

NHS Overview and Scrutiny Briefing Note

Foundation Trust status

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What is Foundation Trust status?

The Department of Health (DoH) states that “The introduction of NHS Foundation Trusts represents a profound change in the history of the NHS and the way in which hospital services are managed and provided”.

Foundation Trusts (FTs) were established under the Health and Social Care (Community Health and Standards) Act 2003 as “independent public benefit corporations”. These are a new type of organisation, existing within the public sector to provide public services on a non-profit basis – but with unprecedented commercial and managerial freedoms. The government states that the model for these corporations is the “mutualism” and “social ownership” of co-operatives, “social enterprises” and the voluntary sector.

FTs are part of the NHS, and their “principal purpose” is to provide NHS treatment free at the point of use; but they are able to act in ways that are not open to the rest of the NHS. FTs are free to:

- borrow from the private sector;
- retain any financial surpluses that they generate;
- retain all moneys from the sale of NHS land and other assets;
- exercise a greater degree of flexibility than other Trusts in setting pay and benefits for staff;
- provide paid-for healthcare services, in order to generate additional income;
- form joint ventures with the private sector.

FTs are also free from the control of the Secretary of State for Health, and are not subject to performance-management by their local Strategic Health Authority.

Each FT is run by a Board of Directors, which works with an elected Council of Governors, representing “key stakeholders”. Some Governors are elected by Trust “Members”, who are drawn from among local residents, patients and staff (residents and patients must opt in; staff membership can be on an opt-in or opt-out basis, depending on the constitution of the FT concerned). There must be a “staff constituency” and a “public constituency” for elections; there may also be a “patients’ constituency”. Other Governors are appointed to represent local partner organisations (Primary Care Trusts, local authorities and others). Governors play an advisory, guardianship and strategic role; they are not involved in the day-to-day running of the FT and so do not deal with matters such as budget-setting and performance-management.

Governors directly appoint the non-executive directors of FTs, including the Chair, but cannot mandate or recall them. The DoH states that “The executive directors are appointed by a committee consisting of the Chair, the other non-executive directors

and the chief executive". The Chief Executive is appointed by the non-executive directors, subject to approval by the Governors.

A regulatory body, the Office of the Independent Regulator (known as "Monitor"), which has the status of an independent corporate body, grants authorisation for Trusts to become FTs and ensures that they comply with their terms of authorisation.

Access to FT status is based on the principle of "earned autonomy" – only Trusts that perform well (as evaluated by the Healthcare Commission) are permitted to apply for FT status. Trusts must show a financial surplus before they are permitted to become FTs.

The government is committed to seeing all hospital Trusts in a position to apply for Foundation status by 2008, a target that all Strategic Health Authorities must seek to fulfil. There appears to be an intention for all NHS Trusts to become FTs eventually (along with the service-delivery arms of PCTs – which are to become "Community Foundation Trusts").

As NHS Bodies, FTs remain subject to local authority NHS Overview and Scrutiny Committees – but matters relating to FTs cannot be referred by OSCs to the Secretary of State; instead, the power of referral is to "Monitor".

It has been suggested that Trusts that fail to become FTs, especially those that are small and financially weak, could be subject to predatory takeover bids by FTs. This has already happened in one case: Good Hope Hospital NHS Trust in Birmingham was recently taken over by Heart of England NHS Foundation Trust. Opinions differ as to whether this will turn out to be an important precedent or just an isolated case.

What are the arguments in favour of Foundation Trust status?

FTs are a major plank of the government's NHS reforms and have proved to be politically controversial (the passage through Parliament of the Bill that established them saw a substantial backbench revolt on the government side in the Commons).

The main arguments in favour of FT status are as follows:

- FTs are a key expression of the government's commitment to the decentralisation of public services and the creation of a patient-led NHS. FTs are intended to allow the devolution of decision-making to local level, making Trusts more responsive and accountable to their patients and communities.
- By becoming more autonomous, flexible and locally accountable, FTs are better able to tackle health inequalities.
- FTs are able to offer additional financial incentives to staff, so as to address the problem of recruitment and retention in areas that have a high cost of living or are unattractive to work in.
- FTs have greater financial freedom than other Trusts, which incentivises innovation and entrepreneurialism, leading to the improvement of services.
- FTs support the Patient Choice agenda by increasing the plurality and diversity of providers within the NHS.

FTs are subject to a set of legal safeguards, designed to ensure that they do not damage the cohesion and continuity of the NHS:

- local ownership and control, through “Members” and Councils of Governors, representing patients, staff and other stakeholders in the community;
- legal incorporation as non-profit “independent public benefit corporations”, with “Members” (rather than shareholders who draw dividends) and provision of free NHS care as FTs’ “principal purpose”;
- a “lock” on NHS assets (designated “protected property” may not be sold to generate a surplus), preventing any “asset-stripping”;
- controls on borrowing by FTs from private sources;
- a “cap” on income from private patients, ensuring that FTs cannot fundamentally shift the balance of their activities away from their “principal purpose” of providing NHS care;
- a ban on charging NHS patients for care (in accordance with primary NHS legislation);
- protection of staff under nationally negotiated agreements on terms and conditions of employment;
- regulation by “Monitor”, which ensures that FTs abide by the terms of their authorisation;
- continued applicability of national NHS standards, performance ratings and systems of inspection (enforced by the Healthcare Commission and other regulatory bodies).

What are the arguments against Foundation Trust status?

FT status is opposed by a number of stakeholders (including several major trade unions within the NHS) on the basis that:

- The existence of FTs will lead to the creation of a two-tier NHS, widening health inequalities and geographical disparities in healthcare. FTs are able to poach staff from other Trusts (by “topping up” national terms and conditions of employment) and have access to sources of funding not open to other Trusts (private-sector borrowing, sale of assets, commercial income-generation). The resulting “uneven playing field” is even more damaging in the context of Payment by Results.
- FTs are not genuinely accountable to their local communities. Governors have only limited powers. Not all Governors are elected and those that are elected, are elected by “Members”, who are a small group of self-selecting individuals and are not accountable to the wider community. Only a small minority of “Members” may actually be involved in elections (in some cases, e.g. University College London Hospitals NHS Foundation Trust, Governors have been elected with votes in single figures).
- FTs are primarily “market actors”, pursuing surpluses within an emerging NHS “market”, rather than ensuring provision of the services that their local population needs. FTs can choose, on the basis of commercial considerations, which services they will provide – this runs counter to the core NHS principle of needs-based planning of services.
- FTs do have scope to shift the balance of their activities towards providing paid-for private healthcare. The “cap” on income from providing private healthcare: allows for private work to grow in line with overall growth in income; does not cover all commercial income; and does not cover income generated in joint ventures with commercial partners or through subsidiaries and spin-off companies (it has recently been reported that many FTs are now going down these routes in order to circumvent the cap on private income). Moorfields Eye

Hospital NHS Foundation Trust is controversially using its ability to borrow more freely in order to set up a clinic in Dubai, in the United Arab Emirates, providing paid-for services under, as the Chief Executive has put it, “the widely recognised Moorfields brand name”. Meanwhile, the Foundation Trust Network, which represents FTs, is lobbying for the abolition of the private-income cap.

- The “lock” on NHS assets is not absolute. If a service is contracted to an outside provider, the NHS estate thereby freed up can be “unlocked” and disposed of, with the proceeds staying entirely within the FT.
- FTs have a commercial incentive to charge patients for an enhanced NHS service. The possibility of such charging within the NHS is shown by the “Jentle Midwifery” premium NHS service (offering continuity of care from a designated midwife), now being provided for a £4,000 fee by Queen Charlotte’s and Chelsea Hospital (which is actually not a FT hospital). There is also an incentive to charge privately for procedures that can be re-classified as “cosmetic” and thereby removed from the scope of NHS provision. This is illustrated by the case of the Foundation Skin Clinic, set up by the Harrogate and District NHS Foundation Trust, which charges for services previously available as free NHS care. FTs further have an incentive to maximise revenue from charging NHS patients for facilities such as parking and telephone services.
- “Monitor” is essentially a market regulator, concerned primarily about FTs’ financial viability, rather than their provision of services. It is not bound to ensure the continuation of a comprehensive, free and universal NHS.
- Handing more power to certain privileged acute Trusts, through FT status, cuts across the empowerment of the Primary Care sector, which the government has said is a key strategic aim for the NHS.

Becoming a Foundation Trust

Preliminary Stage: A Trust wishing to apply for FT status must first prepare:

- a service development strategy (showing it is financially viable in the long term);
- a draft constitution (detailing governance arrangements, including the recruitment of “Members” and Governors);
- a long-term vision (including a Human Resources strategy).

This will involve consultation with staff and the public. The Trust must then apply to the Secretary of State for permission to proceed with its FT status application. Success at this stage is no guarantee of success at the next stage.

Preparatory Stage: Once the Secretary of State has approved the application for FT status, the Trust must draw up a detailed business plan and compile further information for submission to “Monitor”.

If “Monitor” grants authorisation (effectively a licence to operate as a FT), the Trust enacts its constitution in “shadow” form before finally “going live” as a FT. Annual reports must be submitted to “Monitor”, and the Trust must continue to show compliance with the terms of its authorisation.

Possible themes for questions on Dartford and Gravesham NHS Trust’s FT status application

- In 2006, Dartford and Gravesham NHS Trust’s service development strategy indicated that it envisaged, as a FT, playing a competitive commercial role,

seeking to draw in patients from South London, South Essex and elsewhere in the South East through “marketing services to a wider population” under Patient Choice. This raises the question of whether this strategy could work to the detriment of less commercially advantageous services for local people – and to what extent FT Members and Governors would be able to influence the direction of FT policy in this regard.

- Similar issues potentially arise regarding the possibility of the Trust, as a FT, disposing of assets and seeking income from providing paid-for healthcare in response to commercial imperatives, and whether Members and Governors could influence decisions on such matters.
- The service development strategy referred to the shift towards Primary Care envisaged by the government in the White Paper *Our Health, Our Care, Our Say*. However, the strategy did not spell out how FT status would allow the Trust to work with this agenda, and this might be queried.
- As regards how FT Members would be informed and involved, the Trust’s 2006 consultation document said only that the Trust would develop a strategy for this. Further detail could be sought on what this “membership communication strategy” will entail and how successful it is likely to be.
- The Trust’s FT status application stalled in 2006 as a result of the Trust’s financial problems. It would be appropriate to ask whether the Trust’s finances are now sufficiently sound, on a long-term basis, to allow it to progress to FT status – especially given the continued high cost of the PFI contract for Darent Valley Hospital (which consumes around 20% of the Trust’s annual turnover).
- The continuing NHS “Fit for the Future” programme in Kent and Medway, and the “A Picture of Health” project in London, will potentially have significant impacts on Dartford and Gravesham NHS Trust. Questions might be asked regarding how FT status will affect the way that the Trust deals with those impacts.

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Foundation Trust Application

Briefing Paper

Kent County Council NHS Overview and Scrutiny Committee

7 September 2007

1. Background

Between Dec 2005 and May 2006 the Trust prepared an application for Foundation Trust status, having been invited, as a high performing Trust, to apply by the Department of Health. In June 2006 the Trust Board agreed to defer the application. This was done in order to allow the necessary actions to be taken to return the Trust to financial balance.

These plans were delivered and the Trust ended 2006/07 with a small surplus. The S.E. Coast Strategic Health Authority proposed the Trust for FT status again and it was accepted onto the 'Wave 7' list of applicants.

2. How are Foundation Trusts different to other NHS Trusts

NHS foundation trusts are part of the NHS and subject to NHS standards, performance ratings and systems of inspection. However they differ in the following respects.

- They are independent legal entities - Public benefit corporations.
- They have unique governance arrangements and are accountable to local people, who can become members and governors. Each NHS foundation trust has a duty to consult and involve a Council of Governors (comprising patients, staff, members of the public and partner organisations) in the strategic planning of the organisation.
- They are set free from central government control and are no longer performance managed by health authorities.
- They have new financial freedoms and can raise capital from both the public and private sectors within borrowing limits determined by projected cash flows and therefore based on affordability. They can retain financial surpluses to invest in the delivery of new NHS services.
- They are overseen by Monitor (the Foundation Trust regulator).

3. Rationale for Foundation Trust – What are the advantages to Dartford & Gravesham NHS Trust, its patients, staff and the public

There are a number of reasons why the Trust believes FT status will bring benefits to the organisation, its patients, staff and the public.

- Foundation Trust status is a 'badge of honour'. The Trust believes that as a recognised high performing organisation, we will be better able to deliver high quality services to patients and to continuously improve our care, than if the Trust did not achieve this status.
- As a self-governing organisation, it would be free to determine its future, acting flexibly and quickly to meet local needs and priorities. The freedoms granted from central government control mean that it can focus more time and resource on health outcomes and, with the PCT, its contribution to reducing inequalities.
- It can retain financial surpluses to invest at Darent Valley Hospital in improving patient care. This new ability to reinvest surpluses or to borrow money means that new developments, agreed with governors and members to meet specific local needs, can be implemented quickly.
- It would strengthen efforts to involve patients & the public in shaping services, engaging in a way it could not achieve before. The Board of Governors is responsible for representing the interests of the local community in the management and stewardship of the NHS Foundation Trust, and for sharing information about key decisions with other NHS Foundation Trust members.
- The Trust would be much more accountable to governors and members and therefore the local population, and can take decisions autonomously in the best interests of the Trust and local people, rather than through SHA or Secretary or State direction as before.
- It would build on the way in which it uses the skills and experiences of its staff to deliver modern & effective care & treatment and to explore innovative approaches to a range of workforce issues e.g. creating new types of jobs, new ways of working and more flexible shift patterns to meet local needs.
- It could better thrive in the 21st century NHS across Kent and SE London, developing as the community grows along the Kent Thameside.

4. Consultation & Membership

4.1 Consultation

A copy of the 2006 Consultation Response is attached to this paper. A number of postscripts update certain aspects. Having undertaken this process last year the Trust does not need to formally re-consult in full. However it does need to demonstrate effectively that key partners and stakeholders are engaged in, and supportive of, the move to FT status.

From July-Oct 07 the Trust will engage with a wide range of partner organisations and the general public in re-communicating the key aims and objectives of the application and seeking continued support for it.

The response last year showed broad support for all the relevant aspects of the application. The table below is an extract from the response.

Membership	Broadly supportive
Board of Governors	Broadly supportive (further explanation of the role)
Board of Directors	Broadly supportive
Elections	Broadly supportive
Constituencies	Broadly supportive
Boundaries	Broadly supportive
Constitution	Broadly supportive
Age limits	Little comment
Youth Representation	Little comment
Staff representation	No one preferred option.
Vision	Broadly supportive

During the pre-consultation and consultation process the Trust engaged with patients and carers, staff, members of the public, MPs, Councillors, Overview and Scrutiny, GPs, minority ethnic groups, faith groups, disability groups, neighbouring NHS organisations, schools, colleges and universities.

4.2 Membership

A comprehensive Membership Strategy was developed in 2006. The Trust is now aiming to sign up c1000 members from the public and partner organisations. This is an increase on those that it targeted in 2005/06. It wants membership to be meaningful, with members choosing from a range of levels of involvement, from recipients of information about the Trust to active involvement in the Trust's activities. The intention is to develop a public membership that is fully representative of the local community, reflecting the local socio-economic, ethnic and cultural diversity of people that are served by the Trust.

It plans to change its staff membership from an 'opt in' to an 'opt out' scheme and will ensure that all members are involved effectively in the governance arrangements for the Trust. The Board of Directors and Council of Governors, once constituted, will agree a set of objectives and actions to maintain effective membership activities. Broadly these will be.

- Building and developing the membership base
- Communicating with members to assist them in contributing effectively
- Reinforcing the Trust's position as a trusted and accessible participant in the life of the community
- Working with other membership organisations
- Evaluating success – has the membership strategy become the property of the membership? Is the strategy still meaningful for the evolving membership?

- Planning future recruitment

5. Developments since the 2006 application

One of the main concerns raised in the previous consultation was financial stability. This was accepted by the Trust and was the reason for deferral. The Trust has now delivered financial balance (and a small surplus), has robust strategies in place to maintain this, and is therefore in a much stronger position to apply.

The other main changes relate to the service developments the Trust was proposing to undertake as part of its overall strategy. In the main these have been delivered, either fully or in part. They were.

- Cancer services repatriation – The Trust now provides breast, lung, lower GI and haematological oncology.
- Heart Centre development – This opened in January 07 and means local people can have interventional cardiology locally, in purpose built, high quality facilities, rather than travel to London.
- Growth in maternity services and a midwife led unit opening – The Trust delivered its 3000th baby for 2006/07 at the end of March. The midwife led unit opened in May and provides high quality service for low risk deliveries, adjacent to the maternity unit

For this application the key service developments the Trust will focus on are linked to its 2006/07 three strategic objectives.

- Darent Valley will be the “First Choice” for patients in West Kent and South East London
- Dartford and Gravesham will become a NHS Foundation Trust
- Darent Valley will deliver the 18 week Referral to Treatment target.

Within these high level objectives are a number of key supporting developments that will take place over the next few years. They include.

- Developing the Heart Centre further to increase its capacity and expertise in treating patients locally
- Planning for the Kent Thameside expansion and, with partners, ensuring the health needs of this population are met.
- Working with West Kent PCT and other organisations in delivering the objectives of the ‘Fit for the Future’ programme for specialist services.
- Working with the SE London ‘A Picture of Health’ project to plan for more patients to come to Darent Valley Hospital from the Bexley and Sidcup areas.

6. Timetable

- July –Sept 07 –Complete application
- End October –Application to Secretary of State
- End December –Approval by Secretary of State
- Jan –March 08 –Monitor assessment phase
- April 08 –Authorisation as FT by Monitor*

* There is currently a backlog of Trusts to be assessed by Monitor and therefore this deadline may change.

7. Future relationship with the Overview and Scrutiny Committee.

The Trust has always valued its relationship with the Overview and Scrutiny committee, and regards it as an important marker of accountability to local people. This can only strengthen as the Trust becomes more responsive to local views through its members and governors, however the Trust would still expect to be called to account for its actions by the OSC. Regarding any statutory duties relating to NHS relationships with Overview and Scrutiny committees, we will need to watch carefully if there are future amendments to Section 11 of the Health Act, (for example in relation to the demise of Patients Forums and establishment of Links).

8. Recommendation

NHS Overview and Scrutiny Members are asked to re-assert their support for the Foundation Trust application and to consider a process for nominating a KCC representative to the Council of Governors.

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Responses to Dartford and Gravesham NHS Trust application for Foundation Trust status

Respondent	Response
Sutton-at-Hone and Hawley Parish Council – 21 August 2007	<p>“This Parish Council supports any moves to improve the service to and treatment for our residents. We would be interested in contributing to your membership strategy both by nominating a Parish Councillor and encouraging representatives from our local residents should you welcome that input.”</p>
Mr John Beadle (member of the Working with Darent Valley Hospital Patient and Public Involvement Forum) – 19 August 2007	<p>“I am concerned about the question of Accountability for Services which are provided at Darent Valley Hospital by neighbouring Trusts.</p> <p>My specific concern relates to Audiology.</p> <p>A ‘Service’ is provided at Darent Valley by Medway Maritime Trust, but for a catchment area the size of DVH (250,000 growing to 310,000), this is currently one of the worst in the UK. This is NOT due to lack of effort by the Staff but quite the reverse. The Staff are dedicated to attempting to provide a Service, often working additional hours, but are handicapped by totally inadequate facilities provided by DVH Trust. The ‘Best Practice Standards for Adult Audiology’ published in July 2002 clearly define the facilities required, but those at DVH fail on several counts, and cannot house the number of Audiology Staff required for the catchment area of the Hospital. These deficiencies have been identified by the PPI Forum for the past three years, and although minor changes were made a year ago, the situation remains unsatisfactory.</p> <p>The Audiology ‘Service’ provided at Darent Valley Hospital clearly fails the high aims set in this Briefing Paper, and this situation needs to be urgently addressed.”</p>
Mrs Audrey Gee (member of the Working with Darent Valley Hospital Patient and Public Involvement Forum) – 18 August 2007	<p>“At the moment I am visiting my husband , daily, in DVH as he has had a major stroke. I am observing first hand how the ward is run and how the patients are cared for.</p> <p>I have great concerns, not for the quality of the staff but the LACK of them. They are trying to look after very helpless patients with far too few nursing staff .</p> <p>Visitors have to daily check on their patients needs and see they are comfortable, not slipping out of bed, that they are having oxygen masks on, food and water drips working, and are getting some treatments.</p> <p>This is not because the staff do not care but because in cutting back staff they can barely cope with basic needs.</p> <p>Will Foundation Status improve this situation, or is it just another layer of administrators, absorbing the limited funds?</p>

Respondent	Response
	<p>Will the funds that could be retained for patient care really go to increasing the grass level staffing?</p> <p>The care for the patient is the biggest problem at the moment, but this is what is needed.</p> <p>No more administrators please in fact a reduction in the top layer would be sensible.</p> <p>Will you really be able to keep to an 18 week service?</p> <p>Will that include Audiology?</p> <p>The hospital is too small , always has been and is unlikely to cope with the 'Gateway surge'. Are there any realistic plans to raise money to extend the hospital?</p> <p>If the Foundation Trust is not positive about these concerns, they should not proceed."</p>
<p>West Kent Patient and Public Involvement Forum – 24 August 2007</p>	<p><i>“First Comment</i> I have scanned through the report and it all seems very sensible as far as it goes, but all I have to say at the moment is that there must be some potential disadvantages to the Trust's proposed course of action, however I have seen none mentioned in the report.</p> <p>In a properly balanced report both sides of an argument should be set out and the rationale for favouring a particular outcome demonstrated. In my opinion the objectivity of this report is, therefore, suspect.</p> <p>I would have appreciated more time to consider this matter, and obtain further information about the issues. As usual, the Forum members are expected to give their considered responses to a consultation process within a totally unrealistic timescale.</p> <p><i>Second Comment</i> As we have not been informed whether there is any opposition to this application, and if so, on what basis, it is impossible to give an informed opinion based solely on the Trust's own briefing paper.</p> <p><i>Third Comment</i> Having experienced an attempt to give hospitals Foundation Trust status in the early 1990s, I ask if the new Foundation Trust initiative will allow the Trusts to set their own rates of pay. If rates of pay are set at a higher level than the NHS, prime nursing staff will be attracted to work for Foundation Trust Hospitals to the detriment of local NHS hospitals. It is hoped there will be parity in rates of pay with the NHS.”</p>