GOVERNANCE OF FOUNDATION TRUSTS

DILEMMAS OF DIVERSITY

Patricia Day and Rudolf Klein

The Nuffield Trust
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Foreword by Sir Denis Pereira Gray

Chairman, The Nuffield Trust

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59 New Cavendish Street
London WIG 7LP

Telephone: 020 7631 8450
Facsimile: 020 7631 8451

E-mail: mail@nuffieldtrust.org.uk
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Foreword

Foundation Trusts are one of the big new changes in the NHS. Bitterly controversial in Parliament, they are much more welcome in the hospital world, where managers and clinicians have long chafed under a stream of central directives from Whitehall. In an era when governance arrangements are so much in the public eye, whether in the public or the private service, the arrangements introduced for these new entities are of particular interest.

Day and Klein now report on these governance arrangements designed to "introduce a new form of social ownership where health services are owned and accountable to local people…" and "…a co-operative society owned by its members" (Department of Health, 2002). They found a multiplicity of arrangements, concluding that devolution breeds diversity. The ambiguities are substantial: governors who are not fully governing and who may not even be called governors, and organizations which can hardly be said to be "owned" by local people. NHS Foundation Trusts thus appear to be post-modern institutions.

Yet Foundation Trusts are alive and kicking and increasing in number. The alteration in balance they represent in giving significant freedoms for secondary, sometimes tertiary, care but not yet primary care - contrary to guidance from the World Health Organization (1978) - is so far unresolved. Day and Klein conclude that it is too soon to reach a final judgement on this important organizational development. The Trustees of the Nuffield Trust are grateful to them both for initiating this debate, asking some important questions and pointing the way to further research.

Sir Denis Pereira Gray, OBE, FRCCP, FRCGP, FMedSci
Chairman, The Nuffield Trust
May 2005

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Introduction

Foundation Trusts (FTs) are central to the Government's vision of a National Health Service in which power has been devolved from the centre to the locality. In setting them up the Government has two professed aims, as set out when launching the new policy initiative in December 2002 (1). The first is to give providers "freedom from Whitehall control". The second is to introduce "a new form of social ownership where health services are owned by and accountable to local people rather than to central Government". The model, which is intended ultimately to apply across the NHS, is that of "a co-operative society or mutual organisation owned by its members". FTs are accountable not to the Secretary of State but to the "local community" and an Independent Regular (now re-styled Monitor).

How is this vision being translated into reality? Has the experience so far confirmed or dispelled the anxieties expressed when the Government unveiled its plans? In many respects, it is much too early to answer these questions. We do not know how far Ministers will keep their hands off FTs. We do not know how their systems of governance will work out. We do not know how they will use their financial freedoms. The aim of this study is therefore modest. It is to focus on the process of setting up the new machinery of governance of FT in the first 20 to be granted the new status: the recruitment of members and the election of Boards of Governors. But while the scope of the study is narrow, it raises fundamental issues about an experiment that is intended to transform the NHS. FTs have varied considerably in how they have set about creating their governance structures. Variations are the norm, predictably so since the Government has throughout insisted that FTs should not be fettered in the way they interpret the legislative framework. This indeed is the logic of a new style, decentralised NHS. However, it prompts the further question, central to the whole experiment, of what variations should be deemed to be acceptable or unacceptable: in short, what criteria are going to be used to assess the way in which individual FTs use their discretion in setting up and operating the machinery of governance?

This question provides the central theme of our study. We do not attempt to provide a complete picture of the process of setting up the new system of governance, let alone of

how it is operating in practice. That would be to duplicate the work of the Healthcare Commission's review of the first 20 FTs, commissioned by the Secretary of State for Health. This has been carried out by a large team working full time on the project. Our report is the product of a small-scale, short-term study by two part-time researchers and designed to look at the evidence selectively and illustratively: the intention is to identify policy issues, not to provide a comprehensive picture. Nor do we presume to define what criteria should be used in judging variations. This report is an analytic, not a prescriptive exercise. It is only prescriptive to the limited extent of arguing that issues – such as what a representative membership (a central concept in government statements) should look like – need clarifying.

We start by examining the policy debate when setting up FTs. Thanks to the Freedom of Information Act we examine some of the policy papers produced within the Department of Health before the publication of the unveiling of the detailed proposals in December 2002. We look at what Ministers said (and equally important, as we shall see) what they did not say about the governance machinery; we also note the various points made during the legislative process by the Government's critics. We then look at various dimensions of performance, and what the problem of interpreting variations tell us about the ambiguities and gaps – many of them deliberate – in the framework within which FTs are operating.

In making our selection of illustrative examples, we were constrained by one variation between FTs that became immediately apparent when we started our study: their willingness and ability to supply us with information about their applications, about their strategy for recruiting membership, about the composition of that membership and about the elected governors as well as minutes of meetings. Some were most co-operative and helpful in assisting us to interpret the documentary evidence; we are grateful to them. Others were surprisingly defensive and reluctant; in a few cases we were forced to invoke the Freedom of Information Act in order to obtain even the most basic information, though some ignored even this request. However, we were able to supplement our sources by drawing on the FT websites though these, once again, proved to be extremely variable in their scope and quality.

We are grateful to the Nuffield Trust for funding our study. But the views expressed are entirely the responsibility of the authors.

1. POLICY GENESIS AND EVOLUTION

Foundation Trusts were the answer to a policy puzzle (2). By the end of 2001 the Secretary of State for Health, Alan Milburn, had become convinced that the command and control model which the NHS had developed in the previous four years of the Labour Government was both managerially and politically counter-productive, with perverse effects. Managerially it stifled initiative: NHS managers were loud in their denunciations of central government target setting, performance monitoring and interventions in the day-to-day running of services. Politically, the system centralised blame: Ministers had to stand up in Parliament to answer for every dropped bed-pan (in Bevan's phrase) and every mishap. Moreover, the model was at odds with the whole direction of Labour policy in the new millennium, which was to move towards a pluralistic, payment-by-results system in which providers would respond to market signals reflecting consumer choices. The logic of such a system was to give providers freedom from central control; to make a reality of what the Conservative Government had sought to do, but failed to carry through in practice, when introducing the internal market in 1991 – i.e. to give provider trusts a real degree of autonomy in financial and other respects. Enter Foundation Trusts.

But there was still a need to introduce a "circuit breaker", in the words of one of the participants in the policy process, to prevent the Secretary of State from being directly accountable for everything in the NHS. Enter the Independent Regulator (since re-styled Monitor) whose remit was to approve the applications of providers to become FTs and to ensure that their performance matched legislative and financial requirements. Financial performance was a key element: if FTs were to be given financial freedom, lenders needed assurance that they were managing their affairs competently. With the introduction of the Regulator the chain of accountability to the Secretary of State was broken: Ulysses was tied to the mast, no longer able to listen to voices tempting him to intervene in local matters. In 2004 the Secretary of State told MPs that in future Ministers would no longer be in a position "to comment on, or provide information about, the details of operational management" within FTs.

Once the idea of a Regulator had been introduced into the policy discussions, the next question was what the status of FTs should be. Various models were considered: the Scandinavian model of accountability to an elected body, the Dutch model of charitable foundations and the co-operative model. In coming to a decision about which model to choose, policy advisers had to satisfy a number of interests: the Labour Party, doctors and the thrusting NHS managers who had been pressing for greater autonomy but who "didn't want anything which would stop them managing…the last thing they wanted was democracy in a trust", to cite the same participant in the policy process.

Finally, the policy puzzle was resolved by embracing the notion of mutualism, championed by the Secretary of State's special adviser, Paul Corrigan among others. Foundation Trusts were to be public interest companies owned by their members. An advisory group of academics and others with an interest in, or experience of, mutualism was set up. It appeared to be an ideologically attractive formula, drawing both on a long line of left-wing advocacy of co-operative models (going back to at least G.D.H.Cole in the 1920s) and the Government's new emphasis on localism. As such, it was designed to make the notion of giving independence to providers acceptable to Labour Party traditionalists: a hope which, however, was disappointed - opposition within the party to what was denounced as covert privatisation continued throughout the legislative process and forced the government to make a series of concessions to the rebels.

Many other questions had to be resolved, notably the extent to which FTs were to have freedom to borrow money (involving a bitter tussle with the Treasury) and to set their own pay levels (involving conflict with Labour backbenchers and NHS trade-unions). These matters are, however, outside the scope of our study. Our concern here is exclusively with governance arrangements. And here, too, there were many issues which had to be considered. The evolution of ideas within the Department can be traced through a series of policy papers running from June to October 2002, supplied under the Freedom of Information Act. These give only a partial picture. The internal discussions had started six months earlier. Some of the policy debates reported by participants do not feature in them; ministerial reactions and comments do not feature in them. For example, the arguments for and against adopting the New Zealand system of using the local government voting register, and having the elections to health boards at the same time as local government elections, were "considered again and again" but do not appear in the documents made available to us (the New Zealand model was eventually rejected on the grounds that it would identify FTs too much with local government). Nevertheless, the policy papers made available do identify some of the main issues considered by policy makers, many of which still have relevance today.

The starting point of discussions in June 2002 was a paper setting out a proposal for a two-tier system of governance for FTs. A Council of Trustees, representing "the interest of stakeholders", would "oversee" the Board of Management, responsible for the day to day management. The names would change. The Council of Trustees was to become the Stakeholder Board or Council in later papers before finally emerging as the Board of Governors in the legislation, while the Board of Management was to become the Board of Directors. By July Ministers had apparently accepted the principle of a two-tier structure,

and the policy debate moved on to considering the relationship between the two bodies and their respective roles. Two models were put forward in a paper dated 10 July 2002. The first model was that of a management board *accountable* (our italics) to a supervisory stakeholder council. Under this model the stakeholder council would have responsibility for the stewardship of the trust and would also have the "power to veto management recommendations on major decisions".The second model was that of a management board carrying responsibility for the stewardship of the trust, with an advisory council. The latter would not have a veto over management decisions. Unsurprisingly, the paper recorded that soundings among the Chief Executives of prospective FTs showed that these were "inclined to the second of these models".

The choice of model, in turn, would influence decisions about the appropriate size of the Stakeholder Council or Board of Governors as it was to become. The first model implied a Council of "manageable size", capable of promoting "coherent and corporate behaviour". The paper quoted the example of Germany and France where there was a cap of 21 and 17 respectively for the supervisory boards of commercial companies, adding the comment "I think we should have small caps". The second model implied more flexibility to take account of local circumstances: no specific caps were suggested.

The other issue addressed in the policy papers was that of how the Stakeholder Council was to be chosen and composed. As late as September 2002, a paper proposed that the Council should consist of five " colleges of stakeholders: 1) people from the local area 2) employees of the trust 3) business and partner organisations, e.g. representatives from the local chamber of commerce, voluntary organisations and local strategic partnership 4) NHS commissioners and 5) local education, training and research bodies". Each college would carry equal weight and have 20% of the total vote; the intention being that no one group should be able to dominate the Council. Even at this late stage in the evolution of policy, the question of whether the Councillors should be appointed or elected was still open, though there was much discussion of how elections should be organised if the ministerial decision were to favour that option. In the event, Ministers plumped for direct elections. By December when the Government published its policy proposals, in *Guide to NHS Foundation Trusts* (1) which was to become the basis of the subsequent legislation, the notion of colleges had been dropped in favour of the election of public and staff representatives. It was left to prospective FTs to satisfy the Secretary of State for Health (and the regulator) that they had "established a properly representative public and patient membership base and set up a Board of Governors that is in fact representative of the members" as a condition for approval.

No such clear decision is apparent, at least in the available papers, when it came to make a choice between the two models of the respective roles of the Board of Governors and Directors (as these had become re-christened). In effect, something of a hybrid emerged. A degree of local flexibility was allowed to prospective FTs in deciding the size and composition of the Board of Governors (see Box 1 on p11): no caps were specified, suggesting that the first model of a small, supervisory Board had tacitly been dropped. Further, the role of the Board was defined in terms (see Box 2 on p11) which suggested that its role was more limited than the supervisory board model would require, although perhaps

more than advisory given the power to appoint and dismiss directors. On one point, however, there was insistent clarity. The Board was to concern itself only with strategic matters, but was not to involve itself in operational matters of day-to-day management: a distinction which, as we shall argue, is easier to make in theory than in practice.

The ambiguities in the Government's proposals were explored and exposed when parliament came to consider them and to debate the subsequent legislation. The House of Commons Health Committee (3), for example, pointed out that there were "no minimum standards for involvement" and that the proposed system "could lead to a system of patient and public involvement that is fragmented, confused and inequitable". To which the Government replied (4) that "Whitehall does not always know best and should not try to force one solution on all NHS Foundation Trusts" – a theme that was to run through all subsequent parliamentary debates - and that, in any case, FT constitutions and the definition of membership constituencies would be supervised by the Independent Regulator. The Committee also asked how disputes over strategic plans between the Board of Governors and the FT Board of Management were to be resolved: would the Governors have a right of veto? To which the Government replied that "Governors do not have a right of veto but that they could remove the directors if they considered that they were making unreasonable decisions".

Many of the same issues, as well as new ones, were raised during the Committee stage of the subsequent legislation - the Health and Social Care (Community Health and Standards Bill – in the House of Commons. But it was the House of Lords which dug deeper into governance issues when it came to debate the Bill. Lord Howe argued that "Hospitals will land up with members who, being self-selected, will almost certainly be unrepresentative of the population at large… We are looking at a government model for the articulate middle classes"(5). Further, he suggested, the requirement that the membership of FTs should be representative of the local population begged the question of what the word meant: It is a requirement which seems to imply that hospitals will have to become socio-economic research bodies"(6). Baroness Noakes argued that "The types of people who come forward for election as governors are more likely to have a detailed interest in how a foundation trust will operate than in its strategy "(7). Baroness Hanham, chairman of a large hospital trust, raised the question of the size of the Boards of Governors: "As far as one can see, the board will include a huge number of people, presumably all of whom will want to dip in and out of the hospital's activities. We cannot have 30 to 50 people with a right to dip into and out of those activities"(8). Lord Hunt repeatedly pressed for the ambiguities about the role of the Board of Governors to be resolved: "…corporate responsibility for foundation trusts resides in the board of directors … the only power the board of governors has is the nuclear option of being able to appoint and replace the non-execs, and to approve or not approve recommendations made by the chief executive". So "we will have to depend on the skill of the chairs of the new foundation trusts to ensure that the governing bodies, notwithstanding that they have hardly any power, are given useful work to do so that their members feel that they are worth while" (9).

To criticisms such as these, Lord Warner had a standard reply: the approach of the government was "to set minimum requirements and to allow individual foundation trusts

to develop arrangements locally that best suit their needs"(10). However, he was clear that "governors cannot have a direct role in the operation of the trust". Instead their role was "to provide a voice and influence for local communities in defining the culture and strategic development of NHS foundation trusts" and to act as a "mechanism for disseminating information to members and partner organisations about the NHS foundation trusts…"

The Department of Health's role in the implementation of the legislation was not entirely passive. The first step in achieving FT status was to gain the Secretary of State's approval: this involved an assessment of the quality and completeness of the application in the context of the NHS as a whole. Once that had been achieved, it was the Independent Regulator who took the final decision: this involved an assessment of the trust's financial viability and managerial competence. The Department also provided a programme of support to applicants. This included a model constitution, a good practice sourcebook and seminars.

Nevertheless, FTs were given considerable latitude – in line with the emphasis on minimising prescription – on how to interpret legislation and guidance. In what follows, we set out some illustrative examples of how this laid-back strategy of devolution has worked out. If Whitehall does not know best, do the Foundation Trusts? And what criteria should we be using in assessing their performance? We start with the elections to the first 20 FTs.

Box 1: Boards of Governors: composition

Every Board of Governors must have:

* A majority of members elected by the public constituency and if there is one, the patients' constituency
* At least three governors representing staff
* At least one governor representing local NHS Primary Care Trusts
* At least one governor representing local authorities in the area
* A chair
* At least one governor representing the local university

Source: Department of Health : NHS Foundation Trusts information guide

Box 2: Boards of Governors: responsibilities

* Representing the interests of NHS Foundation Trust members and partner organisations in the local health economy
* Regularly feeding back information about the Trust, its vision and its performance to the constituency they represent
* Appointing the non-executive directors, including the chair, of the Trust
* Appointing the Trust's auditors
* Working with the Board of Directors to produce plans for the future development of the Trust
* Receiving, at a public meeting, copies of the Trust's annual accounts, auditor's reports and annual reports
* If concerns about the performance of the management board cannot be resolved at a local level, informing the Independent Regulator.

Source: Department of Health : NHS Foundation Trusts information guide

2. ELECTIONS AND MEMBERSHIP

The arrangements for the elections to the Boards of Governors of the first 20 FTs provide ample illustration of the main theme of this study: devolution inevitably leads to diversity. Some FTs had separate constituencies for patients and public; others did not. Some FTs organised the elections around geographical constituencies; some did not, pooling all members in one constituency. Most FTs used the single transferable vote system; a minority opted for the first past the post method. The qualifying age of eligibility for membership, and therefore for voting, varied from 11 to 18; a few FTs did not have any minimum age requirement.

The numbers taking part in the elections also varied greatly. Table 1 sets out the results, distinguishing between the number of patients and public eligible to vote and the proportion actually doing so: we have amalgamated the public and patient membership because the distinction is artificial inasmuch as some FTs recruited patients (in any case an ill-defined category) to the membership roll and then allocated them to public constituencies. The figures do not include the participation rates for the elections of Governors representing staff: we discuss these separately, below.

The most obvious conclusion to be drawn from the Table is that University Hospital Birmingham is an outlier in both respects: it had the highest number of members eligible to vote and the lowest proportion actually doing so. The reason is that Birmingham was the only one of the 20 Trusts which, for patients, availed itself of the opt-out clause in the legislation. If Trust patients did not actively opt out, they were counted as members: a form of inertia selling. Of the Trust's 40,058 members, 38,804 (95%) fell into this category; public members, who had to opt in, numbered only 2154 (although, oddly enough, they elected the same number of Governors – 13 in each case). But the result of this mass baptism was massive apathy: clearly the patient members had little commitment to involvement in the Trust's affairs. And, as we shall see, Birmingham has since decided to change its policy: a change which, however, appears to have more to do with the costs involved than concern about democratic participation.

Table 1: Participation in the elections

NHS Foundation Trust	Numbers of patient and public members eligible to vote	Proportion actually voting: %
Basildon & Thurrock University Hospitals	3388	31
Bradford Teaching Hospitals	1153	47
Cambridge University Hospitals	9214	53
City Hospitals Sunderland	1903	60
Countess of Chester Hospital	2762	45
Derby Hospitals	1658	60
Doncaster and Bassetlaw Hospitals	1551	53
Gloucestershire Hospitals	14,162	64
Guy's and St.Thomas' Hospital	4808	48
Homerton University Hospitals	2398	43
Moorfields Eye Hospital	9213	61
Papworth Hospital	2652	65
Peterborough and Stamford Hospitals	1056	63
Queen Victoria Hospital	7558	35
Royal Devon and Exeter	8346	52
Sheffield Teaching Hospitals	4338	52
Stockport	1398	47
The Royal Marsden Hospital	503	77
University College, London Hospital	1501	32
University Hospital Birmingham	40,958	18

Source: Monitor NHS Foundation Trusts: Report on Elections and Membership August 2004

All other Trusts recruited public and patient members on an opt-in basis. That is, both public and patients were invited to join up as members. They were thus self-selected. And it might have been expected that this would produce more commitment and a higher

degree of participation. And this is, in fact, what we find. With a few exceptions (Basildon and Thurrock; Queen Victoria; University College, London) participation rates were respectable or better. The proportions voting were higher than in local government elections and in elections to many member-based organisations: for example, participation rates for recent elections to the Consumers' Association Council and to the governing body of the Royal National Institute for Deaf People were 34% and 24% respectively. The Royal Marsden was conspicuous for having the lowest membership – a mere 503 – but the highest degree of commitment; University College London stood out in that it had both a low membership and a low degree of commitment.

Even excluding the two extremes – Birmingham and the Royal Marsden – the variations in the size of the membership eligible to vote were far greater than differences in the size of the catchment areas of the Trusts concerned: the range was more than tenfold, from 1056 (Peterborough and Stamford) to 14,162 (Gloucestershire). Nor is the explanation to be found in the type of Trust: among specialist trusts, Moorfields had almost four times as many members as Papworth. Differences in the socio-economic context of different Trusts, and in the extent to which there is a reservoir of people with an interest in taking an active role in public affairs, may be a factor. Another may be the age structure of the population.

Most of the low membership Trusts are in urban settings, particularly in the north; most of the high membership Trusts are in areas combining a middling sized town or towns with a rural hinterland. The picture is, however, suggestive rather than conclusive. There were exceptions in both categories. In the urban category, Guy's and St.Thomas' was much more successful in recruiting members than either Homerton or University College, London. In the mixed category, Peterborough and Stamford had, as already noted, the lowest membership of all 20 Trusts. Clearly a much more sophisticated analysis of the impact of socio-economic factors than either we or the Trusts themselves have been able to carry out would be needed to establish what the relationship is, if indeed there is one.

The other possible explanation of the variations in membership size might lie in the recruiting strategies used by different FTs. All Trusts had to carry out elaborate public consultation exercises as part of the application process for FT status, in order to get Department of Health approval, so creating at least a degree of public awareness of the arrival of a new institution on the NHS scene. Subsequently all Trusts seem to have pursued much the same mix of strategies: mail shots to the population, the distribution of posters and leaflets, contacts with community groups and public meetings (the last of which tended to founder on lack of public interest: the Royal Devon, one of the more successful recruiters overall, found that attendance ranged from two to 22). Some employed consultants, like The Campaign Company, with experience of drumming up public interest. However, the documentary evidence available to us gives little indication of the degree of enthusiasm and energy which Trusts brought to their membership drives and therefore does not allow us to draw any conclusions about what a successful recruitment formula should look like.

One conclusion which might be drawn, however, is that recruitment is a cumulative process over time, and that it is premature to make much of the first round of elections by the first wave of FTs at a time when their existence had hardly had time to sink into the

public consciousness. Some first wave FTs have set themselves ambitious targets for increasing their membership, with some signs of success: there was an increase of almost 40% in the total membership between the elections and August 2004. And subsequent waves, responding to Department of Health warnings that a low membership might put their application at risk, have notched up respectable figures.

Another conclusion is that the Birmingham model does not provide the way forward. For Birmingham has now abandoned it. The arguments used to justify this change in policy are worth setting out at some length, given that they have wider relevance:

"The opt out recruitment approach adopted by UBH has provided a membership which is large in number and, because it is substantially drawn from current patients, highly representative of the users of the trust's services", the chairman argued in a report to the Board of Governors in September 2004 (11), "The scale of the membership does, however, involve costs for the administration of membership records, communication with members and for electoral processes and these costs rise in direct proportion to membership numbers". Accordingly the Board of Directors proposed "to stabilise future costs by moving to an opt-in system of membership for patients and public members". Further, it was proposed to stratify the membership according to their level of interest. Level 1members (an estimated 75%) would simply receive an annual communication. Level 2 members (15%) would additionally receive quarterly or bi-annual communications and summaries of key documents. Level 3 members (10%) would receive annual plans and reports, participate in seminars and surveys and have opportunities for further involvement.

The Birmingham policy turn-about is doubly interesting. First, it is an acknowledgment that most FT members are likely to be passive, which suggests that much of the rhetoric about governors becoming engaged with members may be over-optimistic. Second, it underlines the fact that the new system carries considerable costs – Birmingham being exceptional only in the size of its membership - and that these costs are likely to rise in proportion to the effort invested in informing and involving members.

We discuss the policy issues prompted by the elections – what criteria might be used in assessing the level of participation and whether the membership is representative – in the next section. Before doing so, however, we briefly examine the elections of the staff representatives to the Boards of Governors. Here the FTs split down the middle as between choosing the opt-in model or adopting the opt-out model. A clear pattern emerges. The opt-in model produced small memberships but a relatively high rate of participation in the elections (in the range of 40% to 70%). The opt-out model produced large memberships but lower rates of participation (in the range of 16% to 60%, with most of them at the lower end of the distribution). In some cases the number of mass-recruited staff members greatly exceeded the number of self-selected patient and public members. For example, Guy's and St.Thomas' had 8,473 staff members (of whom just 17% voted) as against 4808 patient and public members; the figures for University College London were 6865 staff members (of whom 16% voted) and 1501 patient and public members.

These figures help to put a perspective on the figures presented in Monitor's report on the elections. This gave a figure of 185,038 for the membership of the first 20 FTs. But when account is taken of the opt-out effect - the mass conscription of patients in Birmingham and of staff members elsewhere – the figures look considerably less impressive as an indicator of interest and involvement in what is supposed to be a new form of institutional democracy. So next we ask: could we devise criteria for judging the adequacy or otherwise of levels of participation?

3. CRITERIA FOR JUDGING PERFORMANCE

In presenting their proposals for FTs, Ministers resolutely refused to commit themselves to any minimum level of public and patient membership for aspiring FTs. Privately, it seems, they did not have high expectations: according to one participant in the policy process, they expected membership figures to be in the hundreds rather than thousands. Similarly, in reviewing applications the Department of Health appears to have been more concerned with process than outcome: aspiring FTs were expected to demonstrate that they had been energetic in their recruitment campaigns – that they had gone through all the right motions – but there was no minimum below which the membership figures would have disqualified the aspirants. And the same applies to the Independent Regulator: no trust seems to have fallen off the FT bandwagon because of low membership figures, as distinct from financial or managerial weaknesses in performance (though at least one low-membership Trust stepped up its post election recruitment drive in response to ministerial warnings that its continued FT status might otherwise be at risk).

Would it be possible to devise outcome criteria for the membership dimension of performance? One possible strategy (familiar in the NHS when assessing performance in other contexts) would be to have relative rather than absolute criteria. Instead of picking out some arbitrary figure of acceptable patient and public membership, performance could be assessed in relation to the average achievement of FTs. If, say, the average level of membership were 5,000, then it might be reasonable to question whether trusts with much lower figures should be given or retain foundation status. And if, over time, FTs increased their membership, the minimum figure could be ratcheted up accordingly.

Such an approach could be criticised as overly mechanistic. It would ignore the socio-economic context of different trusts (though in theory the figures could be adjusted to take account of this). It would not take into account the degree of commitment that members bring with them: here the mass baptism strategy, with its low participation rates, carries a warning. It is not self-evident that a large, passive membership is necessarily to be

preferred to a smaller but committed membership if the aim is to bring about active citizen participation in the affairs of the NHS (always assuming, perhaps over-heroically, that this is the aim).

There is, in any case, a different line of argument. This is to say that the size of the membership is irrelevant provided it is representative: that it is an accurate mirror of the community and interests served. And indeed the emphasis of government policy has throughout been on the requirement for FTs to have such a representative membership. The notion of "representativeness" if, of course, problematic (12): it is not self-evident, for example, how many categories of "interests" should be accommodated and whether the membership should be weighted to reflect the patterns of health service use by different sections of the population? However, if we make the simplifying assumption that the membership should be the equivalent of a sample survey of the population – as in opinion polls – so providing a reasonably accurate sounding board for views about NHS services, then matters become relatively straightforward. The main variables then become the familiar ones of age, gender, social class and ethnic origin. How do the FTs match up to these criteria?

The answer is that the available information is, at best patchy. Many FTs seem to have acted on the assumption that a reasonably representative mix would emerge from geographical constituencies with different socio-economic characteristics, though a few acknowledged that this might be over-optimistic. Not all have carried out a detailed analysis of their membership, though more are in the process of doing so. Of those which have done so, Moorfields reports that half of the membership was over 65 and a further quarter was in the 51-65 range (which perhaps reflects the characteristics of its patients); the Countess of Chester reports that women were over-represented while the young were under-represented; Sheffield, among others, reports a lack of ethnic diversity among its members.

But even if the membership overall is reasonably "representative", a further problem emerges when we look at individual constituencies. This is that the number of members within these constituencies is often so small that it cannot be held to be an accurate microcosm of the population within them: that the numbers would be dismissed as inadequate by anyone conducting a survey. Only consider the following examples. Bradford's Shipley constituency had 228 members, of whom 125 voted to elect 3 Governors; University College London's local residents constituency had 229 members of whom 89 voted to elect three Governors; Derby's East Staffordshire constituency had 76 members, of whom 56 voted to elect one Governor; in Birmingham's Edgbaston constituency, one Governor was elected by just 95 votes – a result which "would be considered disgraceful in local government elections", as two distinguished political scientists commented (13).

Figures such as these raise a further question. Will governors elected by a small coterie of members be perceived to have legitimacy when speaking on behalf of their populations? The answer to that question depends largely; of course, on the role that governors are expected to play. The next section therefore turns to examining the Boards of Governors, their composition and what has been learnt, so far, about their role.

4. WHO ARE THE GOVERNORS?

Diversity is once again the norm when it comes to the governing bodies. To start with the name: Only eight of the first 20 FTs have stuck to the original nomenclature – as it appears in the 2003 Act and in government guidance – of Board of Governors. Some have opted for Council of Governors (for example, Royal Devon and Homerton); others have chosen Members' or Membership Council (for example, Derby and UCL). There are variations also in the size of the governing bodies. Only one has fewer than 20 members (City Hospitals Sunderland, with 18), four have between 20 and 29 (for example, Cambridge and Gloucester); 15 have between 30 and 39; one has 43 with a plan torise to 53 by 2005 (Basildon and Thurrock).

Interpreting the significance of such variations is difficult. As far as the name is concerned, the transformation of the Board of Governors into a Members' Council would seem to be a semantic signal that the governing body is not actually expected to govern. However, the converse does not follow: it cannot be assumed that FTs which have retained the original title expect their governing bodies to play a more assertive role. That will only become clear when the governance arrangements have had time to settle down.

Similarly with the size of the governing bodies. Some of the variations can be explained by differences in the number of PCTs with representatives on the board (the higher their number, the more elected patient/public members will be needed, since the legislation requires the latter to be in a majority). But some may reflect divergent views about the function of the board. According to the Department of Health's guidance in the early stages of FT development (14) "The trend in governance in organisations of all types is towards smaller boards of 12 or less, but a larger board is often considered appropriate where the main role is advice and representation". So, clearly, most FTs have plumped for an advisory and representative model, rather than an effective decision-making one.

In the next section we examine some of the early and (at this stage of the development of FTs) inconclusive evidence about how this advisory and representative model works in practice. First, however, we ask: who are the governors? In the Department of Health's

2002 document unveiling its plans to the public (1), one of the proposed requirements for a FT was that it had set up "a Board of Governors that is in fact representative of its members". The Department's subsequent, more detailed guidance to governance arrangements (14) repeated this requirement and elaborated it: "the board should represent the socio-economic mix of the local community, paying attention to diversity and ethnicity and should include safeguards against 'entryism' where a single issue group can dominate".

The subsequent legislation made no mention of this requirement, with the result that Monitor has not thought it part of its remit to examine the representativeness or otherwise of the governing bodies or to collect data about the characteristics of the elected members. However, the Department's early publications suggest that Ministers and civil servants did, in fact, have both positive and negative criteria for assessing governing bodies: representativeness, on the one hand, and freedom from capture by single interest groups, on the other. So what do we know about the elected governors on either of these scores?

The answer is: far too little. In the absence of systematically collected information by either FTs themselves or Monitor, we have to rely on fragmentary clues. Representativeness is, as previously noted, a complex, contested and elusive notion. It becomes even more complicated in the case of the FT governors since it is not self-evident whether they should be representative of the wider community (whatever that may mean) or of the members who elected them: the two do not necessarily point in the same direction. So in what follows we set out the available wisps of evidence without attempting to draw any strong conclusions.

Table 2, based on an analysis of the elections by Electoral Reform Services, provides the only available evidence about the characteristics of the governors elected in 2004: their gender. Overall, women were under-represented: only 45.5 % of the elected governors (patient, public and staff) are women. As always, though, there are great variations. The range is from 30% or under (Moorfields, Papworth) to 60% or above (Sheffield; UCHL). A few even managed a neat 50:50 split (Basildon and Thurrock, Countess of Chester). However, just to underline the slipperiness of the whole notion of representativeness, is a 50:50 split a sign of success or failure – given that women are a majority in the population and of NHS users?

The table also shows the proportion of governors with a declared political interest: less cast-iron evidence than in the case of gender, since 'political interest' is a rather vague concept. While a high proportion would not prove that there had been political "entryism" – there might well be other explanations – it would suggest that there was a case for investigating the possibility. Here the two leading candidates would be Basildon and Thurrock (37.5%) and Homerton (44%). But, again, there are problems of interpretation: if "political interest" turns out to be synonymous with interest by local government councillors - as some evidence suggests - is that desirable or undesirable? Given policy emphasis on co-ordination between the NHS and local government, it might be thought to be a positive outcome. There might, additionally, be other forms of "entryism" by special patient groups but we have found no evidence of this: indeed no such evidence could be generated given the haphazard way in which information about governors has been collected by FTs.

Table 2: Characteristics of elected Governors: the first 20 FTs

Trust	% women	% with declared political interest
Basildon & Thurrock	50.0	37.5
Bradford	43.8	12.5
Cambridge University Hospitals	47.4	5.3
City Hospitals Sunderland	n.a.	n.a
Countess of Chester	41.7	0.0
Derby	50.0	16.7
Doncaster & Bassetlaw	38.5	11.5
Gloucestershire	60.0	10.0
Guys & St.Thomas'	40.7	11.1
Homerton	38.9	44.4
Moorfields	30.0	25.0
Papworth	25.9	3.7
Peterborough and Stamford	40.0	5.0
Queen Victoria	37.0	11.1
Royal Devon	41.7	16.7
Sheffield	66.7	0.0
Stockport	34.6	23.1
The Royal Marsden	50.0	7.1
University College London Hospitals	70.6	0.0
University Hospitals Birmingham	n.a	n.a

Source: Electoral Reform Services. The figures include staff as well as public/patient governors. The Electoral Reform Society did not handle the elections to the two FTs where the data is marked as not available.

To complement the statistical information in the table, we trawled the biographical information provided by individual elected governors in their election manifestoes or otherwise. This turned out to be an exercise in frustration. Some FTs collected and made available such information. Others did not. And even when information was available, it was often idiosyncratic, based on incomplete self-descriptions. Not even the age of governors was recorded consistently. So we are dealing with shards of evidence yielding only flickering insights.

One clear-cut, if entirely predictable, finding to emerge from those FTs which provided relevant information is that a high proportion of elected governors representing the public are drawn from the retired population: 11 of the 13 at Gloucestershire, 11 out of 20 at Stockport, 6 out of 10 at City Hospitals Sunderland and 10 out of 24 at Queen Victoria gave their status as retired (which implies that they were 55 +). This is entirely predictable given that it is the retired who are most likely to have the time for serving on committees. In this respect, they are unrepresentative of the population at large – though their demographic profile may be nearer that of NHS patients. Whether they are also unrepresentative of the population in that the they are drawn disproportionately from "the articulate middle classes", as predicted by Lord Howe, cannot be determined on the basis of the available information, although it seems highly likely.

Consistent with other studies of participation in unpaid committee or governance work (see, for example, ref.12), many of the elected governors are involved in a variety of public service or charitable activities. As far as can be ascertained from the incomplete self-descriptions, 38 of the 162 elected public members for whom any information is available (23%) are also members of other public or charitable boards. For example, at least 10 out of the 20 public and patient elected governors at Doncaster and Bassetlaw and 5 out of 13 at Gloucestershire fell into this category. While this makes them less "representative" of the population at large, it can also be interpreted as a source of strength within FT boards insofar as these governors can be seen as active citizens with links to a variety of networks. In any case, ensuring diversity may be more important than chasing the elusive goal of representativeness (15).

What knowledge of the NHS do the governors bring to their task? The logic of Department of Health guidance is that public and patient governors – in contrast to those elected by staff – should not be employed in the NHS at the time of their election. This exclusion does not, of course, cover GPs as independent contractors or those who have retired from working in the NHS. So we find that 48 out of the 162 (34%) public and patient elected governors giving information were self-declared ex-NHS employees or had current family associations with the NHS. For example, eight out of 15 elected governors at Cambridge, five out of 14 at Peterborough and Stamford, five out 17 at UCHL and seven out of 20 at Doncaster declared an ex-NHS status. Basildon and Thurrock had seven out of 19 in this category, plus one practising GP. Both Stockport (with three out of 20 in this category) and Bradford (three out of 17) also had a practising GP among their public governors.

Interpretation, once again, is difficult. The fact that such a relatively high proportion of governors had worked in the NHS makes them unrepresentative of the population at large and could mean that they bring a particular kind of bias to their role. However, it also means that they bring more knowledge, experience and perhaps confidence as well to their role. To what extent this should be seen as an asset depends, in turn, on precisely what their role will be.

5. WHAT ARE THE GOVERNORS DOING?

Boards of Governors, in their various semantic incarnations, are still at a very early stage in their evolution. In effect, their roles are being defined as they go along. And, as always, this is being done in different ways. It would therefore be both premature and rash to pronounce on how they are functioning, and it is no part of this paper's purpose to do so. If the FT experiment is to be assessed, a large scale study over time will be needed. In what follows, we simply note – selectively and illustratively, once again – some of the policy issues which are emerging.

In previous sections we have stressed the diversity among FTs. Here we start by identifying two themes where there is apparent consistency: where everyone is singing from the same hymn sheet. The first is that it is the role of governors to advise and support the Board of Directors and to act as guardians of NHS values. In short, they may have influence but they do not exercise power. It is the Board of Directors which is legally accountable for adverse managerial performance or for any clinical error, as Derby's Chief Executive told the first meeting of governors: "The Members' Council will help to shape the Trust's future strategy but will not carry personal or collective liability for the decisions they make…" Full Board meetings are infrequent – three times a year appears to be the norm – though governors are also kept busy on sub-committees and working parties: in particular, many FTs have put them in charge of expanding the membership.

The second theme flows from the first. This is that Boards of Governors should concentrate on strategic issues and not meddle with operational matters, the latter being the exclusive domain of the Board of Directors. On this point the Department of Health has been clear and unambiguous in its guidance from the start. And FTs themselves, in defining the governing body's role, have emphatically reiterated this point. So, for example, The Royal Devon and Exeter's public consultation document stated that "The Council of Governors will not be involved in matters of day-to-day management such as setting budgets, staff pay and other operational matters".

But in practice the distinction between strategic and operational matters is difficult to draw or maintain. No one is better placed to know this than the Department of Health, and it

might have been well advised to reflect on its own experience. Over the decades successive attempts to institutionalise the distinction within the department (16) have foundered and in the outcome the two functions have once again been fused. So it is no surprise to find that, in the case of FTs too, the boundary appears already to be blurred and porous.

Consider the example of the Members' Council at UCHL. At their 15 September 2004 meeting, the Council agreed that their three main domains were: matters of strategy and policy, legal and constitutional issues and high level performance management issues. Under the rubric of "high level performance management issues", they sought information about hospital cleanliness, cleaning services and cross-infection issues. At a subsequent meeting, in January 2005, they added waiting times in A & E to the high level management issues they were concerned about. Concern about infection control and cleanliness is indeed a theme running through the minutes of many FT Boards (The Royal Devon and Exeter and Gloucestershire among others), reflecting no doubt the salience of this issue in the media and political debate. For example, Birmingham governors were given a detailed account of staff hand washing, eating and drinking by the staff in clinical areas and the decontamination of equipment at their November 2004 meeting. Another theme to crop up in the minutes of several FT Boards is that of car parking. Birmingham's Board had a "useful discussion" and made "a number of suggestions", in the chairman's words, about car parking charges at its 24 November 2004 meeting. Other FT Boards to consider parking issues at their meetings included Gloucestershire and Stockport.

The interest of FT Board members in getting "to grips with some of the basics of how the NHS is run"(in the words of one Birmingham governor) is natural. Presumably many of them - perhaps most of them - stood for election, and are prepared to give up their time, because they are concerned about the end-product: the actual patient experience. Given this, it is probably inevitable that they will want to discuss what might appear to be operational matters. Does it matter? To the extent that strategy should be informed by a sense of what life in a trust is like – where actual experience parts company from the rhetoric of visions, goals and aspirations and what statistics mean when translated into on-the-ground reality - the interest of governors in operational matters makes a great deal of sense, is not unexpected and not necessarily regrettable, given that strategy and operations are the two sides of the same coin.

But there would seem to be a twin danger. The first is (to return to the House of Lords debate cited in section 1) that "a huge number of people" will "want to dip in and out of the hospital's activities". In other words, there is a risk that governors may get too involved in the detail of how policies are implemented – like hand washing and hospital hygiene - so overlapping with managerial and clinical responsibilities. The second, and obverse danger, is that the Board of Directors might welcome – perhaps even encourage – a preoccupation with some day-to-day matters, on the assumption that this would divert the Board of Governor's attention from strategic issues. So, for example, an interest in car parking charges might be a welcome diversion from an interest in the trust's financial affairs. It is much too early to tell which way the balance of risks will tilt – and there will inevitably be differences between trusts – but clearly this is a question which should be addressed in any long term study of the evolution of FTs.

There are other uncertainties and tensions. Governors, as all FTs appear to be agreed, are expected to be both the voice of the community in the affairs of the trust and the trust's representatives in the community. So governors should not only "act as the eyes and ears of the wider community" (Homerton) but also be active in explaining the trust's policies to the public. Easier said than done, as many FTs have come to realise. Sending out newsletters to members is a one-way channel of communication. Devising a two-way channel of communication which allows governors to engage actively with members and public – assuming the latter want to do so – is a different matter. So, for example, the UCHL governors have puzzled – as reported to a meeting on 5 February 2005 – about how to do this: "It was generally accepted that the elected representatives were not able to represent a specific constituency neither was there support for surgeries as these could lead to the championing of individual cases which raised concern that roles would become operational". There was also agreement that the UCLH membership "was not representative and the trust needed to find ways to engage with minority groups whether age, gender or ethnic minority groups". Most FTs are still grappling with this dilemma, and it remains to be seen what strategies they adopt and how successful they will be.

We conclude with what is perhaps the biggest uncertainty and possible source of tension: the future relationship between Boards of Governors and Boards of Directors and, crucially, the bridging role of the FT Chairmen who presides over both. Are governors steering or being steered? On the evidence available to us – which is exclusively documentary – only the most tentative answer to this question is possible: which is that in the first few months since the birth of FTs, it is the chairmen and chief executives who have been firmly in charge, controlling the flow of information and determining the agenda. But this may not necessarily be the pattern for the future: there are sporadic signs of governors kicking against their constraints: for example, by demanding more information from chief executives. And it remains to be seen how active or passive Boards of Governors will be, and what scope for choice they will have, when it comes to selecting new chairmen and chief executives: the only opportunity for them to exercise power as distinct from influence.

6. POLICY CHALLENGES FOR THE FUTURE

A policy of encouraging a thousand flowers to bloom – the Government's stance towards the governance of FTs – may be a welcome change from over-centralised control. Indeed the invention of FTs is, as we have seen, part of the reaction against that dirigisme and is an essential part of the strategy for creating a new-style NHS: a service where power is devolved and which is largely driven by market forces. But tolerance of diversity should not imply tolerance of ignorance. We return to the question with which our study began: what kinds of diversity are acceptable? Before answering this question, and before trying to devise criteria for distinguishing between flowers and weeds, we clearly need to know how the legislative provisions for FTs are working out: a simple exercise in political botany designed to establish what the garden looks like. And, as we have seen, some of the most basic information is simply not being collected. Yet the whole point of encouraging diversity is to be able to learn from it, which means being able to compare different models, a point that applies particularly strongly to the case of the devolved NHS in Scotland, Wales and Northern Ireland (17).

It may be that the Healthcare Commission's inquiry, disposing of far greater resources than our study, may be able to fill in some of the gaps in the basic information: for example, about the composition of FT memberships and the characteristics of elected governors. But one-off studies, whether conducted by the Healthcare Commission or academic researchers, tend to lag behind events. As wave after wave of FTs succeed each other, the aim should surely be to make the production of standardised data about members, elections and governors automatic. As it is, most FTs attempt to analyse their membership but do so in a somewhat idiosyncratic fashion which makes it difficult to obtain a clear picture of them individually, let alone to compare them.

This brings the argument to the role of Monitor, the Independent Regulator. From the minutes of Monitor's Board meetings, it is clear that so far there has been an almost exclusive concentration on financial affairs and management capacity. Issues of governance scarcely figure in the Board discussions. The only governance data published by Monitor are the election results. There seems to be a strong case for Monitor to take more of an interest in

governance: starting with requiring standardised information about membership and governors. FTs may well resist any requirement for producing more data: they have formed a strong pressure group, headed by an experienced lobbyist, which is apt to protest loudly at any attempt to look over their baronial walls. However, in this case, the data in question could be produced routinely and easily by any well-organised Trust: contrary to the fears of Lord Howe in the House of Lords debate, FTs would not have to become "socio-economic research bodies".

There are other issues of governance which should, surely, concern Monitor as well as everyone interested in the evolution of the FT policy experiment. There are great variations, as we have seen, in the size of Boards. Does this matter? If Boards of Governors are to be seen as no more than institutionalised Citizens' Juries – sounding boards for the executives – then it may not make much difference if they suffer from gigantism, except perhaps for the up-keep costs. But to the extent that they are supposed to play any sort of effective as distinct from dignified role – as in the appointment of chairman and chief executive - then it might matter a great deal. To answer the question of whether size matters therefore requires more clarity as to the role of Boards of Governors than offered by the Government's spokesmen in Parliament or the Department of Health's guidance, exercises in ambiguity both.

But political rhetoric needs to be tested against reality in another, more fundamental respect still. Central to the case for FTs, as put by the Government, is that they represent "a new form of social ownership where health services are owned by and accountable to local people rather than to central government" (to return to the quote in our opening paragraph). But in what respects, and how, are Boards accountable to local people? Accountability, like representativeness, is a complex notion (18). Elected governors appear to be accountable in two of the many senses of the word. They are answerable to the community (as represented by members) in that they are expected to give an account or explanation of performance. And they can be dismissed by the electorate if their explanation fails to convince.

So much for theory and rhetoric. Reality suggests that there is less to the accountability of governors than meets the eye. First, there is the practical problem – already discussed – of how governors will engage with members, let alone the wider public: the mechanics of accountability, as it were. Second, and more crucially still, there is the fact that the elected governors are not responsible for the performance of their trust: they do not exercise direct control, have no right of veto and have only the nuclear option of sacking the chairman and executives. It is the chairman and the Board of Directors – not the elected governors – who are accountable for the Trust's performance to Monitor. So elected governors can at best only hope to exert some influence. But how can anyone be held accountable for the exercise of something as intangible as "influence"? So what is left of the notion of accountability to local people? Very little, it would seem: effective, as distinct from notional, accountability still runs upward rather than downward: to Monitor, if no longer the Secretary of State.

At this early stage in the development of FTs, such questions may seem like academic quibbles. It is tempting to argue that in practice, ways of accommodating the problems will be found. But, given that FTs are supposed to become the norm in the NHS – that wave will succeed wave until all trusts are FTs – this may be an over-complacent view. For expansion may create new problems even before the old ones have been resolved. All the more so if Primary Care

Trusts acquire FT status. The logic of community control, whatever that may mean, applies even more strongly to PCTs than to provider trusts, since it is the former who purchase care on behalf of the population. The case was strongly argued during the Parliamentary debates, but foundered on the Government's belief that PCTs were not ready for such a change in status.

But if the number of FTs multiplies, there may be a real risk of election fatigue. Different trusts in the same geographical area might well be competing to recruit members and governor candidates. And it cannot be assumed that there is an infinitely elastic supply of either. There may therefore be a case for reconsidering the rejection of the New Zealand model of electing district health board members using the local government electoral roll and combining the two elections: in 2005, this produced a 42% turn-out, with 1,134,000 voters participating in the elections (19). In Canada, however, Alberta, Saskatchewan and Quebec have at various times also flirted with similar electoral systems but subsequently abandoned them (20). There would seem to be a strong case for a comparative study of how these various experiments have worked out, and what their effect is on the governance process.

The problems we have identified should not be taken as implying the Foundation Trust governance model is necessarily or inherently flawed. Our assumption rather is that the FT initiative, like all policy initiatives, represents an experiment. As such it should not be judged by whether it succeeds in solving every problem or resolving every ambiguity from the start. Indeed, our assumption is that many problems can only be identified in the process of implementation, as indeed is the case with FTs. The task for policy makers is then to monitor that process and to respond to the lessons learnt. From this perspective, a commitment to diversity should be seen not as a policy of laisser-faire but as an opportunity to find out how the different emergent models work out in practice and a challenge to devise explicit criteria for choosing between them.

Endnotes

1. Department of Health *A guide to NHS Foundation Trusts* London: DoH December 2002

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10. *ibid.* cols.429 – 430

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