What foundation trusts mean for the NHS

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Summary

What are foundation trusts?

1. The Act introducing NHS foundation trusts was passed on 20 November 2003. It established a new class of organisation – public benefit corporations - which would be responsible for the delivery of healthcare services to the NHS, and would be known as NHS foundation trusts;

2. Foundation trusts operate under license, and are subject to scrutiny by a regulator;

3. The purpose of the introduction of these new types of provider organisation is twofold:
   - To make hospitals more accountable to local populations; and,
   - By freeing them from central control to give hospitals the flexibility to improve the services that they provide;

4. The key differences between foundation trusts and existing NHS trusts are:
   - The board comprises local people, patients and staff as elected members;
   - They have more freedom to invest and dis-invest coupled with the right to work with private partners from any industrial sector;
   - They can retain surpluses for investment in the development of services; and,
   - They may have some advantages in recruiting and retaining staff.

What is the role of the Secretary of State?

5. THE SECRETARY OF STATE DETERMINES WHETHER AN APPLICATION BY AN NHS TRUST TO BECOME A FOUNDATION TRUST SHOULD GO FORWARD TO THE REGULATOR. TWO TRANCHE OF NHS TRUSTS HAVE PUT THEMSELVES FORWARD FOR CONSIDERATION, THE FIRST TO BECOME FOUNDATION TRUSTS IN APRIL 2004, AND THE SECOND IN OCTOBER 2004;

6. The Secretary of State determines the terms on which public dividend capital of a foundation trust is to be treated as having been issued;
7. The Secretary of State can intervene to dissolve a foundation trust where the options open to the regulator have been exhausted; and,

8. The Secretary of State appoints the regulator, and can remove the regulator from office on grounds of misconduct or incapacity.

**What is the role of the regulator?**

9. The regulator is a body corporate consisting of up to five members which is appointed to oversee foundation trusts. It is accountable to Parliament, and will report to Parliament on an annual basis;

10. The regulator is responsible for authorising the creation of an NHS foundation trust. This is a form of ‘licence’ setting out the conditions under which the trust will operate;

11. These conditions relate to:
   - governance arrangements for the trust – it must fulfil the requirements as presented in the Act;
   - the goods and services that the trust will be expected to deliver – it is expected to be able to deliver goods and services to meet the needs of its local population as agreed by the regulator;
   - the limits on the amount of money that the trust is allowed to borrow – the trust can borrow from private sources but must be within a ‘prudential borrowing limit’ as defined by the regulator;
   - the limits on the assets which the trust is allowed to sell – the trust can sell assets and use the income to develop its service provision, but this is subject to some assets being ‘protected’ from such sale, as agreed with the regulator.

12. The regulator is independent of the Secretary of State but must behave in a way that is consistent with the duties of the Secretary of State.

**What will the new regime mean in practice?**

13. Foundation trusts will remain part of the NHS. Their primary purpose will be to provide healthcare services to people living in their local
communities. But they will have greater operational freedom than NHS trusts;

14. Contracts between foundation trusts and primary care trusts will be legally binding unlike those between NHS trusts and primary care trusts;

15. Foundation trusts will have more freedom to determine their investment strategy. They can borrow from private lenders in order to invest in the development of better services; they can sell existing assets where these have not been defined by the regulator as ‘protected’. Security for borrowing will be based on their projected cash flows. However they will be expected to borrow within a prudential borrowing limit.

16. Foundation trusts will have the same freedoms to develop local recruitment and retention initiatives as NHS trusts. However, if as expected they are among the first trusts to be covered by Agenda for Change, they will have additional flexibilities.

The terms of the debate

17. Critics have argued that the introduction of foundation trusts is tantamount to privatisation of the acute hospital sector;

16. Critics have also argued that it will produce inequity in the national system, and will increase the bias towards hospital provision at the expense of primary and community care;

17. The Government has argued that the introduction of foundation trusts will improve the provision of healthcare for local people;

18. The Government has alluded to international evidence to support its case, but this does not bear close scrutiny. Comparisons with international experience are not made on a like-with-like basis. Moreover the evidence is equivocal;

19. There is no firm evidence to support either the Government’s claim that the new Foundation Trust structure will be effective in improving care, or its critics’ claims that it in fact heralds a break-up in ‘national’ health services.
Key questions for local partners

20. The key questions that an overview and scrutiny committee (or any local partner) might ask in assessing the application of an existing NHS trust for Foundation Trust status are:

- Will there be real involvement of local people; what powers will they in fact have?
- Does the trust’s business case make sense?
- What will be the impact of the trust’s plans on other providers within the local health economy?

An overview

21. If the objective of the legislation was to introduce governance arrangements that are more locally accountable, then we find the new arrangements have the potential to meet this requirement.

22. If the objective was to improve the care available to the local population, then we find no evidence to support the conclusion that the new arrangements will ensure this. Nor can it be proved otherwise. The basis for the assertion that this objective will be achieved is so inchoate as to not be open to formal analysis.

23. We accept that foundation trusts will have more freedoms to develop their business than NHS trusts. These freedoms offer possibilities but also risks. The regulator will have a key role in focusing the trust on the delivery of better services for local people.

24. We do not believe that the arrangements in place at the moment are likely to be adequate to ensure the robustness (and fairness) of the system of healthcare as a whole in local areas served by foundation trusts. It will require strong intervention by the regulator to remedy this, which is not impossible under the current legislation, but may be unlikely.
Section 1

Introduction

This report provides an analysis of the proposed introduction of foundation trusts to the NHS that considers:

- The context for this development;
- The Act’s implementation of foundation trusts in the NHS;
- Some key issues arising from the introduction of foundation trusts;
- Some international evidence on foundation trusts; and,
- Some questions to Foundation Trust applicants that local partners may find helpful.

The report is based on an analysis of existing material in the public domain.

The next section describes briefly the context for this development. This is followed by an explanation in Section 3 of the terms of the Act as it relates to foundation trusts. In Section 4 we examine some of the key issues that arise as a result of the introduction of foundation trusts.

Section 5 discusses the use of international evidence relating to foundation trusts. We conclude in Section 6 by giving a brief overview of what we have found. We go on to suggest how local partners might assess the case of a local trust that is applying for Foundation Trust status, and what the nature of their ongoing relationship is likely to be.

Finally an extensive set of references is included at the end of the report, where they are listed in alphabetical order. They are referred to in the text by author and year in parentheses.
Section 2

Background

In April 2002 the Government announced proposals for developing a new type of NHS organisation - NHS foundation trusts – with new freedoms and greater independence from central government control (Department of Health, 2002a). Although there was much to be clarified about what this concept would mean in practice (Robinson, 2002), the proposed introduction of foundation trusts aroused enormous controversy both within the governing party, and across the political spectrum. In March 2003 the Secretary of State introduced a Bill to the House of Commons which included the introduction of foundation trusts to the NHS. After considerable debate and amendment, the Bill was eventually passed on 20 November 2003.

In the intervening period in a series of revisions the meat was put on the bones of the concept - and sometimes stripped off as the difficulties of getting the Bill through Parliament became apparent. In this section we briefly describe the genesis of the idea and how it developed into what eventually became the Act introducing foundation trusts to the NHS.

The genesis of the idea

When the Government published its plans for the NHS in July 2000 (Department of Health, 2000) there was no mention of foundation trusts. At the time of the election in May 2001, although there was considerable detail in the Labour Party Manifesto (Labour Party, 2001) about how the NHS Plan would make a difference over the following five years, there was no indication that a new organisational structure for hospitals was being considered.

However in a speech to the New Health Network in January 2002, the Secretary of State, Alan Milburn, hinted at the changes that were about to be introduced. In April 2002, the Government’s description of how it was going to implement the NHS Plan (Department of Health, 2002a) contained the proposal to create new bodies to be
known as NHS foundation trusts. What had happened between May 2001 and April 2002?

Much has been written about different ways of organising health service provision (Harrison and Prentice, 1994; Harrison, 2001; Saltman and Figueras, 1997), but this has mainly focused on the organisation of services. More recently commentators have been developing radically different propositions for governance structures in the public sector.

In *The Mutual State*, Mayo and Moore (2001) proposed a new form of governance for the public sector that has many of the features that have emerged in the foundation trust legislation. In observing ‘New Labour has no consistent vision of public sector organisation’, the authors offered a radical alternative with a potentially twofold benefit: by involving people in delivery this could produce a wide-ranging and participatory civic renewal; and local community involvement could improve design, delivery and experience of public services.

Their ideas were based on the notion of ‘mutuality’ which they attempted to tie back to a long historic tradition. In their words ‘*the mutualisation of public services means... ownership and accountability passes from Whitehall to the direct stakeholders of public services – typically users, staff and, in some way, the broader stakeholders of the local community.*’

The relationship between these ideas and the legislation that was finally passed in November 2003 is clear. Government minister Patricia Hewitt had written the Foreword for the authors. The New Economics Foundation, which published *The Mutual State*, later claimed to be advising the Government on the design of ‘foundation trusts’, which it described as ‘*the new non-profit NHS super-hospitals*’.

Mayo and Lea (2002) went on to develop specific proposals for a ‘Mutual’ health service, proposing that the NHS should become a group of independent mutual health care providers. At the same time the King’s Fund published its call for the establishment of hospitals as not-for-profit independent organisations (King’s Fund, 2002).
The thinking behind the introduction of foundation trusts (King’s Fund, 2002; Dewar and Chantler, 2002) was based on three principles:

- The separation of government from the delivery of healthcare;
- Greater freedom for provider organisations; and,
- More patient choice.

So if these ideas were not yet publicly espoused by the prospective Labour Government of 2001 it seems likely that they were more than a glint in the eye of ministers.

**From proposal to law**

In May 2002 in a speech to a European management conference, the Secretary of State, Alan Milburn, expanded on the theme of introducing NHS foundation trusts. In a press release he announced that:

*Foundation Hospitals will have the ability to develop governance arrangements that enable patients and the public to play a more effective part in the running of the NHS at local level.*

(Department of Health press release 2002/0240, 22 May 2002)

In July 2002 the Department of Health set out more details of the developing foundation trust policy (Department of Health, 2002c). The Government announced in the Queen’s Speech in November 2002 that it would bring forward legislation to establish NHS foundation trusts. A month later the Department of Health published *A Guide to NHS Foundation Trusts* (Department of Health, 2002d) and asked for applications from suitable NHS trusts by February 2003.

In November 2002 the Health Committee of the House of Commons had announced an inquiry into the Government’s proposals to create foundation trusts, and a report was published in May 2003 (Health Committee, 2003a, 2003b).
In March 2003 the Secretary of State introduced foundation trusts as part of the Government’s Health and Social Care (Community Health and Standards) Bill. This was designed to remove central control over local hospitals by creating NHS foundation trusts as new legal entities – public benefit corporations – that would manage hospital services. Foundation trusts would be run by boards of governors\(^1\) directly elected from and by local communities rather than appointed by government.

The Secretary of State said that every hospital would be able to become a foundation trust within four or five years. They would be not-for-profit organisations, wholly part of the NHS and subjected to NHS standards and inspections, but no longer run from Whitehall:

\[
\text{They will be owned and controlled by local people with hospital governors directly elected from the local communities. (They will be) firmly rooted in the co-operative and mutual tradition.}
\]

(Department of Health press release 2003/0111, 13 March 2003)

Meanwhile the Government had been preparing the NHS for the immediate introduction of foundation trusts. In May 2003 the first 29 prospective NHS trusts for Foundation Trust status were announced. This first tranche of foundation trusts would go live in April 2004.

The Bill had its second reading in the Commons in May 2003, and its third in July 2003. After a series of amendments in the Lords, the Bill achieved its third reading on 18 November 2003. After a considerable to-and-fro between the two Houses, considerable arm-twisting by the Government, and some major amendments, the Bill gained Royal Assent on 20 November 2003.

A number of changes were made to the original Bill. Foundation trusts are to be constituted so that all patients and staff are automatically considered members of the

\(^1\) Although by the time the legislation was passed, it was unclear what influence the board of governors would have on the day-to-day running of the trust, which is in the hands of the board of directors.
trust unless they opt out; there is a requirement on a foundation trust to set up a Patients' Forum; there is a requirement for boards of directors to include medical and nurse members, and there are changes to the powers of the separate board of governors over executive appointments.

In December 2003, and not without controversy, the current Secretary of State, John Reid, announced the next tranche of 32 Foundation Trust applicants which hope to be established in October 2004. The controversy stemmed from the fact that some MPs had understood that there would be no more foundation trusts established until the first 25 had been evaluated. But by calling these ‘wave 1a’ the Secretary of State was able to claim them as part of the first wave.

Bill Moyes was appointed by the Secretary of State as the Chairman of the regulator in December 2003. In January 2004 the Secretary of State gave his support to 24 of the 25 NHS trusts who had put themselves forward in the first tranche of foundation trust applicants.
Section 3

How the Act implements NHS foundation trusts

In this section we outline the main points of the Health and Social Care (Community Health and Standards) Act relating to the implementation of NHS foundation trusts. The Act addressed issues other than the introduction of foundation trusts, the major one of which was the establishment of new independent inspectorates for healthcare – CHAI, the Commission for Healthcare Audit and Inspection – and social care – CSCI, the Commission for Social Care Inspection.

The elements of the Act relating to foundation trusts are covered in Part 1 of the Act (NHS Foundation Trusts), sections 1 - 40; Part 2 on Standards has some pertinent areas where the role of the regulator with respect to foundation trusts is defined. Finally some more detailed aspects are presented in Schedules 1 to 5 of the Act, and Part 1 of Schedule 14. Part 1 of the Act applies only to the NHS in England. However it will have implications for people living in Wales who use health services in England.

The Act defines an NHS foundation trust as:

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‘a public benefit corporation which is authorised ... to provide goods and services for the purposes of the health service in England.’
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(HSC(CHS) Act 2003, Section 1(1))

The Act goes on to explain what a public benefit corporation means in this context, to define a range of powers available to a foundation trust, and the regulatory framework within which it will operate.

There are four key elements relating to foundation trusts:

- Authorisation;
- Governance;
- Purpose and powers; and,
• Role of the regulator.

Authorisation

Any existing NHS trust can apply for Foundation Trust status, provided this application is supported by the Secretary of State (for Health). At the moment this support is limited to acute hospital trusts that perform well, which has been interpreted as attaining three-star status in the NHS performance ratings, but the Act refers to any trust. Moreover the Act allows any other persons to apply for incorporation as a public benefit corporation, and subsequently Foundation Trust status, again provided the application is supported by the Secretary of State.

In law such applications are made to the regulator who will then decide on suitability based on the following criteria:

1. the applicant's constitution is considered appropriate and in accordance with Schedule 1 of the Act;
2. the applicant has taken steps to secure that (taken as a whole) the actual membership of any public constituency, and (if there is one) of the patients' constituency, will be representative of those eligible for such membership;
3. there will be a board of governors and a board of directors, constituted in accordance with the constitution;
4. the steps necessary to prepare for NHS Foundation Trust status have been taken;
5. the applicant will be able to provide the goods and services which the authorisation requires it to provide; and,
6. any other requirements which the regulator considers appropriate.

The Act specifically requires the regulator in assessing the ability of each applicant to supply appropriate goods and services, to take into account the applicant’s financial
position, and any report or recommendation in respect of the applicant made by the Commission for Healthcare Audit and Inspection².

The regulator must also ensure the applicant has sought the views of the following:

1. if the applicant is an NHS trust, the Patients' Forum for the trust and the staff employed by the trust;
2. individuals who live in any area specified in the proposed constitution as the area for a public constituency;
3. any local authority that would be authorised by the proposed constitution to appoint a member of the board of governors;
4. if the proposed constitution provides for a patients' constituency, individuals who would be able to apply to become members of that constituency; and,
5. any persons prescribed by regulations.

Points 2 to 5 apply to any persons applying for NHS Foundation Trust status whereas point 1 applies only to NHS trusts.

Variations to the authorisation, ie the licence under which a foundation trust operates, can be agreed by the regulator. However, in deciding this, the regulator must take account among other things of any reports or recommendations made by the overview and scrutiny committees of qualifying local authorities, or by the Commission for Patient and Public Involvement.

A key impact of authorisation will be that an NHS foundation trust is not a servant or agent of the Crown (which is also true of NHS trusts) and hence does not enjoy any status, immunity or privilege of the Crown; moreover the trust's property is not to be regarded as property of, or property held on behalf of, the Crown. (Section 7(7))

² Given that the CHAI is only set up by this Act, initially there will be no recommendations. There is no reference to existing CHI (one of the organisations that CHAI is replacing) recommendations, although there is nothing to stop the regulator taking these into consideration.
Governance

The governance of NHS foundation trusts is defined in Schedule 1 of the Act which deals with the constitution of public benefit corporations. The constitution of a public benefit corporation which is applying to become an NHS foundation trust must meet requirements relating to:

1. Membership eligibility;
2. Boards of governors and directors; and,
3. Reporting procedures.

Membership Eligibility

The constitution may³ specify one or more geographic areas as areas for public constituencies, each of which must be an electoral area for the purposes of local government elections in England and Wales, or an area consisting of two or more such electoral areas.

The Act defines three types of members:

- Public constituency;
- Staff constituency; and,
- Patients’ constituency.

Anyone living in an area specified in the constitution as an area for a public constituency can become a member of the foundation trust. Anyone employed by the corporation under a contract of employment and, if the constitution so provides, anyone who exercises functions for the purposes of the corporation other than under a contract of employment with the corporation can be a member. Finally if the constitution so provides, anyone who has attended any of the corporation's hospitals as either a patient or the carer of a patient within a period specified in the constitution can be a member.

³ The Act says ‘may’. It is not clear what would happen if no constituency was so defined. The implication of other sections of the Act is that a public constituency will always be defined. The application could be rejected by the regulator if no public constituency is defined but it is not clear that this would be based on any particular section of the Act.
Setting up a patients’ constituency is not mandatory; the staff constituency is, and the public constituency is by implication (but see footnote 3). People cannot be a member of more than one constituency at a time. Those who are eligible to be members of the staff constituency are not eligible to be members of the other two constituencies.

The constitution must require a minimum number of members of each constituency or, where there are classes of people defined within a constituency, of each class. However, the size of this minimum is not specified.

**Becoming a member**

A person who is eligible to be a member may become one on application to the foundation trust. Eligibility does not imply automatic membership; however the Act introduces a form of opt-out clause for the staff and patients’ constituencies.

Thus the constitution may provide for a person who is eligible to be a member of the staff constituency to be invited by the trust to become a member without an application being made, unless that person informs the foundation trust that he-she does not wish to do so. The same applies to patient members of the patients’ constituency, but not to carers who must actively apply for membership.

The implication is that staff members or patient members automatically become a member on invitation by the foundation trust, although it remains to be seen how this is interpreted in practice.

**The board of governors**

The foundation trust must have a board of governors. This will consist of elected and appointed members. The constitution must make provision as to:

1. Conduct of elections for membership of the board of governors;
2. Appointment of persons to membership;
3. Practice and procedure of the board of governors; and,
4. Removal of a member from office.
Members of the board other than those appointed are to be chosen by election. Members of a constituency or, where there are classes within it, members of each class may elect any of their number to be a member of the board.

Members of the public and patients’ constituency are to be in a majority on the board. Thus more than half the members of the board are to be elected by members of the foundation trust other than those who are part of the staff constituency. There must also be a minimum number of three board members from the staff constituency.

The Act allows for the appointment of members of the board from the following organisations:

1. Primary care trusts for which the foundation trust provides goods or services;
2. One or more qualifying local authorities (where a local authority is qualifying if it includes whole or part of an area specified as the area for a public constituency);
3. A university where any of the foundation trust’s hospitals include a medical or dental school provided by that university; and,
4. An organisation specified in the constitution as a partnership organisation.

In the case of primary care trusts, local authorities and universities, there is a minimum requirement of one member; in the case of partnership organisations it is a possibility but there is no minimum requirement.

There will be a chairman of the foundation trust who will preside at meetings of the board of governors. There is no specific clause relating to how the chairman of the board of governors will be elected (or selected). However the board of governors at a general meeting will appoint (or remove) the chairman and other non-executive directors of the board of directors. By implication both boards will have the same chairman\(^4\). The Act does not state specifically that the chairman of the board of directors must be a member although section 16(4) of Schedule 1 implies that this will usually be the case.

\(^4\) This was confirmed by Lord Warner on behalf of the Government in a debate in the House of Lords (9 October 2003).
Meetings of the board of governors will be open to members of the public but the constitution may provide for members of the public to be excluded from a meeting for special reasons.

*The board of directors*

The foundation trust must also have a board of directors. The board of directors can exercise all powers of the foundation trust, and these powers can be delegated to a committee or to a single executive director. The board consists of:

- executive directors, one of whom is to be the chief executive (and accounting officer) and another the finance director; and,
- non-executive directors, one of whom is to be the chairman.

One of the executive directors must be a registered medical practitioner or dentist, and another must be a registered nurse or midwife. Non-executive directors (and this therefore includes the Chairman) must either be a member of the public or patients’ constituency or, where the trust’s hospitals include a medical or dental school provided by a university, be exercising functions for the purposes of that university⁵.

The board of governors appoints or removes the chairman and other non-executive directors to the board of directors. Non-executive directors appoint or remove the chief executive. The appointment of the chief executive requires the approval of the board of governors. A committee comprising the chairman, the chief executive and the non-executive directors appoints or removes executive directors.

However some interim arrangements are envisaged as NHS trusts become foundation trusts.

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⁵ We assume such a person would be a university appointee although this language is not used in this section of Schedule 1.
Interim arrangements

Where the applicant to become a foundation trust is an existing NHS trust then the initial chairman of the foundation trust will be the existing NHS trust chairman provided he-she wants to be appointed. The same applies to the existing NHS trust chief executive. Similarly, as far as possible, other existing non-executive directors of the NHS trust will be appointed as non-executive directors of the foundation trust. The non-executive appointments will last for the unexpired period of their current terms of office, or for 12 months, whichever is the longest.

The Act specifically states that the requirements regarding non-executive directors to be either members of the public or patients’ constituencies (or a university appointee) do not apply in the case of these initial arrangements. Moreover the chief executive does not require the approval of the board of governors – although it is highly unlikely that this would not be forthcoming. Less clear is what happens if the board subsequently decides to remove the chief executive.

Reporting procedures

To ensure financial probity a foundation trust must have an auditor and audit committee, and must prepare accounts in accordance with directions given by the regulator (with the approval of the Treasury). The trust must also prepare a document giving information on its forward planning with respect to each financial year.

In addition a foundation trust must prepare annual reports to be sent to the regulator which indicate that the ‘public’ nature of its governance is being dealt with in a satisfactory way. These must give:

- information on any steps taken by the trust to secure that (taken as a whole) the actual membership of any public constituency and (if there is one) of the patients’ constituency is representative of those eligible for such membership; and,

- any other information the regulator requires.
To summarise, the board of governors of a foundation trust will usually be composed of people elected from those living in areas served by the trust, or staff of the trust or patients and carers of the trust, together with some particular types of appointees –by primary care trusts, local authorities and universities. Members of the public and patients’ constituencies will be in a majority on the board.

**Purpose and powers**

The primary purpose of an NHS foundation trust under the Act is the provision of goods and services for the purposes of the NHS in England (Section 1(1)). Foundation trusts may also be required to carry out research in connection with the provision of health care, and-or to make facilities and staff available for the purposes of education, training or research carried on by others.

The regulator grants a foundation trust an authorisation to operate (essentially this is a form of licence). As part of this authorisation the regulator determines what a foundation trust should be required to provide based on:

1. the need for the provision of goods or services in the area in question;
2. any provision of goods or services by other health service bodies in the area in question;
3. any other provision by the trust with which the provision of the goods or services is connected; and,
4. any previous agreement or arrangement to which the trust is or was a party.

The Act states that the regulator may frame its requirements of the foundation trust in terms of volume, location and time-period for goods and services required, as well as stating these good and services as a general or a particular description, and to meet the needs of general or particular health service bodies, and-or other people of a particular description.
On the face of it this is no small task for the regulator although in practice it may choose not to go into matters of service provision in great detail, accepting the use by a foundation trust of quite general terms to describe what it will actually do\textsuperscript{6}.

\textit{Powers}

In general terms a foundation trust is permitted to do anything which appears to it to be necessary or desirable for the purposes of or in connection with its functions (Section 18(1)). In particular this includes:

1. The acquisition and disposal of property;
2. Entering into contracts;
3. Accepting gifts of property; and,
4. Employing staff.

In particular foundation trusts have a duty of cooperation with other NHS bodies in exercising their functions, and vice versa. But they are also allowed to undertake any other activities for the purposes of making additional income where this income would be available so that they could carry on their primary purposes better. This includes being able to form working relationships (to the extent of forming bodies corporate) with whoever it deems suitable. This is subject to any restrictions imposed in the authorisation. However, taken at face value the trust has considerable freedom, to the extent even of working in areas of commerce totally unrelated to healthcare.

On the other hand, the Act states specifically that an authorisation may restrict the provision, for purposes other than those of the health service in England, of goods and services by a foundation trust. The reality of what foundation trusts will be permitted to do remains to be seen.

However the Act is specific regarding one form of activity. It states that:

\textsuperscript{6} If the regulator were to apply itself in great detail to determining what a foundation trust should be authorised to provide, taking account of provision throughout local or regional areas, it might soon find itself taking on a form of planning role that has previously been assumed by regional and strategic health authorities.
The power (to restrict provision) is to be exercised, in particular, with a view to securing that the proportion of the total income of an NHS foundation trust which was an NHS trust in any financial year derived from private charges is not greater than the proportion of the total income of the NHS trust derived from such charges in the base financial year.

(HSC(CHS) Act 2003, Section 15(2))

This section has been a major source of contention. Many commentators and politicians believe it is too much of a restriction on the freedom of foundation trusts. Yet others believe it does not go far enough.

A foundation trust can apply to the regulator to merge with another foundation trust or with an NHS trust. The decision of the regulator will be based on similar criteria to those discussed above relating to the establishment of the original foundation trust. If the merger is with an NHS trust then the application must have the support of the Secretary of State.

**Capital disposal**

When an NHS trust becomes a foundation trust, the property of the originating NHS trust becomes the property of the foundation trust. The amount which was the public dividend capital\(^7\) of the NHS trust immediately before the granting of the authorisation continues as public dividend capital of the foundation trust held on the same conditions, known as ‘initial public dividend capital’. This is the value of the capital assets of the trust upon which the trust is expected to pay dividends.

However the Secretary of State may, with the consent of the Treasury, alter those conditions as he-she has the power to decide the terms on which any public dividend capital of a foundation trust is to be treated as having been issued (Section 13(3))\(^8\).

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\(^7\)The originating capital of an NHS trust is the excess of its assets over its liabilities when it was set up. This is called public dividend capital, and the trust must pay interest on this at a set rate.

\(^8\) This is the same power as applied for NHS trusts.
Before exercising this power, the Secretary of State must consult the regulator. Nevertheless the dividend to be paid by the trust is to be the same as that payable by NHS trusts in England in pursuance of Section 9(7) of the 1990 Act (dividend on public dividend capital).

Any amount issued to a foundation trust as public dividend capital under section 11 of the Act is (like initial public dividend capital) an asset of the Consolidated Fund. Any amount paid to the Secretary of State by a foundation trust by way of repayment of public dividend capital is to be paid into the Consolidated Fund.

The Act enables the Secretary of State to give financial assistance to any foundation trust. This may be given by way of loan, public dividend capital, grant or other payment. The Secretary of State is also able to guarantee the payment of any amount payable by an NHS foundation trust under an externally financed development agreement in the same way as would apply for existing NHS trusts who fund development by the PFI route.

‘Protected’ property

Although the foundation trust has ownership of the originating NHS trust’s assets, the regulator in its authorisation may designate part or all of this property as ‘protected’ if it considers it is needed:

- for the purposes of any goods or services which the authorisation requires the trust to provide wholly or partly for the purposes of the health service in England; or
- for the purpose of doing anything which the trust is required relating to research or teaching.

A foundation trust may not dispose of any protected property without the approval of the regulator. Disposing of property includes disposing of part of it or granting an interest in it. Nor can it create a floating charge on its property.
However the regulator may give approval to the disposal of protected property on any terms it considers appropriate. This allows considerable latitude to the regulator, and again we must wait to see how this is interpreted in practice.

Financial freedoms

A foundation trust is allowed to borrow money for the purposes of or in connection with its functions. However the total amount of its borrowing is subject to a limit imposed by its authorisation. This limit must be reviewed annually by the regulator.

The regulator will produce a code for determining limits on the total amount of the borrowing of any foundation trust, the ‘prudential borrowing code’. The code will reflect ‘any generally accepted principles used by financial institutions to determine the amounts of loans to non-profit making bodies’ (Section 12(2))\(^9\). In determining the Code the regulator will consult with the Secretary of State, applicant NHS foundation trusts, and any other people that it considers appropriate.

The Department of Health has already issued some guidelines (a shadow Code) to applicant trusts for planning purposes so that they can prepare for Foundation Trust status: a debt service cover ratio (ratio of net operating income to payments on debt) of 1.5 times; an interest cover ratio (ratio of operating profit to interest payable) of 1.8 times; and a debt service to revenue (the cost of servicing debt as a proportion of total revenue) of 4%. However the regulator makes the final decision on the Code.

A foundation trust is permitted to invest money (other than money held by it as trustee) for the purposes of or in connection with its functions. This investment may include: forming, or participating in forming, bodies corporate, or by otherwise acquiring membership of bodies corporate.

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\(^9\) A body is defined in the Act as non-profit making if it does not carry on activities for the purpose of making profits for distribution to its members or others.
Role of the regulator

We have already seen how crucial the role of the regulator will be in determining how foundation trusts operate. The Act states that there is to be a body corporate known as the Independent Regulator of NHS foundation trusts (Section 2(1)). The regulator is expected to exercise its role in a way that is consistent with the duties of the Secretary of State under sections 1, 3 and 51 of the National Health Service Act 1977 with respect to health services generally and to university clinical teaching and research. More generally the regulator is required to exercise its functions effectively, efficiently and economically.

Given the relationship between the regulator’s role and the duties of the Secretary of State, it will be interesting to see how independent the Secretary of State can allow the regulator to be.

The regulator will consist of not more than five members who are appointed by the Secretary of State. One of the members is to be appointed as chairman and another as deputy chairman. A member cannot be appointed for more than four years. A member can resign at any time, and the Secretary of State can remove a member from office on the grounds of incapacity or misbehaviour. The Secretary of State has control over payments to members.

The regulator determines the numbers and terms and conditions of staff it requires, having consulted the Minister for the Civil Service. The regulator may regulate its own procedure and make any arrangements it considers appropriate for the discharge of its functions. Anything which the regulator is authorised or required to do may be done by: the chairman or deputy chairman or any committee, or any member of the staff, if authorised by the regulator (generally or specifically) for that purpose.

The regulator may do anything which appears to it to be necessary or desirable for the purposes of or in connection with the exercise of its functions. That includes in particular:
1. Acquiring and disposing of property;
2. Entering into contracts;
3. Accepting gifts of property; and,
4. Co-operating with other public authorities.

Where a foundation trust is found to be in ‘significant’ breach of the Act or of its own authorisation, the regulator can issue a notice requiring the trust to do or cease specified things or things of a specified description within a specified period, or a notice removing any or all directors or members of the board of governors and appointing interim directors and members of the board.

The regulator can also intervene where a foundation trust is in financial difficulty by requiring the directors to reach a voluntary agreement with its creditors or to obtain a moratorium on its business, as set out in Part 1 of the Insolvency Act 1986. If all else fails the Secretary of State has the power to dissolve a foundation trust, with its property, rights and liabilities transferred to another foundation trust, an NHS trust, a primary care trust or the Secretary of State.

**Reporting**

The regulator is accountable to Parliament. Thus the regulator will report on the exercise of its functions to Parliament on an annual basis, with a copy of this report made available to the Secretary of State. It will also prepare for Parliament a summary report of the financial position of all foundation trusts.

The Secretary of State can require from the regulator such reports and-or information as he-she thinks fit. Finally the regulator must respond in writing to any recommendations of Committees of the Houses of Parliament which relate to the exercise by the regulator of its functions.
Other matters

As NHS bodies, foundation trusts have some of the same responsibilities and duties as other NHS trusts. In particular this applies to the NHS inspection regime and the involvement of patients and the public in planning service delivery.

**PATIENT AND PUBLIC INVOLVEMENT**

The Act makes amendments to several other acts which essentially put foundation trusts in the same position as NHS trusts with respect to patient and public involvement. Thus there is the same requirement on foundation trusts to consult the patients and public when planning service provision.

In the same way a foundation trust is required to set up a Patients’ Forum, and to allow entry and inspection of premises by members of a Patients’ Forum. When a Patients’ Forum prepares an annual report relating to its foundation trust this must be sent to the regulator. Also the Commission for Patient and Public Involvement in Health is required to promote the involvement of the public in England in decisions made by foundation trusts that might impact upon their health.

**Review and scrutiny**

The powers of local authority overview and scrutiny committees apply to foundation trusts in the same way as to other NHS bodies. In particular if the trust wants to make substantial changes to the provision of goods and services that has been agreed under its original authorisation, it will need to consult the overview and scrutiny committee before making such an application to the regulator.

Foundation trusts have the same duty as all other NHS bodies to ensure that appropriate arrangements are in place to monitor and improve the quality of health care they provide or commission. Moreover as for other NHS bodies, foundation trusts are subject to the same review and inspection arrangements by the Commission for Healthcare Audit and Inspection and the Welsh Assembly (as implemented in Part
2 of the 2003 Act). The key difference is that where there are significant failings foundation trusts will be referred to the regulator rather than the Secretary of State. The regulator may be requested to take special measures in relation to foundation trusts so as to rectify these failings. Finally the Act imposes a duty of cooperation between the regulator and the Commission for Healthcare Audit and Inspection.
Section 4

The key issues: measuring the impact of the introduction of foundation trusts

The introduction of NHS foundation trusts was not without controversy. The debate has increasingly polarised the Government and its critics. Often claims are made that have little evidential basis. It is certainly too early to attempt any definitive statement on how the introduction of foundation trusts will work in practice in the NHS. In this section however we present some key areas of dispute, explain what the issues are, and attempt to indicate how judgements might be made.

The key purpose of the introduction of foundation trusts, as stated frequently by the Government, is to improve health care for local people. This is the criterion on which any final judgement must rest, but it is a criterion subject to broad interpretation and misinterpretation.

We consider the changes as a whole, and suggest what the underlying mechanisms must be that justify the various polarised views.

The key areas that have proved contentious in the introduction of NHS foundation trusts may be classified as:

1. **governance arrangements** – to what extent are these new organisations more accountable to local people;
2. **business arrangements** - what can foundation trusts do that NHS trusts cannot do, eg market and capital freedoms, and what will be the impact on the trust’s performance;
3. **whole healthcare system** - what will be the impact on the local health economy of these new organisations?

We examine each of these in turn. In essence there are (at least) two sides to the debate, the first from the Government and its supporters, and the second from the Government’s critics and other commentators.
Governance arrangements

It is suggested that a major positive feature of the reform is that the new arrangements will strengthen local ownership of hospital services. In the words of the Department of Health’s brochure (Department of Health, 2003b), ‘Major decisions ....will be taken with local communities for local communities.’ (Department of Health’s emphasis)

The Secretary of State claimed in May 2002:

As national control over day to day management of the NHS ceases, so local community input will need to be strengthened. Foundation Hospitals will have the ability to develop governance arrangements that enable patients and the public to play a more effective part in the running of the NHS at local level.

(Department of Health press release 2002/0240, 22 May 2002)

Critics on the other hand argue that the level of local involvement is likely to be low; that it can become unrepresentative of the interests of local people; that it will not be able to change anything; and finally that the fragmentation of national services will result in inequities across the country.

Moreover concern has been expressed over just what role the board of governors will have in the new foundation trusts. It is clear that the board of directors has responsibility for day-to-day management and forward planning and strategy. Some critics fear the board of governors will become little more than a talking-shop.

Thus Mohan (2003) has argued that ‘... a self-nominating electorate is not most people’s idea of democracy’, and that ‘... the odds are surely in favour of governing bodies simply being there to provide a rubber stamp for business strategies which are devised by managers and medics.’ He has gone on to criticise the mutualist model on which the Government bases its policy:
The government draws inspiration from cooperative and mutualist traditions, but hospitals are very complex and large-scale organisations: how many co-operatives deliver a vast range of professional services and have a turnover of several hundred million pounds per annum?

Some of the strongest protagonists for foundation trusts seem to agree with Mohan’s view, arguing the focus should be on smaller-scale organisations with ‘populations’ of 400-600 people (Mayo and Moore, 2001). However the authors went on rather strangely to describe hospitals as such small-scale organisations. Not many of the first tranche of foundation trust applicants would recognise this description of themselves.

This element of the debate comes down to two issues:

- Will foundation trusts be more democratic, involving local people in determining the services they receive and how they are run; and,
- Will the result of the change in governance structures produce better health care for local people?

Involving people

In a significant change to the Act, there is now an opt-out clause for members from the patient (and staff) constituency, ie patients and staff will automatically be members unless they indicate otherwise. It is unclear how this will operate in practice, though one scenario may see foundation trusts claiming massive memberships on the basis that few people have taken the trouble to opt out.

The new structures provide a mechanism whereby local people, either as users of services or as people who live locally, can become members of the board of governors of their local foundation trust. Moreover the Act states specifically that members of the public and patients’ constituency must be in a majority on the board. The board will appoint the chairman of the board of directors, and can as a last resort remove executive directors.
However the day-to-day management of the trust is the responsibility of the board of directors. Members of the board of governors do not have a right of veto over how the trust is run. On the other hand some of them will be non-executive directors, and the chairman of the board of directors will be a non-executive. So there are several possible avenues of influence open to members. Nevertheless how the two boards will work together in practice is an unknown. The legislation leaves much to be determined locally. Only when foundation trusts are up and running will we see the extent to which local people have more say in the way their local services are provided.

Nevertheless local people are potentially in a stronger position to influence the policy of their local foundation trusts. However, as several commentators have pointed out (Steele, 2003; Lewis, 2003), this influence will be very much dependent on their ability to participate in a quite complex decision-making arena; this requires the development of ‘support mechanisms for the new members to take on their rights and responsibilities effectively’ (Lewis, 2003).

Moreover such developments may not bear fruit for some time as initial arrangements – to ensure management continuity – will place existing non-executive directors on the board together with the existing chief executive, and more than likely the same executive directors.

The regulator is tasked to ensure that the membership of the new trusts is representative of the local community, although how exactly this will be judged remains to be seen.

To summarise, the requirements on the constitution of foundation trusts does allow for greater influence by local communities on the running of their local hospitals. How this will operate in practice remains to be seen.

On the second issue of whether these new governance arrangements will result in improved patient care it is difficult to say. The argument for is based on the notion
that increased stakeholder involvement will result in improved services. It may result in different services but whether these are better is a moot point.

Moreover the issue must be seen in the context of a range of changes taking place in the new NHS. Critics argue foundation trusts will add to the fragmentation of the healthcare delivery system and may contribute to the historic situation of over-emphasis on acute hospital services to the detriment of locally-provided primary care services.

Moreover this may be reinforced by the introduction of a competitive market system for hospital services\(^\text{10}\) (Department of Health, 2002e), and the freedoms that the rest of the foundation trust constitution allows, which will result in foundation trusts competing for more income at the expense of providers in the local economy both in other acute hospitals and in primary care.

**To summarise**, there is no evidence that the new governance arrangements will improve the care of the local community as a whole, particularly when care provided by other NHS providers is considered.

**Business arrangements**

The second key part of the change in the NHS provider structure introduced with the implementation of foundation trusts is to the way that trusts do business. While some commentators have argued that the change will be tantamount to privatisation of the hospital provider sector in the NHS, others have claimed that the Act has been watered down so much that it will make little difference to the way these bodies operate.

The Government claims the new trusts will have more freedom to develop services that are provided more efficiently, or to a higher quality specification, or are more in

\(^{10}\) Eventually there will be a national tariff system where all treatments are categorised according to average resource use across the country, and prices of these categories of treatment will be fixed annually. Some regional variation in prices will be allowed, but contracts between hospital trusts and primary care trusts (the purchasers) will be for a particular volume at these nationally determined prices. Trusts will be able to compete on quality of service offered, and there will be scope for offering enhanced services.
line with what patients want. The ability of trusts to innovate will be enhanced by the new business arrangements that have been put in place.

In the words of Alan Milburn, erstwhile Secretary of State:

(Foundation Trusts) will be NHS hospitals but with greater freedom to run their own affairs. Freeing NHS Foundation Trusts from day to day Whitehall control will encourage greater local innovation in how services are delivered.

(Department of Health press release 2003/0191, 14 May 2003)

So the argument is that the range of ‘freedoms’ that foundation trusts will have when compared with NHS trusts\(^{11}\) will result in improvements in service delivery and hence better patient care. It is the basis for this argument that we now address.

There are four possible changes to the way foundation trusts will operate that could make a difference. These are:

- freedom to invest;
- freedom to offer variations in terms and conditions of employment;
- freedom to work with any partners and to diversify product; and,
- freedom from central direction, interference and monitoring.

Some argue that many of these freedoms are a bad thing in themselves; others claim the watering-down of the Government’s original proposals has made many of these freedoms illusory; finally, there are those who would question whether these freedoms in themselves are likely to lead to the kind of innovation that would be widely recognised as beneficial to the local patient community – which is after all the key test.

Taking each in turn.

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\(^{11}\) In passing we note that it is questionable whether comparisons should be made just with NHS trusts as many new forms of provision have already been introduced into the NHS using private sector partners, eg Diagnostic and Treatment Centres.
Freedom to invest

The new arrangements for foundation trusts impact on the use of capital in two ways:

- Disposal of existing capital; and
- Investment in new capital.

In theory this will give a foundation trust more freedom in planning its investment strategy and acting upon it. It will no longer have to seek approval from regional or national bodies, or be limited by some fixed regional or national allocation. However the regulator has a responsibility to ensure the trust behaves sensibly.

Disposal of capital

A foundation trust can sell existing assets and use the resulting income for further investment. This has been portrayed by some commentators as a step on the road to ‘privatisation’ of NHS provision. Thus Pollock et al. (2003a) claim that ‘…foundation trusts will be able to sell property and retain the proceeds without reference to the strategic health authorities, which currently have a say in the allocation of such proceeds.’

On the other hand the Government has made the seemingly far-fetched assertion that ‘NHS Foundation Trusts will prevent privatisation of the NHS’ (Department of Health, 2003b): this is based on the argument that these organisations will be protected from the sort of ‘de-mutualisation’ that has been seen in the Building Society sector.

The Act would certainly seem to have changed the way in which foundation trusts will be able to approach capital investment and dis-investment. When an NHS trust becomes a foundation trust the property of the original trust transfers to the ownership of the new body. The foundation trust will be expected to pay interest on the value of this property at the same rate as any other NHS trust, although there is scope for some variation by the Secretary of State in the terms under which the capital is to be treated
as having been issued. This corresponds then to current practice where NHS trust property is treated as ‘initial public dividend capital’.

This much seems clear. However in authorising the change of status to a foundation trust the regulator is likely to designate some property as ‘protected’ in the sense that it is required for the purposes of producing goods and services, mainly for the provision of healthcare to the NHS, as also agreed in the authorisation.

So the power of the new trust to dispose of assets as it considers fit, seems to be limited. However it remains to be seen how ‘protected property’ is interpreted in practice. Moreover the regulator can approve disposal of such property ‘on any terms it considers appropriate’, so this may indicate considerable freedom of manoeuvre.

For example, if a foundation trust wanted to downsize its estate it would need only to convince the regulator that it could continue to supply those services as required under its initial authorisation (or look for a change in those terms). There does not appear to be anything to stop a trust from sub-contracting out provision of say ‘eye services’ to another provider, and disposing of surplus estate. At that point it may become tied in to the external provider for these services.

New investment

It has also been claimed that the new freedoms to invest may prove detrimental to the interests of the NHS by introducing potential inequities. Thus Pollock and Price (2003) have argued, ‘Foundation trust borrowing will be at the expense of other NHS Trusts. Foundation Trust borrowing ... will count against the department’s capital spending limit. Foundation trust borrowing could pre-empt capital spending by non-Foundation Trusts.’

The Government on the other hand argues that foundation trusts will have the freedom to decide locally how to invest so as to improve services and increase capacity, but all within a prudent borrowing regime based on ability to repay debt.
The Act allows a foundation trust to borrow money in pursuit of its main role as a provider of goods and services to the NHS. However the total amount of borrowing is limited by the regulator. This limit is expected to be based on sound financial practice, and the regulator is tasked to ensure this.

On the face of it the Government and its critics’ positions are not incompatible. A foundation trust may have more freedom to determine its ‘local’ investment strategy, and have no clear responsibility to ensure that what it does is compatible with the wider local or national interest. Whether the regulatory mechanism can cope with such broad concerns, or indeed whether the Government expects it to, is not at all obvious.

It is likely that these freedoms will be used by foundation trusts –initially at least – to undertake small investment projects in equipment or refurbishment. Interest on these loans would be repayable out of existing income streams or expected enhanced streams.

In one sense this is a considerable freedom when compared with the restrictions on capital that NHS trusts claim to face. On the other hand we are not aware of any systematic review of the evidence that indicates that ‘good’ capital projects are not being supported. Evidence is largely anecdotal or the unsupported claims of some NHS trusts.

Again we must wait and see what emerges in terms of the definition by the regulator of a code that will determine the level of prudent investment by a trust.

To summarise, the change of status does appear to grant considerable freedoms to the foundation trusts. They can restructure their use of capital without reference to regional or national controls. They are not dependent on some limited regional or national allocation of funds. However the regulator may prove an equally powerful obstacle. How this works in practice remains to be seen.

The key question is whether these freedoms can work in favour of the trust’s local population by improving service provision. The difference can only result from the
foundation trust being able to implement an investment strategy that has these positive results when it would have been impossible under the old NHS trust regime. However there also exists the risk (to counterbalance these opportunities) that the foundation trust is free to choose a poor strategy that results in negative results for its local population.

_Freedom to offer variations in terms and conditions of employment_

This is a key freedom which seems to have been watered down as the Bill has been amended on its way through Parliament. Originally it was proposed that foundation trusts would have considerable freedom to offer different terms and conditions to those which are available in the rest of the NHS. However this is no longer the case (Dixon, 2003).

Currently it seems foundation trusts will be among the first trusts to implement the Department of Health’s _Agenda for Change_, which is essentially the standardisation of NHS pay regimes (Buchan, 2003). This will allow staff working in these trusts to switch to more flexible terms and conditions, although eventually all trusts will be able to offer the same.

One advantage that foundation trust status will provide is the freedom to develop local recruitment and retention initiatives. This means that they may be able to attract staff from neighbouring (rival) trusts. The Act itself is not specific about the powers of foundation trusts when it comes to the terms and conditions of staff. Nevertheless commentators believe that there will be little variation from best practice in NHS trusts as currently constituted.

So this is a freedom which is difficult to assess. Clearly the ability to attract better staff (or indeed any staff where there are shortages) is an advantage. More flexibility in terms of how work is carried out, and by whom, may also be an advantage. However, as Jobanputra and Buchan (2003) point out, if foundation trusts are simply about implementing best practice, then there is evidence of this already being done at the national level through central directives.
If foundation trusts are able to vary terms and conditions of employment and change ways of working this could have three effects. First, some staff could be paid less (this appears to be ruled out), or certain functions could be covered in ways that are effectively cheaper (this is not ruled out but would also seem to be allowed under the old regime). In either of these cases the foundation trust may be able to provide services more cheaply.

Second, staff recruitment may become easier for foundation trusts at the expense of the remaining NHS trusts. For hard-to-fill posts, the foundation trust will be able to offer a recruitment and retention premium above that available to NHS trusts. Moreover foundation trusts may seem more attractive to employees even if they cannot offer better terms and conditions.

Third the trust may be able to develop new ways of working that result in more efficient production of existing products or higher quality.

A final aspect that some commentators have speculated upon is that trusts could sub-contract work to other providers, and there would be no limit on the terms and conditions that these ‘partners’ could offer to staff.

**To summarise,** the effect of all this is largely unknowable. In labour markets where staff are in short supply, we might see the price of labour being bid up, and hence NHS trust providers suffering. Where labour is abundant the opposite is possible though the Government has claimed this will not happen.

*Freedom to work with a range of partners, and on a range of products*

The Act (Section 18) grants foundation trusts the general power to do ‘anything which appears to it to be necessary or desirable for the purposes of or in connection with its functions.’ This seems to give quite extensive powers. Attention is also drawn within the same section to particular powers: to enter into contracts; to employ staff; and to acquire and dispose of property. General powers are modified by other sections in the Act, and ultimately the regulator will have to agree what is a reasonable interpretation.
The abuse of such power is not an issue that appears to have been picked up on by Government other than to refer to the regulator as omniscient and omnipotent in this respect; however some critics have highlighted this as a potential problem area. Thus Pollock and Price (2003) concluded that ‘... the freedom (of foundation trusts) to enter into joint ventures with for profit corporations for the sale of both NHS and non NHS health care services including private insurance, could see some patients getting better access to care as a result of ability to pay’.

On the other hand other commentators have welcomed the opportunity for foundation trusts to set up new joint ventures, partnerships and other enterprises linked to non-health organisations (Walshe, 2003).

It is at least possible that a foundation trust could diversity its activity into a range of health-related products, or into other areas of activity in which it might perceive itself having some natural advantage, eg project management consultancy. It is also open to the trust to work with partners from any sector of industry and hence this gives it a potential route for producing an even wider range of products.

These powers go beyond what current NHS trusts are able to do. Certainly they open up a lot of new possibilities, but these are possibilities for failure as well as success. The question is whether the actual exercise of such powers is likely to lead to improvements in the care that the trust provides to its local NHS patients

One argument in favour is that profits from such activity could be used to enhance the health care services that the trust provides – some kind of cross-subsidisation. This is similar to arguments used to justify the provision of private health services by existing NHS trusts. On the hand such diversification may cause management to pay less attention to the core business and so lead in the opposite direction, to a deterioration in services for the local population. All of this though is very speculative; it remains to be seen what kinds of activities the regulator will actually authorise, and how successful the first two tranches of foundation trusts are.
To summarise, while foundation trusts will potentially have quite wide-ranging powers to co-operate with whatever bodies they wish, and produce whatever they wish, the key test is intended to be ‘for the purposes of its functions’, and it will be for the regulator to interpret this appropriately. Once again we must await the practice, though the possibilities do seem quite broad.

What the impact of any of this is likely to be on the care offered to the local population is almost impossible to estimate. Equally important is how it impacts on the whole health system, an issue we return to at the end of this section.

Freedom from central direction

This is a key positive feature highlighted by the Government, and yet there are inherent contradictions. Foundation trusts will be free from central direction but the regulator will ensure they behave appropriately. To what extent will the regulator simply ‘be the secretary of state’s creature’ as some commentators have suggested (Klein, 2003). Klein goes on to argue that the problem is an excess of accountability, with the regulator, the Commission for Healthcare Audit and Inspection, the overview and scrutiny committee of local authorities and primary care trusts lining up to keep foundation trusts in order. At the same time, other commentators are concerned there will be insufficient control over what these trusts do.

Although foundation trusts have been established as public benefit corporations, free from central control, the Department of Health (2003b) has stated that they will ‘operate within a clear accountability framework, and in particular that they ‘will not be allowed to sink or swim, ... to ‘cherry pick’ services or set loose to pursue organisational goals at the expense of the needs of their local health community’.

The independent regulator is the key body established by the Act and tasked to ‘oversee foundation trusts’, in the words of the Department of Health (Department of Health, 2003b). The regulator will be accountable directly to Parliament and will issue each foundation trust with an authorisation to operate which will set out a wide range of conditions on the trust.
Foundation trusts will also be subject to inspection against national standards by the new Commission for Healthcare Audit and Inspection. The regulator will receive these reports and determine what action is needed in the event of problems. Moreover if a foundation trust wants to make substantial changes to the provision of ‘protected’ services it will need to consult the overview and scrutiny committee of its qualifying local authority, before it can apply to the regulator for a change in its terms of authorisation.

But again there are commentators who believe that the power of the regulator will be insufficient to ensure that the new trusts operate in the best interest of the NHS. Mohan (2003) points to the key role that the regulator has under this new system, and doubts its ability to deal with the wide range of issues that will arise. While Pollock et al. (2003) acknowledge the regulator is required to act in a manner consistent with the duties of the Secretary of State, they argue that the Department of Health has also stated ‘The Independent Regulator will ... not replicate the Secretary of State’s existing powers of direction or have a role in performance management.’

Lock (2003) argues that ‘... direct departmental control from Richmond House is being substituted by licence terms, professional controls by standard-setting, directed frameworks and nationally agreed priorities, all set at the centre.’

To summarise, this is a key issue for foundation trusts. If the regulator has all the powers of the Secretary of State, and exercises them in a similar way, then it would seem disingenuous to claim no central direction. On the other hand there are elements of the regime under which foundation trusts will operate that will require consistent monitoring and intervention where appropriate. It could be argued that there is a fine line between this and central direction.

Impact on the local health economy

This is an issue that arises not so much as a result of a specific freedom of foundation trusts but because these trusts in exercising their powers will have an impact on the way in which the local health economy works, and in some instances the national health service.
The argument rests on the extent to which foundation trusts have a particular duty to consider what may happen in neighbouring health care providers as a result of the policies they pursue. In some respect each of the issues that we have dealt with in this section impact to a greater or a lesser extent on the local health economy in which a foundation trust is located.

With the emphasis on decentralisation it should not perhaps be an unexpected policy consequence that the impact on the local health economy as a whole is not a prime motivator for the new trusts. But the Government argues that each foundation trust has a duty to work in co-operation with its local healthcare partners, and by implication this will ensure that the broader interests are met. If not, the regulator, the Commission for Healthcare Audit and Inspection, the overview and scrutiny committee of local authorities and local primary care trusts are all there to act as a constraint on what the foundation trust can do, and to ensure that the broader health interests of the community are taken into account.

But critics see this as a potential problem. Pollock et al. (2003) claim that the ‘core principles of universality and access on the basis of need’ are not protected. Mohan (2003) argues that ‘what is missing … is the idea of a planned service containing the elements of secondary and tertiary services, backed up with appropriate community care, which one might expect to see in any locality.’ They argue that the introduction of foundation trusts is a movement back from an integrated system of healthcare delivery. Lock (2003) makes a similar point, arguing that in a situation in the last 15 years where there has been substantial competition for healthcare resources, it has been a struggle to move resources from acute to community services.

We believe the structure under which foundation trusts operate encourages them to take more account of their own interests – albeit that these do relate to the provision of particular healthcare services - rather than to look at the overall impact of their actions on the local health economy. This is really little different from the current situation that existing NHS trusts find themselves in. However ‘central direction’, the removal of which is one of the main purposes of the reform, can be seen as providing some of this integrating role in the healthcare system. We should add that the NHS
has no record of success in this respect in the past but these changes do seem to militate against the development of an integrated system of care in the future.

**To summarise,** we have already discussed the kind of issues that arise for the national system as a whole due to the new freedoms available to foundation trusts: in competing for contracts; in developing new and-or competing services; in competing for key human resources; in gaining access to funds for capital investment. If the Government’s claim that this reform does represent substantial freedom is to be believed then all of these remain issues for a ‘national’ health service; if the freedoms are in fact so diluted either in theory or in practice as to be ineffective, then they remain issues only in as much as they always have been.
Section 5

The international evidence

The experience of other countries was widely quoted by the Government as a justification for the introduction of foundation trusts in England, arguing that alternatives to centralised models of ownership and control in other states have produced improvements in services. However, the evidence for this is scant, and there are countervailing claims that the healthcare systems in for example Spain and Sweden have not been as successful as has been suggested.

We believe that references to international experience are something of a red herring. Our preferred approach is to seek a clearer understanding of the basis for the improvements or deteriorations that are claimed to emanate from one system or another; there is little benefit to be gained from crude reference to international experience as this cannot be used to establish the case one way or the other for foundation trusts. A leading European commentator, Øvretveit, (2003) has argued that

...detaching a particular type of privatisation or public-private mix from its context can be misleading. The pressures driving particular changes, the process of change and the consequences depend largely on the particular context, even in a comparison of similar Nordic systems.

We base our view on three arguments. First it is very unlikely that we are ever comparing like with like when referring to international experience. This is true both because the nature of the organisation in each country will differ (foundation trusts are a country-specific form of organisation and definitions are necessarily stretched to try to get some comparison that suits the protagonist); and perhaps even more importantly, as Øvretveit has observed, because the context within which services are delivered, both historic and contemporary, will differ from country to country. That is not to say there is nothing to be learnt from international comparisons, but it is an argument against the kind of crude use that is made of such comparisons (where this is often not an attempt to learn, but to justify).
Second, even if we were to accept that ‘Fundaciones’ in Spain for example are the equivalent of foundation trusts in England (and not just a variant on the original NHS trusts of the early 1990s as some Spanish commentators have claimed), there remains the difficulty of finding an adequate way of measuring cause and effect in any large and complex healthcare system.

Where studies exist they operate at a level of crude comparison between aggregate measures such as length of hospital stay, or waiting times, for one or more sets of hospitals differentiated along some often pre-determined lines. But we know that differences in such measures are attributable to any number of factors that cannot be measured in this simple way. Moreover we are usually dealing with situations where the samples are self-selecting. If only the best NHS trusts can become foundation trusts then it may not be a surprise that in three years time they are doing better than other trusts. It can be argued that ‘you have to make the best of what data you have’ but equally when a method is inappropriate it should not be applied.

Finally such statistical methods are inappropriate when we are so far from true experimental conditions. We cannot assess whether other forms of organisational change may have had similar results to those we observe. Moreover there are frequently other factors at work that may have allowed similar improvements (or disasters). Where complex changes to organisational structures are taking place, and where the way things work in practice is little understood and even less studied, it would seem unwise to take such a crude statistical approach to learning from other health systems.

The current change in England is taking place at a time when new contracts have been introduced for doctors, a different system of payments has been introduced, the rhetoric of patient choice is being made concrete, and more private provision is being allowed into the NHS. Can we then determine with any real confidence what the cause of any improvement is?

What is required is a more substantial study of the organisational structures and differences across countries better to understand where possible future routes to
improvement may lie. But this is asking for a lot when such studies are only in their infancy even within individual European countries. The minimum requirement, as we emphasise here, is at least to explain how different structures are intended to bring about change. Only then can some pre-assessment be made of the arguments and post-assessment made of the results.

Nevertheless the Government has quoted international evidence in support of its polices, and its critics have answered in kind. So in this section, despite the reservations discussed above, we report briefly the main points of this debate.

**International experience: the case for and against**

The Government drew on experiences in Spain, Denmark and Sweden, bringing together chief executives from these countries with NHS chief executives and Department of Health officials in a seminar in May 2002. Although differences were noted between the organisation in each country of these ‘foundation-like’ hospitals, and what was being proposed for England, this was not allowed to detract from the use of positive experiences which were reported.

For example Luis Carretero, chief executive of the Son Dureta hospital in Spain explained that ‘our experience is centred around quality and patient satisfaction. We have very good outcomes’. However he also observed that ‘We have higher salaries than other hospitals and there is a pressure to increase numbers.’ Carola Lemme, chief executive of Stockholm’s Karolinska Institute claimed ‘... in the two years since the ‘foundation’ hospital system was introduced to Sweden, there had been a dramatic reduction in hospital waiting times.’ (Department of Health, 2002f).

However Mohan (2003) has argued that ‘the experience of not-for-profit hospitals elsewhere suggests that we should not assume that social ownership per se will guarantee socially-desirable outcomes’. He claims for example that New Zealand has drawn back from a similar policy of Crown Health Enterprises which were introduced in the 1990s. He also refers to a wide range of mainstream US evidence which suggests that US non-profit hospitals have found it difficult not to adopt the mantle of the market at the expense of community orientation and the capacity to innovate.
Bayle and Beiras (2001) have argued that the ‘Fundaciones’ which were introduced in some areas of Spain as independent substitutes for NHS facilities and services were essentially copies of the trusts developed by the Conservative government in the UK in the early 1990s – the precursors of current NHS trusts. These are the bodies on which the Government now is basing its claim that foundation trusts have been successful in Spain.

Bayle and Beiras write that there was a movement against the Fundaciones which eventually resulted in them being returned to the regional public sector. They claim that ‘Fundaciones … have not been able, in spite of the special budgetary treatment they have received, to achieve better results in the quality of their services.’ They go on to say that the conservative government in Spain has announced its abandonment of this policy of transforming public hospitals into Fundaciones.

To summarise, we do not believe that international evidence has anything to offer the current debate on the introduction of foundation trusts to England.
Section 6

Concluding remarks

In this report we have considered the implications of the introduction of foundation trust status to the NHS. There has been considerable heat generated by the debate on foundation trusts over the last 18 months. However this has generated little in the way of hard evidence.

Governance

If the objective of the legislation was to introduce governance arrangements that are more locally accountable, then we find the new arrangements have the potential to meet this requirement. However this depends very much on what is actually implemented, and on the attention that each foundation trust gives to its duty to ensure the membership, and by implication the board of governors, is representative of local people. Moreover, as most commentators agree, representation in itself is of little use unless efforts are made to ensure the membership and the board of governors are able to make an effective contribution to the running of the trust.

The business

If the objective was to improve the care available to the local population, then we find no evidence to support the conclusion that the new arrangements will ensure this. Nor can it be proved otherwise. The basis for the assertion that this objective will be achieved is so inchoate that it is not open to formal analysis.

We accept that foundation trusts will have more freedoms to develop their business than NHS trusts. It is probably the case that different outcomes will occur as a result, but whether these are better or worse for local people cannot be assessed. This depends on the extent to which foundation trusts get it right in terms of their business plans, and the extent to which the regulator, and others, particularly the Commission for Healthcare Audit and Inspection and the overview and scrutiny committees of local authorities, are able to put in place guidelines and/or constraints that will encourage the trust to deliver better services for local people.
The local health economy

Finally a key issue is the impact that the new arrangements will have on the overall provision of healthcare within the local health economy. The foundation trust may prosper at the expense of other local acute providers, or at the expense of non-acute services. We believe that this is a real danger inherent in the introduction of the new arrangements. We do not believe that the arrangements in place at the moment are likely to be adequate to ensure the robustness (and fairness) of the system of healthcare as a whole in local areas served by foundation trusts. It will require strong intervention by the regulator to remedy this, which is not impossible under the current legislation, but may be unlikely.

It is important that local partners are able to contribute to the direction that their local NHS trusts take if these trusts are intending to apply to become foundation trusts. We suggest some issues that the overview and scrutiny committee of a qualifying local authority might consider:

• First in assessing when or if Foundation Trust status is likely to be a good thing for people in their local area (or the public constituency in the words of the Act); and,
• Second in considering the nature of the committee’s continuing relationship with local foundation trusts.

Addressing the specifics of a bid for Foundation Trust status

The key questions that an overview and scrutiny committee (or any local partner) might ask in assessing the case for a foundation trust applicant are:

• Will there be real involvement of local people; what powers will they in fact have?
• Does the trust’s business case make sense?
• What will be the impact of the trust’s plans on other providers within the local health economy?
Governance

The first question comes down to a matter of how the new foundation trust will actually be run. It is important to examine carefully how the new governance arrangements are intended to work. The following are some of the issues that should be addressed:

1. Has the trust sought the views of local people on its application, and with what result?
2. How will the public constituency be structured?
3. How will the staff constituency be structured?
4. Is there a patients’ constituency?
5. If so, how will the patients’ constituency be structured?
6. Does the trust intend to invite all staff and patients to be members (which would automatically make them members unless they decline)?
7. What is the structure of the board of governors? What is the rationale for this structure?
8. What involvement will the local authority have on the board of governors?
9. What other organisations will be asked to appoint people to the board of governors?
10. How is the trust ensuring that local people will be able to play an important role in the running of the trust?
11. What steps is the trust taking to ensure the membership will be representative of those eligible?
12. What are the arrangements for a Patients’ Forum?
13. How will the trust consult patients and the public on service planning issues?
14. If the new board and executive is largely the same as the existing NHS trust board, when will changes to the existing board and executive be possible?
15. What powers will the board of governors have?
16. What relationship will the local authority have with the regulator prior to Foundation Trust status being authorised?
Business

The trust will have a number of freedoms. These offer possibilities but also risks. It is important to examine carefully the applicant’s business strategy as a foundation trust. The following are some of the issues that should be addressed:

1. What are the goods and services that the trust intends to offer as part of its authorisation, and what is the rationale for this?
2. What other activities does the trust intend to be involved in over the next five years, and what is the rationale for this?
3. What part of the trust’s assets does it believe should be defined as ‘protected’, and what is the rationale for this?
4. Does the trust intend any change in its asset base over the next five years? If so, what? How will the trust ensure this does not prevent it from delivering the goods and services that local people require?
5. What NHS and other partners does the trust intend to be involved in? What other areas of activity will the trust pursue?
6. What view does the trust have on what its ‘prudential borrowing limit should be’?
7. What investments is the trust planning over the next five years? What are the key risks to the trust maintaining its stream of payments for any investments that it is planning? What contingency plans will it make?
8. Has the trust had difficulty in the past in getting agreement from the Department of Health to its investment plans, and if so why?
9. What plans does the trust have for changing ways of working in the trust, eg by the introduction of different types of employee?
10. What difference would early implementation of Agenda for Change, the new NHS pay system, make to the way the trust intends to operate? What would happen if this was postponed?

Local health economy

The plans of the trust will have implications for the overall care that will be available in the local area. The following are just a few of the issues that should be addressed:
1. Is the trust intending to expand its NHS business? How will the trust ensure that this does not have a destabilising impact on other NHS providers?

2. How will the trust ensure that it works in partnership with the broader NHS community in its local health economy?

The ongoing relationship with a foundation trust

Several areas are identified where an overview and scrutiny committee will have an active role in monitoring (and guiding) the work of local foundation trusts. Thus:

1. If the trust wants to make a substantial change to its provision of goods and services, as agreed under its initial authorisation, then it will have to consult with qualifying overview and scrutiny committees before applying to the regulator.

2. An overview and scrutiny committee may be represented on the board of governors.

3. An overview and scrutiny committee can examine and report on any issues pertaining to the operation of a foundation trust, and the regulator would be expected to take note of these views.

4. An overview and scrutiny committee can monitor the degree of local involvement in the membership of the trust, and of the board of governors.
Bibliography


