen and treated inappropriately in order to meet the requirement of a speedier pathway. However, at the Executive Level, all the FTs were supportive of 18 weeks pathway. They were acutely aware of this national target which they were responsible for achieving. Moreover, speeding the patient pathway meant that greater volumes of care were handled by the FTs and there was more income, increasing the potential for growing the surplus. But, as much of the additional income received by the FTs to achieve the 18 weeks target was money ear marked specifically to ensure the target was met ('waiting list money'), it was not recurring income which could be counted on in future years.

In practice, the 18 weeks target had dramatically reshaped the delivery of care in the FTs in the study. It had produced a better mapped and co-ordinated patient journey. All the FTs had appointed specialist project managers to increase co-operation between clinical directorates. Additional volumes of care had led to a series of consequences in the FTs. First, there were additional demands upon clinicians to run more clinics and to perform out of hours theatre work on weekends and in the evenings. Some clinicians were happy to co-operate, others less so. Clinicians suggested that elevation to FT status was supposed to provide better incentives for innovation and service improvements within clinical directorates, however, the only 'incentives' currently on offer related to the delivery of the 18 weeks target. Some of the FTs in the study had spent money on treating their patients in the private sector in order to achieve the 18 weeks target.

Effect of 18 weeks target on internal organisation of the FTs

Managers generally supported having a specific waiting time target, even if much effort was required to meet it.

"I think if there wasn't the 18 week – the peculiar, the specific target, 18 weeks, Service Line Reporting, new to follow-up ratios, Choose and Book, definitely would reduce the Pathway, definitely would, because it would have to. But whether it would hit 18 weeks, who knows? My gut says that in some of the subspecialties, no"

(Service Manager).

The 18 weeks target has consumed the energy of both managers and clinicians to the detriment of some service developments. But there was some fear that successfully achieving the 18 weeks target will only produce more activity in the short run and that, eventually there would be a slow down in activity when pent up demand had been met. For this reason the business manager for orthopaedics in one FT decided to subcontract to a private provider, rather than expand the capacity in the FT itself.

In all FTs, the 18 week patient pathway was the dominant policy drive in all clinical directorates.

"At the moment we are chasing 18 weeks targets- that's putting a huge strain on us"

(Clinician)

As a manager noted:

"18 weeks. Nothing else. Here and now, it's the absolute; it's the number one drive."

(Service Manager)

And it has had a large effect on the delivery of care.

"The speed in which we see people now is nothing to do with being an FT. It's to do with the 18 week wait"

(Service Manager)

Respondents noted that being an FT had not made a difference. The 18 weeks target was an equally challenging policy for all NHS Trusts.

"I think being an FT hasn't made any difference for 18 weeks. I think we'd have found it as difficult and challenging if we weren't an FT"

(Executive)

On the other hand, one manager did think that their FT was more focused on meeting the national targets, due to the dual regulatory effect of Monitor in conjunction with the national target regime run through the Health Care Commission.

I think our reporting regime, where we have to report milestones, etc, to Monitor has meant that we have had to focus on that more than NHS Trusts"

(Executive)

Although the 18 weeks target had caused clinical directorates to delay their business planning, Executives were broadly supportive of the policy.

"Phenomenal change. But we're quite happy with that, because it's better for patients to have 18 weeks"

(Executive)

It was recognised at many levels that FTs have a financial motivation to develop a speedier pathway, as it would enable them to generate larger amounts of income.

"If we actually deliver on the 18 weeks we'll be doing more work and therefore we'll be generating more income. So in fact what we're expecting is that this year the PCT is going to have to fork out a lot more money than they were expecting because of the increased activity to do with 18 weeks"

(Clinician)

The 18 weeks target also required some of the FTs to appoint specialist managers to map the patient journey and link up the various service lines and the various GPs.

"Within the Medicine Directorate, we've got... who is our Performance Manager, and she's very pivotal to the 18 week target, understanding the data, what's coming through"

(Service Manager)

The 18 weeks target has led to large internal changes in the delivery of care in FTs, particularly with regard to diagnostics.

"I mean, the effort for us to hit 18 weeks has been massive and still is.... it's been a fabulous improvement in Diagnostics, people used to wait forever, ludicrous amounts of time, and no-one's waiting for Diagnostics... everything is down to four weeks across the board, and that's a dramatic improvement"

(Executive)

The 18 weeks target has also led to improvements in record keeping and information sharing. It has required them to re-organise their service lines in terms of a better mapped patient journey.

"It has involved the General Managers in the different Directorates, so Medicine, Surgery, reviewing the whole process, in each specialty and seeing where the hold-ups were, and trying to see – to streamline it, and our aim is four weeks to an appointment, four weeks for the diagnostics, and then if there is a surgical procedure required it would be ten weeks"

(Executive)

"We've had to review every speciality within Medicine, to make sure from referral to treatment, patients are going through within 18 weeks."

(Service Manager)

In some specialities, such as endoscopy and neurology, there has been difficulty improving the patient pathway.

"Areas such as Endoscopy and trying to meet the Endoscopy target has been really difficult, trying to get people through that Pathway in 18 weeks"

(Service Manager)

Directorates had made huge efforts to increase capacity within the resources available to them, for example within orthopaedics- extended operating times, increased day surgery, pooling consultant workload, back filling lists and outsourcing to private hospitals. FTs aimed at bringing more work into the Trust; one by renting space from the private sector, another by consideration of bidding for the local ISTC contract when it was tendered.

All these efforts to manage within their means were constrained by lack of theatre time for orthopaedics and other specific difficulties such as cancellations of operations because of lack of availability of anaesthetists. Some FTs managed these demands better than others, but all mentioned the lack of theatre space. As one clinician reported,

"We don't have the theatre space and that's another reason why it has to be outsourced. There is always movement but it is so ponderous, it takes months and months. …it is such a monolithic organisation. If we had more capacity and more different ways of working- if you work in private practice you see an amazing difference in the ways of working.

(Clinician)

Where in one FT, a clinical directorate experienced difficulty with achieving the 18 weeks target, there were two weekly meetings with the CEO to ascertain how they were managing the issue. The visibility of the issue was heightened by the change in Monitor's reporting regime in 2009, which required FTs to report performance by directorates, in addition to as a whole. In one FT, it had achieved its 18 weeks target overall, but the orthopaedics directorate was marked as red. For the directorate's management team, missing targets brought the attention of the executive, which seemed to replicate the experience of FT Boards when they attracted the adverse attention of Monitor. The managers tried to ensure that all staff in the directorate took some responsibility for the situation, thus pushing individual accountability further and further down the FT. As one clinician remarked,

"You get positive feedback very quickly from on high if you do a good job and equally, if you don't get something right, you get someone very senior very quickly on your tail saying, 'Why is this not happening?' Not in a scary way, not threatening.. but offering support. But you can't hide"

(Clinician)

On a less positive note, service managers objected that 18 weeks target can stifle the development of new service lines. All the theatre space is being used to hit the 18 weeks target and new areas of business could not be adequately explored. As one service manager reported.

"We're developing a pace-making insertion service here. But the challenge or complexity is we can't get theatre space. And the difficulty for theatre space is 18 weeks. All the activity is going – has been gobbled, so the theatre sessions for 18 weeks. So then when you get into a dialogue, as I've done with my General Manager and said "Actually, if we develop this service, we'll get a quarter of a million for doing two pacemaker insertions a week, and the ad hoc emergency." A quarter of a million, not to be sneezed at."

(Service Manager)

Service Managers were required to spend large amounts of their time hitting the target and thus lacked the time to use the autonomy that elevation to FT status had given them to develop ideas for new services.

"You really don't have enough time for anything…I'm not sure whether the Executive Team feel that their life has been made easier. I'm sure they don't. I bet they feel that they've had to create their own structures, their own policies, their own processes, so it's just one that's exchanged the other"

(Service Manager)

"At the moment we're trying not to distract them by anything other than delivering the 18 week target, but they are working at the same time in different Directorates and different ways on their business plans"

(Executive)

Managers could also see problems raised by the target. For example, it could lead to patients being 'bullied 'by the hospital.

"Patients, sort of, being bullied into, you know, they say, "Look, I don't want an operation now. I want my operation in the summer, during the holidays when I've got childcare and things like that." The system has got to grow up and learn to be more sensitive to what patients want"

(Executive)

Some managers thought the target should be adjusted locally.

"I think the right balance is to have a National Health Service with national standards that, you know, that everyone should have a standard, whether it's 18 weeks, or ten weeks, or 20 weeks."

(Executive)

Clinical views of the 18 weeks patient pathway

Where Executive Directors were enthusiastic about the 18 weeks target, the clinical directorates are ambivalent about the policy. The 18 weeks target has demanded a large cultural shift in clinical attitudes. But some clinicians are still yet to buy in. As one service manager reported.

"It's the hardest target that I have ever been involved in delivering .I think it's the poorest that's ever been thought through, to be honest…some clinicians still don't think it's anything to do with them"

(Service Manager)

In all the FTs, most members of staff welcomed the 18 weeks target as an admirable attempt to reduce waiting lists, but clinical staff cautioned that it has produced difficulties. Having 18 weeks as a patient pathway was seen as an arbitrary target, without basis in evidence. It could have the effect of forcing faster treatment upon patients who would prefer to defer for treatment to a specific time. At all four FTs, some clinicians are hostile to the 18 weeks target. They considered it an unwarranted intrusion into clinical decision making. Essentially, it threw certain amounts of confusing priorities into the system. Some conditions get better by themselves and do not require intervention. The 18 weeks target forces the hospital to act, to operate. As one clinician informed us,

"I'm not sure that it helps to just bring in arbitrary targets...there are more things that we can do for more people. I think an awful lot of people who are waiting for operations that are perhaps not terribly necessary... this target culture, we are encouraged to rush people through and only see people if they're likely to require an operation

> (Clinician)

And others pointed out the distorting effect the target had on clinical practice.

"It's been decided that you have to have four weeks lead in time at most to the consultation, four weeks to investigate and decide, and then you've got another six weeks to do any operation. So you've got to have completed the episode within 18 weeks...we're seeing inappropriate numbers of patients of the wrong type who would get better anyway, and also they're going to wrong clinics 'cause of the pressure to get them through the system"

> (Clinician)

"Sometimes disease doesn't change fast enough in-between and so you're making a decision based on not that much fact, but otherwise no. Ah, well you try to make an assessment of how bad things are going to be and use your best guess. Stick your finger up in the air and sort of thing, lick it to see where the wind's blowing"

> (Clinician)

Thus, clinicians lost some control of the type and quality of care they delivered, yet they remained responsible if anything went awry.

"We don't have any power as clinicians. We have the responsibility for patient care, delivering it on a one to one basis, and meeting the targets, which are not of our making"

> (Clinician)

The 18 weeks target has also required clinicians to provide additional clinics. Some have agreed to do so.

"I think 18 weeks is a very bad thing, but to help management at the hospital, and as a gesture of goodwill, to help them, because they were very stressed, we said we'd help"

> (Clinician)

"People are being asked to and those who want to have been doing it, so that says, of course, yeah, it has a huge effect"

> (Clinician)

Executives recognised the huge strain that the 18 weeks target has placed on clinical directorates. But, in the main, they approved of the policy. They also stressed that it was not just clinicians who contributed to the delivery of the policy.

"It's clerks and people like that who have been doing seven days a week. You've got to go through every record, because we don't have the information system"

Effects of the 18 weeks patient pathway on commissioning

For their part, PCTs have heavily supported the delivery of the 18 weeks target.

"Just go ahead and treat as much as you need treat basically to get 18 weeks delivered, basically we pumped loads of money, gave [name of trust] what they asked for

(PCT Executive)

PCTs also recognised the conflict between patient choice and the 18 weeks target. Particular specialities can be swamped by patients anxious for treatment. This makes the delivery of the 18 weeks target quite troublesome.

"Patient Choice and 18 weeks...conflict with each other...[name of speciality] a big waiting list there...so either they refuse to take referrals, or how do you build capacity up in an area where there's nobody else that can do it...so choice is that they want to go and see this Consultant, but in reality, you can't go and see that Consultant 'cause you'd have to wait more than 18 weeks.

(PCT Executive)

A combination of the 18 weeks target and PbR has caused PCTs financial difficulties – this will be discussed in the section on PbR below.

4.5.4 Healthcare Associated Infection Targets

The other set of national targets which had effects on the FTs in our study were those concerning levels of healthcare associated infections, specifically MRSA and C. Difficile. These were progressively tightened during the course of the study. Moreover, Monitor became increasingly concerned with these issues during the course of the study, as reported earlier in this chapter in the section concerning autonomy.

In all the FTs, adherence to these targets seemed particularly inflexible and something that Monitor would be concerned about, if it failed. Thus, although all NHS trusts had to adhere to the targets, there was another interested regulator who would intervene in an FT's affairs if it did not succeed.

"We have reduced our MRSA rate significantly over the last four years, so we've sort of gone from something like 70 cases a year down to 60 cases a year, then last year it was 47 cases, and we're on trajectory at the moment for no more than 25, something like that, so if you drew a graph this would be a, but Monitor's target for us is 22 cases, and he's threatened that if we don't reach 22 then we will be all mightily bollocked, even though there will be this tremendous improvement, so it just feels that there isn't any give and take there, that there's no compromise, there's no respect for what is being done, it's just this very stern position that we're expected, stern position that is taken"

(Clinician)

Some clinicians described infection targets as a key driver within FTs.

"From the Department of Health and Monitor, the Trust, infection control is a big, big issue ... you know, a number of Trusts, or Trust Management, Trust Managers may stand or fold by how they get on with infection control".

(Clinician)

In the FTs in the study where the infection targets were met, there was no intervention by Monitor and the issue was similar to that of the 18 week patient pathway – something that all NHS trusts had to achieve. FTs tended to discuss these in conjunction with other targets.

"The government say this is what's driven the NHS forward, the four hour wait in casualty, the 18 week wait for treatment, the cancer targets, the infection control targets, and you know, they would possibly justifiably say this is what's made things better, but it creates some very strange drivers in the hospital".

(Clinician)

At team meetings in some of the FTs details of MRSA and C Difficile cases within the directorate were discussed. The aim was to get the root cause of infection involved following up and reporting back to the board in a timely fashion.

"There is a very good system within the organisation here, because obviously it's top of everybody's agenda, and we are informed by control of infection as soon as a result comes up from the lab that we've got an MRSA bacteraemia"

(Service Manager)

Most FTs in the study were developing uniform reporting measures. Some were using minutes of meetings to provide a structured accountability framework, which enabled them to account to the regulators. As one manager reported,

"When the HCC first came in, what they were critical about, certainly with infection control, was the evidence that they could pick up through board minutes and ward minutes about what's the message from the top about infection control, how's that getting translated at ward level"

(Service Manager)

But there were concerns among staff that there was a potential conflict if one tried to meet all the targets simultaneously. As once clinician indicated, the emphasis was on

"quality as long as it does not interfere with volume and you can hit your 18 week targets"

(Clinician)

Others doubted their capacity to provide a good service under the regime.

"People want to provide a good service but don't feel able to because they have to get that patient out because the next one is waiting to come in.

(Manager)

Broadly, there was support for targets, but criticism of the way targets were measured and calculated.

I don't have problems with targets...but if you are going to have a target, it has got to be a target which everyone understands and where the point of that target is absolutely clear...[...] If you're setting targets you have to understand a lot more about what you are doing and most of the people who are setting targets have no idea what they're doing

Many FT staff recognized that the public judged the hospital by its health care associated infection rates, whether this was fair or not, and thus they had to make sure the rates were low.

4.5.5 Market mechanisms

Payment by results: main issues

The national tariff system of prospective payment, Payment by Results (PbR), applies to all NHS acute trusts, including FTs, although it was introduced more quickly into FTs than other trusts. PbR creates an incentive on all providers to carry out higher volumes of activity, as they are remunerated on a cost per case basis. This can cause tensions with PCT purchasers, who have a limited budget with which to pay all the providers in their health economy.

The national tariff, fixed at average price also creates an incentive to reduce costs. One way of reducing costs is to discharge patients as early as possible. There are services lines in our study FTs in which it was reported to us that this was occurring. This has created concern among clinicians about the quality of care provided and the relationship between the patient and consultant.

However, one can surmise that PbR would have a greater effect on FTs. This is because FTs are able to retain the surpluses they generate, unlike other NHS Trusts. (And we know from the data about the four FTs in the study, reported earlier, that each of them has indeed made profits.)

A general effect of PbR is to increase the need for accurate coding of procedures within trusts to ensure that all income is recovered from PCTs. As FTs were early adopters of PbR, this contributed to them seeming more 'business like', as discussed earlier in this chapter.

Cost reducing effects of PbR

As explained above, for all NHS trusts, PbR offers an incentive to reduce the cost of the episode to below the tariff. The FTs in our study reported that one major way they used to reduce their costs was by shortening the patient pathway and only admitting patients to wards where necessary. All the FTs in the study aimed to discharge patients as early as possible and have them treated in outpatients or primary care, or even in community health care.

We do look at it more as a business...we try not to admit patients, if we can help it... that's a big saving to the Trust

(Clinician)

The incentive to discharge patients early creates tension. Some clinicians were concerned that under the system of PbR patients might receive poorer quality of care by being discharged too soon. As one clinician suggested,

"Payment by Results will diminish patient care, because I'm under pressure not to follow my patients until they're all right. So the emphasis is to see and treat, discharge the patient"

(Clinician)

Some clinicians were also concerned that the relationship between the patient and the consultant might be damaged by the patients' knowledge of this incentive on the hospital. As another clinician suggested,

"When you come to clinic, you see me or my colleague, and usually you'll see one of us. And then there's the confidence building, the trust. The number of patients who fall out of that trust loop are going to shoot up with the Foundation Trust

(Clinician)

However, other clinicians felt that reducing the patient pathway and working with primary care providers has the effect of better tailoring the FTs services towards patients. For example,

" unless we can discharge our patients, and unless we can design the care that we're going to provide in a better way and a more timely way....we're just going to be swamped with patients who are not really appropriate for our service"

(Clinician)

Equally, some clinicians also saw reducing costs and generating a surplus through PbR as essential to the development and wider viability of their clinical directorate.

"Particularly if we can get our hands on some of the income that comes in then we could be able to use that money to invest in the Directorate"

(Clinician)

Some clinicians even suggested that PbR had the capacity to make 'quality of service' the key element of competition between providers.

"if you're in financial balance or making a surplus... ...competition isn't a big deal. However, over time, I think it will change...competition will come to the forefront, and.....the focus on quality is the right one, 'cause it's not price anymore. 'Cause the commissioner pays broadly the same price....whether the service is bought here or down the road. It's about quality of service that will distinguish whether someone thrives or dies in the marketplace

(Clinician)

Although PbR is a national policy applying to all providers, another reason why FTs are likely to be more sensitive to its effects is service line reporting. This is a method of costing which Monitor has encouraged FTs to adopt. It involves generating income and expenditure accounts at the level of each directorate (or lower), so that the FT and each unit itself is able to judge whether it is profitable. Coupled with PbR, service line reporting

allows FTs to calculate which area is generating a surplus and to plan which areas to expand or contract accordingly.

"I hope, all would [clinical directorates] say that they understood why it's necessary for them to make a surplus...because we're now in a much more competitive environment, and that's nothing to do with being...a Foundation Trust.....Now, as an FT, we believe we're better positioned to actually defend, you know, to come up with...responses to that"

(Executive)

However, in all the FTs in the study, there was some doubt regarding which clinical directorates were the most profitable. Informants in the FTs suggested that they would not be able to assess accurately the leading service lines for some time, until the tariff 'settles down'. As one financial manager suggested,

"Whether they're profitable or loss making....that has to be a function of the tariff, to a certain extent.... we know there are certain specialties...which don't get, sort of, funded. So their position is...driven that way. So I think it's going to take quite a few years...."

(Executive)

Thus, adjustments to the PbR tariff were seen as responsible for producing much of the hospital's surplus. Nevertheless, over time, senior staff in the FTs hoped to use their flexibility and freedom to develop their services in such a ways as to generate increased revenue. (This issue was discussed earlier in this chapter.)

"The flexibility and freedom to invest will enable us to be a bit more fleet of foot and to make sure we are investing in the services that do generate revenue and a slightly more businesslike approach should help us to push that"

(Executive)

Traditionally, NHS coders have not been highly salaried. One manager drew our attention to the United States, where coding managers are enjoy a much more prominent role in the hospital, and stated how s/he could appreciate their value. Moreover, some clinicians were beginning to see the value of careful coding and recording in order to recover income fully, and were trying to ensure all co-morbidities should be recorded.

"I was in the States visiting a hospital, and the second person after the Chief Executive that I met was the coder......Coding Manager and I was really surprised, coming from the UK, yet now......I totally understand, because you have to make sure that your income is reflective of what you've done."

(Service Manager)

PbR and relationships with PCTs

Some of the effects of PbR on the relationships between providers and PCTs apply across the board to all NHS providers. However, some of these effects are exacerbated for FTs, due to their capacity and willingness to retain a surplus.

The point of PbR is that hospitals should be paid for every episode of care undertaken. However, PCTs have a limited budget and cannot pay out for vastly increased volumes of activity. PbR has not eliminated the need for negotiations between commissioners and providers. Under PbR, they dispute different things than previously. Price is not negotiable, but volumes of care, and how they are coded must be monitored. In our study sites, there was a concern from PCTs that that providers might 'rip off' the commissioners by up coding services. As one Executive suggested

"there's definitely this perception that we're – FTs are ripping people off by up-coding ….people probably thought great, you know, there's a nice solid coding structure here and we know everything and all we've got to do is put a price against it and it'll work, but actually, there's massive vagaries"

(Executive)

But, in addition to this incentive, FTs reported themselves keen to maintain good relations with PCTs and reported that they would do work unremunerated at times.

"We… been quite pragmatic about it..we clearly record things more diligently now. We don't necessarily charge for everything, but what we do is we use them as…bargaining chips"

(Service Manager)

Under PbR the business of accurately 'coding' procedures has become very important to all of NHS providers, not only FTs. In our study, the PCTs noticed that under PbR, the coding of procedures by the FTs improved significantly. This usually produced 'a bigger bill' that the PCT had to pay. All had a significant motivation to ensure that their activity was properly coded and properly paid.

"It's been a massive step up because not just an Acute Trust, but every – not just Foundation Trusts, all Trusts have been able to play that game and PCTs have not been able to keep on top of it"

(PCT Executive)

Although PbR affects NHS Trusts and FTs alike, FTs, as profit making institutions, have an added incentive to improve their coding and ensure the accurate payment of their activity. As one Commissioner reported,

"the other Trusts would do it if they could, it's just that they [FTs] are much more minded to do it, and that stuff's catching on"

(PCT Executive)

Another way in which being an FT affects the effects of PbR is on their relationships with PCTs. Some FTs in our study believed that PCTs did not want FTs to make a too large profit. They suggest that PCTs may have resented FTs for draining their resources. These perceptions created a potential for PCTs to challenge the FTs' procedures.

"They don't like to see a Foundation Trust making a surplus at all...because, obviously, they're paying that money to us for extra performance. So it could bankrupt the PCTs if they haven't got their contracts right"

(Service Manager)

Although there were no instances in our study of PCTs running out of funds and shutting down theatres, the potential for FTs to bankrupt their PCTs existed. As this would cause the FT problems too, it led to negotiation about levels of service provision in the interests of preserving good relations. As another service manager suggested,

"no one has said you've got to turn off the Orthopaedic Theatre next month because the PCT can't afford it," but, you know, you, kind of, get – you almost get near those discussions sometimes"

(Service Manger)

Patient Choice

Main issues for Patient Choice

Patient Choice (PC) is part of the market mechanisms which apply to all NHS providers, allowing patients to choose which hospital to attend. As FTs become more business like, PC offers them to potential to draw in more patients from further away, and thus increase income. PC offers FTs a more competitive environment for the delivery of services. Under PC, the FTs in our study recognised the potential for developing a more reliable stream of income that was independent from the influence of the PCT. Their profit making status made them interested in attracting more income. The FTs in our study also considered that PC rewarded them for delivering high quality patient care. Thus, the FTs took advantage of PC by increased marketing of services to patients and GPs.

However, at some of the FTs in study, some clinicians had some concerns about PC. They stated that PC altered relationships between consultants, GPs and patients. Clinicians believed that the Choose and Book system (the computer system which operates PC) de-personalised their relationships with patients. Medical records did not follow the patients from hospital to hospital. They suggested that under PC, consultants treated conditions, not people. This transformation, they suggested, might lead to bad medical decisions.

PC as an additional income stream

PC provides trusts in general with an additional source of income. The FTs in the study believed that if they were able to maintain favourable reputations and offer short waiting times, they would be able to secure reliable levels of income through PC. But they also recognised the potential for tension with the PCT over the policy. As one Executive described,

"their[PCT] remit is to not spend any more money than they have to...alongside that, of course, you've got patient's choice, so my argument is we're only – what we're about is patient's choice being the hospital of choice. So if that means setting up clinics out in the local community, so be it because that is directly...in line with Government thinking."

(Executive)

PC put the PCT in a difficult position. PCTs are required to control demand, but by extending the power of choice to patients, PCTs are removed from part of the commissioning process. PC offers a more flexible and potentially limitless source of income. As an Executive described

"you've just got to look at patients choice and if, you know, the referrals keep coming in and keep coming in, then you have to be paid for those referrals. So the PCTs are in a very difficult position... they don't wield enough power over the GPs"

(Executive)

PC could alter the relationship between the PCT and the FT. With a reliable stream of income delivered through PC, an FT might not need to consult a PCT about developing a new speciality. As one Executive suggested,

"you can't have a market system... ...and then try and control it. And that is a real.....tension between the commissioning role and the providing role. We're in a market. That's the way I see it. . If we provide a crap service, no-one's going to come...the hospital down the road may be coming to try and pinch our work over time. And vice versa. So...the PCT can't overrule that and say, "Well, you know, we want to manage the market."

(Executive)

PC as a reward for good quality services

The FTs in study thought that if they could provide good services, patients would reward them with increased levels of business.

"If the hospital doesn't provide good care.....patients won't come. If they don't come, we don't employ...people..... that's the principal driver".

(Executive)

"developing a high quality agenda of care....is mission critical....that's a big focus for us... and is that easier to do now, because of having the FT status and you've got these structures...we always used to do it.... it's just – it's heightened it"

(Executive)

The FTs in the study recognised that GPs have a large influence over referrals, whether covered by PC or not. Potentially, GPs could direct large amounts of business to FTs.

"From our perspective GPs...have a lot influence over patients where they choose to go....if we could market our services more effectively so we can get people at the margins switching, GPs recommending us rather than......an alternative provider. That's part of my role, looking at and seeing, which services do we exploit and where and we haven't really done that before"

(Executive)

PC provides FTs with a motivation to build the reputation of their services with a view to expanding them. As one manager described,

" At the[nearby trust], their service was perceived by the patients to be really poor, so patients were voting with their feet coming here. We took on an extra Consultant as a result of that, and have built up our service here

> (Service Manager)

The FTs in study saw that their capacity to be profitable or not was to a large extent, based on their ability to deliver high quality care. As one executive described,

"building a reputation of excellence…..is absolutely key"

> (Executive)

Marketing became important to FTs in the study.

"If you're a Foundation Trust, you automatically go onto the Choose and Book list"

> (Executive)

As discussed above, it is arguable that competing initiatives such as the 18 weeks patient pathway might conflict with and limit PC. If hospitals were to keep waiting times down, they could not afford to be too popular in the short run. Thus there was in fact a limit to the amount of addition business that hospitals of any kind were able to deal with under PC.

PC and the patient pathway

Some clinicians and others in the FTs in the study raised concerns about PC which apply to all NHS providers, not only FTs.

First, PC was seen to alter relationships between FTs and other Trusts. Where patients chose a particular FT, treatment may have already been initiated at another trust, or the patient may have had existing records at a distant primary care provider. Thus, PC demands better relationships between Trusts to facilitate the flow of patient related information. Often this is needed in circumstances where patients have rejected the services of one trust in favour of another. As one Service manager described,

"sometimes patient choice is detrimental to us because people… try and search for the Consultant with the shortest wait… but they'd already seen the Consultant over at the [another trust] so then our Consultant has to start all over again"

> (Service Manager)

As one clinician reported,

"Patients end up being referred to this Trust and they've had x-rays or investigations in another Trust. Do you spend time writing and asking them to send stuff on, which takes months to arrive, or do you repeat it all, which tends to happen, and so there's a, sort of, wasteful duplication of services"

> (Clinician)

In the lack of co-operation between trusts, services were duplicated and resources wasted.

PC also altered relationships between consultants and patients, some of the clinicians in our study reported. Consultants found it hard to build relationships with patients who were moving between different providers.

"We get patients who come all the way from [place]… I know nothing about the patient's history. I have to sit there getting it and gleaning it and guessing what's going on. I've got no notes and I've got to make a decision The notes are over there, and they're here. You make a provisional – you make a less good decision"

     (Clinician)

PC, perhaps in combination with the effects of other policies that speed the patient pathway, has had the potential to change clinicians into technicians.

"We don't treat a condition, we treat a patient, and I think people seem to think it's a bit like, you know, you need a particular job done on your car, so you can go to any Peugeot dealer who will ring around and see if he can get the part sent in, and it doesn't matter which garage he goes to, it will be done. But I think it's very different having an operation, because surgery's not like putting a bit on a car"

     (Clinician)

4.5.6 Practice based commissioning

The idea of practice based commissioning (PBC) is to involve GPs more closely in commissioning care for their patients. The FTs in our study were concerned to work closely with the referring GPs in their areas to preserve their income streams, whether these GPs were actively engaged in commissioning or not. These concerns were not specific to FTs, as the PbR payment mechanism made all hospitals concerned to retain income. But the FTs had a greater motivation, as they were able to retain any surplus they made, unlike other NHS trusts.

The desire to retain or even increase referrals led to efforts on the part of the FTs in the study to market their services to local GPs (as discussed earlier in this chapter).

"we need to find ways of protecting our income… so when somebody needs a Diabetes service in the community, we would pitch for it, as well as the GPs or whoever else might be interested in doing it.."

     (Executive)

The FTs in the study were also interested in the co-ordination of care across the primary/secondary care boundary in order to improve care for patients. Some of the FTs conducted regular meetings with local primary care providers for the purpose of discussing the interface between primary care and acute services and how to improve how the services worked with each other. The motivations were both financial and patient based.

"One of the GP's practices said it would be really helpful to have direct access echocardiograms, as opposed to being referred in for an outpatients, then getting the echo done, etc, so we've provided that for that surgery … a lot of it is financially driven as well, to make sure that we cover off all our bases

(Service Manager)

As discussed in the section on relationships with local organisations earlier in this chapter, the FTs were also concerned that under PBC, GPs might try to 'poach' some services from secondary care and carry out the work themselves (or by employing specialists in GP practices).

"when they want to take the specialist out to the community and then give us less money and we can't deliver economies of scale, it's a problem"

(Service Manager)

In one area, one of the diabetologists in the FT was concerned about the quality of care being provided to diabetic patients by one of the GP practices. S/he noted that patients were not referred soon enough, and required more serious interventions by the time they were.

However, the FTs in the study did not indicate that PBC had yet become a major concern in their areas. This may well be because PBC was not well developed.

4.5.7 Conclusion

This chapter has demonstrated the very important effects on the four FTs in the study of a range of national policies which were (and are) not specific to FTs.

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.

In the case of the market like initiatives, such as Payment by Results, Patient Choice and Practice Based Commissioning, one can also see the effects on the FTs in the study. Of course, to the extent that they were operating at all, these market mechanisms were also at work on other NHS trusts at the time. Payment by Results had a strong incentive effect to increase income, especially on the FTs, as they could retain any surplus. The policy of Patient Choice gave the FTs the impetus to attempt to retain existing patients and to attract patients from further afield, and to market their services to GPs (as patients' main choice advisors). In tandem with this, the spectre of Practice Based Commissioning gave the FTs the impetus to market their services to GPs too, and to try to ensure that primary care was not usurping any of their currently delivered services.

5 Conclusions

This chapter will discuss the limitations of the study, summarize the findings of the study, consider how they relate to the early expectations and concerns raised about FTs and then draw some conclusions. Finally, recommendations for practice and suggestions for further research will be made.

5.1 Limitations of the study

We chose a study design in which four FTS were studied in depth. There were some unforeseen limitations to the data we were able to collect. *First*, not all of the FTs in the study agreed to allow access to internal documentation and meetings. This decreased the amount of data in relation to some of the FTs, but not all of them. *Secondly*, it was not possible to recruit patients to participate in focus groups, as was attempted in some sites. Nevertheless, extensive data were collected from observing locally organised meetings with members, providing much useful material about members' views.

Moreover, in the event, we only carried out two, rather than three, rounds of interviews. Despite not conforming with the original study design in this respect, we considered that two rounds of interviews were more than adequate for our purposes. We were able to obtain rich data from two rounds and our other contact with study participants (notably through non-participant observation of meetings).

Some readers might wonder why the two tracer services in the study design (orthopaedics and diabetes) have not been reported separately. It was not our intention that they should be, as the questions in the study concerned aspects of the governance of FTs which the tracers were being used to help us elucidate, rather than the tracers being studied in their own right. We focused on the two services in our interviews (and observation) of clinicians and middle managers, and this allowed us to understand the effect of FT status and NHS wide policies on examples of both elective services and long term conditions. Using the tracers to focus our research helped provided highly illuminating information.

The bigger questions here, though, concern the credibility of our findings. As we noted in Chapter 3 there are threats to validity, in this study as in any other. The main threat to internal validity was that we would produce uneven or incomplete accounts, for example because we could not negotiate equal access to all areas of all of our sites. In the event the volume and diversity of data collected meant that we were confident about our findings and their interpretation. On threats to external validity, the key

is to try to generalise to the right population. In this study we focused on the development of governance arrangements in FTs, and believe that the findings should apply to current or future acute hospital FTs. The results might, if used with care, shed useful light on the development of governance arrangements in other NHS organisations.

The principal challenge in this study concerned construct validity. FTs are both novel and complicated, and there was no single body of evidence or theoretical tradition which helped us to understand them. In the event we used two broad theoretical frameworks, both to guide our approach to our research and our analysis, but recognise that we could have used others, eg democratic network governance. All we – or anyone else – can do here is to make our assumptions and working explicit, so that others can make their own judgements.

5.2 Our findings

The aim of this study was to investigate the governance structures of FTs, which are a new form of NHS provider organisation. We were interested in the dual changes in governance to which FTs were subject: these are external, being their greater autonomy from other parts of the NHS, and internal, being the addition of members and governors. The key findings of the study are set out here.

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. Senior staff were keenly aware of having more room to manoeuvre. 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 boards of 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. The cultural shift to a more business-like focus had penetrated the management level of individual hospital directorates. The trend of devolution of responsibility for business planning and financial and performance management into operational clinical directorates using techniques such as service line reporting were seen to have developed greater understanding of the business elements of the hospitals among lower level managers, some clinicians and other front line staff.

At the same time, the autonomy of the FTs in the study should not be over stated. 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. In the case of the market like initiatives, such as Payment by Results, Patient Choice and Practice Based Commissioning, there were also effects on the FTs in the study. Payment by Results had a strong incentive effect to increase income, especially on the FTs, as they could retain any surplus. The policy of Patient Choice gave the FTs the impetus to attempt to retain existing patients and to attract patients from further afield, and to market their services to GPs (as patients' main choice advisors). In tandem with this, the possibility of Practice Based Commissioning gave the FTs the impetus to market their services to GPs too, and to try to ensure that primary care was not usurping any of their currently delivered services.

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. They were aware that they needed to maintain good relationships with local organisations both for the sake of achieving good patient care and in order to make sure they were on good terms with the PCT, which was the main source of their income.

Turning to the changes in internal governance, we found that the representative structures of the FTs in the study involved significant costs in terms of time and money. 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, whilst in other locations they felt they had a direct relationship with the board. Different stages of FT development and different organisational cultures may have been influential in the varied levels of involvement we found across the four FTs. It should be noted, however, that even if staff were not notable in their involvement as governors, staff were increasingly involved in the operational level of the FTs by participating in the running of directorates and at the level of individual clinical services.

The comparative quantitative data demonstrate that our four case study FTs were similar to other FTs in the country in respect of issues such as financial performance, use of resources and quality of care. This is the case, save that one case study FT had much longer waiting times overall than other FTs, and that three of the case study FTs had longer orthopaedic waiting times than the average for England. (The finding about elective orthopaedic waiting times may explain why the executives and service managers we interviewed placed particular emphasis on the effort involved in trying to achieve the 18 weeks patient pathway.) One area in which two of the case study FTs were performing significantly better than other FTs was in the size of their retained surpluses. This may have affected their attitude to being an FT – making them more positive about the change in status, as they had more resources available for service development and to maintain financial self reliance. The fact that the case study FTs were similar to other FTs in respect of the quantitative measures available aids generalization from our case study qualitative findings to other FTs which did not participate in the research. The quantitative data also demonstrate that, on the whole, FTs are performing better than other NHS hospitals. This is likely to be related 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. Our findings build on the earlier work about the governance of FTs by Day and Klein (2005), the Healthcare Commission (2005), the Healthcare Commission and the Audit Commission (2008), Lewis and Hinton (2008), Ham and Hunt (2008) and Ipsos MORI (2008) discussed in chapter two of this report and tend to confirm what was reported then. As far as autonomy is concerned, all the research to date has found that FTs became more business like once they were freed from some parts of the NHS hierarchy. The ability to make decisions more quickly was taken up eagerly. The capacity to accrue surpluses was used both to develop new services and to retain some cash. As far as membership and governors are concerned, despite the fact that the field work for our study took place in some cases several years after the previous work, it still seemed to be the case that not all the stakeholders were clear about their roles and contributions, staff governors were under used and there was still some duplication between governors and other forms of patient and public involvement. Moreover, our study also showed, like Ham and Hunt (2008), that FTs have widely different attitudes to the importance of recruiting large numbers of members.

5.3 Expectations and concerns about FTs

Our study has provided information which allows us to address the expectations and concerns raised about FTs (and mentioned in chapter 2 of this report) when they were first introduced.

Proponents of FTs took the view that the new organisational form, with members and governors, would operate like a mutually owned organisation, where staff and other stakeholders would have a large part in decision making and feel a greater affinity to the hospital. The legal analysis in chapter 2 has demonstrated that FTs are not actually mutually owned organisations – the assets belong to the state, not the members. Moreover, the results of the case study research show that few staff of the FTs were using the new FT representative mechanisms available to them, despite there being substantial staff membership in each FT.

The case study research does indicate that there has been some increase in patient involvement in decision making using the members' councils, and some were finding new ways of working to incorporate the contributions of governors and members. But a significant number of governors in some of the FTs were uneasy about their ability to contribute properly to decision making, due to their lack of information, and limited capacity (in terms of time, knowledge and skills) to master the information they were given. It appears that 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. This finding has been reinforced recently by the then Secretary of State for Health (Burnham, 2010a). Mr Burnham stated that he was concerned about the effectiveness of the local accountability mechanisms of FTs to hold FTs to account.

'The model was we traded some national accountability for stronger local accountability. I want to satisfy myself that we are really getting that....There is more thinking to be done about accountability at local level and if FTs are really following the aim of the policy set out in 2003-4 for real local accountability and the role of boards.'

(Burnham, 2010a)

Furthermore, following the publication of the report of the Francis inquiry (2010) on the failure of regulation at Mid Staffordshire NHS Foundation Trust, Mr Burnham announced in parliament that FT board meetings should be held in public. This addresses a concern raised by some of the governors in our study.

'I make it clear today that all foundation trust board... meetings should be held in public and governors should have access to all papers.'

(Burnham, 2010b)

The fact that Monitor has recently updated the NHS Foundation Trust Code of Governance indicates that our finding about the uncertainty of some

governors about their roles was widespread. It has been changed to provide

"additional clarification regarding the relative and complementary role of boards of governors and boards of directors".

(Monitor, 2010)

Proponents of FTs also thought that the new governance structures would engender a more business like approach. Our study confirms that this is the case. FTs in the study seized the opportunity to improve their services, and put themselves on sound financial bases. But we cannot go so far as to conclude that the governance structures of FTs were the mechanisms which make them perform better than other NHS hospital trusts because it was not possible to compare like with like. The hospitals which became FTs were those which were already performing better than others and our quantitative data confirm that they continue to do so. But we cannot conclude that it was the new governance structures which produced this result.

On the other hand, the fears of the opponents of FTs do not seem to have been confirmed by our study. We found no evidence of FTs poaching staff from other NHS trusts by offering to pay them more. We did not find that special interest groups had taken over the membership or board of governors of any of the FTs in the study – so it could not be said that any political group was exerting undue influence. It should be noted that older people were disproportionately represented among the memberships, but this is not surprising, given the limited amount of time working people have available, and the contact with hospitals increasing as one gets older. Nevertheless, several of the FTs were making significant and successful efforts to recruit younger members.

Although relationships with PCTs could be difficult at times, it did not appear that having FT status was the main reason for this (although it could at times exacerbate it). The FTs in the study wanted to maintain good relationships with local PCTs and remain part of the local health economy. Where problems arose, they were mainly due to the incentives of PbR, which affected all NHS trusts, including FTs. However, opponents of FTs may have been insightful when they pointed out that FT status would discourage FTs from divesting themselves of business, thus impeding the development of more ways to provide care out of hospital. The FT hospitals in the study were entrepreneurial and wanted to attract more patients (and thus more income), not lose to other providers. Moreover, the fact that FTs in the study were retaining considerable surpluses reflects one of the concerns of the House of Commons Health Committee report (2008) that entrepreneurial behaviour by FTs may not always work in the interests of patients and far too much money was being retained by all FTs across

England. Making a surplus per se is not evidence of patient benefit – the surplus has to be spent on patient care for that to be achieved. But it should be noted that FTs were required to make a surplus by Monitor, and that this surplus was needed to provide funds for development work.

5.4 The future of FTs

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 (Wintour, 2010). There is likely to be less income available for all hospitals, including FTs. Indeed, this change in financial circumstances has already been acknowledged by the changes to the PbR system set out in the Operating Framework for 2010-11 (DH, 2009b). From 1st April 2010, all NHS hospitals will not be able to recover the full national tariff for every episode of care provided. Instead, there will be a ceiling on the amount of emergency activity which will be paid at full rates. Any emergency activity which occurs above the contracted baseline will only attract thirty per cent of the emergency tariff. The Operating Framework for 2010-11 has also indicated that the NHS will move towards negotiated prices in future years, where the national tariffs only represent maximum prices.

The Conservative and Liberal Democrat Coalition government which came to power in May 2010 issued a White Paper on the NHS in July entitled '*Equity and Excellence: Liberating the NHS'* (Secretary of State, 2010). This document proposes that PbR will continue, but that the use of average costs to determine the national tariff will diminish. The aim will be to decrease the level of the tariff.

FTs will 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.

The second lesson from this study relates to the way in which FTs are held to account. The dual remit of FTs to become more autonomous from the central NHS while also increasing local accountability has made it difficult for FTs to develop their governors' roles clearly. There was insufficient

clarity at national level about what local accountability meant and how and to whom governors should be accountable. While Monitor and the FT Governors Network have made considerable efforts to clarify basic understandings, there is still variation at local level which may relate to local organisational cultures. As discussed earlier in this chapter, the study raised some concerns about the capacity of FT members and governors to hold FT executive boards to account, and these have recently been reiterated by the then Secretary of State (Burnham, 2010a and b). The new government's White Paper (Sec of State, 2010) has suggested that a wider range of governance mechanisms for FTs should be introduced.

'Whether we should enable foundation trusts to tailor their governance arrangements to their local needs, within a broad statutory framework that ensures that any surplus and any proceeds are reinvested in the organisation rather than being distributed externally'.

(Sec of State, 2010, page 36)

In addition, the Francis inquiry (2010) raised concerns about the national mechanisms for holding FTs to account. Although our study demonstrated that national bodies such as the Care Quality Commission and Monitor have a large influence over FTs, the Francis inquiry demonstrated that they may not be able to detect serious failures in the quality of care delivered. In response to this finding, the then Secretary of State announced a second inquiry by Robert Francis. This will

'examine the operation of the commissioning, supervisory and regulatory organisations and systems in relation to their monitoring role in Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009. The inquiry should consider lessons to be drawn from that examination as to who in the future the NHS and the bodies which regulate it can ensure that failing and potentially failing hospitals are identified and action taken as soon as is practicable.'

(Burnham, 2010c)

The new government's White Paper (Sec of State, 2010) now suggests that there will radical changes in the regulation of all NHS bodies. *First*, it is stated that all NHS Trusts will be required to become FTs. *Secondly*, Monitor will expand its role to become the economic regulator of all providers to the NHS, including non NHS providers, including regulating competition and co-operation issues. Monitor will also set 'efficient or maximum prices for NHS funded services' where price regulation is necessary (page 38). The Care Quality Commission and Monitor will jointly licence all providers of NHS services.

A final issue to note in relation to the future of FTs is that the new Secretary of State for Health, Andrew Lansley, has indicated that he is not in favour of so many national targets (Sec of State, 2010).

'The NHS will be held to account against clinically credible and evidence based outcome measures, not process targets. We will remove targets with no clinical justification'.

(Sec of State, 2010, page 4)

It is not yet clear which targets will be removed, but the new government has already stated that it will not performance manage the 18 weeks patient pathway target, although 'commissioners should maintain the contractual position' (DH, 2010, page 7).

5.4.1 Recommendations

Internal governance and use of stakeholders

Our study has indicated that the governance structures of FTs designed to allow local people and patients to hold those running the hospitals to account are not entirely satisfactory. As discussed above, the new government is aware of this issue and is in the process of making changes to this aspect of FT governance.

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

- Staff participation. It is clear that the current structures are not attracting any significant degree of staff participation in governance using the FT mechanisms. 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. Although our study found that some members and governors felt that they were performing an effective role as stakeholders participating in the governance of their local hospital, not all did, and neither did all the executives. 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). The issue is to ensure that FT governance and other local mechanisms allow local people appropriately to influence strategic decisions.

- We have noted that the Coalition government intends to reduce the number of national targets. These targets have provided one

rationale for FTs putting emphasis on patients' views and experience. There is a need for this emphasis to continue, despite any changes in the external context within which FTs will be operating.

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 could be extended to other NHS Trusts, as they prepare to become FTs. These consist of a much greater focus on both sources of costs and income in each directorate, as encouraged by the use of service line reporting. Large amounts of information need to be analysed to understand what is driving costs in each area. While this is expensive and time consuming, it pays dividends in terms of allowing the FT to understand how its business works, and where investments and efficiencies are required. And failure to do so can be catastrophic (see the recent financial problems suffered by an existing FT, Heatherwood and Wexham Park Hospitals NHS FT – Monitor, 2009b)

5.5 Need for further research

The previous section has indicated 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.

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Appendix 1 List of interviewees and meetings observed

First round

FT1

Number	Role
1	Chief Nurse
2	CEO
3	Communications Director
4	Chair
5	Deputy Director Medicine
6	Director finance
7	Service Manager (diabetes)
8	Service Manager (orthopaedics)
9	Operations manager
10	PCT Director Communications
11	Clinician (diabetes)
12	Clinician (diabetes)
13	Clinician (orthopaedics)
14	Governor
15	Governor
16	Governor

FT2

Number	Role
1	Governor
2	Governor
3	Governor
4	Director

5	Service Manager (diabetes)
6	Clinician (orthopaedics)
7	Service Manager (orthopaedics)
8	Clinician (diabetes)
9	Member
10	Director
11	Director (ne)
12	PCT Director Communications
13	CEO
14	Finance Director
15	FP-Chair

FT3

Number	Role
1	CEO
2	Medical Director
3	Finance Director
4	Medical Director OD
5	Chair
6	Divisional Director Medicine
7	Manager (diabetes)
8	Manager (orthopaedics)
9	Divisional Director Surgery
10	Clinical Director (orthopaedics)
11	Governor
12	Governor
13	Chief Nurse
14	Governor

FT4

Number	Role
1	Clinician (orthopaedics)
2	Service Manager (diabetes)
3	Service Manager (orthopaedics)
4	Director
5	Clinician (diabetes)
6	Director
7	Governor
8	Clinician (diabetes)
9	Director (ne)
10	Director
11	PCT Director Communications
12	CEO
13	Finance Director

Second round

FT1

Number	Role
1	Links
2	Patient Service Manager
3	Operations manager
4	Manager Medicine
5	Clinical Director (diabetes)
6	Governor
7	Matron (orthopaedics)
8	Deputy Head of Corporate Affairs
9	Finance Director

Number	Role
10	Finance Director
11	Nurse diabetes

FT2

Number	Role
1	Clinician (orthopaedics)
2	Clinician (diabetes)
3	Clinician (diabetes)
4	PALS (Manager)
5	PALS (Assistant)
6	Governor
7	Governor
8	Governor
9	Governor
10	Governor
11	LINKS (Chair)
12	LINKS (Member)
13	PCT Director Marketing
14	PCT Director Communications

FT3

Number	Role
1	Staff Governor
2	General Manager Surgery
3	Governor
4	Governor
5	Chief Nurse
6	Directorate Manager
7	Diabetes year of care ex-manager
8	Governor

9	Links
10	Clinician (orthopaedics)
11	General Manager (orthopaedics)
12	Matron (orthopaedics)
13	PPI Manager
14	Directorate Manager, Diabetes Clinician, Diabetes Nurse one, Diabetes Nurse two
15	Diabetes Nurse one, Diabetes Nurse two, Diabetes Nurse three

FT4

Number	Role
1	Service Manager (diabetes)
2	Clinician (orthopaedics)
3	Clinician (diabetes)
4	Clinician (diabetes)
5	Director
6	Governor
7	PALS (Manager)
8	OSC (Manager)
9	LINKS (Manager)
10	PCT Director Communications
11	Union Representative
12	Chair
13	SHA (FTs Lead)

Meeting attendances

FT1

6 Public meetings of the Board of Governors

1 Orthopaedic Directorate review day (1)

6 Orthopaedic Directorates

1 Medicine for members (Focus on medicine)

2 Divisional Finance meetings

1 Risk management meeting

1 Weekly activity meeting Finance (directorate)

1 Directorate of Speciality Medicine (emergency meeting for Flu)

2 Diabetes clinical management (including No show)

1 Diabetes business management

FT2

3 Governors' Council Meetings

FT3

1 public meeting of Board of Directors

6 public meetings of board Membership Council

1 prospective Membership Council members briefing session

1 training event for new Membership Council Members

Finance meetings

1 Links meeting with Membership Council

1 Corporate social responsibility subgroup – officers and Membership Council members

1 Surgical Division Risk Management Group

2 Surgical Division Board

2 Medical Division board

5 Orthopaedic DMT

1 Staff Management group meeting

2 AGMs

1 post AGM Medicine for Members event

2 Medicine for Members

FT4

4 Members' Council Meetings

1 Clinical Directorate Meeting

2 Service Improvement Meetings

1 Executive Strategy Meeting

Appendix 2 Details of members

(Note all FTs report and analyse memberships differently)

FT1

Membership

How many members does each Trust have and what change is there over time?

Membership	April 2004	2004-5	2005-6	2006-7	2007-8	2008-9
Number of members	2264	3490	4221	9256	44098	51254
Number of public and patient members	1591	1850	1973	4879	39488	46,653
Number of staff members	647	1640	2248	4377	4610	4601
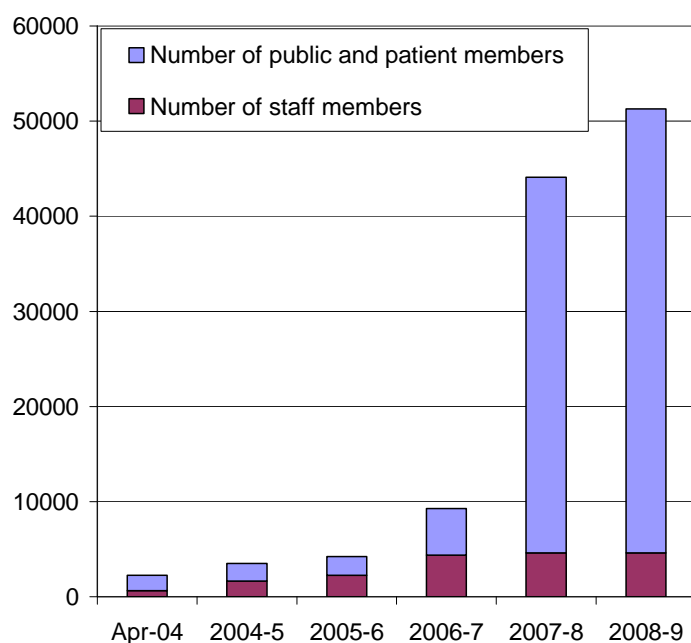
Age Profile of members 2004-5

	16-19	20-24	25-29	30-44	45-59	60-64	65-74	75-84	85-89	90+	Not declared
Total population %	8	7	9	28	22	6	10	7	2	1	
Membership%	2	7	7	19	24	9	16	8	1	0	7

Comparison of age profile of members and of eligible catchment area
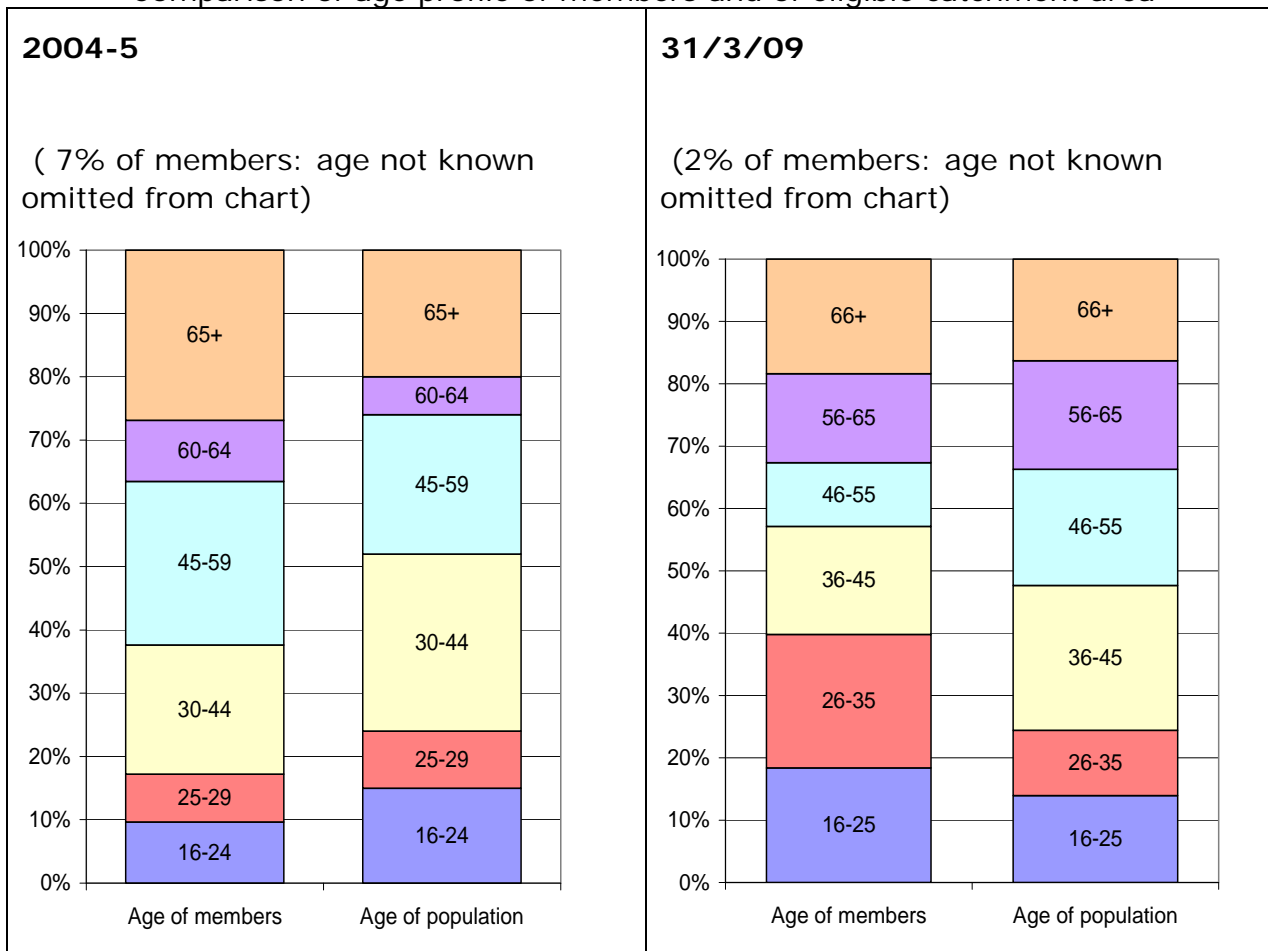
FT2

Membership per constituency at 31 March 2009

Constituency	No. Members at 01-04-08	No. Members at 31-03-09	% increase over year	% population who are members
PUBLIC 1	602	646	7.31 (44)	2.32
PUBLIC 2	447	466	4.25 (19)	2.12
PUBLIC 3	1657	1699	2.53 (42)	3.21
PUBLIC 4	2025	2297	13.43 (272)	3.21
PUBLIC 5	2071	2315	11.78 (244)	3.82
PUBLIC 6	829	836	0.84 (7)	2.51
Patients	595	647	8.74 (52)	
TOTALS PUBLIC AND PATIENTS	**8226**	**8906**	**8.27% (680)**	
Surgery *(Staff)*	434	561	29.26 (127)	
Women and Children's *(Staff)*	294	345	17.35 (51)	
Medicine, pharmacy, A&E *(Staff)*	568	690	21.48 (122)	
Pathology. Radiology & Therapeutics *(Staff)*	270	322	19.26 (52)	

Admin, Management, Estates & Others (Staff)	482	577	19.71 (95)	
Total Staff	**2048**	**2495**	**21.83% (447)**	
Grand Total	**10274**	**11401**	**10.97% (1127)**	

FT3

Membership

	Authorisation August 2006	2006-7	2007-8	2008-9
Number of members	7886	7933	9104	10943
Number of public members	7010	7038	7907	9306
Number of staff members	876	895	1197	1637
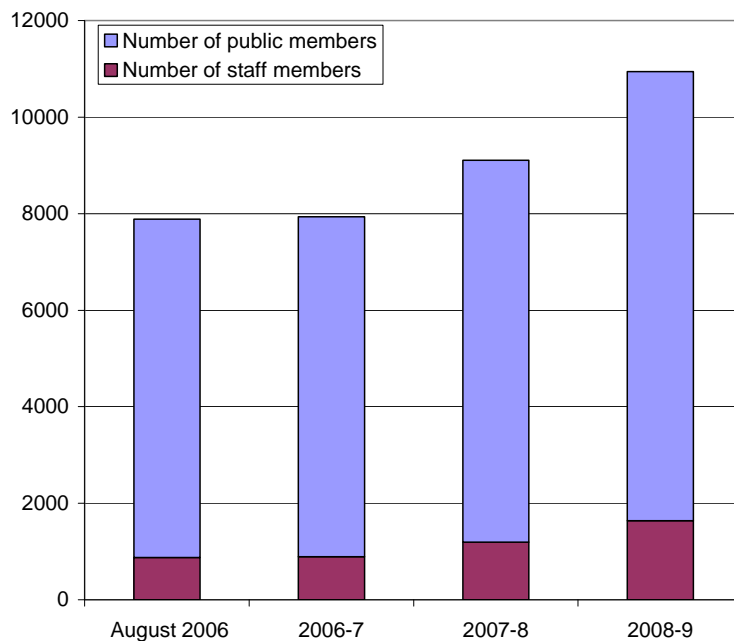
Comparison of age profile of members at 31.3.07 and of eligible catchment area-
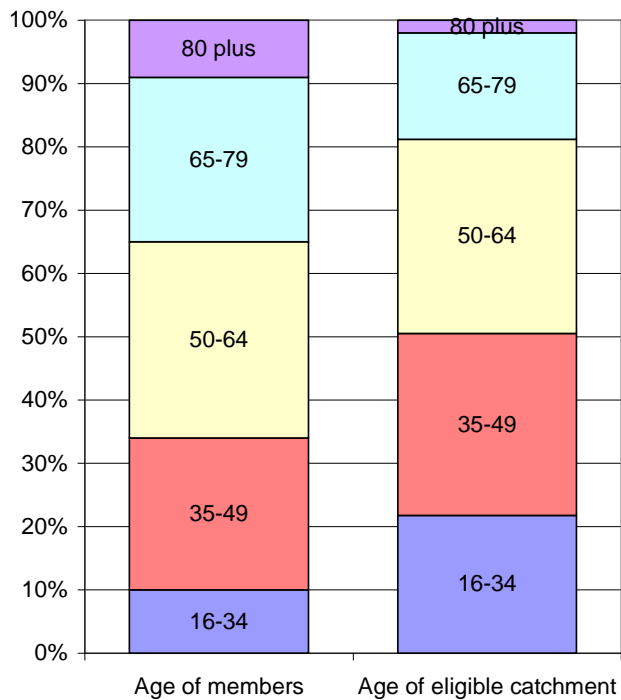
Ethnicity profile of members at 31.03.09

	Membership %	Eligible catchment %
British white	92	90
Mixed	0.8	0.7
Asian	5.3	7.7
Other ethnic group	0.4	0.3

The Asian population in the area is under-represented among the membership

Socio-economic profile 31.03.09

	%public membership	% eligible population
ABC1	49	47
C2	15	16
D	19	20
E	16	16

Electoral participation

Election Turnout for the Public member elections 2007

Constituency	Number of seats	Number of candidates	% Turnout at Poll
1	1	1	Uncontested
2	1	5	25.6%
3	1	4	33.8%
4	1	0	Not applicable
5	1	3	39.0%
8	1	4	29.3%

Date of election	Constituencies involved	Number of members in constituency	Number of seats contested	Number of contestants	Election turnout %
October 2008	1	546	1	2	27.8%
"	2	1829	1	4	23.5%
"	3	1174	1	1	Uncontested
"	4	319	1	1	Uncontested
"	5	1047	1	2	30.9%
"	6	624	1	3	22.8%
"	7	1252	2	3	18.1%
"	9	135	1	1	Uncontested
"	13	358	1	1	Uncontested

Average turnout-24%

FT4

Membership Size and Movements at 31 March 2009

	2008/09	2009/10 (est)
Total Membership		
At year start (April 1)	13140	15438
New Members	3104	1086
Members leaving	805	779
At year end	**15438**	**15745**
Public Constituencies		
At year start (April 1)	6580	6372
New Members	195	436
Members leaving	403	436
At year end	**6372**	**6372**
Staff Constituencies		
At year start (April 1)	495	2930
New Members	2476	0
Members leaving	11	0
At year end	**2930**	**2930**
Patient Constituency		
At year start (April 1)	6095	6136
New Members	433	650
Members leaving	392	343
At year end	**6136**	**6443**

Analysis of Current Membership at 31 March2009

	Number of members	Number of Eligible Members
Public Constituency Age (years):		
0-16	1	127076
17-21	66	41156
22+	5461	771257
Unknown	844	
Public Constituency Ethnicity:		
White	4556	589219
Mixed	245	29013
Asian or Asian British	342	49221
Black or Black British	280	68025
Other	309	204011
Unknown	640	
Public Constituency Socio-economic status		
ABC1 (Low to Moderate Means)	5528	598056
C2 (Comfortable)	2	Not recorded
D (Prosperous)	0	43873
E (Wealthy)	829	Not recorded
Unknown	13	297560
Public Constituency Gender Analysis:		
Male	2550	367501
Female	3779	398326
Unknown	43	173662

Patient Constituency		
Age (years):		
0-16	1	46000
17-21	64	2400
22+	6071	44800

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.