Foundation Trust status
Background Briefing

Characteristics of Foundation Trusts

Foundation Trusts (FTs) were established under the Health and Social Care (Community Health and Standards) Act 2003 (now consolidated into the National Health Service Act 2006) 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 (within limits – this is discussed further below);
- form joint ventures with the private sector.

Foundation Trust accountability and governance

Unlike ordinary NHS Trusts, FTs are not accountable to the Secretary of State for Health – and hence are also not subject to performance-management by their local Strategic Health Authority (SHA).

FTs are instead accountable to a regulatory body, the Office of the Independent Regulator (known as "Monitor"), which has the status of an independent corporate body. Monitor is accountable to Parliament and must by statute "exercise its functions in a manner consistent with the performance by the Secretary of State of his duties …"

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.

Transition to Foundation Trust status

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 usually must show a financial surplus before they are permitted to become FTs.

In order to become a FT, a Trust must go through the following stages:

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. Each FT’s

authorisation lays down a number of limits and obligations on it (this is further explained below).

The government is committed to seeing all acute hospital Trusts, and mental health Trusts, in a position to apply for Foundation status by the end of 2008 (although this appears in practice to have slipped into 2009). All SHAs must seek to fulfil this target.

Trusts that are still not in a position to become FTs by the government's deadline face the prospect of merger, acquisition and rationalisation at the hands of one of the FTs.

There are now precedents for takeovers by FTs. Good Hope Hospital NHS Trust in Birmingham has been taken over by Heart of England NHS Foundation Trust. And South Staffordshire Healthcare FT has taken over the mental health services provider arm of Shropshire County PCT. Ashford and St Peter's Hospitals Trust, in Surrey and Middlesex, considered a merger with Frimley Park Hospital Foundation Trust – but has now decided not to proceed with this and to pursue FT status in its own right.

It appears to be the government's intention that ambulance Trusts and the provider arms of PCTs will also become FTs in due course (the latter as "Community Foundation Trusts"), and possibly the commissioning arms of PCTs too.

Overview and Scrutiny

FTs are subject to the duties and powers set out in the regulations governing Health Overview and Scrutiny Committees (HOSCs). The duty to consult HOSCs about any "substantial development" or "substantial variation" in local services applies to a FT where it seeks from Monitor permission to vary the terms of its authorisation in a way that would affect its "protected services". "Protected services" are all the clinical services that an FT is obliged to offer to NHS patients.

In the case of FTs, HOSCs do not have the power to refer changes in services to the Secretary of State for Health – but there is instead an equivalent power of referral to Monitor.

Political Controversy

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. A number of changes were made to the legislation, in order to assuage concerns raised by MPs. The FT policy continues to be opposed by a number of stakeholders, including several major trade unions within the NHS.

Some of the key arguments for and against FTs can be summarised as follows:

For	Against
FTs help to fulfil the government's aim of decentralising public services; and they aid the creation of a "patient-led" NHS. The devolution of decision-making to local level makes Trusts more responsive and accountable to their patients and communities.	The existence of FTs risks the fragmentation of the NHS, as government policy turns it into a market, made up of competing (public and private) providers, driven by commercial imperatives. Where FTs and other Trusts exist together, there could be a "two-tier" NHS, with FTs having unfair financial advantages over other Trusts. The resultant "uneven playing field" would be even more damaging in the context of Patient Choice and Payment by Results.
FTs support the government's Patient Choice agenda by increasing the plurality and diversity of providers within the NHS. At the same time, they are still subject to national NHS standards, performance ratings and systems of inspection, enforced by the Healthcare Commission and other regulatory bodies.	The emergence of a market in the NHS chiefly benefits those who are best able to exercise choice – who tend to be those who are better off and less ill (those that have always been best able to get what they need from the NHS). And it will encourage commercially oriented providers to "cherry pick" those patients, areas, conditions and treatments that are most profitable – to the detriment of other services.
Local ownership and control are guaranteed through Members and Councils of Governors, representing patients, staff and other stakeholders in the community. This provides much more democracy and accountability than exists in ordinary Trusts, where the only patient and public voice is through Local Involvement Networks, and HOSCs.	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).
By becoming more autonomous, flexible and locally accountable, FTs	Fragmentation and marketisation of the NHS will risk widening health

For	Against
are better able to tackle health inequalities through addressing local circumstances.	inequalities and geographical disparities in healthcare provision.
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. At the same time, staff remain protected by nationally negotiated agreements on terms and conditions of employment.	FTs are able to poach staff from other Trusts, by "topping up" national terms and conditions of employment, exacerbating the trend towards a two-tier NHS.
FTs' greater financial freedoms incentivise innovation and entrepreneurialism, leading to the improvement of services. At the same time, FTs are bound by rules that prevent them becoming primarily businesses rather than providers of NHS services. They are legally incorporated as non-profit "independent public benefit corporations", with Members – rather than shareholders who draw dividends. Any surplus made by an FT is the result of prudence and initiative, and will be ploughed back into providing healthcare. FTs' "principal purpose" is the provision of free NHS care. "Protected services" are set down in FTs' terms of authorisation, which are upheld by Monitor. Any changes to these will be subject to scrutiny by an FT's own governance structures, as well as the local HOSC, which can make a referral to Monitor. Monitor must by law "exercise its functions in a manner consistent with	FTs are primarily "market actors", operating in an increasingly commercial environment and competing with for-profit providers within the NHS. FTs cannot make profits, but they are expected to make a surplus (which they are allowed to keep) – and they are doing this on a significant scale. It has been estimated that the combined cumulative surplus of all FTs currently stands at around £2 billion. FTs can choose, on the basis of commercial considerations, which services they will provide. Monitor is essentially a market regulator, concerned primarily about FTs' financial viability, rather than the adequate provision of NHS services. It is not explicitly bound to ensure the continuation of a comprehensive, free and universal NHS, in the way that the Secretary of State is.

For	Against
the performance by the Secretary of State of his duties …”	
FTs are prohibited from charging NHS patients for care under primary NHS legislation. Care provided by FTs for NHS patients will remain free at the point of use, as it has always been.	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.
There is a “lock” on NHS assets within FTs – designated “protected property” may not be sold to generate a surplus, preventing any “asset-stripping”.	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.
Monitor sets a private income cap for each FT in the FT’s authorisation, in accordance with a statutory rule. Under that rule, the cap in each case is effectively set at the proportion of total income derived from private patients in the financial year 2002–3, or in the first full year in which the FT was a (non-Foundation) Trust (if later than 2002–3).	The private income cap still allows for private work to grow in line with overall growth in income. The cap does not cover all commercial income. Most importantly, it does not cover income generated in joint ventures with commercial partners or through subsidiaries and spin-off companies. Several FTs have exploited this loophole – which

For	Against
This ensures that FTs cannot fundamentally shift the balance of their activities away from their "principal purpose" of providing NHS care. FTs are actually more restricted in this regard than ordinary Trusts, whose income from treating private patients is not subject to any limit.	Monitor believes to be entirely lawful. Moorfields Eye Hospital NHS Foundation Trust has used 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". The trade union UNISON argues that such activities are against the spirit of the legislation governing FTs and is currently seeking a judicial review on the matter. In response to UNISON's action, Monitor is undertaking a three-month consultation on its interpretation of the private income cap rules. Meanwhile, the Foundation Trust Network, which represents FTs, has been lobbying for the abolition of the private-income cap.

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