The first wave of NHS foundation trusts

Low turnout in elections sends a warning signal

On 1 April 2004 the first 10 NHS foundation trusts came into being while another 14 remain on the starting line, awaiting the approval of the independent regulator.¹ So begins an experiment that has the potential to transform the NHS, but in which formidable obstacles remain in the way of translating ambitions into reality. In launching the experiment the government set out two linked aims—decentralisation and democratisation.² Firstly, foundation trust status would give providers “freedom from Whitehall control.” Secondly, it would introduce “a new form of social ownership where health services are owned by and accountable to local people rather than to central government.”³ We do not know how much freedom from Whitehall control will exist in practice and how much scope foundation trusts will have to develop new ways of working. During the passage of the legislation through parliament, the government was forced to appease backbench opposition by introducing a series of restrictions on the way in which foundation trusts can run their affairs. Evidence on the impact of these restrictions will only emerge in the years to come. However, the process of setting up foundation trusts has already produced evidence about the problems involved in devising “a new form of social ownership”³ and creating an appropriate governance system. The rhetoric of ownership by and accountability to local people assumes that local people do indeed want to be involved in running the NHS. Results of the first round of elections to the boards of governors, responsible for the operations of the new trusts, show that this is an overoptimistic assumption. For many of the aspiring trusts the challenge has been how to overcome apathy.

The precise numbers in the mix of governors selected by different methods varies from trust to trust. In all cases, however, elected governors make up a majority of the board, with a sprinkling of nominated governors added. Of the elected governors, the majority are those representing the public and patients, and the staff of the trust concerned elects a smaller number. The representatives of the public and patients are elected by the trust’s “members”—local people who, having registered, are then entitled to vote. The model here is that of a cooperative or mutual society. Whether this is an appropriate model is a different matter: we cannot assume that the “members”—being self selected—are in any way representative of the community. The contrary is more likely. But even leaving this fundamental reservation aside, most

of the aspiring trusts have discovered that it is difficult to persuade enough people to self select themselves as members or to vote after having done so, as shown by the experience of those in the first 10.

Consider the case of Bradford Teaching Hospitals NHS Trust. Giving evidence to the House of Commons committee considering the government’s proposals, the trust stated that its aim would be to achieve a membership of 10% of the local population.³ That seems a reasonable, if modest, aim. But in the March 2004 elections only 1143 ballots were sent out to members, divided into various constituencies, of which fewer than 50% were returned. So 541 local people (or well under 1% of the population) chose the 17 governors. Similar disinterest is evident in other NHS trusts (figure). Only in the case of specialist hospitals is there evidence that foundation trusts can mobilise a large and active constituency: at Moorfields Eye Hospital 59.1% of its 11 000 members voted.

Apathy among public and patients was predictable.⁴ More surprising is that apathy infected the staff of aspiring foundation trusts, although it might be thought that doctors, nurses, and others have a direct and strong interest in representation on the governing board (figure). For example, in Bradford Teaching NHS Hospitals, with a total staff of 3600, only 263 voted to elect four governors.

The public and staff figures are appalling. They might reflect cynicism about the role of the governing boards—why bother if the boards are going to be window dressing, while real power is concentrated in the hands of the executive team? But if the boards do indeed turn out to be largely decorative, as well as unrepresentative, what then becomes of the rhetoric of community control and accountability? And if that turns out to be just pasteboard stuff, then it will be more difficult for foundation trusts to achieve the “freedom for Whitehall control” that they have been promised to the extent that the legitimacy of the boards is compromised by their methods of election, so Whitehall may be tempted to nibble at their independence. So far neither the health secretary nor the independent regulator has made a clear statement as to what the minimum level of electoral participation either is or should be. The results of the elections in the first 10 foundation trusts suggest that either there are no such standards or that they are abysmally lax. If we are to avoid putting a very important experiment in the history of the NHS at risk then surely the time has come to be explicit about what the standards should be and how they are to be achieved.

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Pattern of voting by members and staff in some NHS trusts

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- 2 Department of Health. *A guide to NHS foundation trusts*. London: DoH, 2002.
- 3 House of Common Health Committee. *Foundation trusts. Second report of session 2002-03*. Vol.1 London: Stationery Office, 2003. (HC 395-I)
- 4 Klein R. Governance for NHS foundation trusts. *BMJ* 2003;326:174-5.

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