Scrutiny Review – Whittington Hospital Application for Foundation Trust Status
Issues Paper for Consideration by the Panel

1. Introduction

Review Panel

1.1 The review panel consists of 4 Members and is due to meet twice (September 11th and October 4th).

1.2 The terms of reference for the review were agreed as: "to consider and comment as appropriate on the proposed application for foundation status by the Whittington Hospital NHS Trust and, in particular, its overall strategy and governance arrangements". In its deliberations the panel has sought to focus on 4 key objectives:

- The process of application (consultation)
- Accountability issues raised
- Impact on partnerships and the local health economy
- Impact on local people

1.3 The review panel has heard evidence from the Whittington Hospital and is due to receive written evidence from Haringey PCT and the Whittington Hospital Patient and Public Involvement Forum. In its deliberations, the panel has been assisted by the services of an independent external adviser, Ms Joy Tweed.

1.4 It is intended to produce a short review report of the evidence received and recommendations made by the panel. This review will be submitted in to the formal consultation for the Whittington Hospitals application for Foundation Trust status.

2. Process

2.1 The consultation period for Foundation Trust status runs from July 9th through to 29th September 2007, which conforms to the statutory 12 week consultation period requirement.

2.2 The Whittington has developed a consultation strategy which sets out how the Whittington Hospital intends to engage, inform and canvass responses to Foundation Trust proposals from the public, patients, staff and other local stakeholders (e.g. Local Authorities and Primary Care Trusts). Key elements of this strategy include:

- Production and distribution of the consultation document
- Advertisements in local press (including Turkish press)
- A commissioned film (shown at presentations and available on the website)
- Presentations and feedback sessions in the community, with staff and with local stakeholders
- Public Open Day (26th September 2007)

2.3 The consultation document contains health vignettes, details the new governance arrangements for the Foundation Trust, sets out a number of consultation questions and provides an opportunity to feedback responses. Approximately 3,000 copies of the main consultation document have been produced. The consultation document is available in large print and a number of community languages. Opportunities to feedback on the consultation have been provided through additional abbreviated literature and through the Trusts website.

2.4 The Whittington Hospital has consulted Overview and Scrutiny Committees in both Islington and Haringey and has contributed to a review being undertaken at the latter.. The Whittington has made a formal presentation to the scrutiny review panel in Haringey and responded to Member questions.

2.5 The Whittington has conducted an Equalities Impact Assessment of the Consultation and Membership strategy which did not show any 'material weaknesses'. A further equalities assessment will be undertaken within the Membership at the end of October to assess ongoing impact of recruitment strategies.

2.6 The application for Foundation Trust status will first be submitted to the Secretary of State on November 1st 2007. If this is cleared, the application will proceed to the Foundation Trust regulator (Monitor) on January 1st 2008.

Suggested issues for consideration by the Panel:

- **How will the Whittington Hospital address concerns raised within the consultation?**
- **How will comments and feedback obtained from the consultation be fed back to those that participated and to the wider community?**

3. Accountability

Governance Structure

3.1 There are three tiers of governance to new Foundation Trusts:

- A broad based **Membership** which is made up of patients, staff and members of the public.
- A **Board of Governors** which is a predominantly elected body drawn from constituencies of the Membership (patients, public and staff) and nominated partner agencies (e.g. Primary Care Trusts & Local Authorities).
- A **Board of Directors** made up executive directors and non executive directors, the chairman and chief executive.

Membership

3.2 It is predicted that total Membership within the Foundation Trust sector will be 840,000 by end of 2007/8. Total Membership for each Foundation Trust would appear to vary, depending on the size of the Hospital Trust, the nature of services provided (i.e. specialist care or general) and the model of

Membership used (i.e. opt-in or opt-out). Thus while the University of Birmingham Hospitals Foundation Trust, which has an opt-out model of Membership, has over 90,000 members, the Royal Marsden, a specialised cancer hospital, has fewer than 5,000 members (Monitor, 2007).

3.3 There is considerable debate about satisfactory and appropriate levels of Membership and indeed, what size of Membership constitutes a democratic or representative body. Some Foundation Trusts have 'opt-in' models of Membership (patients have to agree to be a Member) whilst others have 'opt-out' models (where all patients automatically become Members). Opt-in models of Membership, which the Whittington proposes, are associated with more active members (and vice versa). The Whittington also proposes to allow all residents of Haringey and Islington to become Members and wishes to consult if this should be opened up further to residents in part of Barnet, Hackney and Camden.

3.4 There is evidence to suggest that the Membership can be a significant resource to Foundation Trusts in that it can provide data and intelligence about the accessibility and quality of services provided. Foundation Trust membership has also been associated with significant increases in attendance a Trust public meetings. It is therefore important to ensure that the Membership is active and has sufficient opportunity to engage with governors and positively contribute to the development of services.

3.5 The operation of a Foundation Trust Membership does not constitute a public and patient involvement strategy in itself as there is some evidence to suggest that Foundation Trusts have failed to reach traditionally under represented communities through their Membership (Healthcare Commission, 2005). Additional direct patient contact strategies such as surveys and consultations should further inform patient and public involvement within the Foundation Trust.

3.6 The costs associated with developing and maintaining the Foundation Trust Membership (recruitment, communication and elections) may be extensive. At the review meeting, panel Members felt that such costs should be explicit and transparent and should not impact on the provision of services for patients.

3.7 The Whittington intends to have recruited 2,000 members by November 1st 2007 (upon submission to the Secretary of State) and 4,000 by January 1st 2008 (upon submission to Monitor).

Issues for consideration by the Panel:

- **How will the Whittington ensure that Membership is representative of the local community?**
- **How will the Whittington support Member engagement, particularly from those communities which may be hard to reach?**
- **Will the Whittington develop a public and patient involvement strategy?**
- **What costs are associated with Membership recruitment?**

Governors

3.8 The Board of Governors is made up of patient, public and staff governors (who are elected from their respective Membership constituencies) and nominated governors (from local partner agencies). The actual size and composition is at the discretion of local Foundation Trusts, though whatever size the Board of Governors is decided upon, public governors (patients and public) must be have a majority on the Board.

3.9 Cursory analysis of the composition of Board of Governors at other Foundation Trusts indicate a membership ranging in size from 21 to 48. Public governors are generally elected from the Membership resident within specific geographic localities. The number of staff governors ranged from 4 (statutory minimum) to 13. Nominated governors (from partner agencies) ranged from 5 to 13. This same analysis also indicated that few Foundation Trusts have dedicated Patient Governors.

3.10 Audits of Foundation Trusts, have raised concerns about how representative Boards of Governors are to their communities given that in some instances over 60% are made up from retired populations (Day & Klein,2005) and that over 1/3 of public and patient governors are NHS staff, ex NHS staff or had family associations within the NHS (Day & Klein,2005).

3.11 Analysis of public constituency ballots demonstrate that small numbers of people are electing governors: in one UCL area 125 people voted (from a membership of 229, to elect 3 governors. Elections will be held every three years by postal ballot. Average turnout at Foundation Trust elections of Governors is 36%, though this average varies by the type of constituency: public 53%, patient 27% and staff 26% (Lewis, 2005)

3.12 The Whittington Hospital is proposing 29 Governors; 19 to be elected (5 from patient membership, 10 from public membership and 4 from staff membership) and 10 appointed (PCTs, Practice Based Commissioners, Local Authorities, Universities).

3.13 The Board of Governors have a number of formal powers which are:

- To appoint/ remove Chair and Non Executive Directors,
- Approve the appointment of Chief Executive,
- Agree remuneration,
- Appoint / remove auditors,
- Receive annual report & accounts and advise
- To be consulted on strategic developments.

3.14 Governors provide the critical link between the Membership and the Foundation Trust. This link provides the route through which the community is engaged & involved and established a line of accountability between the Foundation Trust and the wider public. Survey data among governors however, has found that governors communication with Membership constituencies was poor, indicating that there are problems around defining

their constituents, lack of training in engagement and inadequate resources. As such, just 32% of governors reported that they had effective channels to communicate with their constituent membership (Lewis, 2005).

3.15 Whilst there is national guidance that Governors should adopt one of three roles (advisory, guardianship or strategic), in practice, much confusion has arisen as to the exact nature of their role. A number of reports have indicated that Governors experience a high degree of initial uncertainty as to their role and responsibilities (Lewis, 2005; Chester, 2005).

3.16 The need to provide a systematic and ongoing programme of training for Governors has been highlighted to provide support and help develop their role (Healthcare Commission, 2005; Day & Klein, 2005; Chester, 2005). Priority areas in which training was needed included: developing an understanding of the governor role, help in setting work objectives and strategies for engaging and communicating with the public and other constituencies (Chester, 2005).

3.17 There is consistent evidence to suggest that Governors need more resources in order to fulfil their roles and responsibilities, particularly in communicating with their constituents (Chester, 2005, Lewis, 2005, Day & Klein, 2005).

3.18 The number of meetings of Board of Governors that take place would appear to be important, not only for democratic accountability, but also in helping to shape and define the roles of Governors (particularly in its early formation). A study at the Homerton Hospital Foundation Trust indicated that Governors felt that 6 meetings per year were insufficient to help understand their role and develop a programme of work relating to this (Lewis, 205). Proposals from the Whittington indicate that the Board of Governors will meet 3 to 4 times a year.

3.19 Survey data among Governors suggests that there is future optimism for the role and effectiveness of the Board of Governors (given time and experience in role). National survey data has indicated that Governors believe that 70% of governors will become more effective in the future (Chester, 2005). The downside of Governors developing experience and a grater ability to contribute, is that the propensity for 'informal co-option' also increases. This may have implications for conflict of interest to arise in respect of accountability and representation of Governors.

- **Will Governors be representative of the local community?**
- **Will the composition of the Board of Governors reflect the diversity of the local community?**
- **What training will be available for Governors to help them fulfil their role and obligations?**
- **Will there be an indicative budget for the Board of Governors?**

Directors

3.20 The Board of Directors is made of Executive (appointed) and Non Executive Directors, the Chief Executive and the Chairman. The responsibilities of the Board of Directors within the proposals for the Whittington Foundation Trust include:

- Day to day (operational) management
- Service performance
- Financial planning and performance
- Overseeing long term (strategic) planning

3.21 The Non executive director role has become of increasing importance to ensure that Foundation Trusts have the necessary skills and expertise to help manage and direct such a complex organisation. In Foundation Trusts, Directors have reported that there is now more local control over appointments has been found to beneficial in helping to select the right skill base for their executive needs.

3.22 Foundation Trusts Boards are required to self certificate their projected performance in relation to finance, governance and mandatory provision of goods and services. Monitor has indicated its concern at the level of over optimistic expectations and inaccurate predictions within the sector, given the number of Foundation Trusts failing to meet set objectives. Monitor has indicated that independent reviews of self certification will be undertaken if this pattern continues in 2007/8.

Relationship between the Board of Governors and the Board of Directors

3.23 There is strong evidence to suggest that the operational role of the Board of Directors is clearly set out and understood by all parties.

3.24 The role of the Board of Governors in strategic planning however has proved more contentious and proved to be a source of great tension in the relationship between the Board of Governors and the Board of Directors (Day & Klein, 2005, Lewis, 2005, Chester, 2005).

3.25 Analysis of the operation of both Board of Directors and the Board of Governors suggest that the Chairman (who Chairs both) and the Chief Executive play a significant in driving the agenda of the Boards. Governors also reported that the dual role lead to conflict as they lacked their own Chair through which to hold the Board to account. In its audit of Foundation Trusts,, the Healthcare Commission (2005) has questioned the role of the Board of Governors in influencing the decisions of the Board of Directors.

3.26 No details are provided within the Whittington Foundation Trust consultation document as to how both boards will interrelate, the Chairman will however chair both boards.

- **How will the Board of Governors have meaningful influence with the decisions of the Board of Directors?**

- **What will be the Board of Governors role in strategic planning for the Trust?**
- **How will an effective relationship between the two Boards be forged at the Whittington Hospital?**

4. Partnerships and the local health economy

Primary Care Trust

4.1 PCTs will be required to enter new legally binding three year contracts with the Foundation Trust. Evidence from other scrutiny reviews (Camden, Birmingham) indicates that there needs to be a careful evaluation of the local PCTs capability and capacity to mange the new relationship with the Foundation Trusts, particularly in relation to commissioning, contract monitoring and performance management.

4.2 Concerns have been noted in respect of the long term (3 year) legally binding contracts that PCTs will enter in to with Foundation Trusts and the flexibility that the PCT will have to develop more primary care based models of service provision (as set out in the review of London NHS services). This is particularly important at this juncture as the PCT is developing its Primary Care Strategy.

4.3 As Foundation Trusts are likely to have contracts with a number of PCTs and operate from a position of greater strength than individual PCTs, there is a danger that services may become provider led (i.e. set by the Foundation Trust). This is particularly pertinent given the development of Practice Based Commissioning, as service are commissioned from smaller purchasing units (groups of GPs). Consortia or joint commissioning arrangements (already developed for specialised services) may increase the ability of the PCT to direct and determine the nature and level of service provision at Foundation Trusts.

4.4 PCTs may need to develop more robust monitoring systems to ensure that 'case mix drift' does not occur, where Foundation Trusts 'select' patients on the basis that certain interventions attract a higher tariff or that certain conditions are associated with higher costs. This situation may be particularly prevalent where there is a high for demand services.

4.5 It is noted that disputes between Foundation Trusts and PCTs have occurred. In such disputes the regulator (Monitor) has been reluctant to become involved encouraging parties to seek local resolutions to problems that occur. A number of these disputes have been facilitated by local Overview and Scrutiny Committees.

- **Does the PCT have the capacity, skills, expertise and infrastructure to commission, monitor and performance manage contracts with the Foundation Trust?**

- **What steps will the PCT take to ensure that the commissioning process is truly commissioning lead?**
- **Will there be sufficient flexibility within the contracts to allow the PCT to develop its primary care based models of service provision?**
- **What will be the role of Practice Based Commissioners be with the Foundation Trust?**

Other partnerships

4.5 Foundation Trusts have a 'Duty of Partnership' with other health and social care institutions in the locality which is obligatory under the terms of their licence. There is however, no mechanism to assess or monitor this. All major partners however, have nominated Membership to the Board of Governors.

4.6 The new financial freedoms available to Foundation Trusts may be likely to place them at a considerable competitive advantage over other NHS trusts in the local health economy. How this may relate with 'Duty of partnership' is undefined, thus there may be need to ensure that Foundation Trusts do not act in an uncompetitive manner.

4.7 It is noted that the North Middlesex Hospital and Barnet, Enfield & Haringey Mental Health Trust are currently preparing applications for Foundation Trust status (also to be submitted in 2008), thus if all local applications are successful, the impact of an 'unequal playing field' among acute trusts may be limited.

5. Impact on local people

5.1 The Whittington Hospital consultation document indicates that new freedoms available within Foundation Trust will be used to prioritise developing services to meet local needs. As such, patients may see an improvement in services through:

- New governance arrangements will ensure that the Hospital is more accountable to the local community (i.e. patients and public on Board of Governors);
- Operation of the Membership will enable local people to become more involved and bring closer links to the community;
- Services may be more responsive to community needs through more localised control over finances (i.e. the reinvestment of operating surpluses in local services) and improved arrangements for patient and public feedback (i.e. through the Membership);
- Speedier access to capital will give staff better facilities and equipment to maintain high levels of patient care.

5.2 In an audit to assess the impact of Foundation Trusts, the Healthcare Commission (2005) found that access and the quality of services available to patients had improved through a number of ways:

- The existence of business strategies that focussed on growth and the development of new services for patients;

- Increased ability to plan and develop services more quickly;
- Had greater ability to focus on patient priorities, particularly access to services and patients environmental concerns;
- Improved financial management of services;
- No real variance in clinical networks or the pathways of care experienced by patients.

5.3 Although early evidence would suggest that Foundation Trust status has had little impact on clinical networks and care pathways, commentators have urged ongoing collaboration to ensure that Foundation Trust status does not strengthen institutional boundaries which may make it more difficult to ensure that patients continue to receive an integrated package of care.

5.4 The Whittington Hospital's would currently appear to be performing well with overall performance rated as good by the Healthcare Commission (2007). For assessment of core standards in the quality of services the Trust is rated as 'good', core standards (i.e.. clinical guidelines) have 'almost been met', national targets (i.e. waiting times) have been 'fully met', new national targets (i.e. health inequalities) the performance has been rated as excellent (Healthcare Commission, 2007).

5.5 Not all Foundation Trusts are currently meeting core NHS standards, a pre-requisite within their licence to operate. In total 25 Foundation Trusts are not meeting all core standards, 22 of which are failing to meet infection control measures (MRSA) or not predicted to meet reduction targets. (Monitor, 2007) Monitor has indicated that it is unacceptable that Foundation Trusts are predicting an operating surplus whilst still continuing to breach standards which are part of their licence agreement, most notably MRSA. The Whittington is currently rated as 'under achieving' on MRSA targets (Healthcare Commission, 2007).

5.6 The Healthcare Commission conduct a national annual patient satisfaction survey in the acute sector where patients are asked to rate services according to admissions, the hospital ward, treatment received and interaction with doctors and nurses. In this survey, the Whittington scored in the top 20% of Trusts for 5 variables and scored in the bottom 20% of Trusts for 14 variables (Healthcare Commission, 2007a).

How will the acquisition of Foundation Trust status help to meet local health inequalities targets?
What will be priorities for service improvement and service development once Foundation Trust status has been achieved?

6. Finance

6.1 Overall the Foundation Trust Sector is financially stable with a predicted operating surplus of £198 million predicted for 2007/8. 57 of the 59 Foundation Trusts are predicting an operating surplus in 2007/8. Projected operating surplus across the sector varies from £10,000 to £14.45 million

(median £1.81million). There is evidence that the Foundation Trust sector is reducing operating costs, where £344million (3%) of cost savings have been achieved in 2006/7.

6.2 All Foundation Trusts are prescribed a borrowing limit set by the regulator based on an individual assessment of their finances. Increases in capital expenditure (2005/6) would appear to be financed predominantly financed through public sector loans (£137m), though other sources were used such as private sector loans (£74m) and disposal of assets (£63). There is a however a concern that there is an under development of capital in the Foundation Trust sector at present given the uncertainty around PCT commissioning plans.

6.3 There is evidence to suggest that there is a strong financial monitoring system in place to support Foundation Trusts. Those Foundation Trusts that fail to meet standards set by the regulatory authority are required to submit monthly recovery plans.

6.4 Monitor has an 'Asset Protection' process to ensure that there is due process in the disposal of key capital assets of Foundation Trusts.

- **How will the Whittington use new financial freedoms available under Foundation Trust status?**
- **What are the consultation processes for any plans to dispose of capital assets?**
- **What are the investment priorities for any operating surpluses?**

7. Relationship with Overview and Scrutiny

7.1 The relationship of the Foundation Trust with Overview & Scrutiny Committee should continue as before, with one exception, that appeals should now be directed to Monitor (the Foundation Trust regulator) instead of the Secretary of State. There is no public evidence of any appeals being lodged to date with Monitor.

7.2 Patient and Public Involvement Forums will be dissolved in April 2008 and be replaced by Local Involvement Networks (LINks).

- **What will be the implications of the establishment of Local Involvement Networks (LINks) for the Foundation Trust?**
- **How will the Membership of the Foundation Trust interrelate with LINks?**

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