By: Overview and Scrutiny Manager

To: NHS Overview and Scrutiny Committee – 9 February 2007

Subject: **Medway NHS Trust – Application for Foundation Trust Status**

Summary: The Committee will be invited to agree a response to Medway NHS Trust's consultation on applying for Foundation Trust Status.

Introduction

1. (1) At the Committee's meeting on 12 January 2007 I was authorised by the Committee in conjunction with the Chairman, Vice Chairman and the Liberal Democratic Spokesman of the Committee to invite colleagues who represent an electoral division in Maidstone and Swale Borough Council areas, to meet with Mr A Horne, Chief Executive of the Medway NHS Trust and other colleagues, regarding their application for Foundation Trust status.

(2) The Committee were keen to ensure that colleagues who represent an electoral division in both Maidstone Borough and Swale Borough Council area should be invited to attend this meeting.

Meeting – Monday, 22 January 2007

2. (1) The meeting with Mr Horne and colleagues took place on Monday, 22 January. A copy of the note taken at that meeting is attached as Appendix 2.

(2) Printed with the papers for this meeting is a briefing note on Foundation Trust Status (Appendix 1).

(3) At the meeting or 22 January 2007 Mr Horne was asked whether the views of the NHS Overview and Scrutiny Committee could be made known to the Trust following the meeting of the Committee on 9 February 2007. Mr Horne said that this would be possible.

(4) Mr Horne has very kindly agreed to attend the meeting for 30 minutes to answer Members questions. Once again Members from Maidstone and Swale electoral divisions have been invited to attend this meeting.

Recommendation

3. The Committee are invited to agree a formal response to Medway NHS Trust consultation on applying for Foundation Trust Status.

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Background Information: *Nil*

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Appendix 1

NHS Overview and Scrutiny Briefing Note

Foundation Trust status

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1 February 2007

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" – this is a new type of organisation, which exists 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" – self-selecting volunteers drawn from among local residents, patients and staff. 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".

What are the arguments in favour of Foundation Trust status?
FTs are a major (and politically controversial) plank of the government's NHS reforms. The key 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, incentivising 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 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:

- 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 the 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 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. 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 puts it, "the widely recognised Moorfields brand name".
- 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 facilities.

- "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 stated as 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.

Appendix 2

Note of informal meeting with Medway NHS Trust re application for Foundation Trust status
22 January 2007

Present:

Medway NHS Trust
Andy Horne (Chief Executive)
Jacqueline Geoghegan (Director of Nursing and Operations)
Amanda Bedford (Head of Corporate Affairs)

KCC NHS OSC members
Alan Chell (Chairman)
Dan Daley (Liberal Democrat spokesman)
Adrian Crowther

KCC officers
David Turner (NHS Research Officer)
Paul Wickenden (Overview and Scrutiny Manager)

Mr Horne explained that the Trust's consultation on its Foundation Trust status application was due to finish on 2 February – however, it would not be a problem if NHS OSC were to respond a little after that date (following the committee's meeting on 9 February).

Mr Horne noted that a year previously the Dartford and Gravesham NHS Trust had also been consulting about applying for Foundation Trust status – but had not proceeded with its application. This showed that not all applications went ahead: around 50% of them were stopped at, or before, one of the two hurdles that had to be cleared – namely approval by the Secretary of State for Health and approval by "Monitor".

However, it was intended that all Trusts would become Foundation Trusts eventually, so a halted application only affected *when* a Trust became a FT, not *whether* it did so.

Mr Horne said that applications were usually halted by financial issues, often relating to large, expensive PFI projects (Trusts had to make a surplus before they were allowed to proceed to FT status). There were also sometimes issues relating to the quality of services provided, since quality criteria also had to be met before a Trust could become a FT.

Mr Horne said that the government had originally required all Trusts to become FTs by 2008. It was now saying only that every Trust must be in a position to apply for FT status by 2008. Questioned about the possibility of FTs taking over Trusts that failed to become FTs, he admitted that this had been proposed in one case – where Heart of England NHS Foundation Trust was bidding to take over Good Hope Hospital NHS Trust, in Birmingham. However, he thought this was an exceptional case, as Good

Hope Hospital Trust was very small – and, in any case, he thought it had still not yet been decided what was to happen in that case.[1]

Mr Horne denied that there was any rush to meet a government deadline: "it's not a race, it's about getting it right". He said the issue of reconfiguration of services was very relevant to achieving FT status, and that this was all part of a clinically-driven process to achieve better services.

It was noted that the Trust aimed to achieve a modest surplus of £69,000 in 2006–7. Mr Horne was asked what would happen if the Trust were to fail to achieve a surplus in future as a result of competition with other providers in the emerging NHS market. He said that, as a FT, the Trust's emphasis would be on managing its business better – which would include planning for loss of income as a result of the intended shift towards primary care within the NHS. Medway PCT was already investing in primary care, for instance by taking on community matrons. If the Trust ended up losing services as a result, it would be able to reduce its cost base by knocking down some of the 100-year-old buildings at the hospital that were no longer suitable for medical use, and by reducing its number of nursing staff through natural wastage. He said that, if the Trust were to get into a deficit in the millions as a FT, he and other members of senior management would be dismissed.

Mr Horne was asked about Medway Trust's relationship to the Maidstone and Tunbridge Wells Trust and whether the two were in competition. He explained that there was cooperation in some areas (such as cancer care) and competition in others, particularly areas of planned care such as orthopaedics, urology and ENT. Medway would never seek to compete with the specialist cancer care that MTW provided as a tertiary specialist provider.

The Trust representatives were asked what effect "Fit for the Future", and the associated PCT commissioning plans, would have on the Trust. Ms Geoghegan replied that a lot of the Trust's business plan depended on "Fit for the Future" and they would need to be flexible. Asked whether it was wise to apply for FT status ahead of "Fit for the Future", Mr Horne replied that there would always be uncertainty in the NHS – but they would manage if they were flexible.

Mr Horne spoke about the plans for Membership arrangements under FT status. He explained that there would be two types of Members: Staff Members (all members of staff would be automatically enrolled); and Public Members (who would be recruited from the general public). The Trust aimed to get between 7,000 and 8,000 recruits out of a catchment population in Medway and Swale of some 370,000 (as well as the wider North Kent population, for which the Trust provided some specialist services). Mr Horne said that the Trust would probably change its mind about the proposed minimum age limit of 14 (following representations received in the consultation) and change this to age 16. The Trust would still engage younger people through organisations such as the local Youth Parliament.

Mr Horne was asked about services provided by the Trust outside Medway Maritime Hospital. He said that the Trust provided some medical cover for intermediate care at St Bart's Hospital in Chatham. Asked generally about how intermediate care was provided, Ms Geoghegan explained that this was an issue between Trusts and PCTs

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[1] The takeover is set to go ahead, subject to public consultation – http://www.heartofengland.nhs.uk/publicconsultation/goahead.asp

everywhere. Mr Horne added that it was possible Medway PCT would be putting a polyclinic at the Rochester end of the Medway Towns (to be built under Local Improvement Finance Trust arrangements) and that diagnostic work could be shifted into this setting.

Mr Horne went on to explain about proposed arrangements for Governors under FT status. There would be three types of Governors: Staff; Public; and Stakeholder (representing Medway Council, KCC, local universities, the Hospital League of Friends, etc.). Mr Horne said that the Governors "appoint the Board [of Directors] and can sack it".[2]

Mr Horne explained that LINks would also play a part in patient and public involvement in the work of the Trust as a FT.

Mr Horne was asked about the Trust's financial situation and whether good financial performance in future might actually result in reduced income. He explained that the Trust was now operating substantially under the Payment by Results system, which was based on a national tariff derived from average costs. If the hospital could attract more patients it would receive more income.

Mr Horne was asked about the Trust's current financial situation and how that would impact on its FT status application. The most recent financial report presented to the Board indicated a likely deficit of £1.5m at the end of 2006–7 – yet the Trust was aiming to achieve a surplus (of £69,000), and apparently needed to do so in order to achieve FT status.

Mr Horne said that "Monitor" was able to live with short-term financial instability in a FT if its underlying finances were sound. Some FTs had been allowed to run up modest deficits. He thought that Medway Trust's FT status application could still go through even if the Trust ended 2006–7 with a small deficit. In any case, they still had 10 weeks to go before the end of the financial year and could yet achieve the planned surplus. Mr Horne said that Medway Trust was clearly in a better financial position than Dartford and Gravesham Trust, whose finances were significantly weakened by their PFI costs.

Asked about the role of the Strategic Health Authority in the Trust's FT plans, Mr Horne said that FTs, unlike ordinary Trusts, were not performance-managed by SHAs – but, as a FT, Medway Trust would be "good partners" with the SHA.

Mr Horne was asked about stakeholder involvement in the FT status application. He explained that the Trust's consultation booklet had been widely distributed locally and a series of public meetings had been held. He admitted, though, that attendance at the meetings had been "poor" – with numbers between a dozen and 30. The Trust would be working to encourage local people to join up as members, but he admitted public engagement "is a challenge". The problem was that the public tended to see the change to FT status as merely a technical, administrative matter that wasn't relevant to the actual delivery of services.

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[2] In fact, Governors can only directly appoint the non-executive directors of FTs, including the Chair, and 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 – http://www.dh.gov.uk/assetRoot/04/13/02/32/04130232.pdf

Mr Horne was asked about the relationship between acute and community services. He said that the shift to community services proposed in the *Our Health, Our Care, Our Say* White Paper was based on European and American models (in particular a model developed in California),[3] that were possibly not replicable in the UK. A significant number of older people in the UK lived alone and it was not practical for them to receive medical care at home.

However, Mr Horne said that his Trust's expertise was at the acute end of the medical spectrum, and it ought to concentrate on providing acute services. The PCTs wanted to support people living with chronic conditions, and that was appropriate.

It was noted that PCTs appeared to be cutting back on health visitors and district nurses; and Social Care in Kent and Medway did not have the staff to cope with large numbers of ill people being cared for in the community.

Ms Geoghegan said that the Trust would tend to agree with those statements. But work was being done to develop the NHS workforce to accommodate the shift to community provision. This was apparent from the documents *Modernising Nursing Careers* and *From Hospital to Home*. The Chief Nursing Officer was leading on this, which indicated that it was a clinically-led initiative.

The matter was raised of whether the Trust was consulting on the principle of becoming a FT or simply on the arrangements for doing so. Dartford and Gravesham Trust had indicated in their consultation that question of whether the Trust became a FT was not up for discussion, as it was government policy for all Trusts to become FTs. Mr Horne said he hoped that the Trust could convince the local community that FT status was a good idea.

Asked about opposition to the principle of FT status, he said that the main concern expressed had been in relation to privatisation – but the Trust did not believe that FT status was related to privatisation. Some groups and trade unions were concerned, but he stated there had been "no direct opposition" and "no large groups are actively opposed". Two members of the Staff Side (from UNISON and the BMA) actually sat on the FT Steering Group. He thought that the trade unions' concerns were "really around PFI".

Mr Horne was asked about the potential impact on the Trust of competition between providers in the NHS, driven by Patient Choice. He said that the Trust was focusing more on emergency services and those acute services where Choice did not apply (for instance, urgent referrals by GPs). Choice did mean that providers were obliged to consider the quality of their service – even down to whether receptionists were welcoming and friendly to patients.

Mr Horne was further asked about the possibility of new private providers (such as the new hospital planned at Maidstone) entering the NHS "market" and "cherry-picking" work under the Free Choice arrangements from 2008, thereby taking income from NHS providers under Payment by Results. He noted that the Will Adams Independent Sector Treatment Centre in Gillingham had actually found it very difficult to get patients to choose them rather than Medway Maritime Hospital. He thought this

[3] The California model was developed by the company Kaiser Permanente.

was because the ISTC was a new provider and patients preferred to stay with their local NHS hospital, with which they had an established relationship.

It was pointed out that Medway PCT appeared to be blaming local GPs for the low uptake of the services at the ISTC – it had been suggested that many GPs were not informing patients about the options available to them and were not using Choose and Book.

Mr Horne said he was sure there were “lots of reasons” why the ISTC was underused. He talked to local GPs and they had their explanations as to why so few patients were using the Treatment Centre. He said that he wished the Trust had all the advantages that had been given to the ISTC – including guaranteed payment regardless of how many patients were treated.

The Trust representatives were asked about the possible impact on Medway’s A&E department of the proposals to remove emergency surgery and emergency orthopaedics from Maidstone Hospital. Ms Geoghegan said that just 12 patients per day would be going by ambulance to somewhere other than Maidstone under the proposals – and not all of those 12 would be going to Medway. Mr Horne said that the Trust was not anticipating the need for any extra beds in consequence of this: “if anything, our bed needs are diminishing”.

Mr Horne was asked whether, as a FT, Medway Trust would be “kicking patients out more quickly”, due to commercial pressures. Mr Horne said that the Trust could not just do that – they would continue to work with partners to ensure that patients were discharged appropriately and at the right time. It should be borne in mind that patients themselves did not want to stay in hospital longer than was necessary, not least because of concerns about hospital-acquired infections.

The question was raised of whether London hospitals would suffer as a result of losing patients from Kent if more specialist tertiary services were to be developed in the county. Mr Horne said that new specialties were developing in the London teaching hospitals that would take the place of specialties that shifted to providers in outlying areas.

It was put to Mr Horne that the Trust actually had a large “captive market” for its services in the Medway Towns – on this basis, did he think that FT status would help to bring stability to the Trust?

Mr Horne noted that the unprecedented recent growth in NHS spending would end in 2008; thereafter, growth would return to normal levels – there might even be cuts in the future. Therefore, attempts were currently being made to get the NHS in robust shape for the future. He had been in the NHS for 32 years, and he knew it was quite possible that a future government could change it all again.

Mr Horne was asked what he thought of the suggestion that the NHS was effectively turning into an insurance system. He said that he could not see that. There had been a review of NHS funding a few years ago[4] and he had not heard any recent discussion about the possibility of introducing a new method of funding. The issue now was how to manage the extra money that had been put into the NHS.

[4] This was the Wanless review (published in 2002), which recommended that the NHS should continue to be tax-funded.

The matter was raised of “overperformance”, which had been an issue in the Medway Trust in early 2006, with some clinical activity being suspended due to the inability of commissioning PCTs to pay for any further work until the new financial year. Mr Horne said that this was PCT-driven – they too had to live within their means. It was pointed out that Medway PCT again appeared to be struggling to stay out of deficit in the current financial year. Mr Horne agreed that there would be challenges before the end of the financial year.