

House of Commons

Health Committee

FOUNDATION TRUSTS

Second Report of Session 2002–03

Volume I

HC 395–I

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Second Report of Session 2002–03

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Footnotes

In the footnotes of this Report, references to oral evidence are indicated by 'Q' followed by the question number. References to written evidence are indicated by the page number as in 'Ev 12'. The oral and written evidence is published separately in Volume II (HC 395-II).

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SECOND REPORT

The Health Committee has agreed to the following Report:

FOUNDATION TRUSTS

SUMMARY

Political opinion remains divided over many of the fundamental questions underlying the Government's proposals for Foundation Trusts, and these broad issues will be the subject of considerable debate as the legislation necessary to introduce Foundation Trusts is presented to Parliament. Rather than attempting to anticipate these discussions, this report instead concentrates in detail on the practicalities of the policies set out in the Government's *Guide to Foundation Trusts*. The report examines two key issues: will the proposed changes bring about improvements for patients who are treated by Foundation hospitals? And what implications will the proposed changes have for patients being treated in the rest of the NHS?

We have identified several areas where, if they are implemented, more work will be needed to ensure these proposals bring about improvements for the patients of Foundation Trusts. Care will need to be taken to ensure that new accountability arrangements do not leave Foundation Trusts more encumbered with more bureaucracy than their predecessors. There is also considerable confusion surrounding arrangements for local accountability, and it will be vital that, if implemented, these plans do not raise expectations they are not able to meet. We also feel that it is inappropriate to leave the determination of systems for democratic accountability entirely at the discretion of individual NHS trusts, as this could lead to a system of patient and public involvement that is fragmented, confusing and inequitable. Equally, if Foundation Trusts' Boards of Governors are to wield real power, it is imperative that their relationship with PCTs, including how disputes will be solved, is established on a transparent national basis. Foundation Trusts will also need to be better integrated into the national system for patient and public involvement than is currently being proposed.

We are not convinced that it will be possible for all NHS trusts to achieve Foundation status within four to five years, not least because of logistical issues surrounding the star ratings system. We feel that using star ratings as a 'one way' gateway to Foundation status could give rise to serious contradictions within the NHS performance rating system, and we also remain concerned that current proposals lack adequate incentives for Foundation Trusts to maintain or improve their performance.

A number of issues have also arisen relating to the impact of Foundation trusts on the wider NHS. If these reforms are introduced, steps will need to be taken to prevent the introduction of Foundation Trusts from undoing the recent shift in emphasis from secondary to primary care, and stronger safeguards will be needed to ensure continued co-operation between the primary and secondary care sectors. Equally, mechanisms will need to be established to prevent Foundation Trusts attracting resources away from poorer-performing hospitals. We are concerned that in certain areas the introduction of Foundation Trusts could lead to wage inflation and 'staff poaching', and to this end we recommend that if these reforms are to go ahead, stronger safeguards will need to be introduced, including an obligation on NHS Foundation Trusts to consult other local NHS employers before altering staff terms and conditions. It may also be the case that the introduction of Foundation Trusts could, at least in the short term, risk compounding resource inequities between trusts to such an extent that the Government's long-term vision of extending Foundation status to all NHS organisations is not achievable. We have therefore stressed that, if these proposals go ahead, the impact of Foundation Trusts on the resourcing, staffing and performance of other NHS organisations must be carefully monitored to ensure equity within the NHS.

INTRODUCTION

1. The proposed establishment of NHS Foundation Trusts is an issue which has rapidly become loaded with ideological tensions, as evidenced by the headlines that have followed Government announcements on this subject:

“Milburn’s ‘Railtrack of the NHS’” (*Guardian*, 20 Jan 2002)

“NHS plan threatens mental patients” (*Independent*, 19 Jan 2003)

“Alarm at NHS ‘companies’” (*Guardian*, 8 Mar 2003)

2. As well as from the more expected sources, polarised views have also been expressed by those who may usually be less forward in entering debates about the ideology of the NHS. Ken Jarrold, Chief Executive of County Durham and Tees Valley Strategic Health Authority, was reported in the *Health Service Journal* as describing the reforms as “the end of the NHS as we know it”,¹ and the Royal College of Nursing has argued that “many clinicians are suspicious that Foundation Trusts are a threat to the service to which they are committed”.²

3. Although initially Foundation status will only be available to 3-star organisations, the Government is quite clear about its intention that within the next four to five years it intends for all NHS acute trusts to have become Foundation Trusts. This will mean that all NHS acute trusts will be given greater autonomy than currently, and will be accountable to an appointed independent regulator, rather than directly to the Secretary of State for Health. In addition to this, boards of governors will be established by local stakeholders to attempt to strengthen local accountability.

4. Political opinion remains divided over the fundamental changes these reforms imply for the structure, make up, governance and culture of the NHS. There are many critical and difficult questions surrounding these proposals: should the three elements of the reforms, the increased financial freedoms, introduction of an independent regulator, and the reforms to local accountability, be considered and introduced separately? Will the introduction of Foundation Trusts, coupled with reforms to NHS financial flows, reintroduce some of the problems that led to the abolition of the internal market in 1997? Should chief responsibility for the NHS be moved from the Secretary of State to a regulatory body about which very little is yet known? Are high-performing acute trusts the most appropriate place at which to start these reforms?

5. These very broad, difficult issues will obviously be the subject of considerable debate as the legislation necessary to introduce Foundation Trusts is presented to Parliament. Rather than attempting to anticipate these discussions and provide conclusive answers to these questions, we have instead used this inquiry to focus in detail on the policies set out in the Government’s *Guide to Foundation Trusts*, assuming legislation in its current form is enacted, in order to assess their likely impact on those who stand to gain or lose the most by their success or failure: current and future patients of the NHS. In doing so, we are considering the practicalities of these policies from a purely pragmatic standpoint.

6. We announced this inquiry on 20 November 2002, with the following terms of reference:

The Committee will examine Government proposals to create Foundation Trusts from existing NHS organisations, considering in particular:

¹ *Health Service Journal*, 5th December 2002

² Ev 113

- *Financial implications*
- *Staffing implications*
- *Governance and accountability*
- *Impact on quality of management and quality of patient care*
- *Impact on the wider NHS*

7. Our advisers for this inquiry were: Melanie Henwood, an independent health and social care analyst; Professor John Mohan of the University of Portsmouth; Professor Nick Bosanquet of the Imperial College School of Medicine; and Séan Boyle of the London School of Economics. We are very grateful to them for their help with the more technical aspects of this inquiry. We are also very grateful for the very high quality research and analytical support provided by the newly-formed Clerk's Department Scrutiny Unit.

8. We took oral evidence from the leaders of a range of NHS trusts in Teesside, Bradford, East Anglia and London. We encountered considerable reluctance amongst NHS organisations to discuss the policy of Foundation Trusts on the record at such an early stage, especially amongst organisations who were not eligible to apply for Foundation status, and so we are particularly indebted to those who agreed to give evidence. We also took very useful evidence from experts in social ownership and patient involvement, including the Co-operative Union, Mutuo, the Democratic Health Network and the Association of Community Health Councils; and from the Rt. Hon. Alan Milburn MP, Secretary of State for Health.

9. The NHS Confederation arranged an informal meeting for us with representatives of a wider cross-section of NHS organisations than we were able to take formal oral evidence from. This gave us an invaluable opportunity to gauge the views of NHS organisations off the record, and we are extremely grateful both to the NHS Confederation and to the NHS representatives who attended.

10. We received 32 written memoranda from a diverse range of interested organisations and individuals, including NHS organisations, independent healthcare providers, the BMA, the RCN, the NHS Confederation, and policy organisations and academic institutions including the King's Fund, the University of York, and the Nuffield Centre. We are very grateful to all those who submitted evidence.

11. The concept of NHS Foundation Trusts has been introduced in two key documents: the eligibility criteria and timetable document published in July 2002, and the *Guide to Foundation Trusts* published in December 2002.³ The Health and Social Care (Community Health and Standards) Bill which implements these reforms was introduced in the House of Commons on 12 March 2003.⁴

³ *Foundation Trusts - eligibility criteria and timetable*, Department of Health, July 2002; *A Guide to Foundation Trusts*, Department of Health, December 2002

⁴ Health and Social Care (Community Health and Standards) Bill.

12. Foundation Trusts will differ from other NHS Trusts in three key areas:

- They will have access to increased financial freedoms, including the freedom to borrow capital, sell off assets and retain surpluses.
- They will see the relaxation of central control by the Department of Health, signalled by the removal of the Secretary of State's powers of direction. Linked to this will be greater management freedoms, including increasing flexibilities to reward staff. Foundation Trusts will be governed by an independent regulator appointed by the Secretary of State.
- They will have to establish a new Board of Governors which will be elected in part by local communities.

13. The first wave of Foundation Trusts will be drawn from 3-star Trusts according to the performance ratings published in July 2003, whose application is approved by the Secretary of State. The aim of the Government is that, subject to sufficient performance improvement across the NHS, all NHS acute trusts will "graduate" to Foundation status within the next four to five years.⁵ In the first instance, Foundation status will not be available to Primary Care Trusts (PCTs), mental health trusts or other types of NHS trust, although this may happen in the future. Subject to legislation, successful organisations will become 'shadow' Foundation Trusts in October 2003, and will begin operating as Foundation Trusts in April 2004.⁶ To set these reforms in context, a summary of the freedoms and constraints within which NHS organisations currently operate is included in an Annex. The past 12 months have seen a number of significant structural reforms in the NHS, the most relevant of which are also summarised in the Annex for ease of reference.

Report outline

14. Our report is divided into two chapters which aim to explore what we believe to be the two key issues that will determine the success of this policy:

1. Will the proposed changes bring about improvements for patients who are treated by Foundation hospitals?
2. What implications will the proposed changes have for patients being treated in the rest of the NHS?

⁵ Q 482 (Secretary of State for Health)

⁶ *A Guide to Foundation Trusts*, Department of Health, December 2002, p 44

1. WILL THE PROPOSED CHANGES BRING ABOUT IMPROVEMENTS FOR PATIENTS WHO ARE TREATED BY FOUNDATION TRUSTS?

15. A chronology prepared by Kieran Walshe in an article recently published in the *Journal of the Royal Society of Medicine* shows that there has been some kind of organisational upheaval in some part of the NHS almost every year for the last twenty years:

1982	Reorganisation of health authority tier – abolition of area health authorities and restructuring of district health authorities
1983-85	Introduction of general management function throughout the NHS, with the appointment of general managers in all NHS health authorities and units, and establishment of a separate NHS board within the Department of Health
1989-93	Establishment of NHS trusts to manage health service provision, previously directly managed by health authorities but now accountable directly to the Department of Health while contracting with health authorities and GP fundholders as healthcare purchasers.
1989-95	Establishment of GP fundholding (and other models of GP commissioning), giving general practices direct control over an increasing proportion of healthcare services purchased from NHS trusts
1989-95	Creation of the NHS Executive (first called the NHS Management Executive) as a separate entity from the Department of Health, and the separation of responsibility for policy development and implementation/service delivery
1990	Abolition of Family Practitioner Committees (FPCs) accountable to health authorities and establishment of family health services authorities (FHSAs) as separate organisations from health authorities to manage primary care services
1991-97	Reconfiguration of district health authorities as health authorities, and then continuing reduction in numbers of health authorities (from around 200 to around 100) through mergers and consolidation
1991	Restructuring of the boards of NHS organisations to create executive and non-executive membership (replacing the distinction between members and officers)
1994	Reorganization of regional health authorities to reduce numbers from 14 to 8 regions
1994	Abolition of FHSAs and the incorporation of their responsibilities into those of health authorities
1995-2000	Reconfiguration of acute services involving extensive reorganisation of acute NHS trusts and succession of mergers and restructuring
1996	Abolition of regional health authorities and their incorporation into the NHS Executive as its regional offices
1997-2000	Abolition of GP fundholding and its replacement initially with primary care groups (PCGs) and subsequently, in some areas, by primary care trusts (PCTs)
2000	Abolition of the NHS Executive and the incorporation of its functions into the Department of Health
2002	Abolition of the NHS Executive regional offices, devolution of some functions to new strategic health authorities, and the creation of four new regional directorates of health and social care in the Department of Health.
2002	Reorganisation of health authorities into strategic health authorities, going from around 100 to about 28 StHAs in England, and the devolution of many responsibilities of health authorities to PCTs

2002	Creation of primary care trusts (PCTs) in all areas, replacing primary care groups (PCGs), including some mergers and restructuring, and transfer of responsibilities from health authorities
2003	Proposed creation of first wave of Foundation NHS trusts, based on existing NHS acute hospital trusts with proven good performance records

[Source: 'Foundation Hospitals - a new direction for NHS reform?' Kieran Walsh, *Journal of the Royal Society of Medicine* 2003; 96, 106-110]

16. As Kieran Walshe points out, perpetual reform is very costly, both in terms of the time and effort invested by managers and other NHS staff, and in terms of the financial costs of establishing the physical fabric of new organisations and of meeting the redundancy or retirement costs of displaced staff. It can create a significant diversion of time and effort from the focus on delivering improvements to patient care, and, crucially, may promote a cynical attitude to innovation and change in the NHS, and prompt NHS managers to take only a very short-term view. Kieran Walshe goes on to argue that perpetual reform is turning the NHS into an “organisational shantytown in which structures and systems are cobbled together or thrown up hastily in the knowledge that they will be torn down again in due course”.⁷

17. The upheaval that can be brought about by continual cycles of reform within the NHS serves to reinforce the crucial importance of ensuring that new reforms, such as proposals for Foundation Trusts, are carefully scrutinised to see whether they have been properly designed to achieve their aims. So what are the overall aims of the proposals for Foundation Trusts? Government publications on Foundation Trusts present a complex model of organisational change, supplemented by various reforms to governance and regulation and supported by references to comparator models in other sectors and countries. While the theoretical and academic arguments behind the policy of Foundation Trusts are clearly interesting and relevant, for the lay commentator this may have the effect of detracting from the key purpose of Foundation Trusts, which was summed up very simply in *Delivering the NHS Plan*, the Government policy document published in April 2002:

Foundation Trusts will have greater freedoms than existing trusts, and will be able to use their freedoms to bring about benefits for patients.⁸

18. Benefits for patients of Foundation Trusts will potentially be brought about in three separate ways: increased management freedoms; increased access to non-ringfenced resources; and a new form of social ownership designed to involve patients and the public in setting the strategic direction of the trust. Although these elements come as a closely entwined package, they are each new and very separate policies, and require careful consideration as to whether or not they are likely to translate into real benefits for patients.

How will management freedoms benefit the patients of Foundation Trusts?

19. The biggest concern expressed by our witnesses from the NHS was how real the promised management freedoms would in fact be. Foundation Trusts will be directly accountable to four separate bodies (PCTs, the proposed Commission for Healthcare Audit and Inspection (CHAI), the independent regulator, and the Board of Governors) as opposed to the three organisations currently (CHAI, PCTs and the Secretary of State, through Strategic Health Authorities). The key difference for Foundation Trusts is that instead of

⁷ 'Foundation Hospitals – a new direction for NHS reform?' Kieran Walsh, *Journal of the Royal Society of Medicine* 2003; 96, 106-110

⁸ *Delivering the NHS Plan*, Department of Health, April 2002, p 30

direct accountability to Government, the trust will be accountable to a Government-appointed but independent regulator, and to a locally elected Board of Governors. As the King's Fund argued, what this may mean in practice is that "top-down 'vertical' control of Foundation Trusts by the centre will simply be replaced with 'horizontal' control by PCTs or regulatory bodies, potentially leaving little room for autonomy".⁹ The King's Fund also pointed out that "the experience of the 1990s with NHS Trusts suggests that there were fewer freedoms than the NHS and policy community were initially led to believe", an argument which has been put forward in detail by several health policy academics over recent months.¹⁰

20. David Jackson, Chief Executive of Bradford Hospitals NHS Trust, told us of his understanding that there would be less "micro-management", and gave as an example the central initiative to introduce 'Modern Matrons' into the NHS, to ensure strong and visible leadership on the wards.¹¹ For Mr Jackson, freedom from this type of central control was a key attraction of Foundation status, to the extent that "if that does not materialise, then many of us will say it is perhaps not an idea which is worth pursuing".¹² When questioned by the Committee, the Secretary of State agreed that his powers of direction over NHS Trusts were very seldom used, although he argued that its existence was still significant.¹³

21. Malcolm Stamp, Chief Executive of Addenbrookes Hospitals NHS Trust, expressed a hope that Foundation Trusts would be subject to fewer national targets, allowing them the freedom to develop more locally relevant targets and priorities: "I would like to see more locally driven targets ... if we are going to get buy in at a board of governors level it would be good to have relevant targets emanating from that engagement rather than just follow the national targets".¹⁴ Although we asked for it, we did not receive any evidence about inspection, review or performance ratings from the Commission for Health Improvement, suggesting that thinking may not yet be well developed on this issue. However, speaking recently in the House, the Secretary of State was quite clear that "NHS Foundation Trusts will be subject to the star rating system, just as every other part of the national health service will be, whether it is a primary care trust or other NHS trust",¹⁵ and the Bill introduced on 12 March makes provision for CHAI to carry out reviews and publish ratings of Foundation Trusts' performance on an annual basis.¹⁶ For Joan Rogers, Chief Executive of North Tees NHS Trust, this represented a serious problem:

They are quite clear that we are stuck with all the targets as before and that quite bothers me. If you had a foundation community, you might go for a different target. Chris [Willis, Chief Executive of the local PCT] might want more money on children's health improvement through SureStart than six-month access time.¹⁷

The Government should make it clear whether there will be fewer targets for Foundation Trusts.

22. As well as performance information on the nine key targets and 28 performance indicators that feed into the star rating system, the *Guide* specifies that "an NHS Foundation Trust will also need to contribute to standard national NHS data flows which

⁹ Ev 123

¹⁰ Ev 123

¹¹ Q5; Q6

¹² Q8

¹³ Q430; The little information available on exactly what the Secretary of State's direction powers are at the moment reinforces this case. As we write this report the Government still has not replied to the written question by Julia Drown MP tabled on 30th January which asked when the Secretary of State last made direction to a) an NHS Trust and b) all NHS Trusts and what that direction was. We do know that there were no instances in the three months up until 29 January 2003 where the Secretary of State used his power of intervention to give direction to a particular trust.

¹⁴ Q252

¹⁵ HC Deb, 3 December 2002, col. 751

¹⁶ Health and Social Care (Community Health and Standards) Bill

¹⁷ Q140

are required to support policy development and funding decisions for the NHS as a whole¹⁸. Further to this, the independent regulator will also carry out a review of each Foundation Trust's licence every two years. As Joan Rogers pointed out, there is also a danger of increased bureaucracy, including legal contracts, surrounding the new contracting process, as was the case when the internal market reforms were first introduced. Many of our witnesses were therefore acutely aware of the danger that, in applying to become Foundation Trusts, their organizations would be "jumping out of the frying pan into the fire"¹⁹. We are deeply concerned that there will be a need for contracts between Foundation Trusts and PCTs to be legal contracts and thus involve extra costs. We would find it a poor use of NHS funds to employ lawyers by both sides to drag contractual problems through the courts. If the Government genuinely wants an NHS family of organisations and a lack of bureaucracy a way needs to be found for these contracts to stay within the current legal framework. Such matters should be addressed in the package of support and development of model template contracts the Department will be providing for PCTs commissioning services from Foundation Trusts.

23. Maria Goddard of the Centre for Health Economics based at the University of York questioned the need for "parallel but separate regulators for hospitals with identical health care delivery requirements"²⁰. **While we believe that the abolition of the Secretary of State's powers of direction over NHS organisations is a gesture underpinned by a genuine intention to remove micro-management, we are concerned that current plans for Foundation Trusts which include direct accountability to four separate types of organisation, in addition to the increased complexities of new contracting arrangements, may in fact leave Foundation Trusts encumbered by more bureaucracy than their predecessors. In line with the general move towards rationalising inspection and regulation in healthcare, we recommend that CHAI and the proposed independent regulator act in a complementary way, integrating their work.**

Will the proposals increase resources for Foundation Trusts?

24. Painting a grim picture of the present situation, prospective Foundation Trusts such as Bradford Hospitals NHS Trust welcomed the idea of increased access to non-ringfenced resources both in terms of capital and resources:

Currently the imperative to expand capacity to meet access targets is frustrated by the physical limitations affecting our diagnostic and treatment facilities and the near impossibility of accessing capital. This process is excessively bureaucratic for relatively trivial levels of funding.²¹

25. However, some of our witnesses felt that the new freedoms may not, at least initially, lead to significant increases in resources. Peter Dixon, Chair of University College London Hospitals NHS Trust told us:

I do not believe that the capacity of trusts to borrow money is going to be that great initially. They do not have the cash flows, the revenue streams just are not there and a three-year revenue stream or even a seven-year revenue stream is not going to excite many bankers.²²

¹⁸ *A Guide to NHS Foundation Trusts*, Department of Health, December 2002, p 28

¹⁹ Q136

²⁰ Ev 140

²¹ Ev 7

²² Q101

26. The Government's proposals to limit the proportion of Foundation Trusts' private patient income to 2003-04 levels have attracted considerable media attention, and have been welcomed by the independent healthcare sector. While Malcolm Stamp made clear to us that he would not be seeking to increase the volume of private patients as an income generator, he told us that this element of the proposals felt "a bit like philosophical overdrive".²³ However, General Healthcare pointed out that despite these restrictions, it was far from clear that Foundation Trusts would not be able to reinvest NHS surpluses in developing other commercial enterprises, for example offering occupational health services to businesses.²⁴ **We believe that the Government's proposals, as they stand, have the potential to get a greater proportion of the increasing NHS funds going to Foundation Trusts, and we believe that limitations on private work are appropriate and necessary to ensure that Foundation Trusts' primary function remains the delivery of healthcare to NHS patients.**

Social ownership

27. The Government's *Guide* to Foundation Trusts states that NHS Foundation Trusts will be "independent public interest organisations, modelled on co-operative societies and mutual organisations".²⁵ Mutuo, a think-tank promoting social ownership models, was unequivocal about the success of mutualism and equally positive about the extension of social ownership models to the National Health Service: "Mutual structures work. They enable appropriate levels of involvement to be enjoyed by all stakeholders and allow managers to manage ... Community ownership could make a real and positive difference to delivering the aims of the National Health Service ... Mutual governance structures will provide a means for the local community to hold professional management to account and to play a partnership role in setting strategies to drive the organisation in serving the community".²⁶ The Co-operative Union was similarly supportive: "Management [of Foundation Trusts] by the identified membership will give accountability and this will drive efficiency and success. We believe that this harnesses public sector values and ethos and private sector flexibility".²⁷ We are also familiar, through the experiences of individual members of the Committee, of social ownership schemes that have brought significant benefits to the organisations that have adopted them, including football clubs and housing associations.

28. However, because of the nature of the NHS, the scope for similar activities may be limited. Other commentators have also questioned the applicability of the model of social enterprise that is being proposed for Foundation Trusts. Quite apart from the question of complexity identified by Mutuo are other considerations concerning scope and scale. Examples of mutuals or social enterprise schemes are typically small scale and labour intensive, and have tended to operate in areas requiring limited inputs of technology or specialist skill. It is questionable whether parallels can be drawn between such initiatives and organisations like hospitals that require substantial technical expertise and professional services, operating within large and defined budgets. Analysis of the development of mutuals has highlighted the extent to which they have emerged in communities marginalised from the economic mainstream; they have often required heroic efforts on the part of key individuals; have relied substantially on public funds, and success has often only come after years of struggle. Moreover, success is patchy and owes much to local circumstances and individual champions.

²³ Q249

²⁴ Ev 137

²⁵ *A Guide to NHS Foundation Trusts*, Department of Health, December 2002, p 3

²⁶ Ev 52

²⁷ Ev 49

29. In their written evidence, Mutuo cited Greenwich Leisure, a communally owned sports and recreation facility, as a “fine example” of a mutual enterprise taking on some of the old functions of the state far more efficiently and cost effectively than the private sector ever could.²⁸ However, in oral evidence, the chief executive of Greenwich Leisure, Mark Sesnan, delivered a stark warning about the dangers of assuming the mutual model could be easily extrapolated to the NHS, arguing that it had not been tried in an organisation as complex as an NHS Trust, and should be piloted carefully in one or two hospitals.²⁹

30. The presumption behind the proposed new model of local governance is that social ownership of local hospitals will lead to “local decisions being more responsive to community and individual patient needs”.³⁰ However, it is a significant leap from this commendable aspiration to the devising and implementing of a system which both allows patients and the tax-paying public, as well as staff and representatives from local partner organisations, to have their interests fairly and transparently represented, and which also facilitates meaningful contribution to the strategic direction of a hospital in order to improve services. **Much of the oral evidence we heard showed strong support for the principles behind plans for Foundation Trusts to secure local ownership and involvement, but also elements of scepticism and genuine bewilderment at the array of different problems, both philosophical and practical, facing those charged with implementing them. We agree with the Secretary of State that “either this is for real or it is not” and feel that it absolutely crucial that these proposals are able to deliver the genuine improvements in patient involvement that they promise, rather than raising expectations they are not able to meet. There might have been even wider support for the concept of social ownership if the Government had first introduced the model in smaller scale community-based parts of the NHS.**

Membership of a Foundation Trust

31. The *Guide* specifies that “Local people, patients and staff who become members will elect representatives on to a Board of Governors. The Board of Governors will have defined responsibilities for advising and overseeing the activities of the Management Board who will be responsible for the day to day operation of the NHS Foundation Trust”.³¹ The *Guide* sets out the following framework for the membership of a Foundation Trust:

1. Membership will be by registration rather than by automatic right
2. Membership will be open to:
 - < People living in the local community.
 - < People living outside the local community who have been patients at the hospital in the past 3 years.
 - < Employees of the Trust.
 - < Representatives of ‘partner organisations’.

Registration as a member will bring with it the right to participate in the election of representatives to the Board of Governors, to receive information about the NHS Foundation Trust (for example its annual report) and to be consulted.³²

32. Beyond these broad guidelines, each Foundation Trust will have considerable freedom as to how it implements arrangements for social ownership. It will be able to set

²⁸ Ev 53

²⁹ Q283

³⁰ *A Guide to NHS Foundation Trusts*, Department of Health, December 2002, p 7

³¹ *Ibid*, p 15

³² *Ibid*, pp 16-17

out the boundaries for its own membership constituency, determine how elections are run, and decide on the scope and method of its consultation with the local community it serves. All these elements will need to be set out by trusts as part of their application for Foundation status. Trusts who wish to apply for first wave status will have six months to consult local stakeholders and prepare plans for their constitution before they are assessed, during September 2003, by a so-far unnamed “panel of experts drawn from inside and outside the Department of Health” in advance of announcements of successful candidates in September-October 2003.³³

Who will the members be?

33. The most immediate difficulty surrounding these plans concerns entitlement to ‘membership’ of a Foundation Trust. While all prospective Foundation Trusts will be obliged to have a membership community based on geographical boundaries, and to offer membership to current patients and those treated in the past three years, geographical boundaries of constituencies will be drawn by trusts themselves, and trusts will also be free to extend their membership to other groups if they choose. This is significantly different from other democratic organisations in this country, whose constituency boundaries are determined by the Boundaries Commission, an independent non-departmental public body.

34. The *Guide* states that “the policy is about inclusion rather than exclusion”.³⁴ However, as in order to keep the system manageable limits will have to be set, this is likely to result in a policy which could be construed as exclusive rather than inclusive. For example, the *Guide* is not clear whether people will be able to be members of more than one Foundation Trust, and this raises a number of questions: what if someone living in central London is equidistant between two Foundation Trusts, and, under the patient choice initiative, has chosen to have treatment at both? Is it reasonable to reserve membership for those who have actually used a service, thus excluding potential users (for example someone waiting for an appointment, or someone who was turned away from a GUM clinic because there were insufficient services available) who may in fact have a far greater interest in contributing to service improvements than those who have just been discharged? Will one-off users of A&E services be offered membership or will this be restricted to patients being treated for an ongoing problem? A significant number of prospective Foundation Trusts provide undergraduate teaching, but should medical and nursing students be considered part of the membership community?

35. NHS organisations serve diverse and complicated constituencies, particularly those which function as regional or even national referral centres. Of the 32 Trusts that have expressed an interest in Foundation status, at least half fall into this category. The Secretary of State told us that approximately 50 PCTs commission specialist services from Moorfields Eye Hospital in London, with no single PCT responsible for more than two per cent of Moorfields’ income.³⁵ As he put it, “clearly it would be pretty difficult if they get to Foundation Trust status to have 50 PCTs on the board and then the patients and the staff, that is going to be one hell of a board and it is going to be unmanageable”.³⁶ Alternative forms of representation will obviously have to be found in situations like this, but again arrangements will be at the discretion of Foundation Trusts.

36. Another key issue is what proportion of local people will need to be members to achieve a reasonable representation of the local community. While the Secretary of State told us that for his local NHS Trust, serving a population of between 300,000 and 500,000

³³ *A Guide to NHS Foundation Trusts*, Department of Health, December 2002, p 45

³⁴ *Ibid*, p 16

³⁵ Q368

³⁶ *Ibid*

people, a membership of only 50 people would cause him concern, he did not want to commit himself to saying what a minimum proportion might be, arguing that “at this stage nobody knows because we have not tested the concept”.³⁷ Bradford Hospitals NHS Trust told us they would be aiming towards a membership of 10% of their local population.³⁸ To put this in the context of existing systems of democracy, according to the Electoral Commission the approximate proportion of the population registered to vote in general elections is between 97-98%.³⁹

37. We believe that the time is long overdue to address the democratic deficit in the NHS. However, the proposed system has no minimum standards for involvement and no coherent guidelines for how constituencies will be drawn up to ensure that patients and the public throughout the country have an equal opportunity for involvement. Instead, the Government has left the determination of what is a radical alteration to democratic accountability in the NHS to the unelected leaders of individual NHS organisations, which could lead to a system of patient and public involvement that is fragmented, confusing and inequitable. Although different constructions will clearly need to apply to different types of organisation, it is imperative that the Government safeguards democracy throughout the NHS by providing a national set of guidelines specifying the rules for defining membership constituencies and the process for managing elections so that NHS patients, and the public at large, can have full confidence in transparent and consistent standards of involvement.

38. The BMA argued that although trusts will be “expected to demonstrate innovative approaches to ensuring genuine community membership”, there is no guarantee that these approaches will be successful – it is entirely possible that less organised and less vocal groups in the community, including ethnic minorities who may have specific health needs, will be under-represented.⁴⁰ The NHS Confederation made the point that most people tend to use hospitals episodically and rarely rather than regularly, and that those with most interest in their local hospital may be the least able to exercise membership rights.⁴¹

39. Speaking in the House, the Secretary of State defended the policy of limiting membership of Foundation Trusts to eligible individuals who complete a registration process, arguing that “if people are passionately committed to an organisation, they tend to want to join it. That is the tradition of mutualism and co-operation that underpins NHS Foundation Trusts, and it is a perfectly good principle”.⁴² He also said he would not rule out considering the electoral roll as a basis for membership. Peter Dixon told us that he did not feel, in London at least, that there was a “pent up demand for electoral participation in the NHS”.⁴³ However, experiences of social ownership schemes in other sectors, including sport and leisure, suggest that such schemes have often generated considerably more interest than expected. But there are undoubtedly many groups within society who may be less able to develop or demonstrate a “passionate commitment” to their local hospital, either through lack of time, knowledge, confidence or ability. And these are likely to be precisely the groups who suffer from the most ill-health and therefore have the largest stake in the NHS, those from ethnic minorities, lower socio-economic groups, refugees, those for whom English is not a first language or who have literacy problems, the elderly, and those with learning disabilities or mental health problems. Mark Sesnan also pointed out that it could be difficult to secure proactive involvement in something so new and unknown: “the patients, the users or whatever – do not know what they are going to

³⁷ Q439

³⁸ Q143

³⁹ Data supplied by Electoral Commission - http://www.idea.int/vt/country_view.cfm

⁴⁰ Ev 130

⁴¹ Ev 133

⁴² HC Deb, 8 January 2003, col.196

⁴³ Q148

vote and stand for, so they are not going to go out and fill this form in, are they, because it does not mean anything to them".⁴⁴

40. The *Guide* recognises the problems attached to opening membership up beyond the 'usual suspects' who already engage with the NHS through patient support groups and the League of Friends, and suggests that "applicants may want to take a more proactive approach particularly where there are communities where public participation is particularly low. This might be necessary, for example, in some inner cities to engage minority groups who would not normally expect to be able to take part in the running of a public service".⁴⁵ Although it specifies that "Foundation Trusts will be expected to demonstrate innovative approaches to ensuring genuine community membership" as part of their applications, the standards against which this "genuine community membership" will be assessed are unknown.

41. The decision on whether or not to grant a trust Foundation status will also be made before these plans have been tested, and will not necessarily draw on their track record in community and patient engagement so far. Within the 32 3-star Trusts that have applied for Foundation status, there is very variable performance on the six indicators designed to measure patient satisfaction. Ten trusts scored below average on at least one aspect, and four received the lowest score on at least one aspect. Seven of the 32 applicants were average or below average on all six of the patient related performance indicators and only two of the 32 3-star acute hospitals applying achieved the highest score on any aspect.⁴⁶ This suggests that in some prospective Foundation Trusts, patient involvement may currently leave something to be desired. Fiona Campbell, of the Democratic Health Network, told us she felt that some of our oral evidence demonstrated this point:

[Trusts] have no idea of what is involved in real community engagement ... I think it was pretty clear, from some of the answers you received earlier ... from the group of people, that they do not actually even know what the existing structures of public involvement are, because they referred to PALS [Patient Advice and Liaison Services] as if they were patients' forums and things like that. So I really do not think that by and large the trusts have a sense of what would be involved and the kind of real engagement that their colleagues are talking about.⁴⁷

Whether this reflection is true or not there is a pressing need to clarify the nature and role of community engagement.

42. In order to maximise the breadth and range of membership, we believe that Foundation Trusts must proactively attempt to extend registration so as to achieve real and representative community engagement. This, including the involvement of disadvantaged groups, should be an issue both in assessing applications for Foundation Trusts and an on-going responsibility for the attention of the Commission for Patient and Public Involvement in Health, or, failing that, the independent regulator.

What will membership really mean?

43. Peter Hunt, the Director of Mutuo, argued that currently democratic input into the NHS remains "somewhat remote if our only ability to have any influence is via a general

⁴⁴ Q328

⁴⁵ *A Guide to NHS Foundation Trusts*, Department of Health, December 2002, p 16

⁴⁶ *NHS Performance Ratings – Acute Trusts 2000-2001*, Department of Health, September 2001; *NHS Performance Ratings – Acute Trusts 2001-2002*, Department of Health, July 2002

⁴⁷ Q327

election”.⁴⁸ Mr Hunt went on to suggest that “by giving ownership of the institution to individuals they then have a right to participate constitutionally, they cannot then be excluded from particular decisions and they cannot then be excluded from the whole round of decision-making processes”.⁴⁹ However, we are not convinced that the current system allows members to be as directly involved in the running of Foundation Trusts as Mr Hunt suggests.

44. When questioned by the Committee on whether members of a Foundation Trust could overturn the decision of a trust to reconfigure services, the Secretary of State replied that “the simple answer to that is probably yes”.⁵⁰ But under the present proposals, members’ inclusion in decision-making appears to be limited to the election of Board members, who will then seek to influence the strategic direction of the Trust through an annual public meeting. Further to this, members will have a right to be ‘consulted’, which is again rather sketchily drawn. The *Guide* gives as an example “matters relating to how provision of NHS clinical services by the NHS Foundation Trust could be improved”, but does not specify that members would need to be consulted about major service reconfigurations.⁵¹ It is also important to note that consultation does not of itself equate to support of a policy, and the *Guide* does not specify what impact public consultation would be expected to have. **If it is the case that members of a Foundation Trust will have the right to veto trust proposals through a referendum, then this will invest patients and the public with significant power over the way their local services are run. However, nothing we have seen in the *Guide* or in our other evidence suggests that this is the case, and we would welcome clarification on this point from the Department.**

How will the Board of Governors work?

45. The *Guide* specifies that a Foundation Trust’s Board of Governors “will represent the interests of the members and of partner organisations in the local health economy in the governance of the NHS Foundation Trust”.⁵² As with membership, Foundation Trusts will be free to determine the size and makeup of their own Boards of Governors, subject to the following guidelines:

- The majority of governors must be representatives elected from the patient and public membership
- There must also be:
 - < Representatives elected by the employee membership
 - < Representatives nominated from the main commissioning Primary Care Trusts
 - < Representatives from universities with responsibility for undergraduate training and research in the Foundation Trusts.⁵³

46. The main function of the Board of Governors will be to work with the Management Board to ensure that the NHS Foundation Trust acts in a way that is consistent with its objects and with the conditions under which it is licensed to operate, and to help set the strategic direction. The Board of Governors will not be involved in matters of day to day management – such as setting budgets, staff pay and other operational matters, which will be decided by the management board.

⁴⁸ Q277

⁴⁹ Q301

⁵⁰ Q373

⁵¹ *A Guide to NHS Foundation Trusts*, Department of Health, December 2002, p 17

⁵² *Ibid*, p 18

⁵³ *Ibid*, p 18

47. The Board of Governors will elect a Chair, and will also elect non-executive directors to the Management Board. Non-executive Directors must account for at least a third of the places on the Management Board. The Board of Governors must hold at least three meetings per year, one of which must be in public.

What if the Board of Governors is divided?

48. Bob Hudson, Principal Research Fellow at the Nuffield Institute for Health, argued in his written evidence to us that “democracy and cosy consensus rarely go together hand in hand”.⁵⁴ Many of our witnesses raised the potential difficulty of reconciling competing viewpoints on a board of governors. Mark Sesnan, Chief Executive of the mutually-run Greenwich Leisure, told us that the challenge of empowering consultants, frontline staff, managers and patients should not be underestimated.⁵⁵ We also heard that difficulties could be particularly pointed in relation to the differing interests within a twin-site trust where each individual hospital is intensely parochial, or in a trust which provides both specialist and more general services, which, as we have seen, make up a substantial proportion of applicant trusts.⁵⁶ Peter Dixon argued that for trusts such as his, the already difficult “balancing act” between specialist and general services was likely to be made more problematic by the new arrangements for Foundation Trusts which, he argued, would be likely to “cause some problems rather than some solutions”.⁵⁷

49. The Department has not answered the important question of how disputes will be resolved when a Board of Governors refuses to approve strategic plans related to meeting national priorities. This question was flagged by several chief executives as being crucial to how successful this policy could be. In response to a question about whether Boards of Governors would be able to veto decisions taken by the Management Board, the Department was limited to saying that if the Board of Governors wanted to do this they would need to sack the Chair or non-executive directors subject to approval by a 75% majority of the Board of Governors. This does not necessarily mean the decision will be vetoed. We call on the Department to clarify this situation and to indicate how it expects decisions to be overturned.

Local interests versus wider priorities?

50. Equally, if not more, problematic will be situations where the Board of Governors is in disagreement with local or national needs identified by the PCT. According to Dr Rutter:

Not all demands are the same as the needs of the population. We have a very high incidence of ischaemic heart disease and it would clearly be quite wrong in Bradford not to address that as a key public health issue despite what local residents may feel. There is a silent majority which is clearly dying out there and we need to address those issues.⁵⁸

51. Chris Willis, Chief Executive of North Tees PCT, argued that it would be incredibly difficult to manage a situation “where you have succeeded in having meaningful local democracy and [the Board of Governors] vehemently disagree with national targets. I am not sure what we do at that point. That is when it is either going to stand or fall”.⁵⁹

⁵⁴ Ev 142

⁵⁵ Q306

⁵⁶ Q1

⁵⁷ Q21

⁵⁸ Q158

⁵⁹ Q155

52. Joan Rogers assumed that Government priorities would inevitably prevail over local ones: “I do believe we are still going to have these awful football matches sometimes; sometimes people will not like the change we are making in order to bring in the Government’s agenda”⁶⁰ This very difficult issue has not been directly addressed by the Government, perhaps giving rise to some of the concerns we have heard voiced that boards of governors may in fact just turn into ‘talking shops’. Birmingham NHS Concern felt particularly strongly on this point:

Although the publicly elected governors will be in a majority on the Board, they could lack expertise and simply defer to the minority that represent professional bodies or to the views of hospital managers and doctors. Some hospital managers already believe they can manipulate the Boards into becoming nothing more than talking shops.⁶¹

53. This also raises a crucial point about how effectively the Board of Governors will be able to scrutinise the Management Board’s activities. The line between the responsibility of the Board of Governors and the Management Board is difficult to draw. On the one hand, as the Secretary of State argued, “you cannot have the Board of Governors interfering in the day to day decisions of the hospital otherwise the thing will never run”.⁶² On the other hand, the Board of Governors is ultimately accountable to the membership for the stewardship of the Trust and must be able to make an objective and meaningful contribution to the way in which it is run. Currently, non-executive directors of NHS trusts undergo a tailored training programme. However, no detail has been given as to what training Foundation Trusts would be expected to provide for their governors. Michael Tremblay, director of an independent health policy consultancy, argued that the Board of Governors should involve a wider level of representation beyond that of the more obvious social stakeholders, to ensure that the Board has sufficient access to operational expertise, including, at the least, financial, organisational, technology (information and clinical) and human resource expertise. He also suggested that the chief executive, medical director, and other senior executive staff should hold ex-officio, non-voting or advisory seats on the Board.⁶³

54. We believe that the Government must put in place a national training system to ensure that Governors of Foundation Trusts have the necessary skills and information to hold the management boards of Foundation Trusts fully to account. This programme should be led by the Commission for Patient and Public Involvement in Health.

55. The Government must also give very careful consideration to the difficult questions which are already emerging about how disputes will be managed where the interests of representative constituencies including patients, staff and academics differ, and even more problematically, where the will of the Board of Governors steers a trust away from national priorities, or from a PCT’s assessment of the needs of the local health economy as a whole. Not enough is known yet about formal voting and vetoing rights, and nascent Foundation Trusts cannot be expected to wrestle successfully with these enormously difficult issues on their own. Instead, these principles must be firmly established on a national basis if Boards of Governors are to wield genuine power in the NHS, rather than simply functioning as a focus groups, advisory panels or talking shops.

⁶⁰ Q163

⁶¹ Ev 114; *Health Service Journal*, 7 November 2002

⁶² Q373

⁶³ Ev 118

The costs and benefits of democracy?

56. As Ken Jarrold pointed out to us, “democracy has to be paid for”.⁶⁴ He told us that he would welcome additional money being spent on greater democracy in the NHS. However, given the fact that the NHS operates within a fixed budget and continues to have to make very difficult decisions on prioritisation of spending on medical care on a day to day basis, introducing considerable expenditure without known benefits needs to be carefully justified. Peter Dixon admitted serious doubt about the relative costs and benefits of the proposals under consideration, arguing that despite extremely hard work, previous attempts at securing patient involvement had been nothing more than a “charade”:

I am worried about the bureaucracy which may be associated with the democratic accountability, because you can put an awful lot of effort into that, for fairly limited returns. There are other ways of making sure that we are accessible and accountable to our localities without trying to run an electorate in excess of 1 million for us. If we are going to take it that seriously, it is going to require an enormous bureaucracy. It either becomes “going through the motions” or it becomes very complicated.⁶⁵

57. The King’s Fund seconded this view: “We are not convinced that, for the effort involved, the Stakeholder Council will have much effect in improving services for local people.”⁶⁶ **One way of minimising the bureaucracy and allowing another model for trusts to choose from would be to allow elections to take place based on the electoral roll (not necessarily on existing council boundaries). The Government should consider this as an alternative model which some trusts might want to adopt.**

Lack of Patient and Public Involvement Forums

58. Many groups have also taken issue with the fact that, although they will be subject to PCT patient forums, Foundation Trusts will not be subject to the same arrangements for patient and public involvement as other trusts. Peter Dixon, Chair of University College Hospitals London NHS Trust told us:

We certainly need to engage better, but will we? At the moment we are saying that Foundation Trusts do not have to have a patients’ forum. That seems to me a rather strange thing to say. I would welcome a patients’ forum, but if I am going to be a Foundation, I do not have to have one. All right, I can have one, but it seems to me an odd way of structuring this.⁶⁷

59. Under proposals currently being implemented, in each NHS trust there will be a Patient Advice and Liaison Service (PALS) providing on the spot help and information about health services and an independent complaints advocacy service (ICAS) where people will be able to get help to pursue formal complaints. Patient and Public Involvement Forums will be set up in every NHS trust and PCT to feed in to the day to day management of health services by the Trust, and will monitor the effectiveness of the PALS and ICAS in their area. Patient and Public Involvement Forums will have rights of entry to trust buildings, and will have the right to appoint a member as a non-executive director on the trust board. An independent non-departmental public body established this year to ensure better patient and public involvement in the NHS, the Commission for Patient and Public Involvement in Health (CPPIH), will establish, support and facilitate the

⁶⁴ Q138

⁶⁵ Q138

⁶⁶ Ev 127

⁶⁷ Q153

co-ordination of Patient and Public Involvement Forums.⁶⁸ Foundation Trusts will not have to establish Patient and Public Involvement Forums, but will still be subject to scrutiny by the Patients Forums of local PCTs.⁶⁹

60. The CPPIH were vehement in their condemnation of this exemption:

It is the unanimous view of the Board that the proposal to exempt Foundation Trust Hospitals from the requirement to have Patient and Public Involvement Forums represents a serious threat to the integrity of the new system for involving the public which the Commission is charged with establishing.⁷⁰

61. According to the CPPIH, not having Patient and Public Involvement Forums will mean that Foundation Trusts become a 'blind spot' for PCT Patient and Public Involvement Forums, and ultimately in the bigger picture being built up by CPPIH. CPPIH is charged with providing a national and strategic approach to patient and public involvement in the NHS, but they expressed concern that without Patient and Public Involvement Forums, Foundation Trusts may effectively become 'no go' areas for CPPIH. Although the Secretary of State was clear that "two replicated forms of patient involvement" within Foundation Trusts would be unnecessary, CPPIH argued that it would in fact be more logical to scrap the inclusion of non-executive directors on the Management Board, as it was here that the duplication lay.⁷¹

62. The Secretary of State told us that Foundation Trusts did not need Patient and Public Involvement Forums, as they already had a substantial element of patient involvement built into their structures:

With Foundation Trust status we go way beyond Patient Forums in at least two regards. First of all, it is the local community who will elect the hospital governors, the patients and the public will have a democratic mandate, which is not the case with Patient Forums at all, so it is a much purer form of democracy. If you want to put the patients at the heart of it the best way is to let the patients decide that.⁷²

63. We received evidence cautioning against confusing ownership, democracy and engagement. Securing democracy in the NHS essentially involves putting in place a mechanism whereby elected representatives have an input into service delivery. Ownership is a subtly different concept, stemming, as we have seen, from the co-operative movement, whereby people voluntarily 'opt in' to a mutual or collective organisation. As well as being committed to the purpose and values of an organisation, members have a financial stake in it, and are liable in the case of insolvency. Both democracy and ownership imply a degree of indirect engagement, but this is not necessarily a separate objective of either of these two processes.

64. Another point that is easily overlooked is that the proposed shifts in governance for Foundation Trusts are replacing a distant, but established form of democracy (the Secretary of State) with a new and untried one. If this policy is adopted, Boards of Governors will ultimately represent the only form of democracy overseeing the NHS, because, as pointed out in our evidence, local people will not have the power to remove the independent regulator if they think it is acting against their interests, as they can do with elected politicians. **As well as striving to improve democracy at a local level, as these proposals do, we feel it is important that democratic accountability is maintained at**

⁶⁸ <http://www.doh.gov.uk/involvingpatients/>

⁶⁹ *A Guide to NHS Foundation Trusts*, Department of Health, December 2002, 9 22

⁷⁰ Ev 157

⁷¹ Ev 149

⁷² Q377

a national level. The appointment of an independent regulator must not be allowed to reduce the ability of members of the public to obtain information that they otherwise would have sought from Ministers through their Member of Parliament.

65. Efforts to secure direct patient engagement and involvement are different from democracy, which constitutes at best only an indirect voice in the governance of services. Direct patient engagement often involves methods such as consultation, patient surveys, or the provision of other opportunities for patients to give direct feedback about the organisation, including the resolution of complaints. This is precisely the type of engagement that, according to the CPPIH, Patient and Public Involvement Forums are likely to have the expertise in providing.⁷³

66. Patient and Public Involvement Forums function independently of the Trust Board, reporting upwards to the central, independent body, the CPPIH. Although the Board of Governors will be separate from the Management Board, as we have seen it may be easy for it to appear to be hijacked by the agenda of the Trust Management Board. Secondly, Patient and Public Involvement Forums will be run by staff with proven expertise in patient involvement and will have direct and regular links with a central body established to ensure best practice in this still very new discipline. Without Patient and Public Involvement Forums it is difficult to see how Foundation Trusts will tap into this expertise.

67. In oral evidence to us, the Secretary of State indicated that Patient and Public Involvement Forums (PPIFs) in NHS trusts would be temporary measures, which would ultimately be replaced by the new system of a partly elected Board of Governors. One of the key functions of PPIFs is their right to appoint a non-executive Director to the Trust Board, something the Commission for Patient and Public Involvement in Health (CPPIH) argued might allow patients and the public more direct involvement in a Trust's governance than only being able to elect representatives to a Board of Governors. However we feel that this function of PPIFs will be covered by the provision for Foundation Trusts' Boards of Governors to elect non-executive directors (NEDs) to their Management Boards.

68. Nevertheless, major concerns remain about the differences between arrangements for patient and public involvement in Foundation Trusts and in other NHS trusts. For example, PPIFs are entirely independent of the trust whose population they serve, and account directly to the Commission for Patient and Public Involvement. On the other hand NEDs on a Foundation Trust Management Board would be accountable to the Trust's Board of Governors and the CPPIH would be excluded. We recommend that, in the absence of its own Patient and Public Involvement Forum, a Foundation Trust's patient non-executive directors should have access to support and training from the CPPIH. Such NEDs should be a part of the CPPIH in the same way as NEDs appointed to Foundation Trust Management Boards as representatives from commissioning PCT Patients Forums.

69. Also there are no explicit provisions either in the *Guide to Foundation Trusts* or in the Health and Social Care (Community Health and Standards) Bill to ensure that Foundation Trusts have Patient Advocacy and Liaison Services (PALS) to support patients in negotiating hospitals systems, or that they will have access to an Independent Complaints Advocacy Service. Neither is it clear that they will be subject to the same complaints procedure as the rest of the NHS. The proposal of entirely new arrangements for patient and public involvement for Foundation Trusts does not appear to be well integrated with systems currently being implemented in the rest of the NHS. We feel it is very important that Foundation Trusts are able to

⁷³ Ev 150

benefit from the developing expertise of the CPPIH, and to contribute to the work that the CPPIH is undertaking to improve patient and public involvement in the NHS at a national, strategic level.

A marriage of convenience?

70. Questions have been raised about how naturally and logically the three elements of increased financial freedoms, increased management freedoms, and new local governance arrangements, sit together. It would clearly be possible to have one element without the others; as the Secretary of State has pointed out to us, some NHS trusts have already established wider advisory groups drawn from representatives from the community, with the aim of working alongside the trust board on issues that are of concern to the local community.⁷⁴

71. Evidence we took from chief executives of NHS 3-star trusts suggested that although they had been pushing strongly for less central control, the idea of Foundation Trusts as independent entities governed by local stakeholders was not something that had occurred to them.⁷⁵ While some of the trusts we received evidence from thought that they might still consider applying for Foundation status if increased local accountability through an elected board of governors was the only change on offer, one witness stated that the increased access to capital was by far the strongest incentive for his trust, and several others felt that the proposals would not be worthwhile if the promise of less central control did not materialise.⁷⁶

72. Plans for Foundation Trusts involve far-reaching reforms in three areas. At a central level, they propose the introduction of a new regulatory regime and the establishment of a new regulatory body which will eventually replace the Secretary of State's direct control over NHS organisations. The new regulatory regime will also require Foundation Trusts to develop new skills in order to interact with it successfully. Also at a local level, Foundation Trusts will face the challenge of designing and administering large community and staff elections, and, once elections are finished, ensuring that new Boards of Governors are able to contribute effectively to the governance of the trust, whilst protecting the smooth running of the trust during the transition period. At the same time as this Foundation Trusts will also be learning how best to use their new financial freedoms. The problems we have identified with the proposals as they stand attest to the difficulty of formulating three such complex reforms simultaneously, and we therefore feel it is very important that if these reforms are implemented Foundation Trusts are given dedicated support in introducing each element, and that each element is individually addressed.

⁷⁴ Q353

⁷⁵ Q3

⁷⁶ Q162; Q164; Q8

2. WHAT IMPLICATIONS WILL THE PROPOSED CHANGES HAVE FOR PATIENTS BEING TREATED IN THE REST OF THE NHS?

73. While we believe that some refinements need to be made to the proposed local governance model, we were struck by the high level of enthusiasm expressed for the Government proposals by representatives of some NHS organisations, and we accept that for some trusts, attaining Foundation Trust status has at least the potential to help them improve services for their patients. However, a more contentious issue is the likely impact of the implementation of these proposals on the rest of the NHS, and, most importantly, the patients they serve. While we understand that the Government's intention is that within four to five years all acute hospitals will be Foundation Trusts, the transitional period between now and then still warrants careful analysis, as does the ongoing impact of Foundation Trusts on other NHS organisations such as PCTs.

Are local communities being sufficiently consulted?

74. Community ownership is a key aim of these policies, and concerns have been expressed from many quarters that this policy, at least initially, may have adverse effects on surrounding hospitals and other parts of the local health economy. With this in mind, it would seem important that in deciding whether a trust becomes a Foundation Trust or not, the views of a local community wider than that served directly by the Foundation Trust should be taken into account. Diane Dawson and Maria Goddard, health policy specialists from the Centre for Health Economics at the University of York, argued that currently decisions are being taken on a trust rather than a community basis:

Whilst it is clear that the new governance arrangements may offer benefits for local communities and commissioners if they give stakeholders a greater chance to influence the provision of services, the decision to seek Foundation status will rest with the hospital itself. The incentive to take up this option hinges on perceived benefits to the hospital and its staff, rather than any wider benefits to the local community.⁷⁷

75. The Democratic Health Network also felt strongly that “if the community are going to become involved, if Foundation Trusts go ahead, they will need to have had some sort of a say in whether they are set up or not”.⁷⁸ The Secretary of State told us that trusts were not expected to have consulted local stakeholders during the initial stage of the application process, where preliminary expressions of interest are invited from trusts:

I think there have been some informal soundings but probably no more at this stage. At this stage it is for the trust to decide whether or not it wants to express an interest and basically get itself over the first hurdle ... I think it would be a matter for the individual trust to decide what the appropriate means of consultation is at this stage ... Some will have consulted informally and some will not.⁷⁹

76. The Secretary of State told us that more detailed consultation would be required for the second stage of the application process:

They will need to work up a fully fledged plan to move to NHS Foundation Trust status and that will involve them in pretty detailed discussions not just inside the trust but outside too. For example, they will need to have discussions with their staff, they will need to have discussions with local primary care trusts, they will need to have discussions with various stakeholder groups in the community and

⁷⁷ Ev 139

⁷⁸ Q327

⁷⁹ Q347

they will need to gauge the depth of community and local health service support for their proposal to move forward and we will look at that very carefully.⁸⁰

77. However, Fiona Campbell felt very strongly that a meaningful level of local consultation would not be practicable: “you certainly cannot do that kind of role, consultation and education process in the proposed timescale.”⁸¹

78. The *Guide* specifies that “second-stage applicants will need to provide evidence that both the NHS trust Board and key stakeholders – for example, Primary Care Trusts, staff, partner organisations and local people – have been consulted and support the application and the strategic vision”. The Secretary of State told us that he will then have “the job of gauging their opinions”.⁸² We welcome this duty to consult, although it is less clear by what standards local support will be gauged, and what proportion of staff or local support would be considered an endorsement. Joan Rogers felt that PCTs and the local population would have a very powerful influence, and told us “I sat down with my own top team and the first question we asked was, ‘What’s in it for Primary Care Trusts and the local population?’ If they do not like it they will not vote it in; it is as simple as that”.⁸³ But again, we are not clear at this stage how potential Foundation Trusts would actually be able to put their proposals to a ‘vote’ amongst local people and stakeholders. It is also unclear whether or not the information trusts submit in their applications will be available to the public, or whether organisations or individuals would be able to make separate representations to the Secretary of State if they opposed the plans and felt that their views had not been adequately captured in the trust’s submission.

79. Given the suggestion that has been widely reported in the media over recent months that Foundation Trusts may have a negative impact on neighbouring health economies, it will also be vital for public confidence as well as for equity, that prospective Foundation Trusts are able to demonstrate the support of neighbouring trusts and the communities they serve. The Secretary of State agreed that it would be “wise” for prospective Foundation Trusts to secure the support of neighbouring health economies.⁸⁴

80. We feel that there is much that needs to be clarified surrounding the Government’s proposed requirement that prospective Foundation Trusts must demonstrate the support of local communities as part of their application for Foundation status. If trusts have to undertake lengthy consultation with local communities, which might include public meetings, roadshows, surveys and votes, this could have high administrative costs and could potentially be open to manipulation rather than contributing constructively to debate on how best to deliver healthcare for that locality. However, there is also the risk that if these proposals are implemented only in a tokenistic way, consultation could continue to be the “charade” described by one of our witnesses. Although applications for Foundation status will be assessed on whether their plans are supported locally, it is not clear how such support will be measured, and whether information about this will be made public. If consultation on Foundation status is to withstand accusations of tokenism, it will need to include stakeholders from early on in the process, even before an expression of interest in Foundation status is expressed. It should also include neighbouring health organisations and service users as well as those served by the prospective Foundation trust, and it is important to recognise that the local community of any particular hospital cannot necessarily be defined along boundaries of existing PCT catchment areas or local authorities, or else significant parts of the population may

⁸⁰ Q342

⁸¹ Q327

⁸² *A Guide to Foundation Trusts*, Department of Health, December 2002, p 45; Q343

⁸³ Q25

⁸⁴ Q365

be excluded. These issues must be addressed and resolved by the Government if local ownership is to succeed.

Implementing Foundation Status across the NHS

The star-ratings system

81. In the first instance, Foundation Trust status will be available only to acute trusts who score 3-stars in the star ratings published in July 2003 (based on performance in 2002-03).⁸⁵ The issue of whether the benefits associated with Foundation status should be limited, in the first instance, to the acute hospital sector, is discussed more fully below. But given the benefits which it is hoped will flow from Foundation status, many have questioned the logic of confining the reforms to the best performing organisations. The King's Fund was unequivocal on this point: "the poorest performing hospitals should have access to the same mechanisms that have led to improved performance in Foundation Trusts, whatever those prove to be".⁸⁶ The BMA supported this view, arguing that "helping under-performing trusts to improve should have higher priority, and they would be better able to do so if they had greater freedom to innovate".⁸⁷ This argument was also endorsed by the NHS Confederation: "if freedoms are required by Foundations to achieve modernised and innovative care then they are required by all NHS organisations."⁸⁸

82. The Secretary of State told us that although eligibility for Foundation status will remain conditional upon attaining 3-star status, he was confident that all trusts would be able to achieve this within a four to five year period.⁸⁹ The reasoning behind using 3-star status as a gateway was twofold. Firstly, he argued that non 3-star trusts would not be able to cope with the additional freedoms Foundation status would confer:

I strongly resist the idea that somehow or other the best solution for organisations that, frankly, are not performing terribly well at the moment is yet more freedom ... It is not more freedom that they need, they need more help and support to help them to improve, otherwise you are into sink or swim territory.⁹⁰

83. The Secretary of State was clear that a big bang where all trusts became Foundation Trusts at once "would have a cataclysmic effect on the National Health Service".⁹¹ The second reason he advanced was that although the Government planned for all NHS hospitals to have become Foundation Trusts within the next four to five years, he hoped that reserving Foundation status for 3-star trusts would increase the incentive for organisations across the NHS to improve their performance in order to reach the top level of the star rating system and apply for Foundation status.⁹²

84. However, a significant logical problem connected with this roll-out was articulated by the King's Fund: "it is obvious that not all acute trusts will gain the 3-star status, since the star rating is based on a relative not absolute scoring system."⁹³ This is because for one element of the star ratings system, the performance of trusts on 28 performance indicators, an individual trust's performance is assessed and then compared to all other trusts. It is this element of the system that is used to allocate 1- and 2-star ratings for trusts with a few failings in their key targets and 2- and 3- stars for those that achieved all or nearly all the

⁸⁵ *A Guide to NHS Foundation Trusts*, Department of Health, December 2002, p 13

⁸⁶ Ev 126

⁸⁷ Ev 131

⁸⁸ Ev 132

⁸⁹ Q348

⁹⁰ Q355

⁹¹ Q348

⁹² Q348

⁹³ Ev 126

key targets. The Secretary of State was clear in his evidence that he expected Foundation trust status to be extended to all trusts within four to five years. His evidence also suggested that rather than lowering the hurdle and allowing 1- and 2-star trusts to become Foundation Trusts, this would be done through raising the performance of all trusts up to 3-star level, therefore enabling them to apply.⁹⁴ As the current star rating system has a relative component, it is not clear whether all trusts will be able to achieve 3-star status or not, as their performance will be measured relative to the performance of the rest of the NHS. When we asked the Department for further information, they told us that the relative element of the current system might be reviewed in future, but did not provide a full explanation of how the system would work if the relative element remained in place.⁹⁵ We feel that there is some confusion about this area of the policy, and urge the Government to provide clarification on this point.

A system which is “fundamentally flawed”, “too blunt an instrument”?

85. The star rating system has itself been subject to considerable controversy, prompting the question of whether it is a useful or rational basis on which to base the introduction of these reforms. Star ratings are based on a combination of three different performance measures – nine key targets, CHI clinical governance reviews, and 28 performance indicators. The three elements of the star rating system are each ascribed different weightings. The system is described in detail in the Annex.

86. The Secretary of State told us that “the star rating system is not perfect, but it is getting better”, and also highlighted the lack of appropriate measures of clinical outcomes of NHS care, the single most important element of health service performance.⁹⁶ This view was borne out by an example given by Birmingham NHS Concern, who argued that “under the star rating system, the University Hospital Birmingham NHS Trust is one of the best performing acute trusts. It meets eight out of the nine key Government targets and is likely to be in the first wave of hospitals to apply [for Foundation status]. It also has some of the highest readmission rates and the worst record for MRSA infections in the country. Clearly, a 3-star rating does not necessarily mean top clinical performance”.⁹⁷

87. The star rating system has only been in operation for two years, and its measurements have changed within that time. Comparing the results for 2000-01 and 2001-02 reveals quite startling changes in performance throughout the system:

- The majority of trusts had different ratings in 2001-02 and 2000-01.
- Just under half of the trusts with a 3-star rating in 2000-01 went down to a lower rating in 2001-02.
- Three trusts in fact went from 3-stars in 2000-01 to 1-star in 2001-02.
- Nearly two thirds of those rated as 3-stars in 2001-02 had lower ratings in the previous year.⁹⁸

88. It is not clear whether this instability is a result of the unreliability of the measures used to determine the ratings, or significant year-on-year fluctuation in the performance of NHS organisations. However, it is clear that whatever the cause of this variation, caution should be applied in assuming that 3-star status is a reliable indicator of consistently high performance in an NHS organisation.

⁹⁴ Q348

⁹⁵ Ev 150

⁹⁶ Q408

⁹⁷ Ev 114

⁹⁸ *NHS Performance Ratings – Acute Trusts 2000-2001*, Department of Health, September 2001; *NHS Performance Ratings – Acute Trusts 2001-2002*, Department of Health, July 2002

89. Dr Ian Rutter, Chief Executive of North Bradford Primary Care Trust, described the star system as “fundamentally flawed, it is too blunt an instrument. Even my Autocar rates cars out of ten, ten stars not three stars”.⁹⁹ Mr Ken Jarrold, Chief Executive of County Durham and Tees Valley Strategic Health Authority, told us that he would be very dubious about the star ratings “except for the fact that the star ratings are now being taken over by CHI and they will be responsible for star ratings in future. I feel a lot more comfortable knowing that is going to be the case, because they will be independent of Government and they will be taking into account a wider range of factors”.¹⁰⁰ However, CHI has only been operational for a little over two years, its review system is as new and untested as the star ratings system, and its own performance as an organisation is also untested. Any hoped for ‘independence’ may, at least in the short-term, be largely illusory, as the Secretary of State currently holds the same powers of direction over CHI as he does over NHS trusts, and this year’s star ratings, although they will be collated and published by CHI, will be calculated using Department of Health information and, more importantly, will be measuring performance against Department of Health performance indicators and key targets.

90. Something that is problematic for all indicators of healthcare performance is variations in casemix and other external factors. Joan Rogers, Chief Executive of North Tees and Hartlepool NHS Trust, argued that in some circumstances the system could be a disincentive rather than an incentive even for a high performing organisation:

It is not all about working harder ... it is a fact that a tertiary centre would find it harder to attain 3-stars. At some point it would not matter how hard they were working, for example if they could not recruit plastic surgeons, which they cannot right now, they are not going to hit that waiting list [target]. That is where it gets demoralising. As a 3-star trust myself, the staff are amazingly worked up about the status and I dread the day somebody dies in a mountaineering accident or something similar, as doctors tend to, and the next thing is your service is cut and you have lost your stars ... it is not only about hard work: some of it is about the inescapable problems the NHS has and that can be very demoralising.¹⁰¹

Two-stars missing out

91. Another problem with relying on the star rating system as a gateway to Foundation status is that organisations just as capable of innovation and success may be held back from improving if they narrowly miss 3-star status. Nik Patten, Deputy Chief Executive of South Tees Hospitals NHS Trust, described to us how his trust “missed it very marginally last year; our inpatient data was very, very good but our form in two areas was slightly off the leading pace which has been set by trusts like Joan’s”.¹⁰² While he claimed his trust had been energised rather than demoralised by this failure, Dr Rutter told us of his sense that 2-star trusts who had just missed 3-stars felt “quite aggrieved”, particularly given the new significance now attached to 3-star status, as a gateway to Foundation status.¹⁰³ Peter Dixon described an innovative scheme for which his trust had managed to secure funding “by luck”, and expressed the hope that, for Foundation Trusts, this type of ready access to capital to promote service development would happen automatically.¹⁰⁴ However, UCLH was a 2-star trust at the time of this “lucky” bid. This suggests that limiting Foundation

⁹⁹ Q61

¹⁰⁰ Q53

¹⁰¹ Q65

¹⁰² Q63

¹⁰³ Q61

¹⁰⁴ Q106

status to 3-star trusts might, in the short term at least, systematically hamper this type of innovation in the vast majority of trusts.

Star-stability

92. The Secretary of State was quite clear to us that Foundation Trusts would continue to be subject to the star rating system in exactly the same way as any other NHS organisation, as he told us it would be “difficult and probably invidious” to set up “two parallel sets of assessment”.¹⁰⁵ However, the Secretary of State also told us that “the structure of the performance rating system will need to take account of the mixed economy of both NHS Foundation and non-Foundation trusts for a number of years”. We find these two statements confusing and contradictory, and endorse the requirement for Foundation Trusts to continue to be subject to the same performance ratings system as the rest of the NHS.

93. However, this does raise a key question: if only 3-star organisations are thought able to cope with the additional freedoms Foundation status will confer, what will happen if a Foundation Trust drops below a 3-star rating? The Secretary of State told us that “One’s expectation is that this will not happen since these are hospitals that are performing well”.¹⁰⁶ However, given that as we have noted almost half (16 out of 35) of acute hospitals rated as 3-stars in 2000-01 lost their 3-star rating in 2001-02, this is clearly all too possible, making the Secretary of State’s optimism here rather puzzling. The Secretary of State told us that it was not his intention to establish “a hard-and-fast rule that says... that if in one year when, for example, you might have a major reconfiguration going on in the local area, or you might have new services coming in, whatever, in that one year if it moves from three to two, at that stage automatically they lose Foundation Trust status as I do not think that would be a good rule to establish”.¹⁰⁷ Instead, the independent regulator would be able to use his or her discretion in how the situation is dealt with. This might include writing publicly to the NHS Foundation Trust expressing concern and asking for an action plan to improve performance, implementing various special measures, inviting an external organisation to come in and help turn round performance, or in the most extreme case, dismissing the management team or part of the management team or revoking Foundation status. The Secretary of State went on to tell us that he would only expect these powers to be used “appropriately” and with “discretion”, “otherwise we will be back into precisely the sort of heavy-handed regulation that very often people in the Health Service complain about”.¹⁰⁸

94. Although the Secretary of State felt that using different sets of performance assessment for Foundation Trusts and non-Foundation Trusts would be “invidious”,¹⁰⁹ it appears from our evidence that while the same performance assessment will be applied to both they will not be applied in a consistent or fair way, a point clearly made by the King’s Fund:

Since some 3-star trusts will inevitably fall down to 2-star or lower in future, this raises the prospect of some 2-star trusts not being allowed Foundation status, yet other trusts that may be 2-star or lower will continue to be allowed Foundation status. This is not logical, or fair and will need to be thought through.¹¹⁰

¹⁰⁵ Q409

¹⁰⁶ Q413

¹⁰⁷ Q415

¹⁰⁸ Q415

¹⁰⁹ Q409

¹¹⁰ Ev 126

95. If star ratings are not considered a reliable or subtle enough tool to warrant immediate revocation of Foundation status if a trust's performance drops, then surely they are not a subtle enough tool to establish, on their own, whether an organisation's performance makes it worthy of acquiring Foundation status. Under the proposed system, there could well be Foundation Trusts who are enjoying the considerable advantages that Foundation status will confer both in terms of status and resources, which actually have considerably worse performance than other non-Foundation Trusts who are not allowed to apply for Foundation status. If a service reconfiguration is seen as an excuse to let a Foundation Trust underperform one year, then surely Foundation status should be opened up to 2-star trusts which are able to demonstrate extenuating circumstances.

96. The Secretary of State told us that

Whether or not the star ratings are right, wrong or indifferent does not really matter. The truth is that what the star ratings have exposed is what everybody around this table and, incidently, what every member of staff and probably every patient knows, which is that some hospitals are really good, a few are poor and most need to improve.¹¹¹

97. While we agree with the Secretary of State that performance varies considerably across the NHS, and support his attempts to improve performance, we feel that the question of how good the star ratings system is, whether, in his words, it is “right, wrong or indifferent”, is crucially important. NHS patients as well as NHS staff have the right to expect a performance measurement system that is as sophisticated and reliable as possible, and focuses on issues that matter to patients, most importantly the quality of clinical care. This importance is only reinforced by the fact that star ratings are to be used as a gateway to increased freedoms and privileges.

98. The considerable fluctuation in performance ratings undergone by the majority of trusts suggests that achieving 3-star status is not necessarily a guarantee of long-term high performance or the ability to use freedoms appropriately. If the Government believes that Foundation Trusts that fall to back to 2-stars should not be arbitrarily stripped of their Foundation status, then this might imply that the cut-off for Foundation status applications should be rolled back to include 2-star trusts. Alternatively, if 3-star status is to be rigidly applied as the performance benchmark for aspiring Foundation Trusts, then the Government should consider restricting Foundation Trust status to those who have demonstrated sustained high performance by achieving 3-stars for perhaps two or three years running. **First, we believe it is important for the Government to ensure performance ratings are as accurate and sophisticated as possible. Secondly, we feel that the contradictions in using the star ratings system as a ‘one-way’ gateway to Foundation status need to be addressed and resolved.**

Managing performance within Foundation Trusts

99. High performing 2-star trusts may be disadvantaged by this system, and there is the possibility that trusts who consistently miss 3-star status by only a small margin may feel that this system is unjust if a neighbouring trust is actually performing worse on key targets than they are, after having achieved Foundation status. Anomalies in the system may leave non-Foundation trusts less inclined to strive to improve their performance. However, as the possibility of attaining Foundation status will remain open to them, perhaps of more concern is the issue of 3-star trusts who attain Foundation status and then let their performance slip, confident in the knowledge that their freedoms are now guaranteed

¹¹¹ Q361

unless there is a very extreme problem. The Secretary of State told us that “the ones that are doing well, honestly, I do not need to worry about”.¹¹² However, as pointed out by Birmingham NHS Concern, 3-star status does not mean there is no further room for improvement. Dr Rutter expressed his concern about the performance of 3-star trusts that might be able to keep their stars too easily: “the issue is that if you are already a 3-star trust you sit back and rest on your laurels”.¹¹³ Maria Goddard and Diane Dawson of the Centre for Health Economics made the point that if the performance of Foundation Trusts was going to continue to be measured in the same way as non-Foundation Trusts, then contingencies would need to be put in place to support and improve the performance of failing Foundation Trusts, support currently provided for non-Foundation Trusts by the Department of Health through its Modernisation Agency: “if CHAI reports adversely on, say paediatric surgery in a Foundation Trust, is the independent regulator expected to have the in house expertise to help the trust deal with its problems?”¹¹⁴

100. A key argument in favour of the policy of Foundation Trusts is that it presents a genuine incentive for trusts to improve their performance. However, we are not clear that once Foundation status is achieved there are adequate incentives in place to ensure that trusts improve or even maintain high levels of performance. This shortcoming must be addressed as it has very serious consequences for performance and standards in the NHS, both in the short and the long term.

Rolling out the system

101. Speaking in the House on 8 January, John Hutton MP, Minister of State for Health, expressed his view that “we should begin the reforms in the right place and we should start them carefully”.¹¹⁵ Clearly, there is considerable debate around whether the reforms are being started in the right place, and the King’s Fund have argued that the system should instead be piloted in a whole geographical health economy, which would provide a better proxy if the final intention is that all or most NHS trusts will be Foundation Trusts.¹¹⁶ However, the Secretary of State was quite clear that this option had not been considered, because it removed the ‘incentive value’ of the policy.¹¹⁷

102. As this is a far reaching policy that has the potential fundamentally to change the governance and culture of the NHS and the way in which health services are delivered in England, it is clearly just as important, as the Minister said, to begin the reforms “carefully”. This point was driven home to us by Mark Sesnan, Chief Executive of Greenwich Leisure:

The answer is that no, we have not done it in something as complex yet and to say that possibly we should be saying, “Why don’t we just do it in one or two hospitals?” Indeed in this process we may end up with only one or two. You should pilot these things because it is very dangerous to go launching off until you understand what you are doing ... I am not sure it is something the Government would be wise to go at wholesale without having some very carefully constructed pilots to start with.¹¹⁸

103. The Secretary of State agreed with us that there were few examples of organisations as large or complex as NHS acute hospitals being run along the lines of a mutual or

¹¹² Q361

¹¹³ Q61

¹¹⁴ Ev 140

¹¹⁵ HC Deb, 8 January 2003, col. 278

¹¹⁶ Ev 121

¹¹⁷ Q363

¹¹⁸ Q283

socially owned company.¹¹⁹ However, he rejected the idea of a more cautious piloting scheme: “it would be very easy just to say that we are going to have lots of pilots, let’s just see how it goes, and so on, but I think what people in the Health Service and in local communities want is just some degree of certainty as well.”¹²⁰

104. Instead, the Secretary of State told us that the policy would be introduced through a series of annual waves of Foundation Trusts, with interested 3-star trusts submitting applications shortly after the publication of star ratings in July each year, with the establishment phase beginning three months later, and new Foundation Trusts ‘going live’ in April 2004.¹²¹ As well as 3-star trusts, trusts which are currently rated as 2-star are also being encouraged to think about applying in case they are given a 3-star rating, and if any current 0- or 1-star trusts improve their ratings to 3-stars in July 2003 presumably they would also be eligible.¹²² The Secretary of State felt that the planned introduction in annual waves would enable evaluation, telling us: “I think we have an opportunity to test it”.¹²³ However, candidates for the second wave of Foundation Trusts will have to submit their applications only three months after the first wave of Foundation Trusts go live, before they have been subject to any form of performance assessment. Although they will receive a star rating, this will be based on the financial year 2003-04, during which they will not have been Foundation Trusts.

105. The introduction of Foundation Trusts is centred on improving services for patients, whether those improvements are achieved through increased access to resources, more freedom to unleash local entrepreneurialism, or better engagement with the communities the NHS serves. However, as we have seen, organisations whose performance drops will not be returned to NHS trust status, suggesting that these significant reforms will prove easier to make than to unmake. Although the Regulator will have powers to intervene if services are not being delivered or if an organisation is failing dramatically, this is no guarantee that hospitals will deliver greater improvements under the new system than the current system, or that other organisations and health communities will not be disadvantaged. The answers to these questions will only emerge once the first wave of Foundation Trusts are up and running.

106. We note the Government’s commitment to piloting this policy with a selected group of trusts rather than opting for large-scale ‘big bang’ implementation. We recommend that consideration is given to establishing an additional pilot allowing all trusts in a particular area to become Foundation Trusts, as this would help to evaluate how the system would operate in the long term. We do not think that the proposed very tight schedule of annual waves of reform allows sufficient opportunity for the advantages or disadvantages of Foundation status to be evaluated, or for lessons to be learnt, good practice disseminated, and the policy refined for further waves. In particular, we feel that in the early years of this policy, the success of public involvement measures, and the impact on wider health economies will merit very close scrutiny. We recommend that the Government should commission an independent evaluation specifically aimed at assessing the impact on wider health economies and on public involvement, and geared towards helping refine the policies for ‘second wave’ Foundation Trusts, before announcing the second wave of trusts.

107. The *Guide* states that eventually Foundation Trust status “may be available to organisations that are not currently part of the NHS”¹²⁴. The Department have since clarified that “organisations that are not currently part of the NHS but that hold similar

¹¹⁹ Q422

¹²⁰ Q423

¹²¹ Q431

¹²² Q432

¹²³ Q420

¹²⁴ *A Guide to NHS Foundation Trusts*, Department of Health, December 2002, p 13

values and can contribute to wider health service objectives” would be eligible to apply to become NHS Foundation Trusts.¹²⁵

Promoting integrated and non-hospital based care – will Foundation Trusts reinforce divides?

108. The ongoing need to promote integrated care across health economies was captured well by Dr Ian Rutter:

For far too long we have actually blamed the acute trusts for not delivering waiting list targets, for not delivering on a whole range of issues, when it is a whole health economy problem where the demand generated by primary care is just as important as the efficiency of the supply you are delivering and much more crucial is the flow between primary and secondary care.¹²⁶

109. However, much of the evidence we have received has pointed to the conflict between improving integration and patient care across organisational boundaries, and the policy of Foundation Trusts which appears to centre local involvement, innovation and resources around an acute hospital rather than a wider health economy. The King’s Fund pointed out that the policy of Foundation Trusts bolsters the concept of institutions as central to patient care, perhaps at the expense of other Government initiatives to improve care pathways and ‘whole system working’ which put patients at the centre of good patient care. Examples of these initiatives include National Service Frameworks, clinical networks, the care collaboratives and the expert patient programme. According to the King’s Fund, “Focusing on institutions, such as developing Foundation Trusts, could erect unnecessary barriers in the development of care pathways and integrated care”.¹²⁷ Bob Hudson, of the Nuffield Institute, agreed strongly with this point:

Even the latest generation of hospitals are in danger of becoming quickly redundant. The King’s Fund, for example, has forecast that 50,000 new beds will be available to the NHS through new technology allowing patients to be monitored in their own beds at home. Other new developments will include nurse-led minor injury treatment centres, combined health and social care centres, and hi-tech specialist care units considerably smaller than existing hospitals. The last thing the NHS needs right now is a system of governance that fuels loyalty to an institutional building rather than an evolving system of health and welfare.¹²⁸

110. By the same token, the policy of Foundation Trusts and many of the other initiatives that underscore it, including the patients choice initiative and the reforms to financial flows, seem primarily aimed at addressing the needs of patients on waiting lists for elective treatment. In fact the most costly conditions for the NHS to treat are chronic medical diseases, and patients with chronic illness mostly use primary care or community services.

111. This Government has explicitly recognised the need to change the balance of power, resources and prestige from hospital care towards care in primary or community settings. Evidence suggests that rehabilitation and stepdown care are provided more cost-effectively and to higher standards away from large hospital sites, and there is enormous potential for community-based measures to reduce emergency admissions.¹²⁹ Similarly, modern technology offers the scope for much of outpatient care, including a range of surgical and diagnostic procedures, to be carried out in GP surgeries or small

¹²⁵ Ev 151

¹²⁶ Q13

¹²⁷ Ev 121

¹²⁸ Ev 143

¹²⁹ Ev 122

community hospitals. Yet, paradoxically, the policy of Foundation Trusts positions acute trusts as paragons of innovative service delivery and patient involvement, before community-based services driven by PCTs have had the chance to demonstrate their worth.

112. Dr Rutter told us that “we would have no problem about our trust keeping a surplus because we would be in a dialogue and we would see that as part of developing quality and the whole quality agenda”.¹³⁰ Indeed, much of the evidence we have taken from NHS trusts and Primary Care Trusts has shown that they are well aware of the importance of establishing and maintaining good cross-sectoral relationships. However, Dr Rutter did express concern about the possibility that a Foundation Trust might decide to sell off a community hospital, bringing benefits to the Foundation Trust through increased access to capital, but disadvantaging the broader community it served.¹³¹ (A community hospital would be a regulated asset but we presume that regulated assets can be sold to provide alternative patient provisions – if not, innovation will be stifled in Foundation Trusts). This serves as a useful illustration of the problems that could be caused by shifting resources to individual organisations which only have a responsibility to their own ‘members’, without having, as PCTs do, a responsibility for strategic overview of the health needs of a whole community. The NHS Confederation also voiced concerns in this area:

Whilst we recognise the importance of the freedom to dispose of assets we would hope that Foundations would take into account the interests of the wider community in how the proceeds were applied. This was not always the case in the early period of trust status with sometimes regrettable results.¹³²

113. The Secretary of State told us that he hoped to see “NHS Foundation Trusts coming up with proposals for how they can use their borrowing freedoms, their access to capital, not just to provide better diagnostic and treatment centres and more surgery, but how, for example, they can provide better intermediate care or help with primary care”.¹³³ This is an outcome we would welcome. However, although, as we were told by David Jackson, additional capital and surpluses would get “ploughed straight back into services and because the income streams come from the Primary Care Trust, they have to be services which Primary Care Trusts want to buy”,¹³⁴ the discretion over what to spend the surplus on, whether it is service development in the acute hospital or in the community, rests with the Foundation Trust, not the PCT, and the system still prevents the surplus money from being reinvested at a strategic level, perhaps on community services or preventative medicine. As Chris Willis accepted, without national tariffs the policy of Foundation Trusts does not help PCTs “pull money back to a community level”.¹³⁵

114. In response to a question about the apparent divergence between the policy of Foundation Trusts and the drive towards more integrated, community-based care, the Secretary of State told us of the need to consider Foundation Trusts in the context of the wider reforms of the NHS:

I think you would have a very good point if this was the only policy that we were advocating; it is not ... There are very, very powerful levers that link the acute sector to the primary care sector and to the broader community ... Primary Care Trusts are an absolutely crucial part of the architecture and we want to strengthen that. The reason, for example, that we are introducing Healthcare Resource Groups and new forms of financial flows in the National Health Service is precisely to

¹³⁰ Q134

¹³¹ Q108

¹³² Ev 133

¹³³ Q442

¹³⁴ Q128

¹³⁵ Q27

strengthen primary care and primary care services so that commissioning works.¹³⁶

115. We are concerned that operating surpluses and capital will be invested on a trust rather than a health economy basis. Equally, it is far from clear that these reforms will give PCTs any additional leverage in terms of how acute services are developed. This type of input will come solely through Foundation Trusts' Boards of Governors, and as discussed previously, PCTs may only have one seat, and no power of veto.

116. Aside from the issue of how and where resources are invested, we also heard concerns about ensuring the appropriate engagement of Foundation Trusts with their local partners. Chris Bell, Chief Executive of Huntingdonshire PCT, told us that she would like an assurance that all local PCTs, not just lead PCTs, would be involved in the governance of Foundation Trusts:

That will be particularly important for us in terms of Addenbrookes because we work really closely together in the two trusts and we have clinical networks that go across the two trusts. There is going to be more of that in the future, not just in Cambridgeshire but across the country. I think it would be really important that that connection is made and maintained so that local people in Huntingdonshire feel that we have influence with Addenbrookes.¹³⁷

117. It has been suggested that Foundation Trusts have the potential to fragment relationships between health and social care. Local social services are not included, by right, on Foundation Trust Boards of Governors. The Secretary of State told us in clear terms that co-operation between health and social care was vital:

Unless we can get the Health Service and social services working more co-operatively together, then we will have a problem. It will not be us, but actually it will be the most vulnerable people in the community, the elderly people, people with a mental health problem, people with a disability who overwhelmingly rely not just on the Health Service, but on social services and, for that matter, housing services too.¹³⁸

118. But although the Secretary of State told us he would support the inclusion of social services on Foundation Trust boards, he was clear that that would be a matter for Foundation Trusts to decide for themselves:

Now, we are flexible, as the *Guide* says. If, for example, the Foundation Trust decides that it wants to co-opt people from local social services, it will get a thumbs-up from me. That is fine. I think that will be a great thing. If it wants to have people represented from the local universities if it is a teaching hospital, that is absolutely fine, but in the end the local hospital provides the local service to the local community and, in my view, it is the local community that should have the say over how the hospital is run.¹³⁹

119. The duty of partnership set out in the Health Act 1999 (whereby all parts of the NHS and the local authority are charged to 'work together for the common good') has been frequently cited by the Government as the key safeguard to ensuring that the viewpoints and interests of key partners are reflected within Foundation Trusts' arrangements for partnership.¹⁴⁰ However, it is difficult to know how robust this duty will prove in practice. **We are strongly supportive of recent efforts made to promote the development of**

¹³⁶ Q447

¹³⁷ Q175

¹³⁸ Q403

¹³⁹ Q389

¹⁴⁰ Q403; Q437

primary and community based care, and of whole systems models of care. It is imperative that the introduction of Foundation Trusts does not undermine the good work that has been done, or reverse this trend by re-focusing efforts on acute service provision. In particular, patients rather than buildings should remain at the centre of healthcare, and the needs of people suffering from chronic illness, including mental illness, many of whom receive the majority of their care in community settings, should not be marginalised in favour of those in need of elective care in acute hospitals. We were impressed by the evidence of good partnership working we received from our witnesses from Teeside and East Anglia, but we are not convinced that such good practice exists across the board. The policy of Foundation Trusts does not necessarily mean that partnership between acute and community settings will be damaged, but we believe it does introduce the need for stronger safeguards to ensure continued co-operation between PCTs, Local Authorities, and other NHS organisations across the board, and a continuing emphasis on whole systems working.

Foundation Trust status for other NHS organisations

120. At the moment, Foundation status is not open to mental health trusts, on the grounds that star ratings for mental health trusts are relatively new and still “pretty rudimentary”.¹⁴¹ However, Moira Britton, Chief Executive of Tees and North East Yorkshire NHS Trust, a mental health trust, argued strongly that “if foundation status is to be provided as a means of improving care, then it should be a level playing field and mental health organisations ought to have the option of considering its relevance to them”.¹⁴² She went on to argue that Foundation status could in fact be particularly useful to mental health trusts:

We usually cover a number not only of Primary Care Trust areas, but local authority areas. At the moment my governance arrangements at Board level restrict me in terms of quite how I can pull all these partner agencies in to develop integrated services. As I read the guidance at the moment in terms of Foundation Trusts, it would seem to offer me the opportunity of developing much closer working relations with service users, carers and their organisations in each of the six separate localities where I work with different local authorities. I think that could probably move us forward.¹⁴³

121. The Secretary of State informed us that he is keen to learn from the experience of establishing Foundation Trusts in the acute sector, and to examine how the model could be adapted for other NHS organisations, and he has stated that he will soon be writing to mental health trusts to advise them of future developments. The extension of Foundation Trust status to mental health trusts could counter-balance the acute hospital emphasis of the first wave of Foundation Trusts. If the policy of Foundation Trusts is to be pursued, we urge the Government to address the extension of Foundation Trust status to mental health trusts as a matter of priority.

122. Many of our witnesses expressed frustration that PCTs are also currently excluded from applying for Foundation status. Chris Willis, Chief Executive of North Tees PCT, felt the burden of central requirements and directives as keenly as the chief executives of prospective Foundation Trusts, and, along with Fiona Campbell of the Democratic Health Network, herself a non-executive director of a PCT, felt that PCTs would benefit from the increased local accountability Foundation status could confer.¹⁴⁴ Chris Willis went on to argue that the structure, organisation and nature of PCTs, not to mention their statutory

¹⁴¹ Q449 (Secretary of State for Health)

¹⁴² Q38

¹⁴³ Q38

¹⁴⁴ Q31; Q335

duty to involve and consult the public, meant that many were already ahead of the game when it came to engaging the communities they served.¹⁴⁵ For Fiona Campbell, this suggested that PCTs would be a far more natural starting point from which to introduce Foundation status, rather than acute trusts, many of which in her view were still struggling to understand existing arrangements for patient involvement.¹⁴⁶

123. Although most of our witnesses were supportive of the idea, we received little indication from our evidence of what a Foundation PCT would actually look like. While a Foundation PCT would continue, along with acute Foundation Trusts, to be subject to review and rating by CHAI, the removal of the Secretary of State's powers of direction could give PCTs considerably more local freedom and leverage, and the ability to retain capital and surpluses could promote increased investment over whole health economies, which would seem to be advantageous, in addition to the improved accountability brought about by elected boards of governors. However, the Secretary of State told us he felt PCTs would not be able to cope with the additional change at this stage:

I think it would be a fundamental mistake at this stage, although I do not rule it out at all for the future, to put that bit of the organisation through a further period of organisational upheaval because I do not believe they are ready for it. They are new young organisations that have barely begun their work. In time it might be different, but that is not where we are at today. They have barely come on line and they need to develop their ability to commission.¹⁴⁷

We welcome the Government's aim of shifting power from the secondary to the primary sector, and it is vital that these proposals do not reverse this trend. During this inquiry we have heard much support for extending these reforms to PCTs, and also suggestions that PCTs would be a more natural starting place for these reforms than acute trusts. As PCTs are commissioning organisations, the concept of Foundation PCTs raises a different set of issues and concerns. However, if proposals for Foundation Trusts go ahead it will be necessary to explore these issues as a matter of priority to ensure that the balance of power between primary and secondary care is maintained.

PCT capacity

124. Another key concern expressed in evidence was that, as the Secretary of State argued, many PCTs are very new organisations and relatively inexperienced as commissioners. This means they may not have the managerial expertise, or the information necessary to hold Foundation Trusts properly to account for performance against local contracts. By contrast, Foundation Trusts, which are recognised high performing providers, are likely to be staffed with more experienced managers and have more comprehensive information about activity and costs of services. This imbalance of expertise and information could leave PCTs in a much weaker position in arguing for their own local priorities, and in countering the priorities of the Foundation Trusts where they are different from those of the PCT or other local NHS organisations. The Secretary of State said he recognised these concerns, but argued that making PCTs budget holders would give them great leverage, even without such good skills and information:

I understand the pressures that PCTs feel under, they are new organisations and there is what some call information asymmetry between PCTs and the acute trusts, in other words, the acute trusts have got all the information about prices and so on and the PCTs have not, but what the PCTs have got that the acute trusts have not

¹⁴⁵ Q37

¹⁴⁶ Ev 57

¹⁴⁷ Q327

got is all the money. We have given them the money. We have given them three years' worth of money.¹⁴⁸

125. The King's Fund agreed that "in principle, locating purchasing power at local level makes it easier to develop community options and puts a brake on the provider power of the large acute trusts" but argued that "in practice, PCTs are unlikely to manage to impose themselves in this way".¹⁴⁹ This view was echoed by our witnesses from the NHS. Chris Willis told us that the imbalances between Foundation Trusts and PCTs in terms of management and negotiating skills was "certainly a matter of concern to PCTs".¹⁵⁰ Dr Rutter, Chief Executive of North Bradford PCT, also felt that concerns about power imbalances would probably be justified "if you do not have very sophisticated, well developed PCTs".¹⁵¹ Approximately half of the NHS's 303 PCTs have been in operation for less than a year, and even the most experienced PCTs, which account for only 10% of the total number, have been in operation for less than three years.¹⁵²

126. Dr Rutter told us that it was "imperative to make sure that the PCTs, in the areas in which these foundation hospitals come to be, are given the support they need",¹⁵³ and we are glad to see that the Government has anticipated this need by planning to provide considerable support for PCTs. However, this may not go far enough. The NHS Confederation argued that "to prevent stagnation, domination by the hospital or disaffection in primary care strong, innovative Foundations need to face imaginative and well developed PCTs. This should be a key criterion for the selection of hospitals for Foundation status".¹⁵⁴ **We recommend that in assessing applications for Foundation status, the Secretary of State should make specific provision to assess the readiness of local PCTs who will be commissioning services from prospective Foundation Trusts to meet this new challenge at such an early stage in their organisational development.**

Will competition corrode co-operation?

127. In recent weeks much debate has centred on the issue of competition and market forces, and whether this signals a reintroduction of the 'internal market' in the NHS. The Secretary of State recently told the House that "foundation hospitals have nothing to do with market forces"¹⁵⁵ and went on to explain the details of the reforms in oral evidence to us:

The internal market was competition based on price, that was what happened, people competed on price. It is not about that. However, I think it is quite right that both Primary Care Trusts, as the commissioners of services, and most importantly of all, individual patients as the recipients of services have some choice about where they get their health care from".¹⁵⁶

128. Whether they are described as 'market' reforms or not is largely a matter of semantics. However, it is clear that Foundation Trusts will be introduced at the same time as a strong push to increase patient choice to enable patients to be treated by whatever hospital is able to offer them, in their opinion and that of their GP, the best, most

¹⁴⁸ Q442

¹⁴⁹ Ev 123

¹⁵⁰ Q70

¹⁵¹ Q126

¹⁵² Data supplied by NHS Alliance

¹⁵³ Q126

¹⁵⁴ Ev 132

¹⁵⁵ HC Deb, 3 December 2002, col. 751

¹⁵⁶ Q455

convenient and most timely care, whether it be in an NHS trust, an NHS Foundation Trust, a private hospital or even a hospital abroad.

129. This inquiry has not directly addressed the likely success or failure of these policies. Recent research has hypothesised that the internal market may have contributed to between 2000 and 4000 extra deaths from heart attacks, as increased competition led NHS organisations to focus more on financial imperatives than on clinical quality. That research has been questioned in many quarters, and it is difficult to draw exact parallels with the reforms of the early 1990s and those under consideration now.¹⁵⁷ However, it is widely accepted that health care cannot function in exactly the same way as a genuine market and deliver the same increases in efficiency and quality. In the first instance, those that use the health service, the sick, the elderly, the socio-economically disadvantaged, are often the least able to articulate choice in where they have their healthcare, perhaps due to a reluctance to travel, or an inability to negotiate the system. There is also the wider point that the delivery of healthcare is very complex and it is incredibly hard to supply patients with the information they need to make informed and meaningful choices.¹⁵⁸ It is clear that if the patient choice initiative is going to deliver substantial improvements to the quality of care, GPs will have to work very closely with patients to ensure they have access to the best available information.

130. Dr Rutter felt that the new contracting system put PCTs “in a position to exercise some significant control”.¹⁵⁹ However, he told us that it was “imperative that quite detailed contracts and the financial flows are introduced alongside this initiative”.¹⁶⁰ With the system of block contracting, there would, he argued, remain the potential for Foundation Trusts to act against the interests of the local community, for example by only selecting the most ‘profitable’ patients to treat in order to maximize their surpluses. The *Guide* specifies that all Foundation Trusts and their commissioning PCTs will be encouraged to contract for services on a cost-and-volume basis across as wide a range of services as possible from 2004-05.¹⁶¹ The Department has also said that it would explore the possibility of beginning the convergence process to national tariff prices a year earlier for Foundation Trusts than the NHS as a whole.¹⁶² **We have not studied the financial flow arrangements in depth in this inquiry, but we have heard several concerns relating to commissioning arrangements between PCTs and Foundation Trusts. If these proposals go ahead, these concerns must be addressed by Government.**

131. Questions have also been raised over how genuine the choice and competition will actually be, and whether it will, in fact, be weighted in favour of Foundation Trusts. In December 2002 there were reports in the press that the Secretary of State was planning to guarantee Foundation Trusts’ income for up to seven years.¹⁶³ The BMA argued that “the concept of guaranteed income streams is essentially incompatible with that of exposure to market forces (including patient choice). It is not clear therefore how this requirement can be reconciled with the maxim that funding must follow patients”.¹⁶⁴ **In evidence to us the Secretary of State strongly refuted suggestions of guaranteed incomes, saying that it would be up to PCTs how long their contracts were for,¹⁶⁵ although the *Guide* anticipates that PCTs will enter into at least three year service level agreements with**

¹⁵⁷ ‘NHS Competition Costs Lives’, BBC News Online 29 January 2003, <http://news.bbc.co.uk>

¹⁵⁸ See for example ‘The social psychology of making and responding to complaints: An account model of complaint processes’ (1994) 16(2) *Law and Policy* 123, reprinted in D Galligan (ed.) *Administrative Law. Oxford Readings in Socio-Legal Studies* (Oxford University Press, 1995); *The Autonomous Patient*, Angela Coulter, 1996, London: Nuffield; *Strained Mercy: the economics of Canadian Healthcare*, Robert Evans, 1985, Toronto: Butterworth.

¹⁵⁹ Q77

¹⁶⁰ Q78

¹⁶¹ *A Guide to Foundation Trusts*, Department of Health, December 2002, p 38

¹⁶² *Ibid.*, p38

¹⁶³ ‘Milburn to Underwrite Foundation Hospitals’, *The Times*, 11 November 2002

¹⁶⁴ Ev 129

¹⁶⁵ Q467; Q468

Foundation Trusts in order “to ensure stability”.¹⁶⁶ This needs to be clarified. We support PCTs having a right to determine the duration of contracts.

132. It is not clear how easy it will be in practice for PCTs to move patients away from Foundation Trusts that are not performing well. Also, as General Healthcare, a major provider of private healthcare argued, for the system of patient choice to work, there needs to be genuine contestability amongst providers in PCTs local areas.¹⁶⁷ However, if Foundation Trusts take over failing ‘Franchise Trusts’ in their own local area, this could have the effect of recreating a local monopoly.¹⁶⁸ **We feel that the key to the success of the patient choice reforms is that safeguards are put in place to ensure that Foundation Trusts do not abuse a monopoly position, either by a cumbersome process of legal contracting which curtails PCTs’ flexibility to move patients, or by expanding their services to such an extent that patients have no other viable choice. The Government must take immediate steps to address these points.**

Will patient choice ultimately drag resources away from poorer-performing hospitals?

133. Another well-rehearsed argument is that coupling the introduction of a new ‘elite’ type of hospital, albeit for a transitional period of five years, with reformed financial flows arrangements where cash follows the patients means that, in the words of the BMA, “a system of winners and losers seems inevitable, in which funding flows away from unpopular providers, possibly trapping them in a cycle of decline in which they have a higher proportion of the more complex and ‘unprofitable’ cases but fewer staff”.¹⁶⁹ Potentially, if Foundation Trusts, through their increased access to resources, are able to develop their services in a way that dramatically lowers waiting times or improves quality, GPs and patients will rightly choose to use their services rather than those of poorer-performing local hospitals. As money follows patients, poorer performing hospitals will see their revenue streams dry up and will have even less to invest in improving services, locking them into a downward spiral of poor performance that may ultimately culminate in their closure. Hinchingsbrooke Hospitals NHS Trust, although a 0-star trust flanked by two prospective Foundation Trusts, serves a well defined population in Huntingdon, and did not feel any anxiety about ‘patient poaching’ depleting its services.¹⁷⁰ However, in London, where there is a greater concentration of hospitals and communities are far more mobile, we heard a very different view. Peter Dixon, Chair of University College London Hospitals NHS Trust (UCLH), told us:

We are anticipating that more people will want to use our trust. That is very much an institutional view rather than a system view shall I say. We have one no-star trust which is not a long way away from us. I am aware that they are having difficulties in filling vacancies. They are also having difficulty in meeting their waiting lists; the waiting list is still there, so patients are not yet voting with their feet. I would anticipate that we shall actually be taking patients from that hospital.¹⁷¹

134. Mr Dixon went on to describe how the recent opening of a Diagnostic and Treatment Centre within UCLH had meant “other trusts start getting retentive about their waiting lists, because they can see their income streams getting truncated”.¹⁷²

¹⁶⁶ *A Guide to Foundation Trusts*, Department of Health, December 2002, p 31

¹⁶⁷ Ev 134

¹⁶⁸ Ev 134

¹⁶⁹ Ev 129

¹⁷⁰ Q204

¹⁷¹ Q73

¹⁷² Q132

135. Mr Pattison told us that he felt the possibility of the new system forcing a hospital to close was very remote:

If a hospital were to be branded as a hospital that seemingly was not able to improve its performance and there were consistent, longstanding concerns about its service, if that were allowed to continue, I suppose people might want to think about where they went for treatment. In the well regulated service that we live in, that simply would not be tolerated.¹⁷³

136. However, in evidence to us the Secretary of State took a different view, arguing that the threat of diminishing funding streams and even closure might be no bad thing for failing hospitals:

(Sandra Gidley) If lots of patients do vote with their feet funding streams are not guaranteed and where does that leave the lesser performing hospitals?

(Mr Milburn) Why should I want to stop patients exercising choice? Why on earth should I want to do that?

(Sandra Gidley) I am not saying it is wrong but what is the consequence for the other hospitals? The 1- star and 2-star trusts neighbouring the other trusts who are losing their patients, losing their funding stream, will find it increasingly difficult to turn it round.

(Mr Milburn) It might make them sit up and take notice. It might make them get focused on improving quality. No public service has got a God given right to provide services. It has got to earn that right because either we believe in the language of patient centredness, either we believe that these services should be designed around the interests of patients, either we believe that the people who come first in public services are the people who are on the receiving end of them, or we do not.¹⁷⁴

137. We strongly endorse the drive to put the patient at the heart of the NHS. However, we believe that the introduction of Foundation Trusts, coupled with increased patient choice, has the potential to alter the distribution of hospital services. We therefore urge the Government to overlay these plans with a mechanism to ensure that these potential problems do not materialise. This could include placing a legal duty on the Regulator to safeguard the best interests of the NHS as a whole.

Will staffing freedoms lead to inequities?

138. Although Foundation Trusts will not receive any additional freedoms to those set out in *Agenda for Change*, that in itself provides for significantly enhanced local autonomy. According to *Agenda for Change*, Foundation Trusts will be able to award recruitment and retention premiums above 30% of basic pay, without prior clearance from the Staff Council or Strategic Health Authority, as required of 0-, 1-, and 2-star trusts, and without the requirement to consult other local NHS employers, which is required of 3-star trusts. Foundation Trusts will also be able to offer several other benefits which will not be available in NHS trusts, including team or organisational bonus schemes, additional non-pay benefits, and alternatives in the packages of compensatory benefits such as leave

¹⁷³ Q208

¹⁷⁴ Q456; Q458

and hours. In addition, Foundation Trusts will have greater autonomy to enhance career progression.¹⁷⁵

139. These extra freedoms have prompted claims that Foundation Trusts will have an unfair advantage over other local trusts in terms of staff recruitment, “poaching” the best staff and potentially sparking wage inflation, where other trusts have to match the packages on offer at Foundation Trusts (if they can) just to keep their core staff. However, our witnesses from the NHS were unanimously vehement in their wish to avoid wage inflation, as many had experienced this during the early days of the internal market:

We have all had bad experiences in the past where we set up a wage spiral. Where we have done that in the past, as most of us as trust chief executives did in the heady days of the trust movement, we got trouble at the ranch, because one particular doctor was then in effect valued more highly by me. A whole load of really irritable other doctors were then putting in wages claims or you did attract from another trust and then personal relationships with another trust quite near by were hugely damaged. The whole thing was really awful.¹⁷⁶

140. Mr Jackson argued that “at the moment we have freedom to pay staff what we think is appropriate and it is being used on a very limited basis. My own experience is that trusts have not set out to poach staff from other organisations aggressively by offering higher pay”.¹⁷⁷ According to Mr Jackson, one obvious and simple reason for this was that trusts would not be able to afford it.¹⁷⁸ However, Mr Dixon described his “considerable reservations” over pay freedoms, and his fears of pay spirals in London, arguing that for his trust, costs may not be an issue: “My trust happens to have low reference costs. It has low reference costs because of the way in which the funds flow system appears to work. I think we would have the freedom to up the ante on staff pay... This is the risk area”.¹⁷⁹ Mr Dixon went on to suggest that the legal duty of co-operation between local trusts would be unlikely to prevent such a situation arising once Foundation Trusts had entered the arena:

People want to come and work in my trust, because it is a good place to be. There will undoubtedly be temptations at some point to add money to the other good things. I do not think we should be allowed that freedom, because it is potentially dangerous. In terms of the London issues, I think we should be restricted.¹⁸⁰

141. Although 3-star trusts will be obliged to consult with other local NHS employers before implementing their additional freedoms, and 0-, 1- and 2-star trusts will have to gain formal approval from a central council and their local Strategic Health Authority, Mr Jackson was firmly opposed to the extension of these safeguards to Foundation Trusts: “To have another regulation which says before you agree a minor change for a particular member of staff in particular circumstances you have to get all your colleagues in the community to sign it off, is just overkill frankly.”¹⁸¹

142. Ms Rogers told us that she felt recruitment issues went far deeper than pay:

I do know local trusts who are doing rather better on breast screening and their retention of radiographers because they are paying a bit more, but I do not think that is the whole thing at all. Moira’s trust had a brilliant report in CHI about

¹⁷⁵ *Agenda for Change*, Department of Health, March 2003, p 31

¹⁷⁶ Q88

¹⁷⁷ *Ibid*

¹⁷⁸ *Ibid*

¹⁷⁹ Q86

¹⁸⁰ Q76

¹⁸¹ Q94

morale of staff. I just thought “Wow”. If I were a member of staff, I would wish to go to a trust which had that.¹⁸²

143. However, staff morale is unquestionably affected by star ratings and the further distinction of Foundation status may act as another lure for staff in less well performing hospitals. Douglas Pattison, Chief Executive of the 0-star Hinchingsbrooke Hospitals NHS Trust, told us that although morale had now improved, “plainly when the trust was awarded 0-stars, that was not something that was warmly welcomed by the staff ... I think people were anxious about it. Nobody wants to be labelled as 0-star, do they?”¹⁸³ Mr Jackson described the “very positive effect” a 3-star rating had had on the atmosphere in his trust,¹⁸⁴ and Foundation status is probably likely to be even more attractive to staff: according to Joan Rogers, staff at her trust were immediately in favour of the idea of applying for Foundation status “on the grounds that it gave them status, which they want, in a hospital in the North East, and it gave them a kite mark badge for quality”.¹⁸⁵

144. Our evidence suggests that in local health economies where trusts, PCTs and other health organisations have close and well developed working relationships, the introduction of Foundation Trusts may be less likely to result in wage inflation and aggressive staff poaching. However, in areas where links between local partners function less well, and in areas of high mobility and workforce shortages, for example London, we believe that these problems may emerge.

145. The Secretary of State told us that “there are other safeguards that we have in place within the NHS Foundation Trust policy precisely to ensure that some of these things around aggressive poaching and unfair competition simply cannot happen”.¹⁸⁶ He went on to list the statutory duty of partnership, and *Agenda for Change*. However, it is not clear what measures are proposed within *Agenda for Change* to ensure Foundation Trusts use their additional freedoms responsibly, and Peter Dixon told us he felt the statutory duty of partnership would not be a practical or realistic solution to this: “I believe that will not be sufficient, in the context of London particularly, where recruitment issues are around a lot more than just money.”¹⁸⁷

146. The Secretary of State went on to tell us that “even if what you said was true ... it would be a transitional problem, would it not? It would be a problem for a four or five year period because our ambition, as I say, is to get every hospital to be a foundation hospital”.¹⁸⁸ However, even if Foundation Trusts do not begin to offer different terms and conditions to staff until they come on-stream in April 2004, or even later, the prestige of the new and, for the time being, exclusive Foundation ‘kite mark’ is likely to attract staff from as early as September 2003, when the first wave will be announced. If poorer performing trusts begin to lose staff, they may become locked into a cycle of further worsening performance that in fact prevents them from ever achieving Foundation status, meaning that inequity will become even further entrenched into the system.

147. We understand that in time it is the Government’s intention to ensure a ‘level playing field’ within the NHS, with high performing NHS Foundation Trusts being the norm rather than an elite. However, if these reforms are implemented in their present form, we conclude that, at least in certain areas, stronger safeguards will need to be put in place to ensure that aggressive poaching of scarce staff does not take place. These should include an obligation on Foundation Trusts to consult local NHS

¹⁸² Q90

¹⁸³ Q188

¹⁸⁴ Q66

¹⁸⁵ Q1

¹⁸⁶ Q476

¹⁸⁷ Q76

¹⁸⁸ Q464

employers before altering staff terms and conditions. We recommend that the Government monitors closely the impact of the reforms on standardisation of staff terms and conditions as this was a founding principle of the NHS that encouraged equitable distribution of staff.

Inequitable access to resources – will this compound health inequalities?

148. Moving beyond the potential inequities that might be generated by differences in pay and recruitment, much of our written evidence maintained that allowing Foundation Trusts privileged access to capital and other resources, for example the right to retain operating surpluses, would have the ultimate effect of draining resources away from other parts of the service that need it most. Ken Jarrold initially argued that “a foundation hospital will not have in the main, in terms of its regulated income, sources of income which are different to NHS trusts”, but did agree that retaining operating surpluses would bring extra financial help to Foundation Trusts.¹⁸⁹

149. Mr Jackson argued that the problem of accessing capital was holding back the development of services not only in 3-star trusts, but “right across the board”.¹⁹⁰ While recognising that this was an NHS-wide issue, Mr Jackson was understandably primarily motivated to secure improvements in the services offered by his own trust, going on to tell us “where I am coming from is that I cannot solve the problem for everybody else, but if there is an opportunity for Bradford to be able to move forward on this, without damaging anybody else, then it is an opportunity we would want to grab”.¹⁹¹ However, the NHS Confederation argued that preferential access to capital may in fact have the potential to cause inequities which are damaging to other parts of the NHS:

As long the NHS underspends its capital allowance the differential access to capital enjoyed by Foundations should not present a problem. However, it cannot be assumed that this underspending will continue and in this case there is a danger of rewarding successful organisations whilst depriving those that are struggling and that need capital to solve their problems.¹⁹²

We have not had any indication that the underspend is due to anything other than time lags in spending, so the first part of this argument does not hold.

150. The freedom to dispose of assets could lead not only to inequities between Foundation and non Foundation Trusts, but also between different Foundation Trusts, as some may have access to greater resources than others according to their initial asset base and property values in their local areas. Joan Rogers told us that her trust had “no assets worth discussing which we could sell off so that is not a major feature of any positive kind to us”.¹⁹³

151. A commonly-voiced concern has been that borrowing by Foundation Trusts will be counted against departmental spending limits and that this will restrict the capital resources available to non-Foundation Trusts. We urge the Government to clarify this issue and to provide reassurance that capital schemes based on capital allocations to trusts will proceed on the basis of need, not according to whether or not the trust in question is a Foundation Trust.

¹⁸⁹ Q60

¹⁹⁰ Q97

¹⁹¹ Q97

¹⁹² Ev 133

¹⁹³ Q108

152. There is also the possibility that organisations which hope in the future to become Foundation Trusts might decide to retain assets where it might otherwise have been in the interest of the NHS to dispose of them, in the hope of retaining a larger asset base to sell off when they become Foundation Trusts. This could cause serious problems for the NHS, as the Department of Health Expenditure Plans 2002-03 to 2003-04 indicate that £270 million of (English) NHS capital expenditure in 2003-04 is to be financed by asset sales.¹⁹⁴ If trusts hold on to assets instead of selling them, future capital spend may be delayed as a result of this policy.

153. Mr Jarrold, felt that these issues fundamentally came down to “the balance between equity and incentives ... If you have no incentive, it is very difficult to improve performance. If on the other hand you have no safeguards, you do have a risk of two-tierism”.¹⁹⁵ But although CHAI and the independent regulator together provide a set of regulations to safeguard against, for example, poor quality of care, lack of service provision, asset stripping, and financial mismanagement, the only safeguard that could be construed to apply to resource equity appears to be the Regulator’s power to determine ‘prudential borrowing limits’ for each trust. However, it has not been indicated that this will include an explicit duty on the independent regulator to weigh the needs of Foundation Trusts and the patients they serve against the needs of the rest of the NHS and their patients. The freedom for Foundation Trusts to spend their surpluses and capital funds, without first seeking approval from wider local, regional or national organisations charged with assessing communities’ overall health needs, means that for the first time in the NHS, potentially significant spending will be determined by local organisations.

154. The King’s Fund argued that the policy of Foundation Trusts marked a deliberate shift in Government policy away from one of the basic principles guiding the NHS – equity of access to care, pointing out that the in the list of NHS core principles republished in the latest guidance on Foundation Trusts, the principle of equity of access for equal need does not appear.¹⁹⁶ However, the Secretary of State gave us a clear assurance that equity of access to high quality care remains one of the Government’s guiding principles:

What I have always wanted and what I want ... is to ensure that there is equity in the system, that there are national standards that apply across the piece so that cancer patients in one part of the country can be assured that they are going to get the sort of treatment that cancer patients in another part of the country will get, not according to their ability to pay or on where they happen to live, but according to their right to treatment ... We talk about a National Health Service and of course that is what we want to have with national standards and fairness in the system and appropriate means of inspection ... What I want to see is a level playing field and I am determined that over the course of a four or five year period that is what we will have.¹⁹⁷

155. The Secretary of State put forward to us a strong argument for structuring services to meet the individual needs of local communities:

If you are going to address what the NHS has singularly failed to do for 50 years, which is to narrow the health gap between the poorest communities and the better off communities, then what you have got to move out of is this idea that you can have one-size-fits-all, top down services decided by one person in Whitehall because it will not work.¹⁹⁸

¹⁹⁴ *Supply Estimates 2002-03 to 2003-04*, Department of Health, 2002

¹⁹⁵ Q60

¹⁹⁶ Ev 121

¹⁹⁷ Q401; Q458

¹⁹⁸ Q371

156. However, as pointed out by Fiona Campbell for the Democratic Health Network, the “national character” of the NHS is also “very, very important for tackling the huge health inequalities which exist between different parts of the country and for redistributing health as well as wealth”.¹⁹⁹

157. We received many submissions arguing that the introduction of Foundation Trusts would lead to the creation of a “two-tier health service”. It will create, at least in the short term, legally two different types of trusts, but in terms of NHS services we believe the two tier claims originate from an overly simplistic argument, which fails to recognise that despite the best of efforts, the NHS is a multiple tier service, with significant variation in both access to and quality of care. However it is important to acknowledge that the NHS was established precisely to tackle the severe inequities in service provision and broader health inequalities that existed across the country, and that today that aspiration is, if anything, more rather than less relevant. The Department of Health needs to ensure that in creating Foundation Trusts it does not undermine its determination to reduce inequality in the NHS.

158. The Secretary of State agreed that the argument that non-Foundation Trusts would be disadvantaged against Foundation Trusts would be perfectly valid and reasonable if the overall intention was to limit Foundation status to an elite tier of hospitals. But he was quite clear that this was not going to happen:

It has never ever been my view that this should be a policy that should apply to an elite group of NHS hospitals ... What we want to do is make sure that NHS foundation hospital status is available not just to some hospitals but to all and I do not see any reason why we should not be able to achieve that in a four or five year period. So the problems that many people have identified in the informal discussions I have had with colleagues in a sense become transitional problems.²⁰⁰

159. While we welcome the Government’s aim to ensure ‘a level playing field’ within the NHS, we feel that the Secretary of State may be being too ambitious in assuming that it will be possible to introduce Foundation status to all NHS trusts within four to five years. During the time that star ratings have been in operation, the record shows that the performance of 70% of trusts either remained static or fell. Early implementers of Foundation status will attract more resources, as well as perhaps attracting more and higher calibre staff, which given current shortages in many professions may be at the expense of other worse performing hospitals. The potential for inequity posed by Foundation Trusts therefore needs to be addressed.

160. While this problem could be easily solved by removing the additional financial freedoms on offer to Foundation Trusts, such a measure could seriously limit the Government’s aims for these reforms and would diminish the attractions of seeking Foundation Trust status. An alternative would be to create an immediately level playing field by extending the financial freedoms to all NHS trusts. However, we understand the Government is likely to be reluctant to extend these freedoms to organisations whose performance is not yet top level. We believe there should be established a detailed monitoring system to assess the impact of these reforms on the equity of resource distribution across NHS acute trusts. This monitoring should also involve regular consultation with non-Foundation trusts to identify any problems as they emerge. It could be underpinned by ongoing annual performance assessment of all trusts by CHAI, with particular attention focused on trusts which are failing to improve their performance ratings, to discover whether their problems are related to the introduction of a local Foundation Trust.

¹⁹⁹ Q283

²⁰⁰ Q347

161. In launching these proposals, the Secretary of State declared they would entail a 'lock on assets' in order to protect these assets required for delivering NHS care. The distinction is between regulated and unregulated assets, the former being regarded as essential for delivering NHS care. **Foundation Trusts will be able to do as they wish with unregulated assets. Borrowing against unregulated assets could involve new risks for Foundation Trusts. With responsible management teams, we believe that these arrangements will yield no significant practical difficulties. Further, we assume that the National Audit Office will ensure that best practice is being followed.**

162. The determination of which assets will be regulated in any given Foundation Trust will rest with the independent regulator via the process of issuing the operating license. This appears to imply that the 'lock on assets' actually allows scope for considerable discretion in specifying precisely which services are essential to the provision of health care.

3. CONCLUSIONS

163. We agree with Dr Rutter that “there is a richness and a focus and a clarity which comes with having patients involved in this process at whatever level”,²⁰¹ and we endorse the Government’s efforts to extend patient involvement through the establishment of independent Boards of Governors elected by patients. However, as Mark Sesnan pointed out, the concept of Foundation Trusts is a new and very experimental idea:

In reality, this creature is going to be forced. It is a forced birth, it is not going to be a natural birth, because there is not out there necessarily even an understanding of what we are trying to create here.²⁰²

164. We feel that the policy of Foundation Trusts as presented in the Government’s *Guide* needs changes in several areas if it is to succeed. These include the rationalisation of regulation arrangements, the introduction of clear national standards for the membership and election of Boards of Governors, additional assurances on the access of Foundation Trusts to the NHS’s limited budget, and clarification of the precise powers available to both members of Foundation Trusts and their Boards of Governors. We also think it is vital that PALS and ICAS are maintained within Foundation Trusts, and that Foundation Trusts’ non-executive directors should be affiliated and accountable to the CPPIH. **We also recommend that the Government considers a wider democratic option for trusts, including PCTs, to consider, with or without the freedoms associated with the current Foundation model.**

165. Undoubtedly, as with any new system, more teething problems such as these will emerge as implementation progresses. It is vital that solutions to these problems are put in place promptly so that they do not become more widespread and entrenched, which is why we have recommended that the Government slows down its implementation of these reforms to allow time for evaluation and refinement.

166. As we have heard from the Secretary of State, if Foundation Trust status is not introduced for all NHS organisations, a two tier system may emerge. If it is rolled out across the NHS, it will arguably constitute the most radical recasting of the NHS since its inception. It is important that in any change the principle of a primary care led NHS is retained. This makes it all the more important that the overarching aims and principles of this policy are clear and coherent, and do not contradict or confuse other Government policy initiatives. In oral evidence to us, the Secretary of State also spoke of the need explicitly to codify the differences between Foundation Trusts and non-Foundation Trusts in order to “make it clear both to Foundation Trusts and NHS trusts that remain until they graduate to NHS Foundation Trust status what the rules of the game are”.²⁰³ We strongly support this aim.

167. However, confusion about this policy appears to go beyond the complex mechanics of its implementation, to its interaction with other policy areas. In our view, the Secretary of State was right to question the value of “reductionist” discussions which “pretend that all that is happening are NHS Foundation Trusts or all that is happening is some element of contestability or some element of patients exercising choice. It is not any of these things by themselves which in my view will result in improvements in services, it is how you get all of these levers working in tandem that gets you the improvement”.²⁰⁴ However, we have received much evidence from organisations and individuals confused over the way in which the Government appears to be “pursuing policies that are inconsistent and run counter to one another” and “has made no attempt at producing a coherent vision of how

²⁰¹ Q158

²⁰² Q328

²⁰³ Q482

²⁰⁴ Q454

the various policies it is implementing will fit together once they are all in place”.²⁰⁵ The most fundamental inconsistency lies in this policy’s renewed focus on acute trusts. The Secretary of State told us that he and his Department had not considered piloting Foundation Trusts by geographical area “because in the end the incentive has got to be on the individual organisation to improve”.²⁰⁶ However, he seemed to recognise the paradox at the heart of this problem, acknowledging that “the hospital is not a little island, of course it is not, it has got to work alongside the Primary Care Trusts, it has got to work alongside the community trusts, it has got to work alongside the local authority and, most importantly of all, it has got to engage its staff”.²⁰⁷

168. We have addressed concerns about the possible impact of this policy on patients, both in terms of its potential to skew the balance of resources and power within local health economies, and in terms of its potential to tip the balance against non-Foundation Trusts. For these reasons, we have made a number of recommendations concerned with strengthening local partnership arrangements, and ensuring that non-Foundation Trusts are not disadvantaged either in terms of resources or in terms of staff. While we understand the Government’s aim to use the prospect of Foundation status as a lever to improve the performance of poorer performing trusts, we feel that the proposals as they stand are not entirely fair or consistent, and need to be rethought. Equally, to ensure a genuine ‘level playing field’ across the NHS, the needs of mental health trusts, ambulance trusts and Primary Care Trusts must all be taken into account.

169. The Secretary of State told us in oral evidence that Foundation status would not be introduced for PCTs in the first instance. The justification he gave was that he did not want to put PCTs “through a further period of organisational upheaval” when “they have barely come on line and they need to develop their ability to commission”.²⁰⁸ However, as we have seen, NHS organisations are not isolated units but need to work closely together in order to survive, which means that reforms in one part of the health economy necessarily have a significant impact on other parts. The introduction of PCTs has been as much of an organisational upheaval for the trusts they work with as for the PCTs themselves. Likewise, the introduction of Foundation acute trusts will involve substantial reorganisation and development for the trusts who apply, but will also present huge challenges for the still new PCTs who have to commission services from them.

170. As we have noted there has been some kind of organisational upheaval in some part of the NHS almost every year for the last twenty years,²⁰⁹ and the number of new initiatives the NHS is expected to implement seems to grow daily: in the last 12 months alone, we have seen a substantial proportion of NHS spending power devolved to brand new organisations, the introduction of a far-reaching patient choice initiative, substantial reforms to commissioning, major changes proposed to financial flows, the launch of an NHS-wide employment framework, and the introduction of a new national system for patient and public involvement. We are seriously concerned that the perpetual flux to which the NHS is subject does not permit the climate of stability vitally needed in order to allow clinicians and managers to concentrate on improving care for patients.

171. It is also vital to retain a clear focus on how these proposals will benefit patients. At the close of our first evidence session, Chris Willis, Chief Executive of North Tees PCT, told us that “one of the biggest problems we have in the acute sector is capacity. What you would be trying to do as commissioners is develop high quality capacity in all providers, not just Foundation Trusts, because they would not be able to meet everybody’s

²⁰⁵ Ev 122

²⁰⁶ Q363

²⁰⁷ Q363

²⁰⁸ Q372

²⁰⁹ “Foundation Hospitals – a new direction for NHS reform?” Kieran Walsh, *Journal of the Royal Society of Medicine* 2003; 96, 106-110

needs. It is in our shared interests as commissioners to make sure that all of your local hospitals improve and meet targets”.²¹⁰ However, the Royal College of Nursing expressed concern that “these proposals do not indicate that capacity in the NHS will be expanded by the introduction of Foundation Trusts – surely the problem that most urgently needs addressing in the NHS”.²¹¹ We support the Ministers’ ongoing commitment to equity within the NHS, and have recommended that the Government strengthens mechanisms to tackle the concerns that capacity and equitable distribution is not distorted by proposals for Foundation Trusts. However we also feel that the complex trade-offs between the desire to free up local entrepreneurialism, and the desire to ensure uniformly excellent standards of care, need to be better argued and more fully explored. Achieving the delicate balance between these two aims is central to delivering real improvements to NHS patients over the coming years. We hope that the issues we have raised in this report will inform a wider debate on democracy, accountability and devolution in the NHS.

²¹⁰ Q70

²¹¹ Ev 112

LIST OF RECOMMENDATIONS AND CONCLUSIONS

- 1. The Government should make it clear whether there will be fewer targets for Foundation Trusts. (Paragraph 21)**
- 2. While we believe that the abolition of the Secretary of State's powers of direction over NHS organisations is a gesture underpinned by a genuine intention to remove micro-management, we are concerned that current plans for Foundation Trusts which include direct accountability to four separate types of organisation, in addition to the increased complexities of new contracting arrangements, may in fact leave Foundation Trusts encumbered by more bureaucracy than their predecessors. In line with the general move towards rationalising inspection and regulation in healthcare, we recommend that the proposed Commission for Healthcare Audit and Inspection and the proposed independent regulator act in a complementary way, integrating their work. (Paragraph 23)**
- 3. We believe that the Government's proposals, as they stand, have the potential to get a greater proportion of the increasing NHS funds going to Foundation Trusts, and we believe that limitations on private work are appropriate and necessary to ensure that Foundation Trusts' primary function remains the delivery of healthcare to NHS patients. (Paragraph 26)**
- 4. Much of the oral evidence we heard showed strong support for the principles behind plans for Foundation Trusts to secure local ownership and involvement, but also elements of scepticism and genuine bewilderment at the array of different problems, both philosophical and practical, facing those charged with implementing them. We agree with the Secretary of State that "either this is for real or it is not" and feel that it is absolutely crucial that these proposals are able to deliver the genuine improvements in patient involvement that they promise, rather than raising expectations they are not able to meet. (Paragraph 30)**
- 5. We believe that the time is long overdue to address the democratic deficit in the NHS. However, the proposed system has no minimum standards for involvement and no coherent guidelines for how constituencies will be drawn up to ensure that patients and the public throughout the country have an equal opportunity for involvement. Instead, the Government has left the determination of what is a radical alteration to democratic accountability in the NHS to the unelected leaders of individual NHS organisations, which could lead to a system of patient and public involvement that is fragmented, confusing and inequitable. Although different constructions will clearly need to apply to different types of organisation, it is imperative that the Government safeguards democracy throughout the NHS by providing a national set of guidelines specifying the rules for defining membership constituencies and the process for managing elections so that NHS patients, and the public at large, can have full confidence in transparent and consistent standards of involvement. (Paragraph 37)**
- 6. In order to maximise the breadth and range of membership, we believe that Foundation Trusts must proactively attempt to extend registration so as to achieve real and representative community engagement. This, including the involvement of disadvantaged groups, should be an issue both in assessing applications for Foundation Trusts and an on-going responsibility for the attention of the Commission for Patient and Public Involvement in Health, or, failing that, the independent regulator. (Paragraph 42)**
- 7. If it is the case that members of a Foundation Trust will have the right to veto Trust proposals through a referendum, then this will invest patients and the public**

with significant power over the way their local services are run. However, nothing we have seen in the *Guide to Foundation Trusts* or in our other evidence suggests that this is the case, and we would welcome clarification on this point from the Department. (Paragraph 44)

8. The Department has not answered the important question of how disputes will be resolved when a Board of Governors refuses to approve strategic plans related to meeting national priorities. This question was flagged by several chief executives as being crucial to how successful this policy could be. In response to a question about whether Boards of Governors would be able to veto decisions taken by the Management Board, the Department was limited to saying that if the Board of Governors wanted to do this they would need to sack the Chair or non-executive directors subject to approval by a 75% majority of the Board of Governors. This does not necessarily mean the decision will be vetoed. We call on the Department to clarify this situation and to indicate how it expects decisions to be overturned. (Paragraph 49)

9. We believe that the Government must put in place a national training system to ensure that Governors of Foundations Trusts have the necessary skills and information to hold the management boards of Foundation Trusts fully to account. This programme should be led by the Commission for Patient and Public Involvement in Health. (Paragraph 54)

10. The Government must also give very careful consideration to the difficult questions which are already emerging about how disputes will be managed where the interests of representative constituencies including patients, staff and academics differ, and even more problematically, where the will of the Board of Governors steers a trust away from national priorities, or from a PCT's assessment of the needs of the local health economy as a whole. Not enough is known yet about formal voting and vetoing rights, and nascent Foundation Trusts cannot be expected to wrestle successfully with these enormously difficult issues on their own. Instead, these principles must be firmly established on a national basis if Boards of Governors are to wield genuine power in the NHS, rather than simply functioning as a focus groups, advisory panels or talking shops. (Paragraph 55)

11. One way of minimising the bureaucracy and allowing another model for trusts to choose from would be to allow elections to take place based on the electoral roll (not necessarily on existing council boundaries). The Government should consider this as an alternative model which some trusts might want to adopt. (Paragraph 57)

12. As well as striving to improve democracy at a local level, as these proposals do, we feel it is important that democratic accountability is maintained at a national level. The appointment of an independent regulator must not be allowed to reduce the ability of members of the public to obtain information that they otherwise would have sought from Ministers through their Member of Parliament. (Paragraph 64)

13. In oral evidence to us, the Secretary of State indicated that Patient and Public Involvement Forums (PPIFs) in NHS trusts would be temporary measures, which would ultimately be replaced by the new system of a partly elected Board of Governors. One of the key functions of PPIFs is their right to appoint a non-executive Director to the Trust Board, something the Commission for Patient and Public Involvement in Health (CPPIH) argued might allow patients and the public more direct involvement in a Trust's governance than only being able to elect representatives to a Board of Governors. However we feel that this function of PPIFs will be covered by the provision for Foundation Trusts' Boards of Governors to elect non-executive directors (NEDs) to their Management Boards. (Paragraph 67)

14. Major concerns remain about the differences between arrangements for patient and public involvement in Foundation Trusts and in other NHS trusts. For example, PPIFs are entirely independent of the trust whose population they serve, and account directly to the Commission for Patient and Public Involvement. On the other hand NEDs on a Foundation Trust Management Board would be accountable to the Trust's Board of Governors and the CPPIH would be excluded. We recommend that, in the absence of its own Patient and Public Involvement Forum, a Foundation Trust's patient non-executive directors should have access to support and training from the CPPIH. Such NEDs should be a part of the CPPIH in the same way as NEDs appointed to Foundation Trust Management Boards as representatives from commissioning PCT Patients Forums. (Paragraph 68)

15. There are no explicit provisions either in the *Guide to Foundation Trusts* or in the Health and Social Care (Community Health and Standards) Bill to ensure that Foundation Trusts have Patient Advocacy and Liaison Services (PALS) to support patients in negotiating hospitals systems, or that they will have access to an Independent Complaints Advocacy Service. Neither is it clear that they will be subject to the same complaints procedure as the rest of the NHS. The proposal of entirely new arrangements for patient and public involvement for Foundation Trusts does not appear to be well integrated with systems currently being implemented in the rest of the NHS. We feel it is very important that Foundation Trusts are able to benefit from the developing expertise of the CPPIH, and to contribute to the work that the CPPIH is undertaking to improve patient and public involvement in the NHS at a national, strategic level. (Paragraph 69)

16. Plans for Foundation Trusts involve far-reaching reforms in three areas. At a central level, they propose the introduction of a new regulatory regime and the establishment of a new regulatory body which will eventually replace the Secretary of State's direct control over NHS organisations. The new regulatory regime will also require Foundation Trusts to develop new skills in order to interact with it successfully. Also at a local level, Foundation Trusts will face the challenge of designing and administering large community and staff elections, and, once elections are finished, ensuring that new Boards of Governors are able to contribute effectively to the governance of the trust, whilst protecting the smooth running of the trust during the transition period. At the same time as this Foundation Trusts will also be learning how best to use their new financial freedoms. The problems we have identified with the proposals as they stand attest to the difficulty of formulating three such complex reforms simultaneously, and we therefore feel it is very important that if these reforms are implemented Foundation Trusts are given dedicated support in introducing each element, and that each element is individually addressed. (Paragraph 72)

17. We feel that there is much that needs to be clarified surrounding the Government's proposed requirement that prospective Foundation Trusts must demonstrate the support of local communities as part of their application for Foundation status. If trusts have to undertake lengthy consultation with local communities, which might include public meetings, roadshows, surveys and votes, this could have high administrative costs and could potentially be open to manipulation rather than contributing constructively to debate on how best to deliver healthcare for that locality. However, there is also the risk that if these proposals are implemented only in a tokenistic way, consultation could continue to be the "charade" described by one of our witnesses. Although applications for Foundation status will be assessed on whether their plans are supported locally, it is not clear how such support will be measured, and whether information about this will be made public. If consultation on Foundation status is to withstand accusations of tokenism, it will need to include stakeholders from early on in the process, even before an expression of interest in Foundation status is expressed. It should also include neighbouring

health organisations and service users as well as those served by the prospective Foundation trust, and it is important to recognise that the local community of any particular hospital cannot necessarily be defined along boundaries of existing PCT catchment areas or local authorities, or else significant parts of the population may be excluded. These issues must be addressed and resolved by the Government if local ownership is to succeed. (Paragraph 80)

18. The Secretary of State was clear in his evidence that he expected Foundation status to be extended to all trusts within four to five years. His evidence also suggested that rather than lowering the hurdle and allowing 1- and 2-star trusts to become Foundation Trusts, this would be done through raising the performance of all trusts up to 3-star level, therefore enabling them to apply. As the current star rating system has a relative component, it is not clear whether all trusts will be able to achieve 3-star status or not, as their performance will be measured relative to the performance of the rest of the NHS. When we asked the Department for further information, they told us that the relative element of the current system might be reviewed in future, but did not provide a full explanation of how the system would work if the relative element remained in place. We feel that there is some confusion about this area of the policy, and urge the Government to provide clarification on this point. (Paragraph 84)

19. The Secretary of State was quite clear to us that Foundation Trusts would continue to be subject to the star rating system in exactly the same way as any other NHS organisation, as he told us it would be “difficult and probably invidious” to set up “two parallel sets of assessment”. However, the Secretary of State also told us that “the structure of the performance rating system will need to take account of the mixed economy of both NHS Foundation and non-Foundation trusts for a number of years”. We find these two statements confusing and contradictory, and endorse the requirement for Foundation Trusts to continue to be subject to the same performance ratings system as the rest of the NHS. (Paragraph 92)

20. While we agree with the Secretary of State that performance varies considerably across the NHS, and support his attempts to improve performance, we feel that the question of how good the star ratings system is, whether, in his words, it is “right, wrong or indifferent”, is crucially important. NHS patients as well as NHS staff have the right to expect a performance measurement system that is as sophisticated and reliable as possible, and focuses on issues that matter to patients, most importantly the quality of clinical care. This importance is only reinforced by the fact that star ratings are to be used as a gateway to increased freedoms and privileges. (Paragraph 97)

21. We believe it is important for the Government to ensure performance ratings are as accurate and sophisticated as possible. We [also] feel that the contradictions in using the star ratings system as a ‘one-way’ gateway to Foundation status need to be addressed and resolved. (Paragraph 98).

22. A key argument in favour of the policy of Foundation Trusts is that it presents a genuine incentive for trusts to improve their performance. However, we are not clear that once Foundation status is achieved there are adequate incentives in place to ensure that trusts improve or even maintain high levels of performance. This shortcoming must be addressed as it has very serious consequences for performance and standards in the NHS, both in the short and the long term. (Paragraph 100)

23. We note the Government’s commitment to piloting this policy with a selected group of trusts rather than opting for large-scale ‘big bang’ implementation. We recommend that consideration is given to establishing an additional pilot allowing all trusts in a particular area to become Foundation Trusts, as this would help to

evaluate how the system would operate in the long term. We do not think that the proposed very tight schedule of annual waves of reform allows sufficient opportunity for the advantages or disadvantages of Foundation status to be evaluated, or for lessons to be learnt, good practice disseminated, and the policy refined for further waves. In particular, we feel that in the early years of this policy, the success of public involvement measures, and the impact on wider health economies will merit very close scrutiny. We recommend that the Government should commission an independent evaluation specifically aimed at assessing the impact on wider health economies and on public involvement, and geared towards helping refine the policies for 'second wave' Foundation Trusts, before announcing the second wave of trusts. (Paragraph 106)

24. We are strongly supportive of recent efforts made to promote the development of primary and community based care, and of whole systems models of care. It is imperative that the introduction of Foundation Trusts does not undermine the good work that has been done, or reverse this trend by re-focusing efforts on acute service provision. In particular, patients rather than buildings should remain at the centre of healthcare, and the needs of people suffering from chronic illness, including mental illness, many of whom receive the majority of their care in community settings, should not be marginalised in favour of those in need of elective care in acute hospitals. We were impressed by the evidence of good partnership working we received from our witnesses from Teeside and East Anglia, but we are not convinced that such good practice exists across the board. The policy of Foundation Trusts does not necessarily mean that partnership between acute and community settings will be damaged, but we believe it does introduce the need for stronger safeguards to ensure continued co-operation between PCTs, Local Authorities, and other NHS organisations across the board, and a continuing emphasis on whole systems working. (Paragraph 119)

25. The Secretary of State informed us that he is keen to learn from the experience of establishing Foundation Trusts in the acute sector, and to examine how the model could be adapted for other NHS organisations, and he has stated that he will soon be writing to mental health trusts to advise them of future developments. The extension of Foundation Trust status to mental health trusts could counter-balance the acute hospital emphasis of the first wave of Foundation Trusts. If the policy of Foundation Trusts is to be pursued, we urge the Government to address the extension of Foundation trust status to mental health trusts as a matter of priority. (Paragraph 121)

26. We welcome the Government's aim of shifting power from the secondary to the primary sector, and it is vital that these proposals do not reverse this trend. During this inquiry we have heard much support for extending these reforms to PCTs, and also suggestions that PCTs would be a more natural starting place for these reforms than acute trusts. As PCTs are commissioning organisations, the concept of Foundation PCTs raises a different set of issues and concerns. However, if proposals for Foundation Trusts go ahead it will be necessary to explore these issues as a matter of priority to ensure that the balance of power between primary and secondary care is maintained. (Paragraph 123)

27. We recommend that in assessing applications for Foundation status, the Secretary of State should make specific provision to assess the readiness of local PCTs who will be commissioning services from prospective Foundation Trusts to meet this new challenge at such an early stage in their organisational development. (Paragraph 126)

28. We have not studied the financial flow arrangements in depth in this inquiry, but we have heard several concerns relating to commissioning arrangements between

PCTs and Foundation Trusts. If these proposals go ahead, these concerns must be addressed by Government. (Paragraph 130)

29. In evidence to us the Secretary of State strongly refuted suggestions of guaranteed incomes, saying that it would be up to PCTs how long their contracts were for, although the *Guide* anticipates that PCTs will enter into at least three year service level agreements with Foundation Trusts in order “to ensure stability”. This needs to be clarified. We support PCTs having a right to determine the duration of contracts. (Paragraph 131)

30. We feel that the key to the success of the patient choice reforms is that safeguards are put in place to ensure that Foundation Trusts do not abuse a monopoly position, either by a cumbersome process of legal contracting which curtails PCTs’ flexibility to move patients, or by expanding their services to such an extent that patients have no other viable choice. The Government must take immediate steps to address these points. (Paragraph 132)

31. We strongly endorse the drive to put the patient at the heart of the NHS. However, we believe that the introduction of Foundation Trusts, coupled with increased patient choice, has the potential to alter the distribution of hospital services. We therefore urge the Government to overlay these plans with a mechanism to ensure that these potential problems do not materialise. This could include placing a legal duty on the Regulator to safeguard the best interests of the NHS as a whole. (Paragraph 137)

32. Our evidence suggests that in local health economies where trusts, PCTs and other health organisations have close and well developed working relationships, the introduction of Foundation Trusts may be less likely to result in wage inflation and aggressive staff poaching. However, in areas where links between local partners function less well, and in areas of high mobility and workforce shortages, for example London, we believe that these problems may emerge. (Paragraph 144)

33. We understand that in time it is the Government’s intention to ensure a ‘level playing field’ within the NHS, with high performing NHS Foundation Trusts being the norm rather than an elite. However, if these reforms are implemented in their present form, we conclude that, at least in certain areas, stronger safeguards will need to be put in place to ensure that aggressive poaching of scarce staff does not take place. These should include an obligation on Foundation Trusts to consult local NHS employers before altering staff terms and conditions. We recommend that the Government monitors closely the impact of the reforms on standardisation of staff terms and conditions as this was a founding principle of the NHS that encouraged equitable distribution of staff. (Paragraph 147)

34. A commonly-voiced concern has been that borrowing by Foundation Trusts will be counted against departmental spending limits and that this will restrict the capital resources available to non-Foundation Trusts. We urge the Government to clarify this issue and to provide reassurance that capital schemes based on capital allocations to trusts will proceed on the basis of need, not according to whether or not the trust in question is a Foundation Trust. (Paragraph 151)

35. We received many submissions arguing that the introduction of Foundation Trusts would lead to the creation of a “two-tier health service”. It will create, at least in the short term, legally two different types of trusts, but in terms of NHS services we believe the two tier claims originate from an overly simplistic argument, which fails to recognise that despite the best of efforts, the NHS is a multiple tier service, with significant variation in both access to and quality of care. However it is important to acknowledge that the NHS was established precisely to tackle the severe

inequities in service provision and broader health inequalities that existed across the country, and that today that aspiration is, if anything, more rather than less relevant. The Department of Health needs to ensure that in creating Foundation Trusts it does not undermine its determination to reduce inequality in the NHS. (Paragraph 157)

36. While we welcome the Government's aim to ensure 'a level playing field' within the NHS, we feel that the Secretary of State may be being too ambitious in assuming that it will be possible to introduce Foundation status to all NHS trusts within four to five years. During the time that star ratings have been in operation, the record shows that the performance of 70% of trusts either remained static or fell. Early implementers of Foundation status will attract more resources, as well as perhaps attracting more and higher calibre staff, which given current shortages in many professions may be at the expense of other worse performing hospitals. The potential for inequity posed by Foundation Trusts therefore needs to be addressed. (Paragraph 159)

37. While this problem could be easily solved by removing the additional financial freedoms on offer to Foundation Trusts, such a measure could seriously limit the Government's aims for these reforms and would diminish the attractions of seeking Foundation Trust status. An alternative would be to create an immediately level playing field by extending the financial freedoms to all NHS trusts. However, we understand the Government is likely to be reluctant to extend these freedoms to organisations whose performance is not yet top level. We believe there should be established a detailed monitoring system to assess the impact of these reforms on the equity of resource distribution across NHS acute trusts. This monitoring should also involve regular consultation with non-Foundation trusts to identify any problems as they emerge. It could be underpinned by ongoing annual performance assessment of all trusts by CHAI, with particular attention focused on trusts which are failing to improve their performance ratings, to discover whether their problems are related to the introduction of a local Foundation Trust. (Paragraph 160)

38. Foundation Trusts will be able to do as they wish with unregulated assets. Borrowing against unregulated assets could involve new risks for Foundation Trusts. With responsible management teams, we believe that these arrangements will yield no significant practical difficulties. Further, we assume that the National Audit Office will ensure that best practice is being followed. (Paragraph 161)

39. We recommend that the Government considers a wider democratic option for trusts, including PCTs, to consider, with or without the freedoms associated with the current Foundation model. (Paragraph 164)

ANNEX - Background to Foundation Trusts

Earned autonomy

1. While the new governance arrangements for Foundation Trusts represent a departure from the system that applies to the rest of the NHS, reforms stemming from the *NHS Plan*'s promise of a system of 'earned autonomy' mean that there is already a continuum of freedom and flexibility in the NHS acute hospitals, with four distinct levels linked directly to organisations' performance in the star ratings system. These freedoms are set out in full in *Raising Standards Across the NHS – a Programme of Rewards and Support for all trusts*, and are supplemented by *Agenda for Change*, the recently published NHS-wide human resources framework.

3-star trusts

2. 3-star trusts currently receive:

- i. More resources, including automatic access in 2002-03 to up to £1m additional capital, depending on the size of the trust; higher delegated limits for approval of capital investments; freedom to retain more of the proceeds of local land sales; and access to additional Local Capital Modernisation Funds;
- ii. More autonomy - reduced central reporting requirements, fewer inspections and greater freedom to set up "spin-off" companies;
- iii. More influence – 3-star trusts are used as pilot sites for new initiatives, their chief executives contribute to developing the policy on earned autonomy and their staff support modernisation work (for which the trust can apply to be reimbursed);
- iv. More opportunities – 3-star trusts can apply for NHS Foundation Trust status and automatically go on the NHS Franchising Register of Expertise, giving them the opportunity to bid for franchises of failing trusts.

2-star trusts

3. 2-star NHS trusts are viewed by the Department as "organisations which are already performing well overall across the range of indicators, but which need to improve in particular areas". They are subject to the normal reporting arrangements, but do have access to some of the "earned autonomy" freedoms, namely higher delegated limits for approval of capital investments and the freedom to retain more of the proceeds of local land sales and additional freedom when establishing "spin out" companies. Proposals are also being drawn up to lighten the inspection burden on 2- as well as 3-star trusts.

1-star trusts

4. 1-star NHS trusts are organisations which are "giving some cause for concern against particular key targets". This means there will be much closer oversight by the relevant Strategic Health Authority (SHA). The trust will be supported by the SHA in developing plans to improve the trust's position, and on occasion key personnel will be seconded in, for example at chief executive level, to drive forward improvements. All 1-star acute trusts will be expected to participate in Modernisation Agency's Hospital Improvement Partnership programme (HIP), which is aimed at achieving better care without delay along whole hospital pathways, and contributing substantially to reductions in waiting times. The Department of Health estimates that this expert support from the Modernisation Agency will be worth the equivalent of £200,000 per trust, and further financial help will also be available where needed.

0-star trusts

5. 0-star NHS trusts, as “organisations showing the poorest levels of performance against key targets”, are required to produce Performance Improvement Plans within three months of their 0-star rating, to demonstrate how they intend to turn the organisation around. The most hard-pressed health communities, including where appropriate 0-star trusts, are able to access support from the NHS Bank, a centrally-managed £100 million Special Assistance Fund, to facilitate service improvements. 0-star trusts also receive a targeted programme delivered by two teams in the Modernisation Agency, the Performance Improvement Team (where a trust has failed key access targets) and the Clinical Governance Team (where the cause of the 0-star rating is an adverse review by the Commission for Health Improvement (CHI)).

6. The last resort for failing 0-star trusts, where the SHA considers that there is insufficient capacity within the trust to deliver the necessary improvements, is to franchise the management. The Department has now published an official ‘franchisers’ register, to which all 3-star trusts are automatically added, but which also includes appropriately qualified private companies. If a trust comes up for franchising, any organisation on this register may apply to take it over.

Further freedoms for Foundation Trusts

7. The *Guide* states that

An NHS Foundation Trust, as an organisation with a proven track record of success in delivery of care for NHS patients, and in management and financial prudence, will have increased financial freedoms in three key areas:

- to retain proceeds from asset disposal
- to retain any operating surpluses
- to access capital from public and/or private sector sources based on financial performance and not on the basis of national or local capital rationing by the Department of Health or SHAs.

Like other NHS Trusts, Foundation Trusts will also continue to have access to capital through the Private Finance Initiative.²¹²

8. Foundation Trusts will not be able to dispose of certain ‘regulated assets’ which are deemed necessary for clinical care. An example of an ‘unregulated asset’ frequently given by the Department is a hospital car park, but it is not yet clear exactly where the line will be drawn between regulated and unregulated assets.

Staffing freedoms and Agenda for Change

9. Following the establishment of the internal market in the early 1990s, trusts were able to set their own terms and conditions for staff. Although different professional groups have their terms, conditions and grading structures negotiated nationally, trusts have considerable flexibility about the gradings they give to posts, or for example about one-off recruitment bonuses they can offer to staff.

²¹² *A Guide to Foundation Trusts*, Department of Health, December 2002, p12

10. These difficulties have led to the publication of *Agenda for Change*, which sets out a national pay framework for the whole of the NHS. The reforms bring all NHS staff, with the exception of doctors, dentists and very senior managers into an integrated payscale. If accepted, this will mean that in future, for most employees, basic pay will be determined according to job weight. Job weight will be determined using a standardised NHS job evaluation scheme, which will measure 16 factors covering knowledge and skills, responsibilities, and the physical, mental or emotional effort required. Evaluations of common NHS jobs are currently being finalised on a national basis. Staff will progress up the relevant pay spine at an incremental rate, and the system includes provision for an initial 10% uplift over three years for all staff. Staff will also be subject to standardised arrangements for working hours, overtime, on-call and annual leave payment. Another aim of the framework is to harmonise the current disparate system of allowances available for staff working in high-cost areas. The *Agenda for Change* framework represents an attempt to standardise job roles and pay between NHS organisations as well as within them. However, over and above normal pay arrangements, different types of trusts will have different levels of freedom in relation to certain aspects of the settlement.

11. 0-, 1- and 2-star trusts will be able to offer recruitment and retention premiums to staff coming to posts which are difficult to recruit to, but these will be limited to no more than 30% of basic pay, and will be subject to explicit formal agreement by the NHS Staff Council and, where appropriate, the local Strategic Health Authority.

12. 3-star trusts will be able to offer recruitment and retention premiums at levels above 30% of basic pay without formal agreement from the NHS Staff Council or the Strategic Health authority but will be required to consult with local or neighbouring employers before final decisions are taken on the use of these freedoms

13. Foundation Trusts will be able to award Recruitment and Retention Premia above 30% of basic pay, without prior clearance for the Staff Council or Strategic Health Authority, and without the requirement to consult with local or neighbouring employers. Foundation Trusts will also be able to offer individual, team or organisational performance reward schemes, which must be related to “genuinely measurable” targets. Foundation Trusts will also have further flexibility to offer alternatives in the packages of compensatory benefits available as long as they are of an equivalent value to those in the *Agenda for Change* framework (for example greater leave entitlements but longer hours). They will be able to establish schemes offering additional non-pay benefits above the minimum specified in *Agenda for Change* and will be able to offer accelerated development and progression schemes, giving them greater autonomy to enhance career progression.

Current governance arrangements in the NHS

14. Currently, NHS trusts are subject to the direction of the Secretary of State, which means that although in practice they may be permitted greater or lesser degrees of freedom, the Government retains ultimate control over organisations, and is able to issue directives concerning the conduct of any of their functions. The Government has drawn attention to its efforts to curtail the relentless flow of central directives from Department of Health officials to the chief executives of NHS organisations. However, fewer central directives do not necessarily correlate directly to increased freedom and flexibility, as performance management and control over a trust's activities is now filtered through two more local layers of performance management and control. Firstly, PCTs, as budget holders, hold NHS trusts to account for the delivery of the services they have commissioned. PCTs have their own performance managed by Strategic Health Authorities through Local Delivery Plans, which must include key targets set by the centre, including, for example waiting times and performance in key clinical areas such as cancer and coronary heart disease. Secondly, overarching Strategic Health Authorities have a responsibility for keeping a

strategic overview of all the PCTs and NHS trusts in their area, and will step in if problems arise.

15. As well as the performance management that is conducted between NHS organisations, NHS trusts also now have their performance assessed publicly, in the annual star ratings compiled and published by the Department. The star ratings system is discussed more fully below. There is also now another aspect of performance management, ostensibly separate from government, but still issuing central targets. The Commission for Health Improvement is a Non-Departmental Public Body which carries out large-scale reviews of clinical governance in each trust once in every four-year period. Subject to legislation, the Commission for Health Improvement will be replaced by the Commission for Healthcare Audit and Inspection (CHAI), which will also take over the National Care Standards Commission's responsibilities for licensing private healthcare providers. CHAI's new inspection regime will consist of annual assessment of each NHS organisation's performance against targets and standards set by the Secretary of State, and publication of performance ratings.

New governance arrangements for Foundation Trusts

16. The *Guide* pledged that “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”. It is not yet clear what this will mean in practice, but the Secretary of State told the Committee it was his intention to ‘codify’ exactly what freedoms there would be.

17. Foundation Trusts will be accountable to the local communities they serve via an elected Board of Governors, and PCTs will also hold them to account for efficient service delivery through the contracting process. Both of these aspects of governance are discussed more fully below. In addition to this Foundation Trusts will be subject to a number of other central controls. Firstly, CHAI will conduct annual reviews of performance against central targets and standards, culminating in a star ratings. In addition to this, there will be an independent regulator which will issue and review Foundation Trusts’ licences, which will specify the clinical services it must provide to the local community, its duty of partnership with other NHS and social care bodies, the circumstances in which it can make changes in the services it provides for NHS patients, and the financial duties under which it will operate, including reference to the prudential borrowing regime and restrictions on the disposal of assets used in the provision of NHS clinical services.

18. The independent regulator will also agree the prudential borrowing limit for each Foundation Trust, decide on changes to regulated services, consent to the disposal of regulated assets and ensure that the proceeds from such disposals will be used in the public interest. The independent regulator will be able to intervene when there is suspicion that a Foundation Trust may be in breach of its license. Triggers for intervention could include information from the Board of Governors, an adverse CHAI inspection report, or financial information provided by the Trust. There is a range of ‘step in’ powers that the independent regulator could exercise including the imposition of extra inspections, warning letters, removal of some or all of the Management Board, and ordering new elections to the Board of Governors. In the worst cases they could recommend that the assets of the Trust are transferred to another NHS body.

Star Ratings

19. The Government’s star ratings system, according to which each NHS trust is given a rating from zero to three, will serve as a gateway to Foundation status, with all 3-star

trusts being eligible to apply. The Government began publishing NHS Performance Ratings in September 2001. In the first year this only covered those trusts providing acute hospital services, but in July 2002, the system was extended to include other types of NHS organisations, including mental health trusts and ambulance trusts, although PCTs and Strategic Health Authorities were still deemed too new to be given meaningful ratings.

20. Trusts are awarded a star rating of between zero and three stars based on their Commission for Health Improvement (CHI) report and performance against nine key targets and 28 Performance Indicators (PIs) in the previous year. The current nine key targets are:

- 18-month inpatient waits
- 15-month inpatient waits
- 26-week outpatient waits
- 12-hour trolley waits
- Cancelled operations
- Two-week cancer waits
- Improving working lives
- Hospital cleanliness
- Financial management.

21. The three different factors which determine information sources which feed into the ratings system do not command equal weight. A poor rating on the key targets will assign it to one or zero stars, regardless of how well it does on the remaining 28 Performance Indicators, which cover “Clinical Focus”, “Patient Focus” and “Capacity & Capability”. The PI assessment is done on a ‘balanced scorecard’ approach, where each trust receives a rating between 1 (significantly below average) and 5 (significantly above average) for each indicator. An individual trust's performance is then compared to all other trusts for each of three focus areas. This is used to allocate one- and two- star ratings for trusts with a few failings in their key targets and two- and three- stars for those that achieved all or nearly all the key targets.

22. 3-star status is not a guarantee of very high performance in every aspect of the performance assessment process. Although CHI reviews form part of the star-rating performance, these are only included when a trust has had a CHI review in the past year. 12 of the 32 3-star trusts applying for Foundation status (38%) did not have a CHI review taken account of in the most recent round of star-ratings. Equally, a trust can underachieve on one of the key targets (including financial management) and still achieve three stars. If a trust that does very well in its key targets and if it has a current CHI review showing significant strengths and no weaknesses, then it will be awarded three stars regardless of its performance on the other 28 PIs. Many 2-star trusts do significantly better on the 28 performance indicators than the worst performing 3-star trusts.

Reforms to financial flows and commissioning arrangements

23. *Shifting the Balance of Power*, published in April 2001, set the scene for large-scale structural reform of the NHS, which was implemented through the NHS Reform and Healthcare Professionals Act 2002. PCTs are now taking over commissioning responsibilities from recently abolished Health Authorities, and Department of Health Regional Offices have been replaced by Strategic Health Authorities. PCTs have now received their first 3-year funding allocations, calculated on the basis of a new resource allocation formula. By 2004, PCTs are set to control 75% of the total NHS budget, a figure which is set to increase further by 2008.

Reforming NHS Financial Flows

24. *Delivering the NHS Plan* promised the establishment of a new system of ‘payment by results’ as an incentive for hospitals to improve their performance, and in October 2002, the Department of Health issued *Reforming NHS Financial Flows: introducing payment by results*, setting out plans for changes in the way that healthcare providers will be in paid in the NHS. These plans include reforms to the way in which Primary Care Trusts contract with NHS hospitals, and reforms to the pricing system.

25. Starting in 2003-04, a fixed level of services will be contracted with in each trust in order to meet waiting list targets. However, over and above this, hospitals will be paid on a case by case basis. Historically, NHS commissioners have relied on ‘block contracting’ to purchase care for NHS patients, where funding is fixed regardless of activity, and need is projected on the basis of historical precedents. Theoretically this means that there is little flexibility or incentive for hospitals to improve efficiency and outperform on their contracts, as funding limits have already been set. *Reforming NHS Financial Flows* specifies that in future Service Level Agreements (SLAs) must include ‘explicit links between funding and the volume of services provided’. SLAs will need be agreed at a specialty level, starting with six specialties (ophthalmology, cardiothoracic surgery, ear nose and throat surgery, trauma and orthopaedics, general surgery, and urology). According to the Department, the new system will guarantee that “hospitals generally only receive funding for the activity they actually deliver”. Hospitals who perform fewer procedures than they have agreed to over a set timeframe could have their funding reduced in-year.

26. Currently, the rate at which hospitals are paid for the services they provide for their patients is calculated using a system of ‘NHS Reference Costs’. These costs are supposed to provide a genuine reflection of how much a particular procedure or intervention costs to perform, but are weighted to take account of local cost variations, for example in the prices charged by suppliers, or in staff wages. However, *Reforming NHS Financial Flows* promises a new system based on a single national tariff. Prices will be determined through a system of ‘Healthcare Resource Groups’ (HRGs) which will exist within different surgical and medical specialities, covering individual procedures. HRGs within the initial six specialties (for example cataract extraction) will have a national tariff price set, and HRGs will enable commissioners to adjust contracts to reflect the precise casemix. Because there will eventually be a comprehensive range of national tariffs, trusts will not be able to compete with each other on the basis of price, but Foundation Trusts will be able to keep any surplus they generate from treating patients at a cost lower than the national tariff.

27. These reforms will be phased in gradually over the next three years. By 2005-06, the Department expects ‘most Trust activity to be commissioned on the basis of cost-and-volume agreements’ and for 30-45 HRGs to be commissioned on the basis of output targets and funded at the national tariff. Foundation Trusts and the PCTs who commission services from them will be expected to implement these changes at an accelerated rate.

Introducing patient choice

28. As well as improving efficiency, the Government hopes that allowing PCTs the freedom to contract with providers more flexibly will enable improved patient choice, including greater choice of hospital, with “cash following the patient”. The concept of patient choice will be reinforced by ‘patient prospectuses’, which will be published by PCTs to give comparative information on local health providers. This policy is already being taken forward, and a pilot scheme has been running since last year, whereby

patients in London who have waited over six months for a heart operation are able to choose to be treated by a different provider, either within the NHS, privately in the UK, or abroad. This scheme is currently being extended to cover patients in London waiting more than six months for any types of elective surgery by this summer, and rolled out throughout England by summer 2004. Choice will also begin to be offered routinely to all patients regardless of how long they have been waiting: *Reforming NHS Financial Flows* states that 'patients needing elective surgery will be offered choice of provider at the point of referral by 2005'.

PROCEEDINGS OF THE COMMITTEE RELATING TO THE REPORT

TUESDAY 29 April 2003

Members present:

Mr David Hinchliffe, in the Chair

Mr John Austin
Andy Burnham
Julia Drown
Sandra Gidley

Jim Dowd
Siobhain McDonagh
Dr Doug Naysmith
Dr Richard Taylor

The Committee deliberated.

Draft Report (*Foundation Trusts*), proposed by the Chairman, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 25 read and agreed to.

Paragraph 26 read, as follows:

“The Government’s proposals to limit the proportion of Foundation Trusts’ private patient income to 2003-04 levels have attracted considerable media attention, and have been welcomed by the independent healthcare sector. While Malcolm Stamp made clear to us that he would not be seeking to increase the volume of private patients as an income generator, he told us that this element of the proposals felt “a bit like philosophical overdrive”. However, General Healthcare pointed out that despite these restrictions, it was far from clear that Foundation Trusts would not be able to reinvest NHS surpluses in developing other commercial enterprises, for example offering occupational health services to businesses. **We believe that the Government’s proposals, as they stand, have the potential to get a greater proportion of the increasing NHS funds going to Foundation Trusts, and we believe that limitations on private work are appropriate and necessary to ensure that Foundation Trusts’ primary function remains the delivery of healthcare to NHS patients.**”

Amendment proposed, in line 10, to leave out the words “get a greater proportion of the increasing NHS funds going to” and insert the words “generate extra resources for”.
—(*Siobhain McDonagh.*)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 3
Andy Burnham
Siobhain McDonagh
Dr Doug Naysmith

Noes, 4
John Austin
Julia Drown
Sandra Gidley
Dr Richard Taylor

Paragraph agreed to.

Paragraphs 27 to 105 read and agreed to.

Paragraph 106 read, as follows:

“We note the Government’s commitment to piloting this policy with a selected group of trusts rather than opting for large-scale ‘big bang’ implementation. We recommend that consideration is given to establishing an additional pilot allowing all trusts in a particular area to become Foundation Trusts, as this would help to evaluate how the system would operate in the long term. We do not think that the proposed very tight schedule of annual waves of reform allows sufficient opportunity for the advantages or disadvantages of Foundation status to be evaluated, or for lessons to be learnt, good practice disseminated, and the policy refined for further waves. In particular, we feel that in the early years of this policy, the success of public involvement measures, and the impact on wider health economies will merit very close scrutiny. We recommend that the Government should commission an independent evaluation specifically aimed at assessing the impact on wider health economies and on public involvement, and geared towards helping refine the policies for ‘second wave’ Foundation Trusts, before announcing the second wave of trusts.”

Amendment proposed, in line 2, to leave out from the word “implementation” to the word “term” in line 5.—(*Andy Burnham.*)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 3
Andy Burnham
Siobhain McDonagh
Dr Doug Naysmith

Noes, 4
John Austin
Julia Drown
Sandra Gidley
Dr Richard Taylor

Paragraph agreed to.

Paragraphs 107 to 163 read and agreed to.

Paragraph 164 read, as follows:

“We feel that the policy of Foundation Trusts as presented in the Government’s *Guide* needs changes in several areas if it is to succeed. These include the rationalisation of regulation arrangements, the introduction of clear national standards for the membership and election of boards of governors, additional assurances on the access of Foundation Trusts to the NHS’s limited budget, and clarification of the precise powers available to both members of Foundation Trusts and their boards of governors. We also think it is vital that PALS and ICAS are maintained within Foundation Trusts, and that Foundation Trusts’ non-executive directors should be affiliated and accountable to the CPPPIH. **We also recommend that the Government considers a wider democratic option for trusts, including PCTs, to consider, with or without the freedoms associated with the current Foundation model.”**

Amendment proposed, in line 8, to leave out from the word “CPPPIH.” to the end of the paragraph.—(*Siobhain McDonagh.*)

Question put, That the Amendment be made.

The Committee divided.

Ayes, 2
Andy Burnham
Siobhain McDonagh

Noes, 5
John Austin
Julia Drown
Sandra Gidley
Dr Doug Naysmith
Dr Richard Taylor

Paragraph agreed to.

Paragraphs 165 to 171 read and agreed to.

An Annex (Background to Foundation Trusts)—(*The Chairman.*)—brought up, read and agreed to.

Paragraph entitled Summary—(*The Chairman.*)—brought up, read and agreed to.

Resolved, That the Report be the Second Report of the Committee to the House.

Ordered, That the provisions of Standing Order No. 134 (Select Committees (Reports)) be applied to the Report.

Several papers were ordered to be appended to the Minutes of Evidence.—(*The Chairman.*)

Ordered, That the Appendices to the Minutes of Evidence taken before the Committee be reported to the House.—(*The Chairman.*)

[Adjourned till Tuesday 6 May at Two o'clock.]

**LIST OF WITNESSES
[Volume II]**

Thursday 6 February 2003

NORTH TEES AND HARTLEPOOL NHS TRUST

Mrs Joan Rogers Ev 8

SOUTH TEES HOSPITALS NHS TRUST

Mr Nik Patten Ev 8

TEES AND NORTH EAST YORKSHIRE NHS TRUST

Ms Moira Britton Ev 8

NORTH TEES PRIMARY CARE TRUST

Mrs Chris Willis Ev 8

COUNTY DURHAM AND TEES VALLEY STRATEGIC HEALTH AUTHORITY

Mr Ken Jarrold CBE Ev 8

BRADFORD HOSPITALS NHS TRUST

Mr David Jackson Ev 8

NORTH BRADFORD PRIMARY CARE TRUST

Dr Ian Rutter OBE Ev 8

UNIVERSITY COLLEGE LONDON HOSPITALS NHS TRUST

Mr Peter Dixon Ev 8

Thursday 11 February 2003

HINCHINGBROOKE HOSPITALS NHS TRUST

Mr Douglas Pattison Ev 36

HUNTINGDONSHIRE PRIMARY CARE TRUST

Ms Karen Bell Ev 36

ADDENBROOKES HOSPITAL NHS TRUST

Mr Malcolm Stamp Ev 36

PETERBOROUGH HOSPITALS NHS TRUST

Mr Chris Banks Ev 36

CO-OPERATIVE UNION

Dame Pauline Green Ev 58

MUTUO

Mr Peter Hunt Ev 58

COBBETTS SOLICITORS

Mr Cliff Mills Ev 58

GREENWICH LEISURE LTD

Mr Mark Sesnan Ev 58

DEMOCRATIC HEALTH NETWORK

Ms Fiona Campbell Ev 58

ASSOCIATION OF COMMUNITY HEALTH COUNCILS

Mr Donald Roy Ev 58

Tuesday 4 March 2003*DEPARTMENT OF HEALTH*

Rt Hon Alan Milburn MP, and Mr Andy McKeon Ev 83

**LIST OF MEMORANDA INCLUDED IN THE MINUTES OF EVIDENCE
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Memoranda and supplementary memoranda submitted by:

Chief Executives working in the area covered by the County Durham and Tees Valley Strategic Health Authority (FT 23)	Ev 1
Dr Ian Rutter, OBE (FT 24)	Ev 3
Mr Peter Dixon (FT 25)	Ev 3
Bradford Teaching Hospitals NHS Trust (FT 20)	Ev 5
Huntingdonshire Primary Care Trust (FT 28)	Ev 35
Co-operative Union (FT 2)	Ev 49
Greenwich Leisure Limited (FT 29)	Ev 50
Mutuo, and Cobbetts Solicitors (FT 17)	Ev 52
Democratic Health Network (FT 22)	Ev 55
Department of Health (FT 21)	Ev 72

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Memoranda submitted by:

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1. The Chartered Society of Physiotherapy (FT 1)	Ev 107
2. Royal College of Nursing (FT 3)	Ev 109
3. Birmingham NHS Concern (FT 4)	Ev 113
4. Tremblay Consulting (FT 5)	Ev 116
5. Council of Heads of Medical Schools (FT 6)	Ev 119
6. The King's Fund (FT 10)	Ev 120
7. British Medical Association (FT 11)	Ev 128
8. British Geriatrics Society (FT 13)	Ev 131
9. NHS Confederation (FT 14)	Ev 132
10. General Healthcare Group (FT 17)	Ev 134
11. Diane Dawson and Maria Goddard (FT 18)	Ev 139
12. Bob Hudson (FT 19)	Ev 141
13. Association of Community Health Councils for England and Wales (FT 26)	Ev 144
14. Socialist Health Association (FT 30)	Ev 146
15. Commission for Patient and Public Involvement in Health (FT 31)	Ev 148
16. Department of Health (FT 21A)	Ev 150
17. Commission for Patient and Public Involvement in Health	Ev 157

LIST OF MEMORANDA REPORTED TO THE HOUSE BUT NOT PRINTED

The following memoranda have been reported to the House, but to save printing costs they have not been printed and copies have been placed in the House of Commons Library, where they may be inspected by Members. Other copies are in the Record Office, House of Lords, and are available to the public for inspection. Requests for inspection should be addressed to the Record Office, House of Lords, London, SW1 (tel. 020 7219 3074). Hours of inspection are from 9.30 am to 5.00 pm on Mondays to Fridays.

Memoranda submitted by:

Faculty of Medicine, Dentistry, Nursing and Pharmacy, University of
Manchester (FT 8)
UK University Hospitals Forum (FT 9)
Independent Healthcare Association (FT 12)
Universities UK (FT 157)
John Mohan (FT 16)
The Law Society (FT 27)
Professor Alan Maynard (FT 32)

**LIST OF REPORTS OF THE HEALTH COMMITTEE IN THE CURRENT
PARLIAMENT**

Session 2001–02

First Report: *The Role of the Private Sector in the NHS* (HC 308)

Second Report: *National Institute for Clinical Excellence* (HC 515)

Third Report: *Delayed Discharges* (HC 617)

Session 2002–03

First Report: *The Work of the Health Committee, 2002* (HC 261).