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BEYOND FT STATUS: The future for engagement, involvement & local accountability in NHS Trusts

2017

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Contents

Executive Summary

- The Foundation Trust pipeline has seemingly dried up, with little sign of any new 'FT' authorisations in the coming years.
- This raises questions for the remaining 80 NHS Trusts with regards to engagement, involvement and local accountability.
- There remains plenty of reasons why trusts should (and are in fact required to) engage with their stakeholders. These can be described as cultural (i.e. it is the right thing to do), pragmatic and statutory (thanks to a renewed focus on quality, especially in leadership).
- NHS Trusts recognise the need to engage but there is a lack of direction with regards to how this should be achieved. This is due to the confused and uncertain nature of 'FT status' and the continued squeeze on NHS finances (an issue which dominates the landscape).
- Faced with this dilemma most NHS Trusts are carrying on regardless. Many trusts have yet to address the conundrum they're in and, as such, any change of approach has usually been restricted to the fringes rather than wholesale.
- The two main categories of engagement activity remain systemic survey and feedback collection (usually under the 'patient experience' name) and memberships/panels.
- The quality of engagement and involvement across NHS Trusts has a way to go, with only one trust receiving an 'Outstanding' rating from the CQC in the 'Well- led' category. 27 are rated as 'Good' while 40 'Require Improvement'. 11 are considered 'Inadequate'.
- What is lacking at present is a clear understanding of what is trying to be achieved with engagement and how methods such as membership and patient experience can help to do that. The FT scenario is not helping matters here.
- Trusts could ensure a return on their investment by refocusing their engagement efforts away from attempts to achieve FT status and towards achieving (and maintaining) 'Good' and 'Outstanding' ratings from the CQC as described in the Well-led Framework.
- Trusts should integrate the two most common streams of engagement (patient experience and membership) to ensure effective, meaningful engagement that reaps benefits for all parties.
- Patient experience data provides an excellent starting point for meaningful engagement but data alone cannot deliver the quality of involvement that regulations are trying to encourage.
- Memberships will still prove to be beneficial for NHS Trusts (regardless of the future of the FT model) especially in a more coordinated approach with patient experience.
- At present, there is no easily identifiable way to achieve local accountability in NHS Trusts. The onus is on individual boards of directors to discover this but, ultimately, this will be a question for government, regulators and NHS leaders.

Foreword

In 2004, legislation passed to create Foundation Trusts, a model for the NHS Provider sector of devolved powers and fiscal autonomy that would help 'fix' things. We were told that every trust would one day become a Foundation Trust – this ambition lasted right up to 2012 before target dates started to be revised and qualifications to those earlier ambitions added. The pipeline started to slow down, new structures and legislation were introduced, a recession happened and, of course, the financial crisis within the sector worsened. Whilst the FT model in itself was not the cause of the problems – in many ways the model remained and remains robust and with cross-party support – FT status was no longer a carrot for NHS Trusts. The financial gains and managerial autonomy promised were starting to look less and less likely, and as aspirant trusts' own finances steadily worsened, even passing through the hoops required for authorisation were now so much harder it became a more abstract ambition.

As we end 2017 the Provider sector has just over 150 Foundation Trusts, and 80 non– FTs. This latter group is a mix of trusts that never applied and were never intending to apply for FT authorisation, and importantly a significant number of trusts that got some way down the road of authorisation and are now in a sort of membership-model limbo.

Membership is a cornerstone of the FT model and integral to a Foundation Trusts' governance. Public involvement, consultation and participation remains high on the agenda, at least verbally, and is unlikely to suddenly be considered pointless or a bad thing by any political party. It is written into the NHS Constitution for starters. But what next for those trusts that have built their memberships, invested in that resource, extolled the virtues of local accountability yet have now left that journey to FT-land? Do they still bother? What is the purpose of their membership? How do they get the value out of it? Is it of any benefit or just an awkward legacy? Someone at the party hanging around long after the other guests have gone?

MES works with many of these trusts and we see the good, the bad and the ugly every day. We are often asked these questions ourselves and so we thought it was time to write down what those trusts are thinking and saying, what we see and share the learning. This bulletin pulls it all together – workshops and conversations held with many of our trust clients together with our own thoughts and observations these past few years are in the pages that follow. I hope it is a useful read for NHS Trusts and indeed Foundations Trusts too, as much of it is relevant to all when considering the purpose and benefit of public involvement.

Our company's Philosophy states clearly that we believe engagement and meaningful conversations leads to empowered people and stronger democracy. Our purpose as an organisation is to facilitate and further that agenda. The challenges the sector faces these next few years demands that people are involved and are part of the solution. I am pleased to see that many trusts share this view, and wish to ensure their patients, staff, visitors and communities – their members – remain at the heart of everything they do, regardless of their trust status.

Nick Goodman, Managing Director, MES Autumn 2017

How have we gone about this?

In writing this piece, we've taken the opinion that the FT pipeline has, for a better word, 'dried up'. The future of authorised FTs seems secure for at least the mid-term with the main political parties voicing no opposition to their existence in the most recent general election. However, from what we have seen and read, we do not foresee any new FT authorisations in the coming years.

With that in mind, we set about to discover three things:

- What are NHS Trusts currently doing with regards to engagement, involvement and local accountability?
- Where is the tide heading for engagement, involvement and accountability in NHS Trusts?
- How and where should NHS Trusts refocus their efforts with regards to those themes?

To do this, we did a number of different things:

- We reached out to our NHS Trust clients (there are currently 47 of them) by hosting workshops in Leeds and London, and by having telephone conversations with individual trusts,
- We held an internal workshop for our own staff (who between them have years of experience of working with FTs and NHS Trusts alike),
- We visited each website of the 80 NHS Trusts affected,
- We made use of other publically available material using desktop research.

Introduction

The NHS belongs to the people.

So says the first line of the NHS Constitution, published in 2009. The Constitution, among other things, "establishes the principles and values of the NHS in England. It sets out the rights to which patients, public and staff are entitled." Of the seven guiding principles outlined in the Constitution, two relate to engagement, involvement and local accountability. Principle four says, "The patient will be at the heart of everything the NHS does…The NHS will actively encourage feedback from the public, patients and staff, welcome it and use it to improve its services." The seventh principle states that, "the NHS is accountable to the public, communities and patients it serves." It also states, "The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to the public, patients and staff".

The themes of engagement, involvement and accountability are now well-established in the language of the NHS, thanks in no small part to the Constitution. But these ideas were in existence years before the document's arrival. 2004 saw the creation of the first Foundation Trusts: a new type of NHS organisation designed to free local providers from the control of central government, allowing them to shape their services more closely to the communities they serve. In exchange for these freedoms 'FTs' would be owned by, and accountable to, the local population via a membership structure. Any person could become a member if over a certain age, and they would be entitled to elect 'governor' representatives to hold the board to account for the way services were run and delivered.

In the sixth edition of 'The Membership Bulletin' (published in 2012) we assessed the FT model's impact on engagement in public services. We looked back at life before FTs and marvelled at how established the idea of engagement, involvement and accountability had become in the NHS. At that time it certainly seemed that the ambition for every provider in England to become (or be subsumed by) a Foundation Trust was an unstoppable goal - the 'FT pipeline' initiative introduced by successive Labour governments was also adopted by the Coalition of 2010. But the deadline for that ambition to become reality has been pushed back several times: from 2008 initially, to 2014, to a 'relaxing' of the pipeline, to where we find ourselves today, with 80 NHS Trusts still to be 'authorised'.

How did we get to this point? Well, the scandal at Mid Staffordshire NHS Foundation Trust (followed by the report by Robert Francis QC) played a huge part in changing attitudes and approach to FT status. The Francis Report criticised the organisation for putting its FT application over its quality of care provided. Overnight, the gloss of achieving FT status was tarnished and national priorities changed from decentralisation of decision-making to ensuring quality of care was maintained throughout the service.

Names and language started to change too: the Foundation Trust Network became NHS Providers, NHS Improvement subsumed both Monitor and the Trust Development Authority, and the 'pipeline' was replaced by the Single Oversight Framework.

At the same time, the NHS has experienced the biggest financial squeeze in its history. This has led to greater control and regulation from central government, thus negating many of the beneficial freedoms that FTs and NHS Trusts alike have fought for. This climate has made it almost inconceivable to think that those remaining trusts aspiring to be FTs could pass the assessment criteria and be granted Foundation Trust status. As NHS England Chief Executive Simon Stephens told the King's Fund in 2015, "We are kidding ourselves if we think trusts are going to pass the criteria set out by Monitor [the then regulator of FTs]. An awful lot of time is being spent mucking about on foundation pipelines". He then called for the pipeline to be ended.

And yet, standing here two years later, there has been no formal declaration that the pipeline has ended, and so NHS Trusts could be forgiven for thinking that FT status can still be achieved. However, if that is the case, then there is no clear guidance on how this can be done. Before the creation of NHS Improvement, Monitor had told the Health Service Journal that a "revised approach" for authorising FTs would be revealed in the summer of 2016. That approach is still to materialise.

The message is conflicted. And this raises questions for the 80 NHS Trusts (both at board level and amongst those membership managers, trust secretaries and communication staff that have worked hard to establish engagement practices in the mould of the FT model). Over the past year or so, we've received many questions from NHS Trust staff asking for guidance on what approach similar organisations are taking in this confused scenario, and for insight into what the future of engagement, involvement and accountability looks like beyond FT status.

This commentary looks to address those questions and concerns.

Why trusts should engage

It may seem strange to address why engagement matters (especially when organisations such as ours have extolled the benefits for over a decade) but it's an important thing to reaffirm given the current situation for NHS Trusts. Take the

pressurised financial climate and couple it with the uncertainty and lack of guidance regarding FT status and it's understandable why trusts could be tempted to roll-back (if not entirely do away with) their proactive engagement efforts or any activities that could be regarded as 'non-statutory'. However, to do so would be short-sighted and counterproductive. There are still many reasons why NHS Trusts should continue proactive engagement and involvement:

- **It's just the right thing to do:** engaging with and involving local populations upholds the values enshrined in the NHS Constitution. When done well, these practices benefit communities and organisations alike. When we asked our workshop participants for reasons why their public/patient memberships were still operating, we heard things such as, "it feels good", and "it's culturally right". Another said "it helps with our reputation". The idea of using stakeholder engagement to enhance reputation and to drive-up an organisation's value is something we're beginning to hear more of in NHS boardrooms, partly (we suspect) because of new regulatory emphasis on such matters, which we'll come to in a moment.
- **It makes sense from a business point of view**: the retail and commerce sector has, for years, operated on the premise that customer feedback is essential for both business development and retention. Engaging with customers is the best way to ensure products and services remain in line with what people want. This pragmatic approach is also relevant to public sector delivery – engaging and involving the public is the best way to ensure money is spent in the most appropriate and effective way. This is particularly relevant in times of financial difficulty.
- **The genie is out of the bottle**: even if a trust wanted to cease their engagement activity (e.g. for short-term financial gain, due to lack of clarity, for ease etc.) it would be extremely difficult for them to do so. As one of our work shoppers commented, "The patient and public voice has become louder". We've noticed this too (as outlined in Membership Bulletin 6). But in the last few years that voice has grown even louder through social media and feedback/review sites such as Care Opinion and NHS Choices. In 2017 people are more ready and willing to air their views, to the point where it would seem strange (if not disenfranchising) if they had no way of doing this. Trying to bring about change that affects the local population without involving that population will, in the modern world, always lead to a backlash. Engagement practices are here to stay, and organisations should seek to obtain the potential benefits involved, rather than trying to manage perceived risks.
- **History warns us what happens if you don't**: leading on from the point above, we need look no further than STPs to find a case in point. Rightly or wrongly, there is a perception that STPs are progressing with little to no say from the people affected by the changes they will bring about. As a result, there is notable opposition to the process (even though STPs may ultimately deliver long-term solutions to the sector's problems). When it comes to reputational damage, how things are perceived are as important as any other factor. The other risk area concerns quality of care. The Francis Report of 2013 criticised, among other things, the culture at Mid Staffordshire NHS Foundation Trust. It recognised that "Trust management had no culture of listening to patients." In that instance, patients, staff and other stakeholders knew that things were not right, yet a culture

existed where these comments were not acted upon. Engaging with stakeholders allows trusts to identify what's working and what could be improved, thus ensuring that quality of care is maintained.

- **There is still regulatory requirement to do it**: in a time of competing priorities, whether or not tasks are underwritten by legal or statutory requirement is always going to be a determining factor regarding how quickly (or thoroughly) they're addressed. Our workshop participants certainly thought so, and although there was some debate whether an absence of statutory drive meant engagement would happen at all, all participants agreed engagement and involvement practices would at least be of low priority without that nudge from regulators or government. This may explain the state of inertia that NHS Trusts are experiencing at the moment – without the motivation of an upcoming FT assessment (or promise of authorisation), the encouragement to proactively engage is gone. However, regardless of the lethargy of the FT pipeline, there is still a statutory requirement to engage. Following on from the failings of leadership at Mid Staffs, there is now renewed focus on whether NHS organisations are led effectively. Hence why one of the Care Quality Commission's (CQC) five key questions asked of healthcare services is "Are they well-led?". Furthermore, this area is supported by a 'Well-led Framework' developed jointly with NHS Improvement (the regulator of provider organisations) – i.e. it matters. Under this framework, the CQC will ask "Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?". Each organisation will be rated as either 'Outstanding', 'Good', 'Requires Improvement' or 'Inadequate'. We look at the definitions of these ratings later in this document but what is clear is that the statutory need to engage with stakeholders is as strong as it's ever been. What's needed perhaps is a shift in mind-set – one that moves away from the FT model and focuses instead on engaging to improve quality of service.

What are other trusts doing at the moment?

As we have seen, there remains both beneficial and statutory reasons to engage within the health sector. And, to be fair, the membership managers, trust secretaries and communication teams we've spoken to (i.e. those currently tasked with engagement within NHS Trusts) recognise this. The question for them is not 'why' but 'how' given a) the confused messages (or lack of them) regarding FT status and b) the perilous state of NHS finances in general. So what are the 80 NHS Trusts doing at the moment? To begin answering this question, we visited each trust's website and sought out their public and patient engagement pages. From that we found:

- 43 trusts are still advertising a membership scheme,
- Of those with memberships, only a handful are operating a governor council (or similar),
- 23 operate a form of continuous patient panel (sometimes referred to as forums, councils, user groups etc.),
- The majority are advertising 'fundraising' and 'volunteering' as engagement/ involvement activity,
- Other advertised activities (i.e. mystery shoppers, 'your story' campaigns, arts groups) are sporadic,
- All 80 trusts invite feedback via their website (on pages such as 'Tell us', 'Patient Experience', 'Have Your Say' etc.) but these pages are almost always separated from others called 'Get Involved' or similar, where the involvement activities listed above are usually found,
- 15 do not have a 'Get Involved' page or similar at all.

So what should we make of this? The first thing we would note is some of the activities advertised such as fundraising and volunteering (we've even seen 'clinical research' being thrown into the mix)

are not engagement or involvement practices as would satisfy the definition laid out by the NHS Constitution or the Well-led Framework.

They are more about ‘giving back’ and, although a vitally important part of health service operation, they arguably shouldn’t be presented as examples of meaningful partnership between provider and stakeholder.

Take these things away and you’re left with two main categories of engagement that will be familiar to anyone who’s worked in or with the sector: the first is the systemic use of surveys and other forms of feedback collection, the second is the maintenance of groups of people and patients via memberships and panels. I.e. it’s a very similar picture to how things have been for the last few years.

So why so little change? Why no evidence of an engagement bolter coming up on the rails to overtake these established methods? We suggest there are two reasons for this. Firstly, as we found out from those trusts we spoke with, most are carrying on regardless. Why? Because it is not 100 per cent certain what is happening with FT status and because there are other priorities facing these trusts (usually financial). As such, many NHS Trusts have yet to address the conundrum they’re in with regards to FT and any change of approach has usually been restricted to the fringes rather than wholesale.

Secondly, the reason why these methods continue to be popular is that, when done well, they remain the most effective ways of meeting the statutory obligations of healthcare organisations (while also reaping the rewards of engagement). However, the prevalence of these well-known methods should not be seen as a sign that

the overall level or quality of involvement in NHS Trusts is strong, as this is not the case. The current CQC ‘Well-led’ ratings of the 80 see just one organisation rated as ‘Outstanding’, 27 rated as ‘Good’ while 40 ‘Require Improvement’ and 11 are considered ‘Inadequate’ (in one case there was not sufficient evidence to rate).

We would suggest the tools required to achieve meaningful, effective engagement are already present at NHS Trusts. What is lacking is a clear understanding of what is trying to be achieved and how methods such as memberships help to do that. The FT scenario is not helping matters here. Indeed, the state of limbo currently experienced by NHS Trusts means engagement efforts (including spend) are resulting in little reward for both organisation and patients alike.

So what’s the answer? We would argue return on investment could be markedly improved by doing two things:

1. Refocus efforts: NHS Trusts should now refocus their engagement efforts away from achieving Foundation Trust status and instead look to achieve (and maintain) ‘Good’ and ‘Outstanding’ ratings from the CQC as described in the Well-led Framework. This provides a tangible benchmark by which the trust (and its stakeholders) can measure engagement success. It also provides direction for engagement activity, which is more likely to lead to beneficial results for all concerned.

2. Integrate efforts: as seen from trust websites, the two main methods of engagement activity (patient experience and membership) are usually operating in isolation. This is possibly because they fall under different directorates – patient experience is usually found under Nursing/Quality and memberships have traditionally fallen under Corporate. As we will see in the final part of this commentary, integrating the two streams is, in our opinion, essential to achieving the higher CQC ratings. Integrating these operations is also the best bet of achieving effective, meaningful engagement that reaps benefits for all parties.

Will patient experience activities alone suffice?

Although the engagement landscape at NHS Trusts retains a similar look, the biggest change in the last few years has been in the (decreasing) number of trusts maintaining memberships. At the same time, patient experience activities have become more prevalent thanks to the Friends and Family Test (FFT) and National Patient and Staff Surveys. This would suggest that the tide is turning from one to the other.

Because of this, we asked our workshop participants to what extent they agreed or disagreed with the following statement: "Statutory patient experience exercises such as the FFT and National Patient and Staff Surveys satisfy our Trusts' responsibility to local engagement, involvement and/or accountability". There was some debate here. Some felt these activities would satisfy requirements (given other issues facing the health service). Others felt that experience surveys (and how they are used) did not go far enough to satisfy the requirements.

At this point, let's explore what the Well-led Framework's definitions of 'Outstanding' and 'Good' ratings are for engagement and involvement:

- **Outstanding:** There are consistently high levels of constructive engagement with staff and people who use services, including all equality groups. Rigorous and constructive challenge from people who use services, the public and stakeholders is welcomed and seen as a vital way of holding services to account. Services are developed with the full participation of those who use them, staff and external partners as equal partners. Innovative approaches are used to gather feedback from people.
- **Good:** A full and diverse range of people's views and concerns is encouraged, heard and acted on to shape services and culture. The service proactively engages and involves all staff (including those with protected equality characteristics) and ensures that the voices of all staff are heard and acted on to shape services and culture. The service is transparent, collaborative and open with all relevant stakeholders about performance, to build a shared understanding of challenges to the system and the needs of the population and to design improvements to meet them.

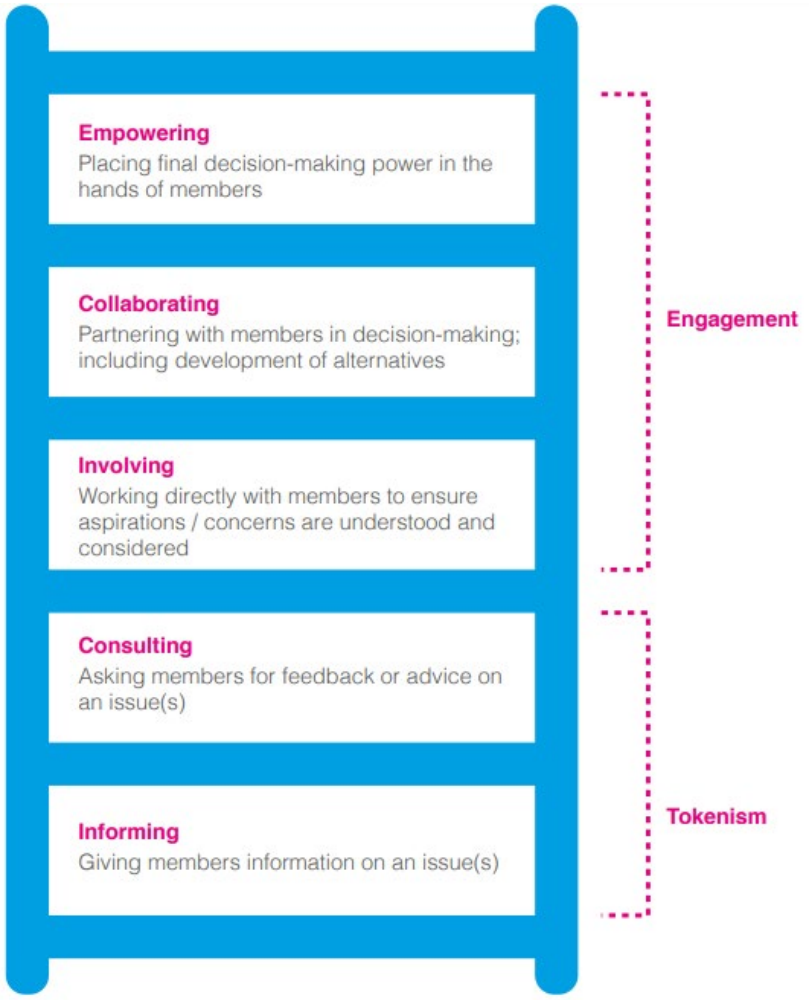
We would suggest that patient experience activities, on their own, do not meet the statutory obligations to engage and involve (at least not to a 'Good' standard). This is not to say that patient experience as a method of involvement has no benefits – of course it does (including those listed earlier). Our view is based on a few things:

- 'Acted upon': from those we spoke to, we got a sense that trusts tend to focus more on the gathering of data and levels of response rather than the insight that data brings. We were told that more in-depth, 'deep dive' type of research is only done when scores are low. This certainly ties with the findings of our 2015 report 'Making Sense and Making Use of Patient Experience Data' where, among other things, we said, "Moreover, teams are so busy gathering data (particularly for the FFT) and compiling reports, that less time is available for doing something with the data – efforts to improve services are in danger of being squeezed out."
- 'Full and diverse range of views': it's very difficult to prove that a trust is listening to a full and diverse range of views using patient experience methods alone, as there is limited control over who completes a survey/provides feedback. Trusts should look to diversify their engagement methods to ensure all groups have a chance to participate and give their views.
- 'Consulting' rather than 'Involving': we've often referred to 'The Ladder of Engagement' as an illustration of how to measure engagement. The surveys that form most patient experience activity naturally sit on the second rung of the ladder, 'Consulting'. To achieve the 'Good' and 'Outstanding' ratings of the Well- led Framework, trusts should be aiming for at least the third rung, 'Involvement'. To do that trusts should look beyond quantitative results and seek out the 'Why' – the useful qualitative data that will bring beneficial change to the organisation and its stakeholders.

Patient experience data provides an excellent starting point for meaningful engagement and involvement. It gives an overview of the current state of play, it allows patients (and staff) to raise

concerns about service and culture, and it provides signposts for further exploration. But data alone cannot deliver the quality of engagement and involvement that the regulations are trying to encourage. To do that, trusts need to proactively approach their stakeholders, discuss what the data is showing, and seek to improve services in a collaborative way.

But how do you seek those stakeholders out?



So are memberships still the way to go?

Memberships will still prove to be beneficial for NHS Trusts regardless of the future of FT status. They may well be called something else in the future – a community/patient/ user panel, forum or network – but they will still be of benefit, especially in a more coordinated approach with patient experience.

As already mentioned, trusts currently enjoy cultural benefits from maintaining a membership. Beyond this, our workshop participants also told us they find their memberships useful for distributing information such as public health messages and trust news. But there's the rub - memberships at present are often used for one-way communication only, and could be used more frequently and effectively. Our workshop participants acknowledged this themselves.

Those NHS Trusts with membership programs would have made a reasonable investment (of both money and resource) in building their respective memberships to date. These efforts have resulted in a resource that, with the correct use, could see a recognisable return on investment.

Going forward, and should there be a refocus towards achieving the better ratings of the Well-led Framework as suggested, memberships (panels, networks etc.) will be useful because:

- They will be a readily-available resource of stakeholders who have proactively decided to help improve services by 'opting in', and who can be approached to take part in more 'deep-dive' research,
- A ready-made audience of participants can provide more qualitative insight and compliment a trust's patient experience efforts (as such there should be a more joined-up approach between activities),
- The personal and preference data held against each individual can be used to target participants for specific quality improvement tasks (as such trusts can feel more confident about obtaining a 'full and diverse' range of views),
- The benefits currently enjoyed (regarding reputation and communication) will remain,
- Should the FT pipeline enjoy a revival, trusts will be well placed to apply for FT status.

However, simply maintaining memberships in their current form may not be advantageous. We heard of a few things that are causing issues for current membership administrators, which NHS Trusts may want to address:

- **Size:** As a hangover from FT applications, some NHS Trusts will have memberships numbering tens of thousands of people. We've been told that those numbers are unwieldy, especially for organisations with large geographical coverage such as Ambulance Trusts. The trend in memberships over recent years has moved from quantity to quality, and perhaps NHS Trusts would want to consider this further: what number of members (panellists etc.) do I require to have good access to a full and diverse range of people and views, while maintaining the benefits of having a membership for all? A word of caution though – going too small invites an invasion by people sometimes referred to as 'the usual suspects' (i.e. those who sit on every public participation body, group and council).
- **Composition:** Categorising your members (according to areas of interest, and desired levels of involvement) can be a very useful thing. But one of the criticisms of the FT model (and how it has been regulated to date) is that it's too focused on structure to the detriment of quality improvement, i.e. is your membership representative of the local population, how are your constituencies arranged, how is your council formed? The problem with this is that it places far more importance on numbers rather than the quality of engagement and involvement. As such, trusts spend a lot of energy on maintaining a structure rather than working with a willing body of participants. Trusts should instead approach engagement in a more pragmatic way, with the ultimate aim of quality improvement always in mind.

At this point, we should recognise that a number of NHS Trusts have already disbanded their membership. When we asked our participating trusts why they had done this, the ultimate reason was money and the difficulty of justifying engagement spend (especially if it's not leading to anything). We would argue that, with a refocus and reorganising of engagement efforts, spend on engagement and involvement will bring rewards. However, we recognise that budgets will continue to be stretched for the foreseeable future.

With that in mind, NHS Trusts could look to do two things:

- **Ensure that memberships, panels etc. are used more widely across the trust:** with a renewed focus on service improvement and quality, NHS Trusts could advertise (if not implement) the use of their membership across different teams and services.
- **Share memberships/panels with neighbouring providers:** with no governance requirement to maintain separate memberships, NHS Trusts could seek to maintain a membership with other providers in their area, allowing all involved to have access to 'opted-in' participants but at a

lower cost. However, trusts should guard against ‘usual suspect’ syndrome where only a handful of (the same) patient and public representatives are engaged with.

What about local accountability?

We know there are benefits (and a statutory need) to engage and involve, and we’ve explored how this can be best achieved in a meaningful way. There is an equal requirement for providers to be transparent and open to constructive challenge. But how NHS Trusts could/should achieve this is much harder to evaluate.

Foundation Trust status provides this chain of accountability with members electing governors who hold non-executives to account. But this structure is underpinned by a legal framework, where governors have the power to appoint (and dismiss) non- executives including the chairperson. Clearly this is not a route open to NHS Trusts.

As mentioned, some (but very few) have tried to mirror these governance arrangements in an NHS Trust setting, as best as can be achieved. But questions remain about the remit of bodies such as this – What are they there to do? Are they elected? Do they serve terms of office? What power do they have? How do they fit into the governance arrangements of the trust? Also, with NHS Trusts not obliged to meet their ‘local accountability’ requirements in this way, the onus is on trust directors to make this type of arrangement work – the very people who would have to deal with that groups’ challenge on a regular basis. It has an element of ‘turkeys voting for Christmas’ about it.

So what are the other options? There has been a suggestion that local accountability should be aligned with commissioners rather than providers. While that proposal makes sense (i.e. those responsible for distributing NHS money work closely with those who use the commissioned service) and while it would pass the NHS Constitution’s stipulation that, “The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear”, it doesn’t address the CQC/NHS Improvement requirement for providers to be transparent, open and collaborative.

NHS Trusts could seek to work more closely with their local Healthwatch who are naturally placed to enhance local accountability as ‘the consumer champion for health and social care’. But this comes with problems too: in order to scrutinise services, Healthwatch will seek out the views of local patients, just as the trust will be doing itself. As such, the process could become one step (unnecessarily) removed.

Alternatively, trusts could view their engagement and involvement activities as natural builders of local accountability, especially if those activities are done well, acted upon and make a real difference to the quality of service. But this approach a) doesn’t allow stakeholders to question strategic decision-making and b) fails to address the themes of openness and transparency.

At present there is no easily identifiable way to achieve local accountability in NHS Trusts, as was the case for all trusts before the advent of FTs. Back then, the catalyst for change was government mandate supported by bespoke regulation. The question of how non-FT providers should be held to account will ultimately be one for government, regulators and NHS leaders. In the meantime, the onus will continue to be on NHS Trusts themselves (and that of course means trust directors) to find the local accountability answer – one which satisfies the regulatory definitions of ‘Well-led’.

A final thought…

There is an irony to the situation that NHS Trusts find themselves in. When Foundation Trusts were introduced in 2004, they promised four headline benefits for aspiring trusts:

- Devolved, local decision-making (sometimes referred to as ‘earned autonomy’),
- The ability to retain surpluses and borrow to invest,
- Greater responsiveness to local needs and wishes of the communities served,
- Local accountability (via a membership and governance structure). These were certainly worth fighting for.

But the current NHS climate – one that is defined by deficits and greater control from the centre to execute financial and quality improvements – has changed all that. The top three benefits mentioned above are simply not attainable at present, which led the King's Fund to claim in 2016: "It is now increasingly difficult to describe a clear distinction between Foundation Trusts and NHS Trusts".

The only real difference that remains is that Foundation Trusts have a recognised structure, designed to promote (if not ensure) engagement, involvement and local accountability. But, again, given the current state of NHS finances, that structure can be restrictive rather than strengthening. With little money available, resources are too often focused on the structure (governors, meetings, reports etc.) than the reason why the structure exists. FTs are becoming prisoners to their own governance arrangements.

Ironically, when it comes to matters of engagement and involvement, NHS Trusts now have greater freedom than their FT cousins. Trusts now have the chance to shape their engagement activity in a way that best suits their surroundings – one that focuses on quality and unlocks the benefits for everyone.

Some trusts will welcome this freedom, others will yearn for the security of structure and imposition. What's clear though is that the opportunity is there for NHS Trust boards to use engagement and involvement to make a real difference to their operation.

It's an opportunity that should be grasped with both hands.

Resources mentioned in this bulletin (and others we like):

Developmental reviews of leadership and governance using the well-led framework: guidance for NHS trusts and NHS foundation trusts, NHS Improvement, 2014 & updated 2017 (https://improvement.nhs.uk/resources/well-led-framework/)

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