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NHS Foundation Trusts in the *Health and Social Care (Community Health and Standards) Bill*

Bill 70 of 2002-3

Part I of the Bill makes provision for a new type of NHS organisation in England, to be known as an NHS Foundation Trust. The Bill provides for these bodies to be regulated by a new non-ministerial department, to be called the Independent Regulator for NHS Foundation Trusts, and to have a new sort of constitution that would include a directly elected board of governors.

Other Parts of the Bill will be covered in separate Library publications.

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Summary

Part I of the Bill, makes provision for a new type of NHS organisation in England, to be known as an NHS Foundation Trust. The Bill provides for these bodies to be regulated by a new non-ministerial department, to be called the Independent Regulator for NHS Foundation Trusts, and to have a new sort of constitution that would include a directly elected board of governors.

The idea of setting up NHS Foundation Trusts to run hospitals is a little over a year old. Yet it has already caused more controversy than any of the other measures in the Bill and is probably one of the most controversial issues of domestic policy before Parliament this Session. The key claim about these new bodies is that they would have greater freedom from central government than do the NHS Trusts that currently run hospitals.

Part of the controversy is to do with how real the new freedom will be. Some think that the new freedom will largely be a token one. The Conservative Party has supported the idea of Foundation Trusts but argued that it does not go far enough and the Liberal Democrats oppose them on the grounds that they will not deliver freedom from central control. There are some who believe that NHS Foundation Trusts are a step on the way to full-scale privatisation of the NHS. UNISON has written a document that sees the NHS unravelling into a market-dominated, profit-making system of health care but some academics have commented that a pull from the centre tends to reassert itself when governments try to decentralise.

The debate is not just about the facts but also about ideology. The Government has described NHS Foundation Trusts as "representing the middle ground between state-run public and shareholder-led private structures" and claimed them as a prime example of its *Third Way* for public services. This has led to arguments about which way the scales will tip in practice. But there is also an argument between those who think that market forces should play a greater role in healthcare and those who think that greater inequalities are bound to result from greater freedom, even if it were extended to all NHS Trusts.

The pressure for greater managerial freedom appears to have come at least in part from local managers and the idea is supported by the NHS Confederation, the body which represents NHS managers. This belief in decentralisation is partly based on the view that managers of services will do the job more efficiently if they are free from the influence of party politics and its vagaries. This view, it is sometimes said, appeals to politicians because it enables them to devolve blame when things go wrong.

It has been argued that it is hard to judge what the reality will be at this stage. The press has made much of conflicts between Ministers and suggested that the outcome is a compromise, or even a set of contradictions, that is still be being fought over. Much of the opposition comes from the Government's own backbenchers, including Frank Dobson, the first Secretary of State for Health after the Labour Government came to power in 1997. At the

latest count (end April 2003) 124 of these backbenchers had signed an Early Day Motion expressing concern that Foundation Trusts would lead to a "two-tier" health service.

The King's Fund has argued that a lot of uncertainties remain. It argues that the new freedom could be constrained by a number of forces, including the new Regulator, the national standards to which Foundation Trusts will be subject, and the contracts with Primary Care Trusts (which in the case of NHS Foundation Trusts will be legally binding). NHS Foundation Trusts will continue to be subject to performance ratings and to inspection by the Commission for Healthcare Audit and Inspection, the body that will replace the existing Commission. PCTs now control most of the funds going to NHS Trusts and are subject to many of the controls from which NHS Foundation Trusts will be freed, such Secretary of State's Directions and priorities contained in the Government's special programmes for cancer, mental health etc.

Another cause of uncertainty lies in the new freedoms themselves. NHS Foundation Trusts will have to be authorised (licensed) by the new Independent Regulator for NHS Foundation Trusts and the details of what an individual Trust can do will be in the terms of its licence. Details of individual constitutions, though subject to the general requirements in the Bill, will also have to be agreed with the Regulator. This means that even the composition of the board of governors and its rules, including the degree of patient involvement, may be subject to a certain amount of local variation (eg for specialist hospitals that do not have an obvious local constituency).

Nevertheless, it is clear that NHS Foundation Trusts will have a different legal status, will be subject to a different type of accountability and control, and that their formal powers will differ in several ways from those of conventional NHS Trusts, whether the changes are valued in their own right or not and whatever difference they may or may not make in practice.

At the end of 2002, the Government invited applications for NHS Foundation Trusts status from acute and specialist NHS Trusts which had achieved three star performance rating that year. Thirty two out of 51 eligible Trusts had applied by the deadline of February 2003. Those selected are expected to be established in April 2004, subject to the passage of this legislation.

This Paper starts by placing NHS Foundation Trusts within the context of the Government's general approach to public services. It goes on to trace the history of the idea of NHS Foundation Trust and places them within the context of other NHS developments. It outlines what an NHS Foundation Trust will be like and provides a separate list of provisions in the Bill. Finally, it contains a section on reactions to the proposals. The provisions in the Bill relating to Foundation Trusts only apply to England. This Paper therefore covers the situation in England.

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I Background

A. Foundation Trusts as a *Third Way* for Public Services

The intensity of the controversy surrounding NHS Foundation Trusts arises not only because of the importance attached to the way that healthcare is provided but also because they can be seen as a symbol of the Government's general approach to public services and a signal of its intentions for the future. While retaining the commitment to an NHS free at the point of delivery according to clinical need not ability to pay,[1] the Government has itself declared NHS Foundation Trusts to be a prime example of its Third Way for politics, as well as a major plank of its NHS reforms. A recent article on the *Third Way* by Tony Blair, the Prime Minister, illustrates this point:

> On public services, we need to explore the usefulness of choice and contestability to extend opportunity and equalise life chances. Social democrats must reconcile both the claims of choice *and* equity. We must develop an acceptance of more market-oriented incentives with a modern, reinvigorated ethos of public service. We should be far more radical about the role of the state as regulator rather than provider, opening up healthcare for example to a mixed economy under the NHS umbrella, and adopting radical approaches to self-health. We should also stimulate new entrants to the schools market, and be willing to experiment with new forms of co-payment in the public sector.
>
> In achieving reform, we need to clarify the balance between bottom up reform, and command and control approaches in restructuring public services. *For example, the principles underlying Alan Milburn's espousal in the UK of community-owned Foundation hospitals need to be applied far more systematically across the public sector.* [2]

In the article quoted above, the emphasis is on moving away from the state as provider of goods and services towards a state that regulates a mixed economy of healthcare. This Alan Milburn, the Secretary of State for Health, suggests, marks a shift in emphasis from when the Labour Government first came to power. In a speech on localism in February 2002, in which he, like the Prime Minister, placed the development of NHS Foundation Trusts within the context of a broader public services philosophy, he said:

> ….Those of us who have had responsibility for frontline public services over the last six years realise that whatever we thought possible on the 1st May 1997 –

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1 Department of Health, *The Guide to NHS Foundation Trusts*, December 2002: http://www.doh.gov.uk/nhsfoundationtrusts/nhsfoundationtrusts1202.pdf

2 (Library emphasis) Extract from Tony Blair, *Where the Third Way Goes from Here, Progressive Politics* Second Edition, on 21st Century Public Services, 2003: http://www.progressive-governance.net/php/article.php?sid=6&aid=25

> however much we believed that taking control of the commanding heights of the central state was enough – we now know that finger-wagging from Whitehall can not deliver public service improvements any more than could the old laissez-faire mentality of the Tories' NHS internal market.
>
> A better balance is needed. Whereas, some suggest there is a choice to be made between national standards and local autonomy I believe that is a false dichotomy. The experience from elsewhere in Europe in the health sector and from across the developed world in other economic sectors is that securing improvements in performance requires both.
>
> As the Prime Minister's four principles of public service reform rightly acknowledge, in any large organisation – public or private – there are some functions only the centre can perform: fair allocation of resources; setting of standards; monitoring of performance.[3]
>
> And it is precisely because we have a framework of national standards and inspection in place that the pendulum can now swing decisively towards local control and greater individual patient choice. I believe these must become the principal drivers of public service improvement in the next period….
>
> ….NHS Foundation Trusts will usher in a new era of public ownership. They will be owned and controlled locally not nationally. Modelled on co-operative societies and mutual organisations, these NHS Foundation Trusts will have as their members local people, local members of staff and those representing key organisations such as the PCTs. These members will be its legal owners and they will elect the hospital governors. In place of central state ownership there will be for the first time in the NHS genuine local public ownership.
>
> It is not and it has never been my intention to retain these benefits solely for an elite few. The freedoms they offer provide a new incentive for all to improve. We do not advocate that any NHS hospital should be left to sink or swim. That is why we have put in place help and support for struggling services to get better. In time, all NHS hospitals could gain Foundation status.
>
> I believe NHS Foundation hospitals will help bridge the gap between public services and the public who use them. With a clear public benefit purpose NHS Foundation Trusts can provide a model of local control and ownership that others could follow. They are localism made real. I believe they provide a model that could apply to other aspects of public services.
>
> Community-owned NHS Foundation hospitals will allow us to tap the great reservoir of enterprise and knowledge which exists in local communities. Some

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[3] The four principles are: national standards within a framework of clear accountability; devolution and delegation to the front line; more flexibility (eg challenging restrictive practices and rewards for good performance); and choice for the customer. The Prime Minister's Office for Public Service Reform website http://www.pm.gov.uk/output/page257.asp has further details.

> say that allowing local people to be elected to hospital governing boards will always favour the sharp-elbowed middle classes. Yet in my constituency – just like any other – the people who make the biggest difference on local council estates are people from those council estates. What we need to do is open up public services in such a way that they can be properly representative of the communities they serve. [4]

At the time of the April 2003 Budget, the other side of the scales, that is the case for the state to provide goods and services itself when it comes to healthcare, was made in a discussion document issued with the other Treasury documents. This argued for public provision to be combined with devolution of power to front line NHS staff and the introduction of financial incentives to improve performance:

> The case for public provision of health care, meanwhile, rests on the presence of extensive market failures on both the demand and supply side that could not be effectively or efficiently resolved by government regulation alone….
>
> …The case for a publicly-funded, publicly-provided NHS does not, however, justify a wholly centralised, unreformed service. Substantial extra investment in the NHS is being matched with reforms to ensure it delivers real improvements in performance. These reforms will devolve power to front line organisations, establish financial incentives to improve performance and deliver more responsive services with greater choice for patients.[5]

B. The Development of the Idea of Foundation Trusts

The Labour Party's 2001 General Election Manifesto did not mention Foundation Trusts but did speak of the need for radical reform of the NHS. It reaffirmed the commitment to decentralisation that the Labour Government had made in the NHS Plan, which had promised that a new system of "earned autonomy" would devolve power from the centre to the local health service.[6] The Manifesto said that hospitals and other local services would have greater control over their own affairs while consistently failing NHS hospitals would be taken over by successful ones.

On 15 January 2002, the term 'Foundation hospital' was used in a speech by Alan Milburn to the New Health Network. He attributed the idea to a meeting that he had had the previous month with chief executives of three star NHS Trusts. He said that they had presented him with a list of restrictions from which they would like to be freed, and that this had led him to suggest a new sort of structure for the NHS, "representing the middle ground between state-run public and shareholder-led private structures":

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4 http://www.doh.gov.uk/speeches/milburnfeb03localism.htm

5 HM Treasury, *Public Services: meeting the productivity challenge*, A Discussion Document, April 2003.

6 Department of Health, *The NHS Plan*, Cm 4818, July 2000, page 11

> Both the Right – through organisations like the Institute of Directors – and the Left – through the Co-operative Movement - have been examining the case for new forms of organisation such as mutuals or public interest companies within rather than outside the public services and particularly the NHS.
>
> Their proponents have argued that there could be potential advantages to such forms of organisation. They have a clear public service ethos and are not-for - profit. The assets remain within public ownership so there is no question of the NHS being privatised. They offer specific public benefits and cannot be transformed or taken over by another form of organisation which will not provide such benefits. They motivate staff and management alike through more active involvement and control. They offer freedom from top down management but are regulated in the interests of consumers. They give greater control to those who use them. They open up more options for greater community accountability.
>
> Our three star hospitals have now asked us to look at whether such models could be applicable to local health services to form Foundation Hospitals within the health service but run more independently than now. I think it is right that we should examine the case they have made. And we will consider the applicability of Foundations not just to the best hospitals but to the best primary care trusts too. Over the next few months we will be working with them to examine the legal, financial, governance and accountability issues. Amongst other matters we will be examining the case for specialist patient organisations to have a more direct role in the management of specialist hospitals or services.
>
> This will only ever be voluntary not mandatory for the health service's best performers. Alongside national standards, new incentives, more devolution and greater choice, however, it will help make for a new sort of NHS.[7]

On 22 May 2002, Alan Milburn made a speech to a conference of NHS managers and representatives of hospitals in Sweden, Denmark and Spain that had used the Foundation Hospital model. He particularly praised developments at Alcorcon in Spain, which he had visited the previous year, and said that in this country Foundation Hospitals would be established as free-standing legal entities, free from direction by the Secretary of State for Health and enjoying other new freedoms, including freedom to retain the proceeds from land sales; freedom to decide what to borrow and make decisions about capital investment; and freedom to develop additional rewards for staff.[8]

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7 Alan Milburn, *Redefining the National Health Service*, speech given to the New Health Network, 15 January 2002.

8 "NHS Foundation Hospitals to be freed from Whitehall control," Department of Health Press Notice 2002/0240, 22 May 2002. See also summary of messages from the seminar on the Department of Health's website: http://www.doh.gov.uk/conferences/foundationtrustsmay02summ1.htm

In July 2002, the Government published a preliminary guide to NHS Foundation Trusts, which outlined some of the Trusts' main features.[9] They would remain part of the NHS but would be free standing legal entities and would not be line-managed by the Department of Health; they would have additional freedoms and new governance structures to reflect the interest of patients, staff and the local community; like other NHS Trusts, they would be inspected by the new Commission for Healthcare Audit and Improvement (CHAI) and held to account by their local communities through cash for performance contracts.

The July guidance left some questions unanswered, including the precise nature of these new governance structures. Of more interest to the media was the question whether borrowing by Foundation Trusts would count against the Department of Health's expenditure limit and thus remain on the public sector balance sheet. There followed reports about differences between the Chancellor of the Exchequer and Alan Milburn on this issue, and on 9 October 2002 the Prime Minister's Office made an announcement that was hailed in the media as a compromise.[10] Referring to Foundation Trusts as not-for-profit companies limited by guarantee, he announced that they would be licensed by an independent regulator who would oversee their performance against their licence. Their borrowing would count against the Department's overall expenditure limits and would be subject to limits set by this new Regulator:

> Foundation hospitals will be free to borrow from either private or public lenders at their own discretion, not that of the Government. Each hospital will be free to borrow up to a prudential limit assessed by the regulator based on the individual hospital's ability to service the borrowing. They will continue to be able to enter into PFI contracts just as now.
>
> To protect the public purse, borrowing by foundation hospitals will be on balance sheet. Department of Health will transfer to AME (Annual Managed Expenditure) from its DEL (Departmental Expenditure Limit)[11] an amount equal to the projected foundation hospital borrowing during the rest of the spending review period. Foundation hospital borrowing itself will score as AME. [12]

The Queen's Speech on 13 November 2002 confirmed that the Government intended to introduce legislation to "give greater freedom to successful hospitals while increasing their accountability to local communities". Soon after, the idea of a new form of organisation for the health service, based on ideas similar to those of the Co-operative

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9 NHS Foundation Trusts: eligibility criteria and timetable: http://www.doh.gov.uk/nhsfoundationtrusts/foundtn.pdf

10 See, for example, "Go-ahead for new-style hospitals," the *Guardian* 10 October 2002

11 Both these forms of expenditure count as part of the Department's overall expenditure but the latter is cash-limited while the former (which includes items like social security expenditure) is considered less predictable and therefore subject to a different system of control.

12 "NHS Foundation Trusts," 10 Downing Street Press Notice, 9 October 2002: http://www.pm.gov.uk/output/Page2617.asp

Society and other mutual organizations, received support from two think tanks, the New Economics Foundation (in conjunction with the Institute of Directors), and Mutuo. They both published documents, the latter with Hazel Blears, Minister for Health, as one of the authors, arguing in favour of "mutuality" within a decentralised health service.[13]

The key document explaining the Government's latest plans for Foundation Trusts, *A guide to NHS Foundation Trusts*, was published on 11 December 2002,[14] incorporating the "compromise" measures on borrowing announced in October and Alan Milburn's ideas for a mutual form of organisation, which he had first mentioned in his speech of January 2002 although this was the first time that the details of such an organisation were described in any detail.

The Guide was written for the first wave of applicants for NHS Foundation Trust status. The Government invited applications at the end of 2002 from those acute and specialist NHS Trusts (ie those providing hospital services) that had achieved three-star status in the performance ratings that year. The Guide explained that there would be no arbitrary cap on the numbers that could apply so that in the long run, as more NHS Trusts improved, more would be able to apply. In his evidence to the Health Select Committee in March 2003, Alan Milburn went further, and said:

> there is no reason whatsoever why every NHS hospital should not become an NHS foundation hospital within a four or five year period...[15]

The Guide also said that in later waves eligibility would be opened up to other types of NHS Trust[16] and eventually possibly also to organisations that were not currently part of the NHS. *Delivering the NHS Plan* (the Government's follow up document to the NHS Plan 2000) published in April 2002 had said that Foundation status would be available to high performing Primary Care Trusts and Care Trusts[17] as well to NHS Trusts[18] but the Guide made no mention of opening up applications specifically to Primary Care Trusts (PCTs). In his evidence to the Health Select Committee, Alan Milburn said that he thought that it would be a fundamental mistake at this stage to open applications to PCTs, although he did not rule it out for the future. He did not think that they were ready for it.

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13 Ruth Lea and Ed Mayo, *The Mutual Health Service: How to decentralise the NHS*, Institute of Directors and New Economics Foundation, November 2003; and Hazel Blears et al, *Making Healthcare Mutual: a publicly funded, locally accountable NHS*, Ed Stephen Hogan, Mutuo, December 2002: http://www.neweconomics.org/Default.asp?strRequest=pubs&strContext=pubdetails&intPubID=122 and http://www.mutuo.co.uk/index2.htm respectively (the latter is a note; the publication is available for sale.)

14 Department of Health, *A guide to NHS Foundation Trusts*, December 2002: http://www.doh.gov.uk/nhsfoundationtrusts/nhsfoundationtrusts1202.pdf

15 Health Select Committee Uncorrected Evidence, Question 348, 4 March 2003: http://pubs1.tso.parliament.uk/pa/cm200203/cmselect/cmhealth/uc395-iii/uc39502.htm

16 Other types of NHS Trust include Mental Health Trusts and Ambulance Trusts.

17 Care Trusts are a sort of Primary Care Trust designed to bring health and social services together.

18 Department of Health, *Delivering the NHS Plan*, April 2002, paragraph 7.8.

They were new young organisations that had barely begun their work and needed to develop their ability to commission services. [19] However, in relation to NHS Trusts he suggested that they are all likely to become Foundation Trusts.

Preliminary applications had to be in by February 2003 and in March, the Government announced that it had received applications from 32 NHS Trusts.[20] This was out of a possible 51 who had achieved 3 star status.[21] These preliminary applicants will be shortlisted and will then have to submit a fuller application but they cannot become fully operational until the relevant legislation has been passed. Subject to this, they are expected to be established in April 2004.

C. The NHS in which Foundation Trusts would operate

The NHS within which Foundation Trusts would operate has itself been changing. This section briefly mentions some of the aspects of the current NHS system that are likely to be particularly relevant to the understanding of Foundation Trusts.

- *The New NHS – Modern, Dependable*, Cm 3807, December 1997 set out the Government's initial approach to NHS Reform
- *The NHS Plan: a plan for investment, a plan for reform* Cm 4818, July 2000 set out a10 year plan
- *Delivering the NHS Plan: next steps on investment, next steps on reform*, Cm 5503, April 2002 supplements the Plan
- *Expansion and Reform: the Next 3 years priorities and planning framework 2003-2006*, October 2002 sets out the targets for all NHS organisations over the coming three years. [22]

1. Purchasers and Providers

a. NHS Trusts

When and where they come into being, the first wave of NHS Foundation Trusts will replace the NHS Trusts that currently run hospitals. These Trusts, which may run a single hospital or a group of them, were created in the 1990s by the Conservative Government

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19 Health Select Committee Uncorrected Evidence, as above, 4 March 2003 Question 372.

20 HC Deb 6 March 2003 c1207-8W. This Paper concentrates on the final guidance and the Bill; it does not cover the first current wave of applications in detail as these are based on a preliminary set of criteria. However, the basis on which this first wave of trusts is being selected was an issue raised during the evidence taking sessions of the Health Select Committee's current enquiry into Foundation Trusts.

21 Uncorrected Evidence to the Health Select Committee from Alan Milburn, Secretary of State for Health, 4 March 2003 Question 344.

22 Numerous other documents on specific topics are available on the Department of Health's website, which also includes an outline and chart of the NHS: http://www.doh.gov.uk .

of the time. They were part of a set of structural reforms designed to introduce an internal market into the NHS.

The internal market meant that instead of money being allocated to hospitals from the top down, services were bought from them as *providers* by local *purchasers*, such as GP fundholders. In order to assist this process, hospitals were reorganised into self-governing bodies, which eventually became known as NHS Trusts. The reforms were controversial and to some extent the debates at the time echo those taking place today. [23]

The reforms gave NHS Trusts a greater degree of management and financial autonomy than hospitals had previously had but did not remove all forms of central control. The Trusts remained with the NHS, with the Secretary of State as central authority for the administration of the law relating to the NHS (and the power to delegate this authority).[24] The original legislation that set them up still applies today although there have been some amendments including the introduction by the Labour Government of a requirement to co-operate with each other and other NHS bodies. [25]

The Trusts were set up as corporate bodies by order of the Secretary of State, who has the power to specify in Regulations many aspects of their board's structure and functions (a single board unlike the two-tier system proposed for Foundation Trusts). The board is accountable to the Secretary of State and NHS Trusts have to furnish him with reports, plans etc. Until April 2001, the chair and non-executive directors of the board were directly appointed by the Secretary of State but, following complaints about political placements, these appointments are now made at arm's length through an Appointments Commission, which is a Special Health Authority funded by the Department of Health.[26]

The Labour Government passed legislation to give the Secretary of State greater control over NHS Trusts by means of *Directions*. These are binding but do not have to be presented to Parliament and there appears to be no published list of those that have been issued. The *NHS and Community Care Act 1990* had made provision for the Secretary of State to issue legally binding *Directions* to NHS Trusts in only limited respects; the *Health Act 1999* gave the Secretary of State the power to direct NHS Trusts in the same way that he can direct other NHS bodies.[27] The 1990 Act enabled NHS Trusts to employ staff on such terms and conditions as they saw fit; the *Health and Social Care Act 2001*

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[23] See Library Research Note 481, 22 November 1989, which summarises responses to the idea of self-governing hospitals.

[24] The White Paper *Working for Patients*,1989 set out policy behind the introduction of NHS Trusts and the primary legislation was contained in the *NHS & Community Care Act 1990* – see in particular section 5 and schedules 2 and 3.

[25] The *Health Act 1999* ssection 26 introduced this duty.

[26] Details of the Appointments Commission are available at: http://www.doh.gov.uk/nhacc/index.htm

[27] Section 12 of the *Health Act 1999* substituted a new section 16D into the *NHS Act 1977*.

potentially subjected this freedom to Directions issued by the Secretary of State,[28] although none of these have so far been issued.

The 1990 Act provides for NHS Trusts to be subject to certain financial obligations. For example, they have to break even and are required to meet financial objectives set by Secretary of State with the consent of the Treasury.[29] They must also carry out their functions effectively, efficiently and economically. (This last requirement that will also apply to NHS Foundation Trusts). Schedule 3 of the *NHS and Community Care Act 1990* sets out their financial powers and duties and, among other things, makes provision for limits on their freedom to use their surplus funds and to make investments. The limits that have applied to NHS Trusts in practice are currently being eased for the better performing ones.[30]

NHS Trusts have the freedom to borrow from the Secretary of State or any other person under the 1990 Act but in practice have rarely borrowed other than from the government. The 1990 Act set limits on the overall amount of borrowing by NHS Trusts in general but does not directly limit the bororowing of individual Trusts. However, in practice, the Secretary of State effectively controls the amount of borrowing by setting an "external financing limit" (EFL) for each trust each year. The EFL is the difference between the trust's agreed capital spending for the year and its internally generated resources and therefore limits the amount the trust may borrow. As Trusts are required to achieve financial objectives set by the Secretary of State, the requirement to remain within an EFL has statutory force.

b. Primary Care Trusts (PCTs)

The Labour Government rejected the Conservative party's internal market but has kept the purchaser/provider split. The key bodies in the Labour Government's reformed system are the Primary Care Trusts, who now control 75% of the NHS Budget and may control more in the future. [31] They are responsible for commissioning services from NHS Trusts. They developed out of groups of GP practices, nurses and others involved in primary care. By April 2002 303 PCTs (covering populations of around 170,000 people) covered the whole of England, replacing 99 local health authorities.[32]

PCTs have taken on many of the old health authorities' functions, such as ensuring that there are enough GPs in an area, while the health authorities' planning and overview

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[28] Section 6 (3) of the *Health and Social Care Act 2001*, amended schedule 2 paragraph 16(1) (d) of the *NHS and Community Care Act 1990*.

[29] The *NHS and Community Care Act 1990* Section 10.

[30] Department of Health, *Raising Standards across the NHS*, December 2002.

[31] *Delivering the NHS Plan*, 2002 as above paragraph 7.4.

[32] "Revolution Day for the NHS", Department of Health Press Notice, 2002/0167 (There are now 304 PCTs.)

functions are now undertaken by a smaller number (28) of *Strategic Health Authorities*, which have responsibility for holding the local health service to account, building capacity and supporting performance improvement.[33]

The system of commissioning now not only has new purchasers but is being reformed in other ways. Proposals were published in the Autumn of 2002 and the intention is that they should be phased in over five years.[34] The aim would be to end any block agreements where funding is fixed regardless of the level of the activity provided and for NHS Trusts to receive funding according to the volume and quality of work that they provide. As patients are given greater choice (see section 3 below), the idea is that funding should in general follow the patients.

A major feature of this system would be a set of standard national prices for different types of treatment (allowing for "unavoidable regional differences").[35] This is intended to end disputes over price and in this respect the system would differ from the Conservatives' internal market, where NHS Trusts could compete with each other over price. Negotiations under the new system would instead cover volume, quality and the mix of services. The Government has said that it will not be possible for hospitals to offer special deals, such as 10% more operations for free.[36]

The plan is to start with elective (non-emergency) care but eventually to widen this out. Providers might include new Diagnostic and Treatment Centres (possibly run by the private sector for the NHS), NHS Foundation Trusts, the UK independent sector and overseas providers, as well as mainstream NHS Trusts and GPs with a special interest in working in large practices. Providers would normally only receive funding once the service had been delivered. Failure to deliver would mean that funding would be reallocated elsewhere.

At the moment contracts or agreements between PCTs and NHS Trusts are not legally binding. Where there are problems between a PCT and an NHS Trust, the Strategic Health Authorities have the job of acting as arbitrator. There will be different arrangements for NHS Foundation Trusts (see part II of this Paper).

2. National Quality Standards

The Government's proposals for NHS Foundation Trusts are based on the belief that NHS standards and systems of inspection should be national while delivery and accountability

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33 *Delivering the NHS Plan*, 2002, as above, chapter 7.

34 Department of Health, *Reforming NHS Financial Flows*, October 2002: http://www.doh.gov.uk/nhsfinancialreforms/financialflowsoct02.pdf

35 using a system based on Health Resources Groups.

36 Letter from David Lammy, Minister for Health, to Julia Drown in response to her questions during the debate on NHS Financial Flows, 25 February 2003, Deposited Paper: Dep 03/832

should be local.[37] Indeed, decentralisation of the sort proposed for NHS Foundation Trusts is considered to be dependent on having a system of national standards in place.[38] The plan is therefore that NHS Foundation Trusts should also be subject to the national systems for establishing quality standards that have been introduced under the Labour Government.

Most of the measures designed to improve quality that have so far been introduced were part of the wave of reforms announced in the Government's first White Paper on the NHS published in 1997.[39] Improving quality remains a commitment[40] and the current Bill includes measures for rationalising the current system of inspection. In relation to providing a secure backdrop for the creation of NHS Foundation Trusts, the Government has often referred to the following measures as the major ones. Others are also relevant, for example, the work of the Modernisation Agency in spreading good practice in the NHS and helping hospitals that have performed badly.[41]

- *The National Institute for Clinical Excellence*: This was set up under *the Health Act 1999* on 1 April 1999. It is part of the National Health Service,[42] and its role is to provide patients, health professionals and the public with "authoritative, robust and reliable guidance" on current best practice. It is perhaps best known for its scientific work on specific medicines that have hit the headlines such as the use of cannabis for multiple sclerosis but the guidance covers various individual health technologies (medicines, medical devices, diagnostic techniques, and procedures etc) and the clinical management of specific conditions.[43]

- *The Commission for Health Improvement*: This was set up under the *Health Act 1999* and started operating on 1 April 2000. It has four statutory functions: undertaking a rolling programme of clinical governance reviews; investigating serious service failures; conducting national service reviews; and providing advice and guidance.[44] The standards and targets that it monitors are set by the Secretary of State. The current Bill would reform the work of CHI and combine it with relevant work of the Audit Commission to form a new body called the Commission for Healthcare, Audit and Inspection, which, among other things will take on the star-rating performance assessments.

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37 See, for example, *The Guide to NHS Foundation Trusts*, December 2002, paragraph 1.7

38 See, for example, chapter 7 on strengthening devolution in *Delivering the NHS Plan 2002*, as above and Alan Milburn's speech to the New Health Network, 15 January 2002.

39 *The New NHS: modern, dependable*, Cm 3807, December 1997.

40 See, for example, *Reforming NHS Financial Flows*, October 2002 paragraph

41 See, for example, Department of Health, *Raising Standards in the NHS*, December 2002.

42 It is a Special Health Authority

43 The NICE website is at: http://www.nice.org.uk

44 The CHI website is at: http://www.chi.nhs.uk/

- *Duty of quality:* All NHS Trusts and Primary Care Trusts have been given a statutory "duty of quality" under Section 18 of the *Health Act 1999*. This means putting and keeping in place arrangements for monitoring and improving the quality of health care that they provide. Proposals in the current Bill would also require NHS bodies to have such arrangements in place.

- *National Service Frameworks*: A programme of National Service Frameworks, specifying the nature and level of services that patients are entitled to expect in key priority areas, were discussed in the 1997 White Paper and the rolling programme of these Frameworks was launched in April 1998. Coverage includes: mental health NSF (September 1999), coronary heart disease NSF (March 2000), the national cancer plan (September 2000), older people NSF (March 2001), and the diabetes NSF (Standards December 2001, Delivery Strategy January 2003). There are National Service Frameworks in preparation for: renal services, children's services, and long term conditions focusing on neurological conditions.

- *The star system of performance rating:* the 1997 White Paper announced that there would be a new performance assessment system; in 2000 the NHS Plan proposed a system whereby "green light" organisations would be rewarded with greater autonomy and national recognition and would be able to take over persistently failing "red light" organizations.[45] In practice this metamorphosed into the current 0 to 3 star performance rating system, whose first results, for non-specialist acute NHS Trusts (general hospitals), were published in September 2001. The assessment is based on various measures, including performance across a range of indicators (e.g.waiting times). [46]

3. Patient Involvement

One of the stated aims of the Government's NHS reforms is to have a patient-centred NHS.[47] This is being implemented in a variety of ways, for example through the Patient Choice initiative, which currently enables certain patients to go to the hospital of their choice if they have been waiting for treatment for more than a certain length of time and which has the aim that by, December 2005, all patients should be able to choose the hospital they want to go to at the point of referral.[48]

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45 *The NHS Plan*, as above chapter 6

46 Information on the current star system is available on the Department of Health's website at: http://www.doh.gov.uk/performanceratings/2002/national.html

47 See, for example, The NHS Plan, as above.

48 *Reforming NHS Financial Flows*, as above paragraph 6.3

There have also been specific measures relating to patient and public involvement in NHS decisions (and there will be separate measures for NHS Foundation Trusts). A chapter in the NHS Plan of 2000 set out Government proposals for giving patients more power. This included abolishing the Community Health Councils that had been established in 1974 and distributing their various functions (representing local people, helping patients with their complaints and monitoring the NHS) to new bodies. The proposals turned out to be controversial and the Government's first attempt to abolish CHCs, in the *Health and Social Care Bill* of 2001/2, failed.[49] The opponents' main concerns were that the proposed new system would be too fragmented and not independent enough.

The Government returned to the issue in the *NHS Reform and Health Care Professions Act 2002*, which makes provision for abolishing CHCs (due to take place in September 2003)[50] and for establishing other provisions for ensuring patient involvement in the NHS. During the passage of this Act through Parliament, the Government was defeated on this issue in the House of Lords but proposed a compromise, which involved giving more power to Patient Forums, one of the bodies it had proposed to replace CHCs. The result was accepted by the Lords and appears to have been welcomed by those who opposed the original proposals. [51]

In summary, the new system of patient involvement, which is coming into force in stages, will include: [52]

- **PALS** (Patient Advice and Liaison Services): front-line advice/complaints services in trusts with a remit of sorting out problems before a formal complaint becomes necessary;
- **Patient and Public Involvement Forums**: patient/public-led bodies in each NHS Trust and PCT able to review services, seek the views of patients and make recommendations to the Board; nominate a member on every PCT and NHS Trust Board; and feed back information to the CPPIH (see below) enabling it to develop a national overview of the delivery of services;
- **ICAS** (Independent Complaints and Advocacy Services): for patients, to be commissioned or provided by PCT Patients' Forums;
- **Overview and Scrutiny Committees**: in local authorities, responsible for scrutinising health issues in their area, including the closure or reorganisation of local services;
- **Duty to consult**: new duty on the NHS to involve and consult patients and the public
- **Independent Reconfiguration Panel**: to which Overview and Scrutiny Committees can refer controversial proposals for local changes in services and which will then advise the Secretary of State;

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49 This is now the *Health and Social Care Act 2001*.

50 David Lammy, Health Minister, HC Deb 12 March 2003 c348W

51 "CHCs welcome deal on patients' forums", *Health Service Journal*, 30 May 2002, p8

52 Information about the programme for involving patients is on the Department's website (from which this account is largely drawn) at: http://www.doh.gov.uk/involvingpatients/positionstatement.htm

- **Commission for Patient and Public Involvement in Health** (CPPIH): a national body to monitor and support patients' forums and take a national perspective on patients' issues, for example by advising the Secretary of State on patient involvement or carrying out national reviews of services from the patient perspective.

These and other structural changes introduced in the NHS have been complemented by attempts to change attitudes in order to make devolution to front-line staff and empowering patients more effective.[53]

II What Will NHS Foundation Trusts Be Like?

The Bill currently before Parliament,[54] described below, provides the legislative basis for Foundation Trusts and is therefore a crucial source of information about them. *A Guide to NHS Foundation Trusts*[55] (referred to as the Guide in the rest of this section) provides more information about the Government's intentions and is the document to which Government Written Answers generally refer Members who ask questions about Foundation Trusts. Other documents that help to build a fuller picture include *Agenda for Change*,[56] which covers the proposed pay agreement for NHS staff and *Reforming NHS Financial Flows*,[57] which describes the new system of commissioning services from NHS Trusts and from NHS Foundation Trusts.

There are some differences between the Guide and the Bill, including changes of terminology.[58] These do not all necessarily represent a change of view as the Guide partly represents what is expected of applicants who are being shortlisted by the Department at the moment and therefore does not fulfil the same function as a normal White Paper. It is also possible that the Bill will be amended as it passes through Parliament and not all aspects of the Government's proposals require legislation. Pay and conditions, for example, have been discussed in national negotiations that are quite separate from the Bill. The Bill provides for a great deal to be left to the terms of the authorisation (licence) of a Foundation Trust whereas the Guide provides some information about what is likely to be in an authorisation.

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53 See, for example, Department of Health, *Shifting the Balance of Power: The Next Steps*, January 2002.

54 The *Health and Social Care (Community Health and Standards) Bill*, Bill 70 of 2002-3, 12 March 2003

55 Department of Health, *A guide to NHS Foundation Trusts*, December 2002: http://www.doh.gov.uk/nhsfoundationtrusts/nhsfoundationtrusts1202.pdf

56 Department of Health, *Agenda for Change: Proposed Agreement*, March 2003: http://www.doh.gov.uk/agendaforchange/proposedagreement.htm

57 Department of Health, *Reforming NHS Financial Flows*, October 2002: http://www.doh.gov.uk/nhsfinancialreforms/

58 For example, the Guide refers to licences, regulated services, regulated property, and to the management board where the Bill refers to authorisations, authorised services, protected property and the board of directors.

Section A below provides a very brief overview and outline of the proposals and measures being taken outside the Bill that might be relevant to some of the claims that have been made for NHS Foundation Trusts. For more details about the proposals, Members are referred to the Guide.

A. The General Picture

The Government's stated aim is to balance decentralisation with safeguards. This means that there are elements of both in the new proposals.

1. Accountability and Control

Controls exercised over NHS bodies by the Secretary of State under existing legislation[59] will be replaced by a new set of accountability and control mechanisms. The Secretary of State's functions in relation to NHS Trusts will be taken over partly by the Regulator, which will be a non-ministerial department of state,[60] and partly by local boards of governors, over half of whom must be elected by self-selected local members, who will the legal owners of the Foundation Trusts. (Under existing legislation, NHS Trusts were created by Order of the Secretary of State – see part I c of this Paper).

The new Regulator (described in more detail in section B. on the Bill below) will authorise an NHS Foundation Trust although the applicant will first have to get the support of the Secretary of State. The Regulator will be able to require and collect information, annual reports etc. and will be able to intervene in the running of a Foundation Trust where there has been a "significant breach" of the authorisation. Where this happens, he or she will have a range of powers, including firing the directors and appointing new ones. Ultimately, if things go badly wrong, the Secretary of State may by Order transfer the property and liabilities of the NHS Foundation Trust to another body or to himself, the Secretary of State, and dissolve the Trust.

The Regulator will be appointed by the Secretary of State but there are no specific provisions in the Bill for the Secretary of State to issue Directions to him or her or to the NHS Foundation Trusts themselves. The Secretary of State will be able to provide financial assistance to NHS Foundation Trusts by means of a grant, loan, public dividend capital or other payment. But there is no provision for him to act a guarantor of a Trust's borrowing, which there is in the case of conventional NHS Trusts.

Control will also be exerted through the commissioning arrangements with Primary Care Trusts. These are subject to directions from above and implement the Government's priorities, as, for example in the programmes for cancer and mental health (see part I c of

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59 Part I C of this Paper.

60 There are many other non-Ministerial Departments including, for example: the Charity Commission, the Crown Prosecution Service, the Inland Revenue, the Office of the Rail Regulator and the Office of the Regulator of Electricity and Gas, OFSTED, OFTEL, OFWAT etc

this Paper). The Guide says that most of an NHS Foundation Trust's funding will come from the Primary Care Trusts who will be commissioning services from them[61] and PCTs now control 75% of the NHS Budget.

These new commissioning arrangements are being developed independently of the creation of NHS Foundation Trusts and will apply to conventional NHS Trusts as well although, unlike the arrangements with conventional NHS Trusts, contracts with NHS Foundation Trusts will be legally binding. The Guide explains that existing arrangements do not need to be legally binding because they are overseen by Strategic Health Authorities on behalf of the Department of Health, who are responsible for sorting out any problems. As NHS Foundation Trusts will not be within this hierarchy and will not be subject to Secretary of State's powers of Direction, the agreements between them and Primary Care Trusts will have to be legally binding.

As well as new forms of control, existing ones, which are currently being rationalised, will continue to apply to NHS Foundation Trusts. NHS Foundation Trusts will come within the remit of the Commission for Healthcare Audit and Inspection (a reformed version of existing bodies that is also provided for in the Bill) and will be subject to the annual star-rating system. Standards operated by CHAI will be set by the Secretary of State.

Although only three-star NHS Trusts can apply for foundation status at the moment, the Guide says that maintenance of three-star status performance will not be a specific condition of the licence. But if a Trust's rating dropped below 3 stars, the Regulator would be expected to exercise discretion, taking into account any other information available, as to whether the rating should be taken as indicative of a breach of a licence condition. A 0 or 1 star rated Trust would almost certainly be in breach of one or more of its authorisation conditions.

There are specific limits on the powers of NHS Foundation Trusts in the Bill. These include: a cap on income from private patients, which will be set at the proportion of income it represented before it became a Foundation Trust; and a lock on the sale of assets needed for NHS purposes, that is, they will not be able to sell such property without the consent of the Regulator (whose job it will be to determine whether property falls into this protected category).

Patient involvement in the running of NHS Foundation Trusts will take a different form from patient involvement in the running of conventional NHS Trusts. The latter are required to have Patient Forums, which when they come into being (due later this year) will be able to review services, seek the views of patients and make recommendations to the Board, as well as nominate a member to each Primary Care Trust and NHS Trust Board.

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[61] See section of this Paper on the changing NHS above.

The Bill does not require a Foundation Trust to have a Patient Forum although the Patient Forum of a relevant Primary Care Trust will have an advisory role and, if Regulations so require, will be able to inspect NHS Foundation Trusts. The Bill does not directly require that there be a representative of someone who has been a patient on the board of governors of an NHS Foundation Trust but it does require that local people in general make up at least half the board and there is a requirement for NHS Foundation Trusts to involve and consult patients and public when planning service provision.

2. New Freedoms

The introduction of the regulatory system outlined above and the new constitutions of Foundation Trusts are presented both as new forms of accountability and control (see above) and as a new freedom, that is greater freedom from the Secretary of State and from Whitehall. This does not necessarily mean freedom from outside influence or from other legislation such as the *Race Relations Act 1976, the Public Health (Control of Diseases Act) 1984, the Children* Act 1989.[62]

The arrangements for drawing up the constitutions are also intended to give the Trusts some freedom to decide what they will be like so that they can adapt them to local circumstances.

> NHS Foundation Trust status will open the way to significant new freedoms. NHS foundation Trusts will be guaranteed, in law, freedom from Secretary of State powers of direction, removing control from Whitehall and replacing it with greater local public ownership and accountability….
>
> ….The governance arrangement for NHS Foundation Trusts are rooted in the freedom from central control which goes with foundation status. And they are designed to allow flexibility to meet local circumstances – whether a general hospital serving a well-defined community, a large multi-site Trust or a teaching hospital. NHS Foundation Trusts will have freedom within the framework of legislation to decide on the governance arrangements best suited to their own needs.[63]

The new freedoms will include financial ones. The Guide says that the financial freedoms will cover three key areas:

- retention of proceeds from asset disposals
- retention of operating surpluses

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62 Schedule 4 of the Bill list numerous Acts that are amended in order to take account of NHS Foundation Trusts.

63 The Guide, paragraphs 1.11- 1.15

- access to capital based on financial performance and ability to meet any liabilities incurred as a result of borrowing

The Guide says that Foundation Trusts will be able to retain the proceeds from asset sales and operating surpluses to invest as they choose, as long as this is in keeping with the primary purpose of a Trust, which is to serve the NHS. According to the Explanatory Notes to the Bill these freedoms are also potentially subject to conditions in the authorisation (licence) of a particular Trust.

The freedom to borrow is intended to contribute towards working capital and new mid-sized projects such as an extension to existing facilities or a new-build Diagnostic and Treatment Centre. It will be subject to a limit in the authorisation (licence) of each Foundation Trust, which will be set according to a Prudential Borrowing Code drawn up by the Regulator. For larger projects procured under the Private Finance Initiative and/or requiring other support from Strategic Health Authorities or the Department of Health, current approval mechanisms will continue to apply. The Government has also said that any borrowing by NHS Foundation Trusts will count towards the Department's expenditure limits (see part I C above.) The 1990 Act also gave NHS Trusts the power to borrow, from the Secretary of State or any other person, but in practice they rarely borrowed other than from government (see part I C above.)

Under existing legislation, conventional Trusts may have to return proceeds and surpluses to the Consolidated Fund and seek approval for capital investments over a certain limit (see part I C above). However, the Government is easing up on some of the limits affecting the better performing NHS Trusts and it is hard to compare these directly with the freedom that Foundation Trusts will have as so much will depend on the circumstances of the individual Foundation Trust.

Another freedom promised for Foundation Trusts concerns pay. The Guide says that NHS Foundation Trusts will be able to recruit and employ their own staff "with flexibility to offer new rewards and incentives". The extent to which this will happen in practice is likely to depend at least in part on the national agreements to which NHS Foundation Trusts are a party. The Government has said that it expects all applicants for NHS Foundation Trust status to be party to the new agreement for NHS staff[64] and the Bill provides for staff to transfer over to a Foundation Trust on existing terms and conditions. The Government has also suggested that they may have freedom over and above that:

> The Government will ensure National Health Service foundation trusts are implementing Agenda for Change, if agreed, on establishment. Once established, they will be able to continue to benefit from wider agreements but will also have

[64] John Hutton, Mnister for Health, winding up the Opposition Day debate on Foundation Trusts, 8 January 2003 c277

> the additional flexibility and freedom to ensure the necessary mix of skills to provide the best standards of care to patients.[65]

Terms and conditions of NHS staff are currently under negotiation. The draft agreement, *Agenda for Change*, published in March 2003 would, if accepted by the parties (the UK Health Departments, the NHS Confederation, the Unions and Professional Bodies) apply to all staff (other than the most senior managers, doctors and dentists) working in NHS Trusts. This would allow for certain local freedoms.

In general NHS Foundation Trusts would be able to act independently as long as this was consistent with their licence and any contractual agreements with Primary Care Trusts. Three-Star Trusts would have to consult local or neighbouring employers. Other NHS organisations would only be able to act as permitted by guidelines agreed through the NHS Staff Council and where appropriate with the agreement of their Strategic Health Authority. *Agenda for Change* lists six freedoms:

- The ability to offer alternative packages of benefits of equivalent value to the standard benefits, among which the employee can make a personal choice (eg greater leave entitlements but longer hours)
- The ability to negotiate local arrangements for compensatory benefits such as expense and subsistence which differ from those set out in the Terms and Conditions of Service Handbook
- The ability to award recruitment and retention premia above 30% of basic pay where that is justified, without prior clearance by the NHS Staff Council and Strategic Health Authority.
- The establishment of new team bonus schemes and other incentive schemes
- The establishment of schemes offering additional non-pay benefits above the minimum specified elsewhere in this agreement
- Accelerated development and progression schemes.

The last consultants' contract negotiated by the BMA, the Department of Health and the NHS Confederation was rejected by consultants in January 2003. On 17 April 2003 the Government finally ruled out any renegotation and wrote to NHS consultants urging them to reach local agreements to implement the contract.[66] At the same time it issued final guidance on a new framework for improving consultation incentives and rewards. This gave health bodies a choice of either implementing the new contract or a new annual incentives scheme for consultants who made the biggest contribution to improving patient care. As for the very senior managers excluded from the Agenda for

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[65] HC Deb 25 February 2003 c510W

[66] Department of Health letter to all NHS consultants and Specialist Registrars in England, 17 April 2003. this included the condition that if implemented locally NHS Trust would not schedule non-emergency work at weekend or in the evenings without the agreement of individual consultants.

Change, the Department is currently developing a new framework governing pay and contractual arrangements for them.

B. The Bill

In order to understand the nature of Foundation Trusts, it is necessary to be aware of the omissions from the Bill as well as its contents. In particular, many of the restrictions relating to conventional NHS Trusts contained in the *NHS and Community Care Act 1990* and schedules to it (see part I C of this Paper) are not included; there is no requirement for NHS Foundation Trusts to comply with directions of the Secretary of State and the Secretary of State is not given power to issue Directions to NHS Foundation Trusts.

As public corporations, Foundation Trusts can only have functions that are given to them by statute. This means that if a power, such as the power to issue dividends, is excluded from the legislation, they do not have that power. Other examples of items not included in the Bill include any power of appeal by a Foundation Trust against a decision of a Regulator and explicit powers for the Secretary of State to act as guarantor of a loan.[67] There is no specific mention of complaints procedures in the Part I of the Bill on Foundation Trusts but they would be subject to the health care complaints procedures being introduced in Part II of the Bill.

Not all of the provisions relating to Foundation Trusts in the Bill are new; some of them are similar to or the same as those that apply to conventional NHS Trusts. For example, neither of them are Crown bodies, both may form trading companies, and both have some of the same general duties such as co-operating with other NHS bodies and exercising their functions effectively, efficiently and economically. Nevertheless, the overall legal framework is substantially different (see section A above and section II C of this Paper).

1. Constitution and Governance of Foundation Trusts

Clauses 1 and 33, and Schedule 1

The Bill provides for a Foundation Trust to be a *public benefit corporation* authorised to provide goods and services for the purposes of the health service in England. Schedule 1 sets out the minimum requirements for the constitution of such a body while enabling Foundation Trusts to add to these with the approval of the Regulator (who is described below).

The minimum requirements contained in Schedule 1 are summarised below.

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[67] It is not possible to run through all the provisions that someone might look for in the Bill but these are examples of items that have arisen in Parliamentary Questions that do not appear to be included in the Bill.

- A public benefit corporation must have a *constitution* and the constitution must name the corporation.
- *Members of the corporation* are to be drawn from individuals who live in the area (the public constituency) or work for it (the staff constituency); the constitution is to specify a minimum number of members from each constituency and may provide for the public constituency to include patients and their carers. Members just pay an agreed sum of not more than £1. People are ineligible if bankrupt or guilty within the previous 5 years of an offence where a 3 month prison sentence was imposed (without the option of a fine and whether the sentence was suspended or not).
- The corporation must have a *board of governors* made up of elected members and appointed members. More than half the board must be elected by the public constituency and at least one must be elected by the staff constituency. The board must include at least one person appointed by a related Primary Care Trust and, where any of the corporation's hospitals includes a medical or dental school provided by a university, one appointed by that university.
- *Meetings of the board of governors* are generally to be chaired by the chairman of the corporation and are to be held in public although the public may be excluded for special reasons.
- The corporation must have a *board of directors* to exercise all the corporation's powers although these can be delegated to a committee of directors or to an executive director. The board of directors is to consist of executive directors and non-executive directors
- One of the *executive directors* must be the chief executive and another, the finance director. The Chief Executive appoints or removes the *executive directors*, subject to approval by a majority of the board of governors voting at a general meeting.
- *Non-executive* directors, one of whom is to act as chairman of the board of directors, must be drawn from the public constituency. They are to be appointed or removed by the board of governors at a general meeting. Removal requires a three-quarters majority. *Non-executive directors* appoint or remove the Chief Executive, subject to approval by a majority of the board of governors voting at a general meeting.
- *Registers* of members, the board of governors, and of the directors must be held by the corporation. The registers and various other documents, such as a copy of the constitution, must be available for inspection by members of the public free of charges at all reasonable times.
- There are various provisions relating to *auditing, accounts* and *business plans:* for example, there must be an auditor and an audit committee to monitor the work of the auditor; the Comptroller and Auditor General may examine the accounts; annual accounts must be made to the Regulator (timing, form and content to be specified by him, with the approval of the Treasury) and laid before Parliament; annual accounts, auditor's reports and annual reports must be presented to the board of governors at a public meeting; in addition, the board of directors must

prepare annual forward business plans in consultation with the board of governors and provide the regulator with the plan.

- Clause 33 creates certain offences in relation to the constitution, which are punishable by a fine.[68] It will be an offence to vote at an election to the Board of Governors, stand for election to the Board or vote at one of its meetings while ineligible to do so. Individuals must make a declaration that they are eligible (for example, that they are members of the corporation if they are voting as members).

2. The Office of the Regulator

Clauses 2 and 3, and Schedule 2

This section describes the provisions in the Bill for the establishment and terms of this new post. Most of the Regulator's functions are covered in ensuing clauses of the Bill but are listed in this section of this paper as well in order to provide a brief overview of the post.

- The Bill provides for an officer known as the Independent Regulator of NHS Foundation Trusts, to be appointed by the Secretary of State.
- The Regulator must exercise his or her functions in a manner that is consistent with the Secretary of State's general duties under the *NHS Act 1977* sections 1,3, and 51. (Amongst other things, these require the Secretary of State to promote and provide a comprehensive health service in England and to provide clinical facilities with medical or dental schools.)
- The Secretary of State is to determine the Regulator's period of appointment, and may remove him or her from office on grounds of incapacity or misbehaviour.
- The Regulator may resign at any time by giving notice to the Secretary of State but, other than that, the terms for holding and vacating the office are to be determined by the Secretary of State. This includes pay, travelling and other allowances and any pension or gratuity.
- The Regulator is given the power to appoint staff on terms and conditions he or she thinks appropriate, subject to consultation with the Minister for the Civil Service. He or she is to appoint a deputy and may delegate functions to his staff.
- The Secretary of State may make contributions toward the Regulator's expenses.
- The Regulator must make an annual report to the Secretary of State on the way he or she has exercised his or her functions, which the Secretary of State must lay before Parliament. The Secretary of State may also require other reports and information relating to the exercise of the Regulator's functions.
- The Regulator is subject to investigation by the Parliamentary Ombudsman

[68] A fine not exceeding level 4 on the standard scale, which is currently £2,500.

- The Regulator is disqualified from membership of the House of Commons and the Northern Ireland Assembly.

Functions of the Regulator (see below for more detail)

- Specifying the timing form and content of the annual accounts of Foundation Trusts (with the approval of the Treasury)
- Authorising (licensing) Foundation Trusts following an application from an NHS Trust, if the application is supported by the Secretary of State
- Authorising (licensing) Foundation Trusts following an application from bodies other than NHS Trusts, if the application is supported by the Secretary of State
- Approving amendments to the constitution of a Foundation Trust
- Varying an authorisation
- Drawing up a prudential borrowing code for Foundation Trusts
- Vetting the disposal of "protected" property by a Foundation Trust (property designated by the Regulator in the authorisation as property required for the purposes of the NHS)
- Reviewing annually the limit on a Foundation Trust's borrowing
- Requiring Foundation Trusts to disclose information to him or her and allowing entry to and inspection of the Trust's premises
- Requiring any other health service body to disclose any information that he or she requires for the purpose of his or her functions
- Imposing fees on Foundation Trusts
- Taking action in relation to failing Foundation Trusts, such as removing the directors, requiring the directors to enter into a voluntary arrangement with the creditors, dissolving the Trust and transferring it to another body.

3. The Process of Authorisation (obtaining a licence)

Clauses 4-10

The process of applying for NHS Foundation Trust status has already started (see part I B of this Paper) but the process cannot be completed until the necessary legislation has been passed. Before an NHS Trust can become a Foundation Trust and start operating it must have an *authorisation* (referred to as a licence in the Guide). Clauses 4-10 of the Bill provide for the allocation of authorisations:

- NHS Trusts may apply to the Regulator for authorisation to become a Foundation Trust if the application is supported by the Secretary of State. Applications must describe the goods and services to be provided, must be accompanied by a copy of the proposed constitution, and provide any other information required by the Regulator. Applications may be modified at any time before authorisation.

- Once an NHS Trust has applied, it must elect a shadow board of directors and has the power to do anything necessary or desirable for preparing it for NHS Foundation Trust status.
- Other organisations (including those outside the NHS) may apply to the Regulator to first be incorporated and registered as public benefit corporations, and then for NHS Foundation Trust status, if the application is supported by the Secretary of State. The process is similar to that which applies to NHS Trusts, with certain modifications – basically that the goods and services to be provided will assist the NHS and that the body will be able to provide these goods and services.
- In either case, the Regulator may give an authorisation if the organisation has satisfied the list of requirements set out in the Bill and any other requirements that he or she considers appropriate. The authorisation may be given on any terms that the Regulator considers appropriate.
- The Regulator may not give authorisation unless he or she is satisfied that the applicant has complied with any regulations requiring consultation.
- The Regulator must send a copy of the authorisation to the Registrar of Companies and the NHS Foundation Trust must send a copy of the constitution and any amendment to the Registrar of Companies.
- NHS Foundation Trust status and the new constitution come into effect on authorisation. Property, rights and liabilities of the applicants continue to have effect.
- NHS Foundation Trusts are not Crown bodies.
- The constitution of an NHS Foundation Trust may only be amended with the approval of the Regulator.
- The Regulator can vary an NHS Foundation Trust's terms of authorisation but must take into account any report or recommendation made to him or her by an Overview and Scrutiny Committee of a local authority or by the Commission for Patient and Public Involvement in Health.
- The Registrar of Companies must keep a register of Foundation Trusts and this must contain documents such as the constitution, the authorisation, the annual accounts etc, including a copy of any notice of failure. In relation to NHS Foundation Trusts, the Registrar must comply with certain aspects of the *Companies Act 1985* which, among other things, cover public access and the retention of documents.

4. Sources of Finance

Clauses 11-13 and 31

The Bill provides that:

- The Secretary of State may give financial assistance to any NHS Foundation Trust – in the form of a loan, public dividend capital, grant or other payment.
- The Regulator must draw up a Prudential Borrowing Code for determining the borrowing limit of NHS Foundation Trusts. In doing so he or she must have regard to any generally accepted principles used by financial institutions to determine the

amounts of loans to non-profit making organisations. Before making the code he or she must consult the Secretary of State, every NHS Trust intending to make an application to become an NHS Foundation Trust, and others that he or she considers appropriate. He or she may revise the code subject to the same conditions as when making it but must also consult any Foundation Trusts.

- The Regulator must lay the Prudential Borrowing Code before Parliament.
- Public dividend capital of an NHS Trust continues as such and continues to be an asset of the Consolidated Fund.[69] The Secretary of State must consult the Regulator before deciding the terms on which any public dividend capital is issued to an NHS Foundation Trust.
- NHS Foundation Trusts will not be subject to tax. The Bill does this by adding NHS Foundation Trusts to the list of health bodies that are exempt from income tax and corporation tax contained in section 519A of the *Income and Corporation Taxes Act 1988.*

5. Functions of NHS Foundation Trusts

Clauses 14- 22, and Clause 32, which introduces Schedule 4

The Bill provides that an NHS Foundation Trust may do anything that appears to it to be necessary or desirable for the purposes of, or in connection with its functions, such as a acquiring or disposing of property, entering into contracts, accepting gifts and employing staff. But it also provides for certain restrictions on the freedom of action of Foundation Trusts and for the authorisation and the Regulator to set others:

- The authorisation must cover the provision of goods and services for the health service in England. It may cover other goods and services as long as the provision of services to the NHS remains the primary purpose.
- It may require the provision of particular NHS goods and services and details of their volume, place or period. In making a decision about such requirements, the Regulator must take into account the needs of the local area and other arrangements and agreements of the Foundation Trust.
- It must impose a cap on the total level of income derived by a Foundation Trust from the provision of services to private patients. This is basically the percentage of total income from private patients in the year before becoming a Financial Trust. The cap only applies to Foundation Trusts that were NHS Trusts.
- A Foundation Trust may not dispose of *protected property* without the approval of the Regulator. Protected property is property that is designated as such in the authorisation. The regulator has the power to designate property in this way if he considers it to be necessary for the provision of any goods and services that the

[69] Under the *NHS and Community Care Act 1990*, each NHS Trust was given originating capital when it was established. This originating capital is *public dividend capital* and the NHS must pay dividends on it at a set rate. It constitutes an asset of the Consolidated Fund.

authorisation requires the Trust to provide to the NHS (referred to as *regulated* goods and services in the Guide).

- A Foundation Trust may not create a floating charge on any of its property.
- A Foundation Trust may borrow money, subject to the limit imposed by its authorisation (see also Sources of Finance above). This limit must be reviewed annually by the Regulator.
- A Foundation Trust may invest money (other than the money held by it as a Trustee), which may include forming trading companies and joint ventures. It may also give financial assistance to anyone in connection with its functions.[70]
- An authorisation must require a Foundation Trust to disclose to the Regulator such information as the Secretary of State specifies. The Regulator is also given power to require any other NHS body to give any information he or she requires.
- An authorisation may require a Foundation Trust to allow the Regulator to enter and inspect premises that it owns or controls.
- An authorisation may require a Foundation Trust to pay a reasonable annual fee to the Regulator.
- The Secretary of State may appoint Trustees for an NHS Foundation Trust to manage charitable assets on its behalf.
- Schedule 4 lists the legislation that the Bill would amend in order to take account of NHS Foundation Trusts. Over 40 pieces of legislation are amended, some of them, such as the *NHS Act 1977*, in several places.

6. Failure To Comply With The Authorisation (breach of licence)

Clauses 23-26 and Schedule 3

The Bill makes provision for the Regulator to act when things are going wrong:

- Where a Foundation Trust has significantly breached requirements in its authorisation or in legislation or has breached a notice about such a breach issued by the Regulator, the latter may by notice require Directors or the Board of Governors to act or cease acting in a particular way; may remove or suspend any or all of them; and appoint interim ones. The Regulator must send a copy of the notice to the Registrar of Companies.
- The Regulator may by notice (in cases of financial failure) require the Directors to enter into voluntary arrangements (with creditors) to obtain a moratorium (over the business of a Foundation Trust) and apply Part 1 of the *Insolvency Act 1986*, with specified modifications so that the goods and services that the authorisation requires the Foundation Trust to provide can continue to be provided. The Regulator must send a copy of any notice to the Registrar of Companies.

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[70] The Explanatory Notes to the Bill say that this power is potentially subject to the terms of a Trust's authorisation.

- Where the Trust fails to comply with a notice, or does not succeed in reaching a voluntary arrangement, the Regulator considers that further use of such powers would still leave the goods and services of the Trust at risk, and the Regulator has consulted prescribed persons about prescribed matters, an order of the Secretary of State may transfer the property or liabilities of the Trust to: another NHS Foundation Trust, a Primary Care Trust, an NHS Trust, or the Secretary of State.
- The legal effect of any transfer of employees to a Foundation Trust is set out in Schedule 3. For example, existing contracts are not terminated but transferred as if they were originally made between the new employer and the person transferring over.
- An Order of the Secretary of State may dissolve the Trust and may apply any of the provisions relating to the winding up of companies in Part 4 of the *Insolvency Act 1986*, with specified modifications for Foundation Trusts. The Regulator must give notice of any dissolution of the Trust to the Registrar of Companies. (The modifications are designed to ensure that NHS services can continue even if the Trust is wound up.)

7. Consultation and Co-operation with patients, public and the NHS

Clauses 27-30

As described in the section on governance and constitution above, the Bill provides for an NHS Foundation Trust to have a board of governors, more than half of whom are to be elected from the *public constituency*. This public constituency must include local people and may include patients. The Bill also brings in patient and public involvement in other contexts, for example the Regulator must consult local authority Overview and Scrutiny Committees and the Commission for Patient and Public Involvement in Health when varying an authorisation. In clauses 27-30, the Bill makes more general provision on these issues:

- NHS Foundation Trusts must co-operate with other NHS bodies in exercising their functions and other NHS bodies must co-operate with NHS Foundation Trusts. (These requirements already exist in relation to NHS Trusts in section 26 of the *Health Act 1977*. The Bill adds Foundation Trusts to section 26.
- NHS Foundation Trusts must involve and consult patients and the public when planning service provision and considering service changes. (Foundation Trusts are added to the existing bodies in existing legislation.)
- Foundation Trusts are not required to have Patients Forums.[71] The Patients Forums of the relevant Primary Care Trusts are given the power to advise Foundation Trusts about how to encourage involvement of members of the public in decisions that might affect their health. (This is done by amending their existing powers to include Foundation Trusts as well as NHS Trusts.) If Regulations so provide, these Patients

[71] unlike NHS Trusts – see section A above and part I C of this Paper.

Forums will have the power to enter and inspect the premises of an NHS Foundation Trust. Any annual report of a Patients Forum that mentions an NHS Foundation Trust must be sent to the Regulator.

- The role of the Commission for Patient and Public Involvement in Health in promoting the involvement of members of the public in England in decisions by various bodies (such as conventional NHS Trusts) that might affect their health is extended to NHS Foundation Trusts.

8. General Duty

Clause 34

- NHS Foundation Trusts are required to exercise their functions effectively, efficiently and economically.

NHS Foundation Trusts, like other NHS bodies, would also be under a duty to put and keep in place arrangements for the purpose of monitoring and improving the quality of health care. This provision is contained in Clause 40 in Part 2 of the Bill, which covers national standards and the Commission for Healthcare Audit and Inspection (CHAI). Part 2 of the Bill is covered in separate Library Research Papers. It contains clauses (45-48) that deal specifically with CHAI's functions in relation to NHS Foundation Trusts.

Separate provision for Foundation Trusts is necessary because CHAI has to review Foundation Trusts against the terms of their authorisation, applicable statutory instruments and the terms of arrangements made between them and other NHS bodies, as opposed to against the general factors that apply to review of other English NHS bodies.[72] The clauses are therefore summarised here but are covered in the separate Library Research Paper on CHAI.

In summary,

- CHAI must keep the Regulator informed about healthcare provided by and for NHS Foundation Trusts
- CHAI may give the Regulator advice and, at the request of an NHS Foundation Trust, give the Trust advice or information
- CHAI must in each financial year conduct a review of each Foundation Trust and give it a performance rating
- CHAI has the function of conducting reviews of the extent to which an NHS Foundation Trust complies with the terms of its authorisation, legislative requirements, and the terms of arrangements under which it provides healthcare for other NHS bodies

[72] Bill 70 of 2002-03, Explanatory Notes, paragraph 143

- CHAI has the power to conduct investigations into any failures and contraventions by Foundation Trusts
- In the case of a review or an investigation CHAI must publish such report as it considers appropriate and must provide the Comptroller and Auditor General with all relevant material
- An NHS Foundation Trust must, if regulations so provide, publish a statement about the action it proposes to take as a result of any review or investigation.
- CHAI and the Regulator must co-operate with each other in the exercise of their respective functions

III Reactions and Comments

This section presents some of the reactions to and comments on NHS Foundation Trusts. Given their controversial nature, there has been a great deal of comment. This section draws on material that is available in the Library. It is not intended to be comprehensive but to give a flavour of the debate.

A. House of Commons and the Political Parties

Labour backbenchers: Within the House of Commons, opposition from Labour backbenchers is encapsulated in EDM 351 of 2002-03 which, at 28 April 2003, had 133 signatures, 124 of whom were from Labour Members. The Motion, which was drawn up in December 2002, reads:

> That this House notes with concern the intention by Government to introduce foundation hospitals, which would create a two tier NHS system; and urges the Government to continue to disseminate best practice throughout the NHS and ensure that all NHS services are brought up to the best possible standards.

In an Opposition Day debate on Foundation Hopsitals at the beginning of January this year (where the Conservatives welcomed the principle of Foundation Hospitals though with reservations), several Labour Members spoke against Foundation Trusts. They included Frank Dobson, who was Secretary of State for Health when Labour first came to power and has been one of the leading opponents of Foundation Trusts from the Labour backbenchers. He said:

> There is a danger that the foundation hospitals will reintroduce competition into the national health service and set hospital against hospital. That is what we promised to get rid of, and which we have done. It would not even be fair competition, however, as it would be a handicap race in which the least favoured horses carried the heaviest handicaps, which would be contrary to Jockey Club rules. That cannot be right, which is why I cannot support it….

He was however in favour of less central direction but said that Foundation Hospitals were not the best way to achieve it and expressed the fear that they might be the beginning of the end for the health service:

> ….interference and central direction is not just a burden for the best hospitals; it is a burden for all of them, except perhaps for one or two desperate cases…..
>
> ….One of the problems with the constant effort towards change is that we are seeing doubt growing about the Government's overall intentions. Foundation hospitals are being linked in the minds of sensible people with the franchising-out of National Health Service hospitals that are in trouble, or the franchising-out of new diagnostic and treatment centres. That is beginning to look like ending the commitment to a national service and a move towards a mixed economy in health care, blurring what has up to now been a clear distinction between the Labour Party and the Tories.[73]

David Hinchliffe, chair of the Health Select Committee, speaking in the same debate also expressed concerns while approving of some aspects of the proposals. In particular he opposed the focus on hospitals but welcomed more local control:

> It saddens me that today's entire debate is geared to the hospital sector. We must understand that one of the fundamental failings of our health care system has been the way in which we have allowed ourselves to be drummed into believing that health is about hospitals….
>
> I am attracted to the discussion on placing NHS governance in the hands of local communities. I have argued for that for many years. If it is OK for foundation hospitals, why not for PCTs? The principle surely applies elsewhere in the health service. We should consider that. NHS governance and the foundation model are two separate issues. I am attracted to one but, frankly not to the other.[74]

Other Labour MPs have also raised concerns. Julia Drown led a Westminster Hall debate in January,[75] where she raised a series of questions about Foundation Trusts, arguing that it was not clear from the details in the Guide how things would work out in practice, and another in February on the proposals in *NHS Financial Flows*.[76] Another example of criticism from the Labour backbenchers has come from Angela Eagle, who wrote in the *Guardian* in February 2003, where she said:

> Ian McCartney (Minister at the Department for Work and Pensions) recently argued in the Guardian that they (Foundation Hospitals) were the the rebirth of popular socialism and would bring about a revolution in common ownership. Yet

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73 HC Deb 8 January 2003 c c204-9
74 HC Deb 8 January 2003 c214-5
75 HC Deb 7 January 2003 c 1-22WH
76 HC Deb 25 February c 62- 0WH

> the proposals have been welcomed with enthusiasm by the Conservatives and universally opposed by the health unions.
>
> My own view is that they are a cul de sac on the road to reform. At their worst they would exacerbate the waste inherent in the purchaser-provider split and add nothing to effectiveness. Allowing one part of the system more leeway than others will inevitably create a competitive environment in an era of scarcity and capacity constraints. This will enable some hospitals to compete more effectively for resources, including staff, leading to a widening gap between the best and the poorest. This is why these proposals have been characterised as elitist.
>
> The new regulator will not be able to stop poaching of staff or competitieve behavior since this is what the extra "freedoms" granted to foundation trusts consist in. I have yet to be convinced that so called independent regulators are preferable to accountability to the secretary of state. It depends on the nature of the regulation and the personality of the regulator….
>
> ….I can think of no co-op that combines producer and consumer interests as proposed here and no one has explained how this would work out in practice. A far more fertile area for co-operative activity in health care is the nursing home area, which is currently overwhelmingly in the private sector. The cooperative movement has been experimenting with innovative models of mutual ownership here that should be supported and encouraged.[77]

The Cooperative Group of Labour MPs is backing the Bill.[78] Responding in March just after the Bill was published it issued a Press notice supporting "the government's intention to pursue the mutual option for Foundation Hospital Trusts, giving patients and staff a role in hospital governance". It also expressed the view that the Government had already responsed to some of the early concerns:

> The Government has already taken on board many of the concerns that increased freedom for hospitals would lead to an increase in private care at the expense of ordinary patiets. Borrowing will be prudential and foundation trusts will be focussed on NHS patients, who for the first time will have a direct say in how they are run.[79]

The Conservative Party: During the Opposition Day debate in the House of Commons on 8 January 2003, in which the Conservatives welcomed the proposal for Foundation Trust status but wanted it extended to all NHS Trusts, Liam Fox, the Conservative Party health spokesman, argued that the Government's approach to decentralisation did not go far enough:

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77 The *Guardian* 12 February 2003

78 It press release says that there are 30 co-operative Labour MPs.

79 The Co-operative Party, "Co-operative MPs will back Health Bill", New Release 13 March 2003.

> The policy is not working because basically the Government have failed to tackle the No.1 problem in health delivery in this country—we have a centralised, bureaucratic and monolithic Whitehall-controlled system. The Government have made matters worse by piling onto that system a ludicrous, almost pathologically obsessive target culture, in contradiction to their rhetoric. They talk about devolving power within the NHS, and the Secretary of State has talked about the fact that primary care trusts can now spend 75 per cent. of the NHS budget. They can handle 75 per cent. of the NHS budget, but they do not have the discretion to decide how they spend it, which limits what they can do in their own locality and their freedom to do what they think necessary for their own health population. Consequently, the Secretary of State is still in control of the entire system, which is a big problem. That approach leads to deprofessionalisation—professionals on the front line, whether medical, nursing, administrative or managerial, with the skills to make appropriate decisions, are prevented from doing so by people in Whitehall who think that they always know best.[80]

The Conservative Party's recent document, *Setting the NHS Free*, says that a Conservative Government would confer Foundation status on all acute NHS Trusts (those running general hospitals). They would be not-for-profit organisations, free to manage themselves. They would be able to set their own pay and conditions, and to borrow money to enable them to invest in the service. The Party would examine ways of making this possible, including the possibility of issuing bonds. However, the document also says that if borrowing is to occur outside Treasury limits, Foundation Trusts will have to be subject to proper financial disciplines. The bulk of funding would come via Primary Care Trusts using a national tariff system or payment for referrals made directly from practice level.[81]

The Liberal Democrats: During the Opposition Day debate on 8 January 2003, Evan Harris, said on behalf of the Liberal Democrats:

> ….The real power in a service with a commissioning-providing split should be with the commissioning side. Yet, as the hon. Member for Woodspring said, the right hon. Gentleman has refused to give any responsibility other than handling money—not decision making—to the primary care trust. He has failed to provide any democratic accountability even of the sham kind that he is proposing for foundation hospitals to that side of the commissioning-providing split. …
>
> ….On the one hand, the Government say that these new beasts will be free from Whitehall control while, on the other, they will still be subject to targets and star ratings through the CHI and commissioning performance management. The more that the Secretary of State describes his policy on foundation hospitals, the more muddled and inconsistent it becomes. In trying to please the right-wing free

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80 HC Deb 8 January 2003 c180

81 *Setting the NHS Free: A Conservative Policy Consultation*, March 2003: http://www.conservatives.com/getfile.cfm?file=HealthConsultationPaper&ref=POLICYDOCUMENT/1664&type=pdf

> marketeers in 10 Downing Street while appeasing Labour rebels loyal to 11 Downing Street, the right hon. Gentleman is trying to have it both ways and will end up satisfying no one but himself—and he looks very satisfied.
>
> The fundamental problem is that foundation hospitals are neither truly free or locally accountable and that, to the extent that they have flexibility, they are divisive. [82]

Since then the Liberal Democrats have announced that they welcome greater financial freedoms for hospitals but object to the Government's propsals on the following particular grounds:

- Foundation hospitals would be a privileged elite
- The method of choosing Foundation Trusts is too centralised and will be based on decisions of Ministers
- The proposals are incoherent over staff pay. The Trusts will have the freedom to pay staff extra but the Government hopes and expects that they will not use it in case it ends up in the poaching of staff
- The proposals for public membership are gimmicky and the new Trusts will not have Patient Forums

B. The Health Sector and Local Government

The NHS Confederation: On publication of the Bill, the NHS Confederation said:

> We support the innovation and sense of local ownership that the Government is trying to encourage through Foundation Trusts. We believe foundations could be an important first step towards a more decentralised NHS. We particularly welcome the Government's recent commitment to roll out Foundation status to all hospitals and eventually to primary care trusts. This recognised that if greater freedoms are needed to raise standards then they are required by all.
>
> However, we need to ensure that the initial focus on foundation status for hosptials does not detract from the Government's welcome drive towards a primary care led NHS. Support for Foundation hopsitals needs to be accompanied by an equivalent investment and strengthening of PCTs – as purchasers of care for local communities.
>
> Foundation status must also strengthen rather than undermine links between hospitals and other NHS organisations if we're to deliver more integrated care for patients.[83]

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[82] HC Deb 8 January 2003 c 203 and c204

[83] The NHS Confederation, "Health Bill Heralds Far-reaching Change to NHS, News Release, 13 March 2003

UNISON: UNISON, the largest NHS union, is opposed to NHS Foundation Trusts and also to the introduction of local pay flexibility in general although, on the latter, it says that the proposals in *Agenda for Change*[84] would not in fact provide the promised extra freedom for Foundation Trusts. In February 2003 it published *Foundation Hospitals and the NHS Plan*, a document that sets what it believes will be the impact of current government health policies. In relation to Foundation Trusts in particular, it says that:

- Foundation Trusts will be part of the reintroduction of a competitive market in the NHS
- Their proposed governance structure is weak
- They will be the backdoor to privatisation
- Planning of NHS services will be more difficult as a result of their introduction
- They will be poor value for money as borrowing from the private sector will be more expensive than public finance
- They will widen inequalities in the provision of health care

The British Medical Association: The BMA is opposed to the proposals for Foundation Trusts. Its views are set out in detail in its evidence to the Health Select Committee.[85] Its general position is set out on its website:

> The BMA shares the Secretary of State's desire to encourage innovation and improved care for the benefit of patients. The BMA sees merit in some aspects of the proposals to create NHS Foundation Trusts. These include a degree of independence for NHS Trusts from central control, the potential for increased flexibility in meeting local needs, and the involvement of local people in determining the shape of healthcare delivery in their areas.
>
> However, the BMA has very serious concerns about the consequences of establishing Foundation Trusts, particularly about the potential for increasing unfairness and inequality within the local health economy.
>
> With the freedom to access new sources of finance and alter the range and volume of services they provide, Foundation Trusts could affect the viability of other hospitals and providers in the area. Neighbouring hospitals that are already struggling will suffer the most by being forced to compete on an uneven playing field, for example, in their ability to recruit and retain experienced and sought-after staff.
>
> We hear what the Secretary of State says about allowing foundation status within five years for all trusts, but this will not redress the relative advantages enjoyed by the first wave or resolve the problems inherent in encouraging competition between providers.

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84 See part I A 2 of this Paper.

85 http://www.bma.org.uk/ap.nsf/Content/Foundationhospinquiry

> The health service currently has too many policy initiatives pulling in different directions. There is the potential both for a real conflict between the strategic role of Primary Care Trusts and the autonomous status of Foundation Trusts, and for PCTs' commissioning powers to be undercut by the power of large providers. [86]

Local Government Association: In a rough guide to the Bill the LGA presents its views on Foundation Trusts:

> The LGA's serious reservation about the establishment of foundation trusts is that direct elections for the board of governors will constitute a new local electorate. Such a parallel mandate – where a separate election is held for an individual public service within one locality – could lead to:
>
> • fragmentation of the public service, with separate elections reinforcing service silos and undermining joined up service provision;
> • fragmentation of representation, who truly represents 'the people' when different representatives are elected to represent different services; and
> • electoral fatigue, with more elections voters' willingness to participate could decline.
>
> The LGA is also concerned that the government's priority in making institutions more locally accountable should focus on securing local democratic involvement in the primary care trusts that commission the services that all hospitals provide. The LGA believes that this link could be best made by those already elected locally – councillors.[87]

C. Independent Commentators

The King's Fund: the King's Fund argues that Foundation Trusts should be piloted rather than introduced in a hurry. It argues that they potentially offer a new deal for managers and clinicians and an NHS more responsive to patients but that there are dangers, for example, they could damage equity and access and lead to unproductive bidding between organisation for the services of too few key staff.

The King's Fund argue that there is too little detail to enable people to judge the impact of Foundation Trusts in practice. In a press release issued on the 13 March 2003, it lists what it considers to be the main issues:

> *Freedom*
> The three main freedoms conferred so far may not amount to significant change in practice as foundation trusts will be operating within an environment

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86 http://www.bma.org.uk/ap.nsf/Content/foundationtrusts?OpenDocument&Highlight=2,foundation,trusts

87 LGA Rough guides 2003, *Health and Social Care (Community Health and Standards Bill):* http://www.lga.gov.uk/Documents/Publication/healthsocialcare03.pdf

constrained by a number of regulatory bodies and rules.[88] They will also need to satisfy the (legally binding) contractual obligations they enter into with their main purchasers - primary care trusts.

Chronic care
Much of the thinking on foundation trusts has been with regard to elective care. The principles of greater competition and autonomy may run counter to effective management of chronic conditions for which integrated care across many institutions is the key. This raises the question of whether or not foundation status should be limited to elective care.

Workforce implications
Foundation trusts will be afforded significantly greater pay freedoms but the effects are difficult to gauge at this stage. If foundation trusts possess the capacity to exploit these freedoms, there will be significant implications for the workforce.

On the one hand, foundations may be in a position to achieve accelerated change in new ways of working - improving retention as well as recruitment of staff and delivering high quality care. On the other hand, it may lead to other trusts losing key members of staff. This might be the case even if all trusts receive foundation status by 2004, as each trust seeks to deliver new services which require specialist staff in short supply.

Genuine local involvement
It is unclear how the board of governors proposal fits with other public and patient involvement policies, and how it would genuinely achieve input reflecting local needs and priorities. If the new boards of governors have such an important role to play, should the idea be extended to primary care trusts?

Malcom Dean, column in the *Guardian* 2 April 2003

Malcolm Dean in his *Guardian* column has expressed scepticism about how far decentralisation will go:

> ….Yet for all the rhethoric – and real changes – scepticism remains over how far devolution will go.
>
> Earlier devolution moves have never lasted long. Accountability remains crucial: PCTs have budgets of up to £300m each. Even if they were given self-selecting electorates proposed for foundation hospitals, that would be insufficient for bodies spending £50bn of public funds. Then there is the public's – and the media's – distaste for postcode services. Finally, there is the firm grip that

[88] Local regulatory bodies include the new board of governors, local commissioners and primary care trusts. National regulators include the Commission for Health Audit and Inspection and the planned independent regulator of foundation trusts.

> strategic health authorities are retaining over PCTs, and the new advertisement for a director of NHS delivery.
>
> Even sceptics do not doubt the ministerial wish for more devolution. There is a clear political incentive: a devolved system devolves blame, as the Tories intermal market showed. But if devolution is to be achieved, PCTs need more legitimacy. Ministers should be exploring new ways of involving local councillors. Ministers will not like that, but it is time to restore some long-lost sense of local accountability. Then we need an open debate on the even thornier issue of diversity: which service standards are absolute and which are open to local discretion?

Ray Robinson, Professor of Health Policy, London School of Economics and Political Science, article in *Health Service Journal* 26 September 2002

In an article in the *Health Service Journal*, Ray Robinson places NHS Foundation Trust proposals within the context of health policy over the last 10 years and questions whether the freedoms that Ministers expect to arise from placing Foundation Trust outside direct line management and control from Whitehall will actually materialise. He begins:

> UK health policy has been on a roller coaster ride for the last 10 years. Command and control was replaced by markets and competition back in 1991. But pretty soon market regulation and managed competition took over, so that by 1997 the internal market was only a pallid version of the vision of 10 years previously.
>
> The election of the Labour government in 1997 seemed to signal the demise of the market. Mniisters searched for a third way in which collaboration replaced comeptition as the driving force. But the incentives expected to encourage collaborative behaviour were always extremely vague. Now a third way-plus model seems to be emerging: this comprises command and control through strong central direction, devolution through earned autonomy plus incentives through the re-emergence of competition and markets.

He concludes:

> What does the experience of the 1990s tell us about the prospects of success for the third way-plus? The main lesson seems to be that there are strong political imperatives for retaining central direction in the NHS. This explains why the legacy of centralised command and control has proved stubbornly resistant to change. It is the reason why the internal market reforms failed to reach their protential. In the words of leading analysts: 'the incentives were too weak and the constraints too strong'. (Le Grand et al, King's Fund 1998).
>
> Despite claims to the contrary, the emphasis on national standards and accountability set out in *Delivering the NHS Plan* suggests that central direction is still an important part of the ministerial mindset. This is likely to place major limitations on the local autonomy elements of the third way-plus model.

Alan Maynard, Professor of Health Economics, York University, article in the *Health Service Journal* 1 August 2002

In an article in the *Health Service Journal* in August 2002, Alan Maynard talk about "boomerang health policy" and also traces its development since the introduction of the internal market into the NHS during the Thatcher years. He questions whether Foundation Trusts will be any more successful than the autonomous trusts created a decade ago and whether the Blair reforms herald the government's withdrawal from the provision of healthcare in England. He concludes:

> These questions are as obvious now as they were in 1989 when this policy first came around. In many cases, the same mandarins are involved now as under Mrs Thatcher. The failure to learn by systematic evaluation and use of evidence is impressive.
>
> The foundation hospitals are to receive no direction from the health secretary. But it is inevitable they will be wrapped in regulations and purchaser contracts, which will restrict their freedom. The government will control them by directing primary care trusts to demand compliance with Whitehall. Thus the hospitals will be 'free' but closely bound to the centre.