



Mutual Interest

Can we learn from Foundation Trusts' approach to engagement?



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Introduction

Somewhat nervously we are all starting to talk about the future of governance and engagement in NHS Wales. The recent consultations across Wales on acute service reconfiguration made us think again about public participation and people power. The Beecham Review is also likely to reignite the discussion on democracy in the NHS, with the focus on citizen-driven public services and the subsequent emphasis on community leadership, partnership working and the respective roles of local councillors and non-executive/officer members.

Against this background, the purpose of this paper is to help navigate through the issues, and to prepare us for the debate ahead. In particular, we focus on the approach to governance and engagement within Foundation Trusts in England, suggesting that this may offer useful pointers to us in Wales.

To say this is emphatically not to argue for Foundation Trusts in Wales. It is, however, to say that their work on engagement is particularly interesting and helpful in exploring more effective ways of engaging and involving citizens in our decision-making. Just as we can learn lessons from Kaiser Permanente without advocating a US-style health system, so too we can look at FTs' work on engagement without needing to import the entire market-oriented policy context within which they operate. The fact is that any initiative which has succeeded in recruiting over 600,000 members – more than all the political parties across the UK combined – certainly deserves examination, as we search for an approach to governance and public engagement which is right for Wales in the twenty-first century

Part 1 – Engagement and involvement

Relationships with the public – a priority and a problem

What makes a public service public? In their paper under this title, written for the Public Management Foundation in 2001, Jane Steele and Paul Corrigan argue that public services matter enormously to people, and that political parties are therefore right to put them at the centre of their election campaigning. But they also underline how this means relationships with the public must be pivotal in the systems of public service governance. The same point is made in a report by the Scottish Office, *Customer and Citizen Focused Public Service Provision*. One of the key characteristics that distinguishes public sector organisations, the report argues, is a need to be responsive to the views and aspirations of the public in their capacity as citizens, and not just as customers or users of individual services.

However, experience everywhere shows that engaging effectively with the public is a lot easier in principle than it is in practice. Public sector organisations adopt a range of different approaches to engaging with the public as citizens that can be described as passive, deliberative or participatory. The latter approach appears to be what we should aspire to, with citizens actively and directly involved in all stages. But the norm would still appear to be the passive approach, where people respond to predetermined issues or questions, or the deliberative approach in asking questions or questioning evidence.

Problems in engaging with the public are not confined to health issues, or to consultation exercises. From their *Public policy-making: a literature review* the Scottish Executive found that across many different contexts there was concern that civic participation appeared not to have made a significant impact on decision-making. There was a lack of public awareness of the scope of power at different levels of governance, and this created difficulties in meeting their expectations about impact.

One common response to the difficulties of engaging with the public is to claim that the public is apathetic. However, this alone will not suffice as an explanation. *POWER*, an independent inquiry into democracy in Britain set up by the Joseph Rowntree Charitable Trust, draws on a great deal of research evidence to show that very large numbers of citizens are engaged in community and charity work outside of politics. There is also clear evidence that involvement in pressure politics – such as signing petitions, supporting consumer boycotts, joining campaign groups – has been growing significantly.

For instance, one of the big stories in early 2007 has been the unexpected popularity of the internet petition against road pricing, which attracted well over a million signatories, to the amazement of politicians, civil servants and other commentators.

We have seen for ourselves recently very graphic evidence of the strength of feeling about health issues here in Wales, with protests over proposals to change services. In addition, a BBC survey showed that health was the top of a list of 25 issues of public concern in Wales, a full 20% ahead of the next nearest subject. Evidence such as this suggests that the difficulties in engaging with the public cannot be attributed simply to public apathy. There are other factors at work here, and research into engagement in local politics more generally provides a clue to the way forward.

Local democracy - In what form for health care?

Devolved government and its application in a small country such as Wales reinforces the importance of political control - at a national level - of strategic direction, policy and national health targets. However, the role of local politicians in health governance at a local level appears less clear-cut.

The findings from the Local e-Democracy National Project show that the big challenge now for local politicians is to get closer to the electorate and keep voters interested in local issues.

As John Curtice observes in his paper *The Crisis of Local Democracy in Britain (1999)*, local elections fail to engage the participation of a majority. Citizens are no longer happy with traditional forms of representative democracy because those forms do not give them sufficient opportunities to express their views. So, as well as the state appearing less efficient, the democratic political system is now less likely to be considered efficacious and able to respond to the demands made on it by an increasingly self-confident citizenry. As a result, people are less likely to participate in conventional politics but to look instead to less conventional means such as protests and demonstrations in order to get their views across.

This perhaps helps explain why a recent MORI poll should show that a large majority of the public did not want politicians involved in decisions about medicines or treatments

Which, if any, groups of people should make decisions about which medicines or treatments are funded by your local NHS?

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| Clinicians working in the local NHS (e.g doctors and nurses) | 70% |
| Patient representatives | 33% |
| Managers working in the local NHS | 23% |
| General public representatives | 21% |
| Members of Parliament (MPs) | 9% |
| Local councillors | 6% |

It is of course extremely important, based on our country's democratic traditions, to find ways to ensure that local elections can achieve a better turnout from the electorate and provide a stronger and more effective base for local representation. This is crucial in Wales, in the context of the health debate, not only to support local government in carrying out its important community leadership role, but also to underpin the role and contribution of local councillors to the development and success of public service partnerships.

However, strengthening the representativeness of local councillors, based on the evidence above, would not seem enough to give citizens a feeling of ownership of the NHS. Citizens do not feel that the processes of formal democracy offer them enough influence over decisions. The point applies not just to elections, but also to consultations and other traditional mechanisms – such as the public meeting - used by the public sector to engage with the public. Moreover, there sometimes appears to be a lack of clarity about why public sector organisations want to engage with citizens and what they plan to do with the feedback they receive. In other words consultation is not always focused on clearly defined questions and linked to decision-making processes. Citizens are often more comfortable responding to practical issues that address their immediate concerns than what they may perceive as more “abstract concepts”

The problem, in short, lies with the processes and systems of engagement, not simply with an allegedly “apathetic” public. The Power Inquiry put the underlying problem very succinctly: “while British society has been fundamentally transformed in the last forty years, the political system has not”. As Steele and Corrigan argue, the relationship between the public and public services is constantly in flux, defining anew and redefining the expectations and responsibilities that accrue

to each party. It is therefore imperative that our systems of engagement, dialogue and mutual education also move with the times, which means going beyond the formalities of public consultation exercises and infrequent elections.

This is not to say that we should dispense with these established mechanisms, or wish to see them weakened. And there is no reason to think that fostering new means of engagement would bring this about. As Jonathan Freedland argues in *Bring Home the Revolution*, which looks at democratic participation in America, different ways of engaging with communities, far from competing with one another, can serve to reinforce each other: a rising tide of engagement can lift all boats.

New ways of involving people – the feeling is Mutual?

If the public can become good corporate governors of public services then we would have a new form of accountability in public services that might be even more focused than traditional ballot box accountability. This is the prospect held up by Paul Maltby of the Institute of Public Policy Research in his New Economy article *Public Interest Companies – Fad or Permanent Feature?* (2003)

In their report *A Mutual Health Service* (14/11/02), Ruth Lea, Head of the Policy unit at the Institute of Directors, and Ed Mayo, the Director of New Economics Foundation, say that there is no exclusive definition of mutuality. At its most simple, mutuality is an institutionalised, value-based model of reciprocity. But a mutual is not a single legal form. Some general points they offer are:

- A mutual is an enterprise owned by its members, which provides a variety of services to its members for their benefit.
- Mutuality may be used to describe mutual models of ownership or decision-making, mutual methods of doing business or simply a mutual ethos.
- Historian Dr Bob James describes mutuality as “a contractual arrangement, which may be unspoken, between a group of people, as few as two, wherein it is understood that no member of the group stands in a superior position to any other in terms of voting power, ownership rights or accrued benefits”
- Examples of mutuals include agricultural co-operatives, building societies, banking mutuals and credit unions, communications co-operatives and co-operative Internet service providers, consumer co-operatives, energy co-operatives, fishing co-operatives, health provision and insurance mutuals, housing co-operatives, mutual insurers,

tourism, and worker co-operatives.

- There are over 700 million members of such organisations worldwide. In the UK the largest sectors are in agriculture and consumer cooperation (the Co-op, which has an annual turnover in retailing of some £10 billion, plus banking and insurance assets of around £30 billion). In other countries, other sectors are more prominent, such as credit unions in North America, and worker co-operatives in some other parts of Europe.

Lea and Mayo reject the privatisation of essential health services, arguing that independent non-profit mutuals will be more efficient. The future of the NHS, in their view, lies in extending the proposals for Foundation Trusts far beyond their current scope, but in a very different form.

Professor John Kay, director of London Economics, has set out several reasons for bodies such as hospitals becoming mutuals. There are specific needs that a competitive market may not meet well. These include situations where:

- i. customers alone have knowledge that is specific to the business;
- ii. there are not only individual, but community, benefits from the activity;
- iii. the service is a local monopoly;
- iv. the market has missed an opportunity.

Lea and Mayo believe that for health services the last three of these apply. With regard to point iii, with the NHS there is a divorce between the users and the suppliers of services; there is no link between the financing and provision of services, and users cannot generally go elsewhere as the NHS is virtually a local monopoly.

In principle, mutuals can therefore be the most efficient way to provide current health services. There are, of course, different types of mutuals. A traditional distinction is between consumer mutuals and those owned by staff – producer mutuals. Both have potential merits in terms of healthcare – giving a say to patients or to staff. However, it is also the case that one group alone running a mutual can exercise a bias towards their interests over those of others. For this reason, Lea and Mayo recommend a stakeholder mutual – where a balance of different interests is represented.

The authors remind us that the starting point for Foundation Trusts to date has been hospitals. These have the advantage of a clear public profile and potential for involvement. Most people could name their local hospital, but few could name their local Primary Care Trust. Yet the nature of primary

care, being lower-tech and often involving longer-term relationships, is in many ways more open to the active and meaningful involvement of patients. For Primary Care Trusts, despite the complexity of being both commissioners and providers of healthcare, mutual status could therefore represent a significant opportunity.

In their report Lea and Mayo say that what is needed is not an imposed solution, but a licence to experiment, including the freedom to move beyond the current configuration of primary and secondary care, for example testing the scope for a single co-operative network of local health provision. But they also believe that there is another intriguing set of reasons for exploring mutuality in relation to health. To a degree, ill-health, and particularly who gets ill, may be the result of the atomisation, stress and anonymity of a less than mutual society and economy.

Successive reports over the last twenty years have highlighted that poor health is unevenly distributed, affecting the most disadvantaged and vulnerable. Many of the drivers of ill-health, therefore, lie outside of the traditional remit of the NHS. This opens up wider questions, such as the costs of inequality and the scope for a 'health promoting economy' but also point to the potential value of health-care models that help to underpin trust and mutual security.

Lea and Mayo assert that what makes new thinking on mutuality different from the traditional model is its emphasis on participation. We have lived through a period where mutual building societies – the main area where people found themselves involved with mutualism – were indistinguishable from non-mutuals. Membership was expressed by an annual vote, normally just to rubber-stamp nominated members of the board. Thanks to the dominant political debate during the 1940s, mutualism was about 'ownership' – and little more than a narrowly legalistic interpretation of it. While participation without ownership can clearly be patronising and exploitative, ownership without participation is often meaningless – as it was with many of the building societies. That is why public ownership all too often does not mean a public sense of ownership.

The new mutualism tries to redress this balance, realizing that in the NHS – as with other public services – professionals can't succeed without active involvement with the public. There is a growing – though not yet universal – understanding of just how much healthcare depends on the co-operation of patients. Doctors complain that it is hard to get patients to change their lifestyles when it comes to eating, lack of exercise or smoking. Alcohol and drug rehabilitation programmes can't work without the enthusiastic cooperation of the people involved and they must also have a support group.

The same is true for bypass surgery or hip replacements. Patients will not recover without some kind of support group who make sure they are not lonely, that they have food in

the house, and that they have somebody to turn to if they succumb to depression. Equally, mutuality implies that they too can have responsibilities. Lea and Mayo believe that it may not be the formal, legal responsibilities of the market and commercial exchange, but mutuality can have a hard edge to it if it sets clearer notions of the responsibility that patients have. This might be in terms of something like diet or self-diagnosis (after all, self-help and mutual aid have always gone hand in hand) or simply in turning up to appointments, avoiding free riding that sees some patients waste resources, to the cost of others.

In this context and in public services generally, mutuals therefore provide a possible route to making services more responsive through building service-users into the governance structure. Following this line the concept of the Public Interest Company is being increasingly considered in public service reform and has led to the formation of Foundation Trusts in the English NHS

Foundation Trusts - new mutuals

In an article in the Guardian on December 2, 2002, Ian McCartney, the then vice-chair of Labour's National Policy Forum, argued that Foundation Trusts were rooted very strongly in the mutuals tradition. He said that NHS foundation hospitals were intended to provide a new form of public ownership, that locked the public resources of the hospital into ownership by the citizen in the community: owned by the community, for the community, serving the community with members drawn from local residents and patients and he saw this as securing, for the first time, strong local ownership and a real connection between local people and their hospital. While they will actually own the hospital and all assets, the owners of NHS foundation trusts, unlike building societies, would not be able to sell these assets to the private sector; they will have to remain in public ownership.

Significantly, McCartney argued that those with some knowledge of the history of working-class people in the UK would recognise that a localised form of ownership has an important role in our politics. He said that mutual organisations have been an essential part of our history and that the Bevens, the Morrisons, the Attlees et al - as the architects of the first comprehensive welfare state in the world - took enormous risks to create a model of public ownership. The government were creating a different and newer model, one in which the public will know that they, and not Whitehall, own the country's public assets. In his view, public ownership which meant exactly that: owned by the public.

The purpose of exploring mutualism in the NHS is not to argue for Foundation Trusts In Wales. The concept of a healthcare marketplace, with a pluralistic and competitive environment that pits state and private sector providers against each other, is not politically acceptable in Wales. It is merely to say that the relationships that Foundations are establishing with

patients, communities and stakeholders may provide some pointers for us in Wales. We can perhaps learn from their approach to governance and engagement, without having to adopt the overall market approach within which they operate. Foundations provide a means of devolving accountability to local stakeholders including NHS patients and staff. They take very seriously their responsibilities to patients and the public, who are very much at the heart of the organisation.

They operate governance arrangements that give local stakeholders and the public opportunities to influence the overall stewardship of the organisation and its strategic development. Such a model could be developed in Wales to introduce the concept of mutualism and public interest into the NHS.

It is still early days for Foundation Trusts in England, and it is impossible to say what different forms they may take. However, the debate in England has now started about introducing Community Service Foundation Trusts, and about the governance of primary health care.

In Wales we have to consider where the concept of mutualism could be most effective. The answer could be at both LHB and Trust level. At a population health level, public involvement through wider membership of LHBs leading to the election of some governors could be beneficial in the key issues of health strategy and service commissioning. At the service provision level, NHS Trusts could well benefit from the membership and election of governors. On the face of it this might address the so-called democratic deficit and could help to fulfill our aim in Wales to involve people more directly in the direction and governance of the NHS.

Beecham describes in detail the advantages of the citizen model and said that it may be more successful in offering different forms of choice and voice. The citizen model may also be more successful in creating a stronger relationship of trust with the public, which may be less strong in the consumer model. It also has the potential to recognise a more complex and longer-term relationship with public services, encompassing both service users, and the wider public who have an interest in the overall pattern of services and their efficiency. Furthermore, it recognises that the public have both rights and responsibilities: rights to receive services but also responsibilities to be concerned about the services available to everyone else.

The concept of mutuality and public benefit could well fit the citizen model and we could build on what we see in Foundation Trusts. With between half a million and one million members Foundation Trust governance - or some form of it - could be seen as an effective way of forging a closer and more democratic relationship between the NHS in Wales and the citizens it serves. The next section therefore looks at Foundation Trusts and their approach to engagement, to see what lessons it may hold for us in Wales.

Part 2 – Foundation Trusts – our mutual friend?

So what exactly is different about NHS Foundation Trusts?

The enabling legislation for Foundation Trusts (FTs), set out in the Health and Social Care (Community Health and Standards) Act, came into force in November 2003. The first 10 Foundation Trusts were authorised by Monitor, the new independent regulator, on 1 April 2004.

Since then, more Foundation Trusts have been authorised in successive waves. As of February 2007, there were 54 FTs in England, with 625,000 members.

The government has made a commitment that all NHS trusts will have the opportunity to apply for foundation status by 2008. If this ambition is retained, the FT governance model in England will become the norm.

FTs are different from existing NHS Trusts in the following ways:

- They are independent legal entities – Public Benefit Corporations.
- They have unique governance arrangements and are accountable to local populations
- They have a Board of Governors (comprising patients, staff, members of the public and partner organisations) which oversees the strategic planning of the organisation.
- They are set free from central Government control and are no longer performance-managed by Health Authorities. As self-standing, self-governing organisations, FTs are free to determine their own future.
- They have new financial freedoms and can raise capital from both the public and private sectors within borrowing limits determined by projected cash flows and therefore based on affordability. They can retain financial surpluses to invest in the delivery of new NHS services.
- They are overseen by Monitor.

Foundation trusts remain part of the NHS and retain a duty to treat patients according to NHS quality standards and principles - free care based on need, not ability to pay.

Foundation trusts in numbers:

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| 54 | Number of FTs in England as of February 2007 |
| £10.8 billion | total income of these FTs, accounting for 25% of all trust activity in England |
| 625,000 | total number of FT members – more than all the main UK political parties put together |
| 75% | Percentage of members who are from patient/public groups |

Membership of Foundation Trusts

FTs have a duty to engage with local communities, to encourage local people to become members, and to ensure that the membership is representative of the communities they serve. To avoid a situation where membership is dominated by a minority of pressure or professional groups, FTs need to demonstrate that the full range of potential members' interests is represented, and that there is a proper balance between different groups.

Members of an NHS FT have a number of important roles to perform as they are able to:

- elect representatives to the Board of Governors
- stand for election to the Board of Governors
- put themselves forward for appointment as Chair of the Trust or Non-Executive Directors on the Board of Directors

FTs strengthen local ownership of – and responsibility for – hospital and other health services. Major decisions are informed by active participation from members based in local communities:

- Residents and patients in areas served by an FT, with an interest in the wellbeing of their local hospital and health services, can register as members of the organisation. FTs may also allow for patients who do not live locally, and their carers, to become members.
- Members of FTs do not receive any special treatment as NHS patients and users. They have the same access to NHS services as anyone who chooses not to become a member.
- All FT members can expect to receive regular information about their local Trust and be consulted on plans for future development.
- Members are able to vote in elections to the Board of Governors of the FT. They can also stand for election as governors, and public members are eligible to be appointed as non-executive directors on the Board of Directors.

There is no limit on the number of people who can register as members, providing they meet the eligibility criteria. It is for FTs to ensure they have a representative membership and sufficient members to mount credible election processes.

Beyond minimum legislative requirements and those of the terms of authorisation, it is up to each FT to make its own arrangements for membership recruitment and retention, and for communicating with its membership base.

The wider governance structures of FTs are seen to give them legitimacy and authority. Most are developing their business plans in close consultation with their stakeholders as represented in their membership and wider governance structures.

Foundation Trusts are keenly aware of the need to listen to the whole community, not just members. But as membership structures grow in strength and confidence their significance as the source of stakeholder authority and FT accountability should be recognised.

The existing foundation trust governance structure could carry out the roles of - and potentially replace - patient forums in England. In future, as 'go anywhere' models, there will be much greater diversity in FT's organisational objectives and structures.

Examples of how FTs are involving their members can be found in part 3.

The Board of Governors

- is responsible for representing the interests of the local community in the management and stewardship of the FT, and for sharing information about key decisions with other FT members.
- is not responsible for the day-to-day management of the organization e.g. setting budgets, staff pay and other operational matters – that is a matter for the board of directors. However, the board of governors allows local residents, staff and key stakeholders to influence decisions about spending and the development of services.
- appoints the chair and non-executive directors of the board of directors.

It is up to each individual NHS Foundation Trust to determine the detail of the arrangements for the membership and election to the board of governors, within certain parameters. In particular, elections must be fair and transparent. Governance arrangements are ultimately tailored to the individual circumstances of each Trust, reflecting the range of diverse relationships with patients, the local community and other stakeholders.

FTs are allowed some local flexibility over the size and composition of their board of governors. However, every board must have:

- A majority of governors elected by members in the public constituency;
- At least one governor representing local NHS Primary Care Trusts;
- At least one governor representing Local Authorities in the area;
- At least three governors representing staff;
- A chair;
- At least one governor appointed from the local university (if the trust's hospitals include a medical or dental school).

The Board of Directors

Boards of directors will increasingly have to operate as corporate entities, not sounding boards, in an English policy context of contestable service provision. This requires a fundamental change in the role of all members of the board.

The chair has a pivotal position in the governance of Foundation Trusts, not just the chief executive. They provide leadership and guidance to the chief executive, and, as chairs of the board of governors, are the key link between the governors and directors. It is the chair's job to unite the constituent parts of the governance model to ensure the two boards work effectively together.

Executive directors must make the transition from operating as functional heads of service to members of a corporate board, bearing the full weight of the fiduciary responsibility that falls on their shoulders and contributing fully to the strategic decision-making of the trust.

Non-executives face an equally significant change. As their traditional role as guardian of the community interest is increasingly transferred to the board of governors, non-executives in foundation trusts must take equal responsibility and accountability for the functioning and success of the business. While financial risk has been under the spotlight so far, Foundation Trusts must also demonstrate their effective management of clinical risk.

Freed from top-down performance management from the Department of Health, boards of directors need to evaluate their own performance, and be capable of performance managing the organisation to achieve excellence. Effective stakeholder management is equally vital. As public benefit corporations, foundation trusts are faced with a complex set of relationships and accountabilities: to the board of governors; to the wider membership and local community; to PCTs as commissioners of their services; and to Monitor as the regulator. Managing these multiple accountabilities in an effective and transparent way and building strong relationships must be at the top of the agenda of the foundation trust board.

To survive and thrive in this new world, FTs must build a team of directors with the skills to take on these new challenges.

Regulation

Monitor oversees all FTs to ensure compliance with the terms of their authorisation. The role of Monitor is designed to give FTs the freedom to deliver services to meet local needs while safeguarding the interests of NHS patients. In normal circumstances Monitor will have no reason to intervene in the running of an NHS Foundation Trust.

Like all other NHS bodies in England, NHS Foundation Trusts are inspected against national standards by the Healthcare Commission which produces an annual performance rating for the Trust. Monitor receives copies of inspection reports and decides what, if any, action is needed in the event of failings.

Part 3 – Harnessing people power: How FTs are doing it?

Chesterfield Royal Hospital NHS Foundation Trust

Consulting members on changes to visiting hours

Chesterfield Royal Hospital NHS Foundation Trust consulted public and staff members on new proposals to change visiting hours at the hospital. As part of plans to reduce hospital-acquired infection, members were asked if visiting hours should be reduced. In exchange, more cleaning would take place on wards and a new visitors' code would be adopted – including a ban on more than two patients per bedside.

Almost 5,000 responses were received (nearly 50% of the membership). Over 96% were in favour of the new code. However the trust was asked to extend afternoon visiting from a proposed one hour, to a two hour slot – to help visitors travelling long distances. The trust agreed to this change. The consultation led to major changes in the way the hospital operates being implemented, with total support from staff, patients and local people.

Frimley Park Hospital NHS Foundation Trust

Foundation Trust Governor/Member Constituency Meetings

Frimley Park Hospital is involving local patients and the public – their members – in constituency meetings which have now been running for over a year. These are led by their governors, elected by the members themselves. Frimley Park has also undertaken regular patient and member surveys, some of which have resulted in changes in practice at the hospital.

Six meetings were held in the autumn of 2006, spread geographically across the local area. Nearly 400 foundation trust members, patients and members of the public attended these events. Each meeting had a clinical focus and also incorporated a strategic planning update followed by the governors conducting an Open Forum session. A board member attended to hear the public's comments and take questions.

Following the success of the meetings, governors have agreed that they should be held 2-3 times a year. Frimley Park is one of the first foundation trusts to hold members' meetings. These are now seen nationally as an example of good practice in foundation trusts and others are developing similar ways of meeting, and listening to, their local populations.

Lancashire Teaching Hospital NHS Foundation Trust:

Oversubscribed for "Focus on..."

Lancashire Teaching Hospitals NHS Foundation Trust has held a number of successful members' events based on clinical subjects, which have proved so popular that each has been oversubscribed. They have followed a 'Focus on' theme, so far covering diabetes, bowel cancer and the work of its cancer centre. A networking session between members and governors is included within the programmes, and feedback forms for comments to be recorded and answered are made available. The interest in attending such events has been unprecedented. Almost 600 ticket requests were also received for the Annual Members' Meeting, requiring a new venue to be booked.

Stockport NHS Foundation Trust:

Championing youth governors

The constitution at Stockport NHS Foundation Trust allows membership from the age of 16 onwards. However the trust is keen to ensure that there is a way for the views of children and young people to be heard. They have a dedicated appointed Youth Governor on their Board of Governors, recruited from, and supported by, the local Corporate Youth Service. They have also established a Young People's Engagement (YPE) Committee - with membership from governors and representatives from internal and external agencies, chaired by the youth governor.

As part of its PPI strategy, Stockport has also set up a "Foundation 500" panel. This operates like a 'Citizens Panel' - gathering opinions from 500 members on specific topics by completing a questionnaire, with the opportunity to attend a member feedback meeting when the results have been analysed and the report written. Their first F500 questionnaire was sent to 575 members. 353 completed questionnaires were returned representing a very high response rate of over 61%.

Reaching the public:

All foundation trusts are engaged in initiatives to involve their governors and members. The following are common ways that foundation trusts are reaching the public:

- **‘Medicine for Members’ seminars** – events on key health themes, led by health professionals for the public, such as cataract surgery, breast cancer services, cardiology, infection control, diabetes.
- **Focus groups** on specific projects being carried out by the hospital e.g. infection control, disability access, smoking policies, communications, privacy and dignity, thus providing a public, patient and carers’ perspective. For example, governors in Cambridge University Hospitals NHS Foundation trust have led focus groups with members on issues including hygiene, hospital food and patient information. A set of standards and recommendations for the whole organisation is now being produced.
- **Members’ newsletters and websites** keep all members up to date, with regular information about their local hospitals being received by all half a million foundation trust members across the country. Responses to these newsletters is often very high. For example, the first Gateshead Health NHS Foundation trust newsletter included a questionnaire about how members wanted to get involved. Over 2,000 members responded. Queen Victoria Hospital NHS Foundation trust produces a quarterly newsletter to give people an opportunity to give feedback on the trust’s services and to shape new developments. Each newsletter leads to over 100 responses from FT members with their views about the trust’s performance.
- **Public surveys and campaigns** have also been used by many foundation trusts to consult members of the public and to engage their local communities. For example, South Essex Partnership NHS Trust used the platform of its public consultation on FT status to raise awareness of mental illness and reduce stigma. They ran a major public campaign which resulted in 7,000 members joining the Trust in less than three months.
- Foundation trusts are also **working with the boards of governors** to listen to their views about new service developments. For example, governors at the Royal Marsden NHS Foundation trust have supported proposals to extend specialist areas of cancer surgery. But they have also demonstrated their strategic role by advising against plans to expand screening services - advice that the board decided to accept. With more than £9million to be spent on capital development over the next few years, governors in Chesterfield Royal Hospital NHS Foundation trust have worked with directorate teams, estates staff, patients and external contractors to look at the proposals from the public’s viewpoint. As a result, an out-patient project has been re- evaluated after governors raised concerns over its potential location.

Conclusions

The need to put our citizens at the heart of our public services is a huge challenge facing us in Wales. The problems which we have experienced in engaging effectively with the public cannot simply be blamed on public apathy. There is a more fundamental problem, which has to do with a wider crisis of trust and legitimacy in the established mechanisms of dialogue and engagement.

Mutuals and public benefit organisations are one possible way forward, which can help increase local accountability and involvement. And as the most prominent examples of mutuals in the NHS, Foundation Trusts deserve serious study. It would be wrong to dismiss everything about FTs simply because they operate in a market-based policy context which is different in Wales. Just as we can learn lessons from Kaiser Permanente without advocating a US-style health system, so too we can look at FTs' work on engagement without needing to import the whole market-oriented approach.

Ultimately, any initiative that succeeds in enlisting well over half a million people – more than all the political parties put together - merits serious examination.

The work of FTs, and of mutuals in general, is thus a potentially rich source of ideas and inspiration, as we seek to find an approach to public engagement that is right for Wales.

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Foundation Trusts: further information

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About the Welsh NHS Confederation

The Welsh NHS Confederation represents the organisations making up the NHS in Wales: trusts and local health boards. We act as an independent voice in the drive for better health and better healthcare through our policy and influencing work, and by supporting members with events, information and training. To find out more about us go to -

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