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The Health Committee

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Oral evidence

Taken before the Health Committee

on Thursday 3 July 2008

Members present:

Mr Kevin Barron, in the Chair

Mr Peter Bone
Sandra Gidley
Dr Doug Naysmith
Mr Lee Scott
Dr Howard Stoate
Mr Robert Syms
Dr Richard Taylor

Witnesses: **Dr Mark Exworthy,** Reader in Public Management and Policy, School of Management, Royal Holloway College, **Mr John Carrier,** Chairman, Camden PCT and **Mr Keith Palmer,** Chairman, Barts and the London NHS Trust, gave evidence.

Q1 Chairman: Good morning gentlemen. Can I welcome you to this one-off session that we are having looking at the issue of Foundation Trusts and Monitor. I wonder if I could ask you, for the sake of the record, if you could introduce yourselves and the current position that you hold.
Dr Exworthy: I am Mark Exworthy. I am a Reader in Public Management and Policy in the School of Management at Royal Holloway, University of London.
Mr Palmer: I am Keith Palmer. My current position in the NHS is that I am Chairman of Barts and the London NHS Trust. Up to a year ago for six years I was a non-executive at Guys and St Thomas's, three years of them as an NHS Trust and three years as a Foundation Trust.
Mr Carrier: I am John Carrier. I am the Chairman of Camden Primary Care Trust. Formerly I was Vice-Chairman and then Chairman of the Royal Free Trust.

Q2 Chairman: As you can imagine with three witnesses we may have a tendency to all say the same thing, so what we would like to do is try to put our questions to individuals concerned. Obviously others may be asked an opinion about them but we will try to keep the session reasonably tight if that is at all possible. My first question is to you, Mark. You argue that the evidence suggests an unwillingness on the part of Foundation Trusts to exercise their autonomy fully and you also state that the Department of Health and the SHAs require a change in attitude and behaviour to reflect the changed landscapes of Foundation Trusts and their activities. In what ways is the Department of Health and SHA's behaviour compromising Foundation Trusts' autonomy?
Dr Exworthy: We have been looking at the issue in terms of local health economies and the ways in which the Department of Health's policy is being implemented at the local level. We have been observing changes from the centre right down to the locality and as part of our research—which we are part way through—we have been identifying issues at all levels. Part of that is the changed landscape both for Foundation Trusts at the local level but it also requires a change in mindset, in attitudes and approach from the centre as well. There are signs that that is changing but clearly there are examples where there might be a tendency to revert back to traditional patterns and there has been some discussion recently between David Nicholson and Bill Moyes about the degree to which the Department of Health is able to influence Foundation Trusts and I think generally Monitor and the Foundation Trusts have been resistant of that change. I think that gives you an illustration of the sort of change of mindset that is taking place but there is probably further work to go if autonomy is going to be fully realised at the local level.

Q3 Chairman: Is it the case that Foundation Trusts could exercise more autonomy but culturally they do not? Or is it the case that they are being effectively advised not to? Which is it? Are people in Foundation Trusts still looking to the Department or beyond for the answer?
Dr Exworthy: I think the balance between willingness and ability is quite crucial because certainly many of them are able. They were high performing trusts in the first place and many of them have very skilled managers and clinicians involved in the governance of these organisations. They are clearly able and Foundation Trusts require them to take another step forward to become more robust and much more independent. I think there is that ability and there are signs there. Their willingness in a way is being compromised not so much in the sense that they are being told what to do but there is a cultural change that is involved. In some ways many of these Foundation Trust organisations have grown up in an NHS that has traditionally been centralised so to some extent they have always been looking up, hence David Nicholson's advice to look outwards and not upwards, but clearly those traditional patterns still persist. Also I think the rules of the game are still a little unclear for Foundation Trusts in the sense that this is such a new departure and represents such a significant change in health policy that their willingness to extend into

new areas—innovations, service developments, capital spending et cetera—exposes them in a much more visible way financially and publicly which you could say is a good thing but clearly, as you are exposed a little more, your willingness to do so leads to a certain caution or a certain carefulness which again might be a good thing but perhaps it starts to explain why, although they are very able and capable, they have not always been willing to exert that. Going back to my previous answer, I think there are still some elements of centralisation of being "told what to do".

Q4 Chairman: We may pick up on one or two of those things. Keith and John, does that tally with your experience?

Mr Palmer: My experience was three years getting into a position where Guys and St Thomas's became a Foundation Trust and then three years before I left the board when it was a Foundation Trust. I would say that Guys and St Thomas's was a first wave Foundation Trust so it is one of the very early uptakes. What it felt like on the board was that during the first 12 months all the Foundation Trusts were made Foundation Trusts as standalone entities, they need to remain financially viable but with no reserves in the balance sheet. The first thing that happened, during the first year or two, was a drive in performance to generate surpluses in part to provide a risk cushion in case things went haywire in the future and also to drive performance because before Guys and St Thomas's at least started to think about rather grander initiatives we felt we needed to get our act together and push for the very best quality of services in what we already provided. By the time I left the board in the third year of a Foundation Trust there were active programmes which I know are ongoing to engage with the rest of Southeast London health economy to see if they can extend the excellence which Guys and St Thomas's now provides to its patients to a wider community. I would say that there have been uncertainties about how much authority there is to do new things; there is an emerging confidence that they are allowed and some of the trusts like Guys and St Thomas's are beginning to put their best foot forward.

Q5 Chairman: John, is that your experience?

Mr Carrier: Yes, I think I would agree with Keith rather than with Mark. I was in at the ground floor with University College Hospital who asked obviously under the Act for a Primary Care Trust representative to be on the Members' Council. My feeling was for the first few months there was some sorting out to do because we had a huge constituency of people coming along who had no experience of Foundation Trusts let alone a health service organisation. There was a lot of discussion about what their role was. The hospital was also moving from an old building to this brand new palace on the Euston Road—you may have seen it, this great giant green thing—but the concern that the executive had and the rather experienced chairman and NEDs was with financial stability, the commissioning position that the PCT would take as well as other targets the PCT were concerned about (delayed discharges, MRSA). There were always debates about the tariff and whether it should be unbundled and whether PbR was the right way of going forward. So all those things were being sorted out in the first year. I then left because the chief executive of the other local Primary Care Trust, Islington, came on board and I thought that my chief executive ought to be on instead of me to match her. One of the issues that was always raised was the accounts, the finance. Innovation, I think, would have been pushing it for the first couple of years. They were the first wave. I was then asked to go onto the Tavistock and Portman, a much smaller Foundation Trust with a budget of about £20 million a year in contrast with a budget of about £400 million or so. What I thought was interesting was the efforts both Trusts made before they were set up to involve the public by meetings et cetera.

Chairman: We may pick up on these matters later. Could we move on to Sandra?

Q6 Sandra Gidley: Innovation has been mentioned. Dr Exworthy, reports by the Foundation Trust Network and Monitor proved some examples of what they term innovative practice being employed by Foundation Trusts, but a recent HCC/Audit Commission report concluded that "On a national level . . . FT status does not yet seem to be empowering organisations to deliver innovative models of patient care". Are there any practical examples or independent evidence that Foundation Trusts are actually delivering care more innovatively or efficiently?

Dr Exworthy: I think you are right to point out that there is relatively little evidence of this so a lot of it does rely on the sort of reports that you have mentioned which clearly have a "vested interest" in some of these issues so independent research or independent evaluations tend to be rather scarce. Having said that, innovation covers a wide range of activities so it would be difficult to categorise all the sorts of things that are going on. Probably there are two points to make, one is that these were high performing, largely innovative, dynamic organisations so, as it were, much of that has continued in the direction that you would expect it to, so what difference would Foundation Trust status over and above that bring? Some of the evidence seems to be a little bit weak in that regard. Whether they are actually offering over and above improvements, I am not too sure whether that exists so far, I am slightly dubious. I think a lot of the work that has gone on is making sure that they are a robust organisation in the sense of greater attention to costs and greater focus on improving the managerial skills, clinical involvement et cetera. I think there is a lot of work that is going on that might not yet have translated into, as you call it, innovative practice or service developments.

Q7 Sandra Gidley: Some of these trusts have been in existence for a number of years now so surely there should be some sign of changes in practice.

Dr Exworthy: We have to remember that all of these operate within a local health system which, to some extent, liberates them and to some extent constrains them. We are seeing some much more innovative practice in terms of developing clinical networks outside the organisation which I think is quite important—cancer surgery, for example, being quite significant there—but that is not necessarily to do with their Foundation Trust status.

Q8 Sandra Gidley: It might be helpful to ask somebody who is representative of a trust. Mr Palmer, you have been in since the beginning, are there any benefits conferred by Foundation Trust status? What have you been able to do that you would not otherwise have been able to do with regard to innovation? It seems that the best high performing trusts were the first off the blocks, as it were, and could have done this anyway. What difference has it made in practice?
Mr Palmer: I asked myself that question right the way through actually because I held great hopes for Foundation Trust status. I would identify two in particular. The first is the fact that that Foundation Trusts are allowed to keep the surplus that they generate through efficiency improvements is a really important driver of behaviour within the hospital trust.

Q9 Sandra Gidley: What do they do with it when they have got that money?
Mr Palmer: At Guys and St Thomas's the promise was that if we can generate the surpluses we can reinvest them in even better health care and that motivates clinicians—not just doctors but a whole community of people, the 8000 people who work over there—that the thought that you are slogging to get cost reductions because the Department tells you you have to is an entirely dynamic to: if you do this and do it well you can then do the things which have been on our planning horizon that we could not afford for a very long time. The question of what you do with it of course is a very important question. As I say, at Guys and St Thomas's the view initially was that we must generate surpluses to create some risk cushion because it is a very uncertain world out there; we do not know what the Darzi plan is going to be for our services; we need to be able to invest in the fabric of the building. The basic position was to get some surplus and then think about what to do with it. I have not been privy for the last 12 months, but there are some very interesting plans to change the models of care, to use language you use. However, as Mark said, you can only change models of care by interacting across the whole network. You have to deal with organisations which are not Foundation Trusts and who are subject to direction by the SHA. I think it has been slow but my observation would be that there is a degree of freedom now and the fact that Guys and St Thomas's plan to use those surpluses is really quite interesting. It would be a shame, I think, to stop the experiment now, but if you do not see some action over the next couple of years then you should be asking the question why. The other important difference is the membership and the engagement and the board of governors of a very wide range of stakeholders. We have a slightly absurd board of governors at Guys and St Thomas's in the sense that it has 40 people on it and you could say that no body of 40 people can do anything effective, but because it is so representative of all the interest groups—staff, patients, PCTs, local healthcare trusts—it really is a tremendously effective forum for sharing ideas and discussing things, not in a governance sense but simply sharing in a single forum the very different interests of everybody. I think that that has been very valuable.

Q10 Sandra Gidley: I would like to be reassured that it is not just tokenistic; can you give me one practical example of something the board has done to make a difference, something you would not have been able to do if you were not a Foundation Trust?
Mr Palmer: I think it is difficult to pick something out. The behaviour of the board of directors at Guys and St Thomas's has been different in the sense that they have felt free to take certain decisions which otherwise they would have been directed when they were an NHS Trust. Things like how to conclude negotiations with the commissioners, how to engage with the sector about the changing models of care, there is a sense of empowerment that there is a right to carry on those discussions which simply was not there before. I am absolutely sure in my mind, having been both an NHS Trust and a Foundation Trust, it feels very, very different on the board of an NHS Trust—which is where I am back again—because you really have to ask permission all the time. It is a different dynamic and it is quite difficult for me to give you a particular instance, but it is tangible and real.

Q11 Dr Taylor: Quality occurs four times in the titles of Darzi's report; four out of eight chapters have the word "quality" in them. When we did our report on Foundation Trusts right at the beginning some years ago one of the recommendations was: " the 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 Trust status is achieved there are adequate incentives in place to ensure that trusts improve or even maintain high levels of performance." Turning to Mark first, I think you say that "initial evidence suggests no significant improvements as a result of Foundation Trust status.
Dr Exworthy: Quality again can be defined in many different ways just like efficiency or any other concept by which you are wanting to measure. I think the evidence is thin or weak at the moment; we do not have too much on which to base other than perhaps anecdotal or experiential evidence. However, I think there are signs of a greater sense of ownership, a greater sense of pride, a greater sense of empowerment through which you might hypothetically suggest that quality would improve. Some of the evidence on decentralisation generally suggests that people who have greater ownership

tend to address things more carefully, more assiduously and as a result quality might improve. There is a hypothetical argument to say that that would happen and there are a few signs that that has happened I think so far.

Q12 Dr Taylor: As to one of the crudest measures, complaints, is there any evidence that complaints have either gone down or up since the Foundation Trust status?
Dr Exworthy: I do not have any information on that.

Q13 Dr Taylor: Moving to Keith and John, would there be any evidence on that side?
Mr Palmer: If the complaints records are kept and constitute part of the insurance framework which the Healthcare Commission expects. As you know, the majority of Foundation Trusts are good or excellent but quite a few of them were good or excellent before they were Foundation Trusts. I think there is evidence that the standard of care and the quality of care of the cohort of Foundation Trusts is very good. There is some evidence it has been improving because the weighted average of the scores of them has improved, but like Mark has said several times, it is difficult to say that because of Foundation Trust status it has happened. Certainly in my trust—which is not a Foundation Trust yet—we are improving the quality of care irrespective of an organisational status.

Q14 Dr Taylor: Do you have anything to add?
Mr Carrier: I think the first thing to say is that we are very conscious of sections 18 to 25 of the 1999 Act about that which lays a duty of quality on us all. That is an overriding issue. Whether Foundation Trusts have made a difference or not I do not have the data on the complaints but we do have data on serious or untoward incidents. However, I think it is wider than that. I think you can measure quality in a number of ways and Foundation Trusts may have made a difference here. There is the speed of care, the speed at which people get into the system. There is the location of care and I think Mark is right about that; networks have helped in that, for example, if you get cooperation between Foundation Trusts and non-Foundation Trusts like the Royal Free in our particular area there is no doubt that there has been an interchange of services where the location is best, so plastics move to the Royal Free, cardiac goes down to UC. Networks are the important issue; you can say it is coincidental but it may have been given a push. Liz Wise who is the Director of Contracts and Performance has passed me a note to remind me that one of the big issues is that Foundation Trusts have to respond to commissioners; they have no option to respond to commissioners on any service change or innovation. However, on the other hand, commissioners need to support innovation and what commissioners are interested in is not just efficiency and effectiveness; clearly we are under some obligation to make sure targets and standards are reached and that means relationships with the Foundation Trusts. We do call for regular quarterly data, financial data but also quality data. They come back to us and say that the tariff is constraining them and they need some more money if they are to meet the 18 week target, that relationship has been set up since the Foundation Trust so there is that interchange. My own feeling is that there is a paradox here and the paradox is that the centre wants more and more care out of hospitals and while we are trying to support centres of excellence which are these hospitals in the middle of London there is a real demand management question here which is quite tense I think. I think quality has been improving and I think you have to use proxy figures to demonstrate it, but you need the evidence to be properly discussed.

Q15 Dr Taylor: Keith, you are going through the phase of applying for Foundation Trust status at the moment.
Mr Palmer: That is correct, yes.

Q16 Dr Taylor: So you have to have quality at a pretty good level before you can get in. Once you have got in what are the incentives to go on improving?
Mr Palmer: They are various. Firstly, as John has said, the commissioners have a responsibility to make sure that standards are maintained at a certain level and of course the Healthcare Commission inspects everybody, Foundation Trust or not, and reports on the systems and processes in place to assure quality. You get a score and all trusts, whether you are a Foundation Trust or not, care mightily whether you are excellent, good, fair or poor. So there are some dynamics in the system. This is nothing whatsoever to do with Foundation Trust status but the dynamics to improve quality of care have not been very strong and I welcome the very recent announcements by Darzi et al for a renewed focus on quality but if that is to be achieved we need instruments that will drive it better than we currently have. I think those instruments should apply to everybody, not just to Foundation Trusts

Q17 Dr Taylor: Can you define what you mean by an instrument to drive it?
Mr Palmer: It has been proposed for quite some time that you should link in part the payment you make to a provider to the quality as well as the quantity of care. Payment by results is a payment per unit. You can develop quality metrics I think in some services quite easily and so the people will recognise quality by paying a bit more but equally we will punish you, as it were, for poor quality by paying you a little bit less. I am a great believer that a properly graduated incentive of that sort would put a renewed dynamic into the system.

Q18 Dr Naysmith: Can we move to the area of governance and democratic accountability? This is an area where, when the legislation was passing through Parliament to set up Foundation Trusts, there was a lot made of it by the Government. You may or may not be aware that there have been a couple of reports into how this has been working, one an Ipsos MORI poll for Monitor and a so far

unpublished report by Mutuo for the Department of Health by Chris Ham and Peter Hunt. It is true to say that there is a bit of evidence in this area but both of these reports contain good things but they are also more than slightly ambivalent and suggest there is still a lot to be desired in this area. I wonder if I could start with you, Dr Exworthy. In your submission to the Committee you said that the new governance arrangements of Foundation Trusts are "seen as an important development but have yet to translate into meaningful change" and that "the relationships between the FT Governors and the Board still require further development." How do you see this development taking place and how can Foundation Trusts governance arrangements be improved? I would like specific suggestions if you can with evidence if possible.

Dr Exworthy: I will try to be as specific as possible. Like my colleagues on the panel who have already mentioned the significant changes in governance and public membership that Foundation Trusts give, having said that I think that the focus—or priority if you like—has not been on that so far, it has been about getting financial stability, robustness and making sure that their operation as a Trust (usually it is a hospital) is efficient and effective. There are signs that they are moving into developing better relationships with their memberships but I think there is a danger that initially at least these efforts have been focussed on people who might have been engaging with those Trusts anyway and extending it out to a broader membership is traditionally very difficult so Foundation Trusts would encounter similar problems. However, I think there are signs of much more outward focus; I mentioned that, rather than looking upwards, looking outwards. There are signs that they are taking that on board, entering into dialogue with all the various stakeholders that have been mentioned—local authorities, other NHS trusts, the public in all its dimensions.

Q19 Dr Naysmith: In both the studies that I mentioned there was evidence that there were members and even some governors who said they did not feel involved and they could not really make much of a communication with even their chairs on some occasions.

Dr Exworthy: Yes, and I think there is some evidence that the governors have failed to identify their role in a sufficiently well-defined sense. In a way that was my implication about this further development in that area. I think also there are areas to test between the board of governors and the executive team in the sense of on what occasions has that role been exercised in audits, appointments et cetera. Maybe they have not entered into that territory yet.

Q20 Dr Naysmith: Do you think there is still hope?

Dr Exworthy: I think so. I think it represents the form of membership and the form of organisation that Foundation Trusts have become, to represent an innovative dimension in this regard. Traditionally the NHS has had rhetoric in this but has not always delivered.

Q21 Dr Naysmith: When it went through Parliament it was described by one or two members as a fig leaf of democratic accountability; do you think it is more than that.

Dr Exworthy: Yes, and also I think it sets up an interesting tension particularly on behalf of the PCT as another constituent because they could claim equally that they have the needs of their resident population in mind. I note that the Darzi report earlier this week allowed PCTs to change their name to become NHS such-and-such a county or town to identify much more with the population on whose behalf they are commissioning. I think there is a tension that patients might well have a very strong affiliation to particular institutions and particular trusts but the PCT loyalty, on the other hand, could set up a tension and clearly there are not enough evenings in the week for people to attend all of these public meetings.

Q22 Dr Naysmith: Do you both have experience of the area we are talking about?

Mr Carrier: There is a tension but I think it is a tension between strategic and operational issues on the board in that the true members are lay people, intelligent and inquisitive and want questions which often are the questions that non-executive directors should be asking. There is this quite interesting way of handling those sorts of things because some of them are not for public discussion and that sets up concerns; others are. One way I have seen it work is by the board of directors through the chairman inviting members' councils to join committees, to form sub-committees and to reach into the organisation in a much greater way so our patients see what reception is like, what discharge policies are like and so on and so forth. There is a way of involving people in working which does not quite cross the operational line but gives people some identity. I am pretty sure there are hard to reach groups of people who have never made their voice known or engaged with a hospital; they take it for granted, it is there, they expect high quality services. I also know that the oversight and scrutiny committees are doing their job. We have just seen a very good example in London in *Healthcare for London* where all 31 of them got together as well as the 31 PCTs to comment on Darzi's *Healthcare for London*. They are also good at calling in both Foundation Trusts and non-Foundation Trusts for scrutiny and the public do turn up and the newspapers are interested.

Q23 Dr Naysmith: That is by-passing the governors in the membership of the Foundation Trusts. I am not saying that is a bad thing.

Mr Carrier: It is another dimension; it covers columns of local newspapers which means that people are informed. The other thing I have noticed is that the staff members do speak out in these governing bodies. As you know, the big issue is the appointment of chairman, the appointment of the chief executive and the NEDs and that in the end a very big piece of knowledge that all members' councils have; it is not used in a threatening way but

it is there. My observation is that they have attempted to involve them but there is this very strange operational strategic issue.

Q24 Dr Naysmith: Do you have anything to add?
Mr Palmer: I would just say that for me it is much better than what was there before. When I think about what was there before there were no local accountabilities at all and everything was directed by the Department of Health. I have always believe that it is not a perfect system and it works less or more well in different settings depending upon the communities you are dealing with, but I think it is the right thing to do to try to create some local accountability and some more effective channels to the local communities so that there is an outlet or an opportunity for them to express views and of course ultimately to get involved in governance. One hopes that that is never necessary because something has gone badly wrong, but the very fact that there is now a local solution mechanism if there are major disputes I think is a very helpful thing. The only other thing I would add is that although Barts and London is not yet a Foundation Trust we have decided to try to create some of these mechanisms anyway. We have created a membership, we have invited people to join and we are absolutely thrilled with the engagement we are getting. We have *Medicine for Members* events which are mostly about public health issues in East London and we get a tremendous turnout of people you would never imagine would ever go to a committee. I would say that it is not perfect but it is a good start and I think it is an approach which should be rapidly generalised across all trusts whether Foundation Trusts or non-Foundation Trusts.

Q25 Dr Naysmith: I find it fascinating what Mr Carrier said about the Overview and Scrutiny Committee. Did you experience that as well when you were involved?
Mr Palmer: The Overview and Scrutiny Committee is of course a statutory component of oversight. We have not found, at least in Guys and St Thomas's, that there is undue overlap between its role and the role of the board of governors of the Foundation Trust.
Chairman: We have a series of questions now on the impact of Foundation Trusts on the wider health economy.

Q26 Dr Stoate: John, I would like to start with you. We heard how Foundation Trusts might be able to improve efficiency and might be able to improve outcomes, but they do have a very, very significant impact on the wider health economy. We know, for example, that Foundation Trusts collectively have a surplus of £1.7 billion and Keith has told us he likes to have a surplus in the bank to make sure they can hedge against the future. However, this is tax payers' money. If it is being locked up in trust accounts does that have a big impact on PCT spending and thinking?
Mr Carrier: No. We think PbR is wrongly named; we do not think it is payment by results we think it is payment by activity. In a sense that surplus is a hidden iceberg and what we are constantly debating with them are issues like coding of procedures and whether the returns we get quarterly are accurate and validated and so on. So there is that very administrative financial detail and we tend not to look at that big issue of the surplus and tax payers' money. We are obviously very keen on effectiveness and efficiency and value for money and I think it is right that the big Foundation Trusts, University College in our particular PCT is £52 million and the Royal Free is £58 million; Tavistock is very much less. We tend as a PCT not to think about the surpluses; we tend to argue about our bottom line and us coming in on budget. We look at it that way. We also view it as a health community rather than a health economy as well because obviously we are very keen to delay wherever possible entry into any hospital if primary care can do the job. Recently, because of the debate about polyclinics, we have certainly had discussions with the UC as a Foundation Trust and the Royal Free as a non-Foundation Trust about polyclinic issues and primary care. We are conscious of that but not the surplus that Keith has referred to.

Q27 Dr Stoate: I am worried about this now because that is evidence of real silo thinking; you are saying that you do not really care about those surpluses.
Mr Carrier: I am not saying that we do not care; I say that our main concern is to make sure that the 18 week target is met, that our chief executive meets the three financial targets he has to meet each year, that services are of a high quality. If you want me to put them in order of priority then high quality comes top. We are obviously interested in cost efficiency and clinical effectiveness—we would distinguish between those two—but all hospitals in our area have quite a good reputation.

Q28 Dr Stoate: Yes but that is not the point I am making. The point I am making is that we have a lot of tax payers' money; £1.7 billion collectively is locked up in trust coffers and surely as a PCT you must be very concerned to ensure that that money is all spent on patient care, or do PCTs not care whether that money is spent on patient care?
Mr Carrier: Again I think it is wrong to say that we do not care but I think you are also right to say that our interest is not directed to that; our interest is directed to the day to day making sure that patients get in when they need to get in as fast as possible and are given the highest quality treatment and there are no delayed discharges and the community will support them once they are out. That is our main concern. I am sure if we changed our direction and started to ask questions about the surplus and how it is being spent we would have a different debate. I do meet the chair of the Foundation Trust at regular intervals; our chief executive meets their chief executive, there is an interchange and the relationship is good. Every now and then it gets tense

because we are asking for details and they are asking for money but you are correct in one sense that we do not concentrate on the surplus.

Q29 Dr Stoate: PCTs are always finding difficulties with their finances and under payment by results they do the work and you have to pay them; there are no ifs or buts or maybes. The more operations they can hoover up the more operations you have to pay for whether you like it or not.
Mr Carrier: No, it does not quite work like that. We have a demand management system in place.

Q30 Dr Stoate: How does that work?
Mr Carrier: It is known as CCAS which is the Camden Clinical Assessment Service where GPs, if they want to refer to a hospital, will refer to this group which is composed of GPs, unless it is an emergency.

Q31 Dr Stoate: They have to apply to you for every single referral they make to everybody; even under choose and book they have to apply to you first.
Mr Carrier: The CCAS does the choose and book unless it is an emergency. That is how that system works. It is based on what is known as the Kingston model which was introduced a few years ago and it is really asking whether the referral appropriate and obviously it is a cost effectiveness mechanism so we have been working that for about two years now and looking at the results.

Q32 Dr Stoate: So the GPs do use choose and book.
Mr Carrier: They do use choose and book, yes. We have about 42 practices in the PCT, about seven of them are still not using choose and book and discussions are on-going with them. It is about technology and cultural resistance.

Q33 Dr Stoate: The point is, when a patient comes to a doctor and the doctor says you need your hip replaced, the doctor has to say, "You can use choose and book but I have to check with the PCT first whether I am allowed to refer you".
Mr Carrier: The point is that our GPs do support this system; they use it and how it is developed is based upon their own thinking and ideas. They are paid and it works. It works for all referrals in our particular Primary Care Trust. The activities are monitored; there have been hiccups. I think if activity is out of line, in other words it is not meeting expectations—what we would have expected in terms of the patient flow—questions are asked, but it seems to be working.

Q34 Dr Stoate: That is slightly off the subject of Foundation Trusts but it is a question of how your PCT works. My main concern really is to ensure that PCTs take a close look at how the surplus is used. Do you think this is something Monitor should look at in terms of ensuring that surpluses are directed towards patient care or is it something that PCTs should keep out of altogether?
Mr Carrier: No, they both have a role in doing that, of course. We obviously expect Monitor to do that but we are very challenging in terms of the volumes of work that come to us and whether they have been properly coded, whether the statistics are validated and so on. We have a whole group of people who deal with the contracts. We are still on the first wave contract although we have given notice—we gave notice two years ago—and we will go onto the model contract that is being introduced. Even then I think our Foundation Trust—the big one, UC—takes patients from around 200 PCTs and whether they will want to have one contract for all of them or negotiate separately is another issue. We are the lead commissioner, that is the point, and that is a way of ensuring economies of scale, keeping an eye on the total picture.
Mr Palmer: Could I just add to that the reason that John is not all that concerned about the surplus is because it is not extra revenue that is being paid to the providers; it is the benefit of providing the same volume of care more efficiently. I think the right way to think about the surplus is as extra resources available.

Q35 Dr Stoate: Yes, but it is still tax payers' money being locked up in coffers and not being used for tax payers' benefit. If you are going making efficiencies surely that money must be recycled back into patient care.
Mr Palmer: That was going to be my next sentence. I think it is not a question for me about the commissioners being concerned; I think that what we lack at the moment is precisely what you have just described. At the moment Guys and St Thomas's, for very good reasons, is still planning on how it wants to spend that money. Whilst it is locked up it should be available to the NHS, recycled, and until it is needed it is available to be used.

Q36 Dr Stoate: There are things the PCT would like to do but cannot do, there is money in your bank that is not doing anything and those two things are not being put together. What I am saying is that this is silo thinking; it is not joined up thinking.
Mr Palmer: It is a question of policy. At the moment there is not the mechanism to recycle surpluses so they can be used elsewhere in the NHS.

Q37 Dr Stoate: That is exactly my point.
Mr Palmer: But on the basis that those who generated the surpluses can get access to them when they have plans to spend them. It is actually relatively straightforward to devise an internal banking system where you re-use those surpluses but you do not take them away from the providers so that when they have good plans for them then they can use them.
Dr Exworthy: Could I just make two quick points, one is that in a way this is the price of autonomy. We are giving Foundation Trusts the autonomy and they keep the surpluses; that is part of the rules. That is the name of the game, as it were. I think also there is a difference between long term and short term here. As Mr Palmer has just said, some of them have

been a little unsure as to what to spend it on, but there is a difference between, as it were, short term improvements you might be able to make and say, capital expenditure which might take several years of surpluses to accrue. Building a new wing of a hospital or even a new hospital would clearly be on a different scale than, for example, I know from the Darzi report one of the Foundation Trusts in Gloucestershire paid £100 to each member of staff as a bonus. There is a short term/long term issue.

Mr Bone: I was going to come in but I disagreed with Dr Stoate and I thought that was dinosaur thinking of the NHS. The effect is that efficiency savings have been made which would not have come about if you did not have Foundation Trusts. That was the problem with the existing system, there was no incentive to make the savings then no savings go to the hospital which they could spend on long term projects. The Government is absolutely right on this, it is the dinosaur thinking that they are trying to get away from which I think actually Mr Palmer did explain.

Q38 Chairman: Let me pick up on one with John who is a commissioner effectively. Your health budgets have been growing, effectively 4% above inflation or something like that. Would your attitude to surpluses being held by your local hospital be different if your budgets were not growing in the way that they are now or indeed have done in the past, a lot less than they are currently? Would it change your attitude?

Mr Carrier: It might well do. We do see the surplus as a much broader issue. I will give you the point, but it is a broader issue and again we see our task as to make sure we commission services that are needed and the tariff and then to check what it is going on. It may sound like silo thinking but that is the accountability thing that we take very, very seriously and that is why we call for the data and statistics, and that is why we have these debates. I think that is a fair point.

Q39 Mr Scott: Maybe I am a dinosaur as well but I would quite like to see that if a PCT needs some money and that one has it that it could be used for the benefits of the patients, which is what I thought it was all about. Mark, you say that provisional evidence suggests that Foundation Trusts are picking and choosing the issues on which they are cooperating with other parts of the National Health Service, especially if it is in their own interest. Could you give us a little more detail, please?

Dr Exworthy: I think it is perhaps implicit in some of the things that we have been discussing already this morning. Clearly Foundation Trusts have been given a set of incentives in which they are much more responsible for their own activities and affairs and, as we have just heard, surpluses as well. So clearly there is a much greater focus on their internal processes and decision pathways if you like and that clearly sets up a self interest type model that they are responsible for the boundaries of their trust and outside that is an externality; it is beyond their responsibility. Clearly in terms of some of the activities that might be going on in the local health community they are deciding the degree to which they might cooperate. Clearly there are areas in the country where there has been a history of collaboration and Foundation Trust status does not immediately change that; there has been an on-going network, many people will have worked in similar organisations, their friends and colleagues work similarly. There is a level of trust often between Foundation Trusts and non-Foundation Trusts in the local health community in the development of HR policies or clinical networks et cetera. There might be some places where the Foundation Trust status sets up a difference of position, responsibility and interest such that there is—to use the term used earlier—more of a silo mentality. That has created not just the acquisition of their Foundation Trust status but some of the central rules and implementation of those rules that set up a degree of resentment between Foundation Trusts and non-Foundation Trusts. That might hinder future collaboration. Some of the specific examples where they might wish to collaborate, for example in some of the big service reconfigurations that have been going on and are likely to continue, in the sense that it is very much in their long term interests for Foundation Trusts to get involved in these decisions. Helping shape that debate locally within the county, city or whatever is part of their interest. As we have heard surpluses might be retained which might set up a kind of tension, the degree to which they are seen to be retaining the surpluses and/or hindering or hampering local service developments. I think it will be very different in different places depending on the history and culture of collaboration.

Q40 Mr Bone: Following on from Lee's question, is it more like internal politics within this very large organisation that Foundation Trusts see themselves as something above the rest and the others think they really do not want to cooperate with them; they are a grammar school and we are a secondary modern. Is it that sort of thing you are worried about?

Dr Exworthy: I probably would not put it like that. Foundation Trusts have a duty of partnership but that clearly gives them quite a wide latitude of how they interpret that. Many of the rules under which they are now operating are much more explicit, so legally binding contracts, payment by results. They are very much more of a higher profile, more explicit, more overt and so clearly they are thinking in terms of managing their risks accordingly.

Q41 Mr Bone: John, earlier on in your evidence you actually said that you thought it had encouraged better working between partners. Could you just say a bit more about that?

Mr Carrier: Since shifting the balance some years ago which emphasises the cultural change that would have to come about, there is no doubt that the large hospitals, especially teaching hospitals, could see that commissioners were going to be important because their income is going to come from commissioners. I think other things which are difficult to quantify are also important, which are

relationships: knowing people, meeting at networks, meeting at the oversight scrutiny committees, exchanging ideas, being invited to seminars and goodbye parties; all those sorts of networking, gossipy things do help to get the feel. As Wellington once said, you look to the wit and spleen of the person to understand who they are. That does help collaboration and I think it also goes beyond that and gives you the idea that whether it is a Foundation Trust or a non-Foundation Trust there is complementarity here, they are both on the side of the patient. For the Foundation Trusts with very high reputations, with teaching responsibilities and medical students, there is another dimension here which is extremely important because they have an intellectual critical mass which they want to defend as well. We want that to get into the service. So there is a whole debate in London about academic health science centres and we have been invited to discuss those and that is interesting. The last president of the Royal College of Physicians but one, myself and the chief executive and the chairman of what is now the Camden and Islington Foundation Trust also had discussions with the Foundation Trusts about the easy and quick reception of people with mental illness who are brought in under section 135 and how that could be improved in the middle of London. That seems to be working. So there are changes but it does very much depend as much on relationships and understanding of each other and not simply on the economy issue. I think it is a health community as well as a health economy. We are not against the economic and financial issues but other things are just as important.

Q42 Mr Bone: Mr Palmer, I think you have seen this from both sides, Foundation Trust and non-Foundation Trust. Would you say that there is any evidence that Foundation Trust hospitals are better at collaborating with the private sector than non-Foundation Trust?
Mr Palmer: If I may I will answer that as well as whether they are any better at collaborating within the NHS because I have, as you say, seen it from both points of view. I do not think that the tensions in the system about service re-design and cross-organisations makes very much difference whether they are Foundation Trusts involved or not. I am now at Barts and the London; we are a high performing, financially in surplus major teaching hospital trying to do re-configuration with clinically less high-performing, financially very troubled DGHs. I think that situation creates enormous tensions in trying to do things that are good for patients that the losers will sign off on and losers will usually the district general hospitals. I see that exactly the same in the Northeast where we do not have Foundation Trusts as it was in the Southeast where they have the same issues. I think they are inherent in service re-design and the way that payment by results works more than whether you are engaging with a Foundation Trust or not. On the private sector, my answer would be exactly the same. There are inherent difficulties in the NHS dealing with the private sector; I do not think it makes very much difference except there are a few more legal powers to do it in Foundation Trusts but that does not make it any easier actually.

Q43 Dr Stoate: I am going to be the Committee Rottweiler for a moment or two and have a go at Mark now. We are talking in theory about primary care in the NHS and yet we are seeing Foundation Trusts which are gaining huge amounts of power and control over the local health economy. What evidence is there that Foundation Trusts have in any way facilitated the move of resources and services into the community away from themselves?
Dr Exworthy: Foundation Trusts were initially acute trusts and have been extended into mental health trusts and there is the potential to move into community foundation trusts so there is a pathway if you like in which that Foundation Trust status is moving. Given my earlier comments about their self interest, they have a clear interest in looking at acute care. Having said that, I think there are some areas where they are moving into primary care and that is either a function of other partners in the local health community—so re-configuration across organisational boundaries (clinical networks might be one example)—but there might be other areas, particularly outside the bigger cities, where the Foundation Trust as it were dominates the area so that in a sense they become the provider across many towns and villages that they encompass. There might be a degree of difference and ability of moving outside their traditional remit for Foundation Trusts to enter into those primary care pathways.

Q44 Dr Stoate: Is it not happening?
Dr Exworthy: Not at the moment. I think there are discussions and areas of debate in which they are thinking about that but have not actually moved in that direction.

Q45 Dr Stoate: Given that the Government's line is for a primary care led NHS do you think it was a wise move to set up Foundation Trusts in the first place? You are going to have Foundation and Primary Care Trusts.
Dr Exworthy: I think that is difficult if PCTs are commissioning on the basis of government allocations and financial allocations. There were some suggestions at the outset of Foundation Trusts that perhaps we should talk about a foundation community so rather than giving it to each individual organisation it would be given to a network of organisations. That obviously did not happen but that would be a very different model than setting it up with each individual, as it were, in competition with others.

Q46 Dr Stoate: You are saying there is no evidence whatsoever that we are moving from the current situation of hospital dominated care into a primary led care as a result of Foundation Trusts.
Dr Exworthy: I think a lot of the rhetoric about primary care led NHS is still to be realised, but I think there are steps in that direction. Clearly

Foundation Trusts have been put in the position that they are going to try to shape that agenda in each health community.

Q47 Dr Stoate: Given their self interest are they helping or hindering that process?
Dr Exworthy: I think they are helping and they might be in a good position to do that because they might be able to coordinate many of these primary secondary care networks.

Q48 Dr Stoate: Why could the PCTs not have done that? Why are we leaving it to Foundation Trusts to do that with their self interest? Why did we not set it up in the way that PCTs lead that process?
Dr Exworthy: A lot of Primary Care Trusts are—and perhaps should be—leading that process. Clearly it makes a difference when one of your partner organisations—your providers—is a Foundation Trust because that sets up a potential tension and a potential resistance to shifting your money, especially under the PbR system which sets up different incentives for the PCT and the FTs.

Q49 Dr Stoate: I am still trying to get a straight answer; is that a hindrance or a help in that case?
Dr Exworthy: For shifting to the primary care led NHS? I would probably say it is a hindrance on balance but I think that balance might be shifting.

Q50 Chairman: Have you got a view on that, John?
Mr Carrier: I think it is shifting and I think it is shifting because the language now differs. The patient pathway/patient journey is an important idea; there is a pathway in and a pathway out. Some services are also clearly negotiated to come out of hospital and back into the Primary Care Trust (dermatology is an example and diabetes is an example). There is also quite a good discussion going on stimulated by the polyclinic, for example there is a discussion between the Camden Primary Care Trust and University College Hospital about the location of four GP practices on the ground floor alongside an urgent care centre, alongside an A&E department, alongside out-patient services. Whether this comes off depends on consultation and whether it is financially feasible, but there are four surgeries round about that are not DDA compliant and it would be very interesting to see if we can get an integrated centre out of that. The Foundation Trust is certainly interested in discussing this with us. I do not think that could have happened before although, to be fair, the Royal Free too is talking about collaboration with local integrated care centres and so on. Coming back for one second to something said earlier, I think one man's silo may be another man's professional division of labour and although you may want to defend a silo you may also want to defend your professional division of labour which is what you have been brought up on, what your skill is, what your competence is, what your knowledge is and what your values are. I think silo as a pejorative term does not really fit here. I think people will defend what they hold out to be good but I think there are gaps here which people are crossing and talking to each other. That is very, very important whether you are a Foundation Trust or not. I think Primary Care Trust is included now because commissioning is extremely important. We have shed our provider service; it is now an autonomous provider organisation and they will have to do what others do in that situation. We are purely commissioning. We have a budget of well over £400 million of which £52 million goes to UC, £58 to the Royal Free (both 2008-09) and we are financially in balance so we are not at the moment strapped for cash and we have taken advantage of the increase year on year.

Q51 Dr Stoate: I understand what you are saying, it is just that my philosophy has always been that we should look at a health community where we spend large amounts of public money hopefully to the public good and anything that causes artificial divisions and effectively barriers to that happening I like to examine. It seems to me, just to step back, that locking money up when that money could be used and freed up for patient care seems to be a barrier rather than a help. I am just trying to tease that issue out.
Mr Carrier: I see the point but my feeling also is that accountability is important, that the more pluralistic and the more multi-services there are, the more difficult it may be to see when things go wrong, who is accountable and where the money is actually being spent. I think there is a case for and against.

Q52 Dr Taylor: I welcome what John says because you are obviously beginning to bridge the purchase and provider split.
Mr Carrier: I hope so.

Q53 Dr Taylor: That is absolutely brilliant. Keith, I want to know about the costs of the Foundation Trust application process. I have to declare an interest because on Saturday I am going to a consultation meeting in my own Trust about doing it. What does it cost to apply?
Mr Palmer: I think the major cost is difficult to put a money value on because it is a huge effort that the whole organisation has to go through to get itself prepared. There is a very structured process that Monitor runs; there are very high standards in terms of compliance with their requirements and I would say at Guys and St Thomas's it caused us at least 12 months to take our eye off the ball; not take our eye off the ball because actually you cannot do that because you cannot become a Foundation Trust if you slip from meeting all the targets. People had to work much, much harder simply to get through an additional major agenda which is the Foundation Trust application process. The monetary cost is mostly measured in terms of the recurrent costs of running the membership. You have a membership; it is not the elections, they are not very expensive, but you have to communicate with them, you have to produce publications quite properly and circulate them to potentially tens of thousands of people. Those sorts of running costs are material but they are measured in hundreds of thousands rather than

millions. The front end cost is really measured in the time and energy that staff have to put in; the actual cash on the table is not that great.

Q54 Dr Taylor: Have there been any specific challenges for your trust particularly that you have had to face other than just getting the finances and the quality right?
Mr Palmer: In becoming a Foundation Trust?

Q55 Dr Taylor: Yes.
Mr Palmer: I think that with hindsight the first wavers have got a relatively easy ride. Some of the follow-on trusts—people like King's—were referred back three or four times and there were major costs in terms of doing extra work and re-submitting that were not immaterial. For my rust at that time we sailed through.

Q56 Dr Taylor: Do you think there are any major challenges to you at the moment?
Mr Palmer: The major challenge for Guys and St Thomas's is to use the surpluses effectively. There is a major push to contribute to service improvement in southeast London outside the narrow ambit of Lambeth and Southwark and the reason they have to spend their surpluses if because that is capital which will be needed to bring about service improvements which have yet to be both agreed and consulted on, so it is simply a timing problem. The challenge for Guys and St Thomas's is to become an academic health sciences centre of international repute and to contribute to service redesign across southeast London.

Q57 Dr Naysmith: This is a question for Mr Carrier because, as well as the acute Foundation Trust in your patch, you have a smaller mental health Foundation Trust as well. I just wondered what are the important management issues this has generated.
Mr Carrier: There is a much smaller commissioning budget—just over £40 million a year—and it is much more difficult in a way because that trust has very deep relationships with two particular boroughs in London, Camden and Islington, with two local authorities and some very challenging users who are well organised into user groups and put a lot of pressure on that trust. I meet the chairman often—in fact I am meeting with him this Friday—and he is a very near neighbour, but we do not have half as much contact even though we are in the same building as we do with University College Hospital or the Royal Free or the Whittington. We do have regular meetings and mental health issues often come up on our agenda but it is not an issue in the same way that our relationship with University College is.

Q58 Dr Naysmith: What about relationships with the local authority because of mental health issues?
Mr Carrier: We have joint commissioning under section 31 of the act. We share senior managers between local authority and our trust. A lot of it has to do with mental health and obviously children and families, but the relationship is a good relationship and we often come into criticism because the local authority—as it has done—wishes to close the day centre and turn it into what they call a recovery centre. My trust then gets the flack in a sense and we have to explain that we are not responsible; we fund it but we would support what is going on having examined the case because we obviously jointly employ the senior managers.

Q59 Dr Naysmith: Would that cause a problem between you and the council if they were proposing to close something?
Mr Carrier: It is not a problem; it is a question of asking them to account for the policy and to make sure that my board agrees with it. The joint commissioner sits on my board and the senior officers from the local authority are members of our partnership board and attend our board and have papers on it. There is a good partnership working with the local authority. We find some of the scrutiny committees rather tense and difficult but they are doing a job.

Q60 Dr Naysmith: Are they more difficult as far as mental health issues are concerned?
Mr Carrier: Every now and then an issue arises, particularly with a closure where people become attached to buildings rather than services. We will pick up that and we will either support or discuss with them. So we are in the middle of all this; it is a bit of a cock pit really.
Dr Naysmith: I am tempted to ask you about commissioning dental services but we will leave it there.
Chairman: Could I thank all three of you very much indeed for coming along and giving evidence to us this morning. It has been a very interesting session, thank you.

Witnesses: **Mr Richard Gregory,** Chairman, Chesterfield Royal NHS Foundation Trust, **Mr Stephen Firn,** Chief Executive, Oxleas NHS Foundation Trust and **Dr Bill Moyes,** Executive Chairman, Monitor, gave evidence.

Q61 Chairman: Gentlemen, could I welcome you to the second half of our evidence session in relation to Foundation Trusts and Monitor. Could you introduce yourselves and the position you currently hold?
Mr Firn: My name is Stephen Firn; I am Chief Executive of Oxleas NHS Foundation Trust. For those who might not know, we are a mental health and learning disability trust in southeast London so we cover the boroughs of Bexley, Bromley, Greenwich, Lewisham and also into Belmarsh Prison. I have been Chief Executive for six years; we were one of the first mental health FTs and that occurred about two years ago.
Dr Moyes: Good morning. I am Bill Moyes; I am the Executive Chairman of Monitor.

Mr Gregory: Good morning. I am Richard Gregory, Chairman at Chesterfield Royal; I have been Chairman there since March 2006.

Q62 Chairman: I know Richard very well although I have never met him in his capacity as Chairman of Chesterfield Royal Foundation Trust; I have met him on many other occasions with difference hats on. My first question really is to all of you. The Healthcare Commission and the Audit Commission have recently recommended that Foundation Trusts should not retain large cash balances over prolonged periods and should set out clearly how they intend to use these balances. Do you agree? If you do, what do you intend to do about it?

Dr Moyes: I entirely agree that we expect Foundation Trusts to use the cash they build up to develop services for patients and that undoubtedly is what we expect to see happen. I think the Committee has to recognise that Foundation Trusts need their commissioners to be clear about what investment they want to see made: investment in buildings, investment in equipment, investing in some new staff to deliver new services. As commissioning becomes a stronger function with a greater degree of clarity about what they want to see—Lord Darzi's report obviously them a platform to do that—then we will see Foundation Trusts respond to that. My sense of Foundation Trusts is that they are anxious to make investments; they recognise the issue that you are putting to me and they are anxious to respond. However, what they do not want to do is to make investments that do not meet the needs of their commissioners. That would be my response to it.

Mr Gregory: We have submitted evidence that shows that we have nearly tripled out capital expenditure since being a Foundation Trust. To be able to plan for that and prioritise for that you need to build up surpluses. We use the phrase to explain this to our local community that it is surplus with a purpose; it is not surplus just to put into a cash account and carry interest forward and not to be used. It is all going to be used on improving patient services. It is a question of timing, it is a question of planning and it is a question of prioritisation. The wonderful thing about Foundation Trusts is that in principle they are enabled by their very status to be able to plan and prioritise and actually shape their own future, their own destiny. You need to create surpluses to do that and you need to hold cash balances to do that. By simply holding a cash balance it does not mean that it is not prioritised. Virtually all our cash is actually committed on a three year capital investment strategy that has been agreed with our governors, agreed with our board and prioritised. That may be re-prioritised according to the demands upon the service; we have flexibility. The surplus and the cash balance give us flexibility to be able to react, whether it is a short term issue or a long term issue. For me it absolutely underpins the principle of Foundation Trusts.

Mr Firn: To answer your question straight away, yes I do agree with that premise and to some extent we have been doing that. Each of the two years we have been a Foundation Trust we have made a surplus which we have carried over of around a couple of million each year. We have invested that both in new services which have been agreed with governors and with commissioners and in improving quality simply focussed around certain things around the patient survey and setting up an opportunity fund. We have £1 million which clinicians can bid towards to set up new services or new innovations and get access to within a month. I could give examples of those sorts of things if it would help. We do have cash balances of about £25 million which is a significant amount of money, but to put that in context if our commissioners decided to stop paying us for whatever reason we would run out of money within two months; it is less than two months' operating money so it is not a huge amount in that sense. However, we also realise that it is NHS money and it should be used for the benefit of the patients and carers. We do not have any major estate and capital issues ourselves; we have been through all that so there is nothing obvious we could and should be doing with it. There are new buildings that I would like to build and new services I would like to set up. For example, I was in Belmarsh Prison on Tuesday and there were ten prisoners there waiting transfers to the NHS. We know the policy is that they should be transferred within 14 days; some of them had been waiting months. We have a medium secure unit about five miles away with planning permission already secure; we could build a unit there. The problem in mental health is that money does not follow the patient so we could build a new service that is semi-psychological therapy—I could open a new for that—but without a tariff, without money following the patient, we would not have the revenue streams to be able to fund that. As Bill says, there is an uncertainty about how best to use it and clearly we are also holding back to see the outcome of polyclinics in London because we would be very keen to invest and be involved in those. There are also other things like community services provider arms which we would be very interested in running ourselves as well. That cash, therefore, is ready and waiting for use when safe and secure investments can be identified.

Q63 Chairman: The Healthcare Commission and the Audit Commission have said that Monitor should have a role in making sure that a proper balance is kept in relation to that. Is that how you see it? Do you think it is the role of Monitor?

Dr Moyes: I would be apprehensive. I would not necessarily rule it out completely but I think the first instance we are looking to commissioners to be clear about what they need to see by way of investment by Foundation Trusts. My hope and my expectation is that when the operating framework is published in the autumn, after Lord Darzi, we will start to see in that a clearer description of what the Department of Health is looking to commissioners to create and that will flow into their own local commissioning plans. If, in a few years' time—I think it would be within that timescale—we were to conclude that even given greater clarity of commissioning intentions and the Foundation Trusts were building

up greater surpluses than they needed for their own investment purposes, that does raise a question then about the tariff. I think that is where I would go next before I tried to position Monitor as the owner, if you like, of Foundation Trusts, requiring them to invest or to give up cash. I am quite apprehensive about doing that.

Q64 Chairman: You would use a tariff on a particular Foundation Trust to take money off them. Is that what you are saying?
Dr Moyes: No, I am not saying that. What I am saying is that if the suppliers are building up a lot of cash, despite investing at the level that is needed, then that does raise questions about whether the commissioners are paying too much for the services.
Mr Gregory: I think one of the problems with the NHS from my perspective—although I am a relative newcomer really—is the lack of being able to plan the refurbishment and the re-building of large hospitals in particular. You cannot wait for a hospital to fall over after 25 or 30 years and then have a problem. If you do that then it is bad public sector planning. Chesterfield is 25 years old—it is not a very old hospital—but it actually does need re-building so we are going through all the wards, we are refurbishing all the wards, we are building a new children's department, we are putting in great new equipment in technology. If all these things did not happen under our stewardship they would have to be bid into central pots whether they are held by Primary Care Trusts, the Strategic Health Authority or the Department of Health. Being able to own that opportunity to actually keep your hospital absolutely up to scratch, then the interesting and exciting agenda is where you go forward—I hope we can assess that post-Darzi—and that is really the financial strength that Foundation Trusts have been given.

Q65 Chairman: How can policy incentivise greater efficiency in Foundation Trusts once they have achieved a surplus? Are cost improvement targets sufficiently ambitious?
Dr Moyes: What we have seen in every year since Foundation Trusts came into existence is that their cost improvements are greater than the assumptions in the tariff about the level of cost improvements. In 2005/06 the tariff issue was something like $1\frac{3}{4}$% and Foundation Trusts delivered a bit more than 2%. The same pattern was true in the two subsequent years. I think again the answer to the question is that Foundation Trusts do feel under pressure—and our compliance regime contributes to this—to make sure that their finances are very strong. However, if that alone was not delivering a high enough level of efficiency then again it comes back to the tariff. The Government can use the tariff to signal a level of efficiency it wants the suppliers to generate and at the moment the figure they are using is $2\frac{1}{2}$ to 3%. It is up to the Government, I think, to take a view on whether that is the right figure or not.

Q66 Chairman: Do either of you have anything to add about that?
Mr Firn: No.

Q67 Dr Stoate: Starting with you, Bill, about the surpluses, obviously I appreciate that you have to have surpluses, just as the others have said, in order to make sure that these trusts are viable, but £1.7 billion of surpluses is enough to put everybody in the country on statins and still leave money for a fish supper on the way home. It is a lot of money. Do you think that is a reasonable amount to have locked up effectively in Foundation Trust surpluses?
Dr Moyes: That is not actually the surpluses they are making. They are making surpluses of about £500 million before exceptional items. What you are describing is the cash they have on the balance sheet. Some of that cash is a one-off effect. Sometimes they get public dividend capital before they actually spend it on capital expenditure so some of that will be drawn down. One of the things that happens when trusts become Foundation Trusts is that they become much more focussed on cash; they manage their cash better. They are much more careful about when they pay bills and when they get paid and that alone is probably creating £100 million of cash that we did not expect to see on the balance sheet because we did not realise that this is what would happen. Again that will be spent on time on service development and capital expenditure when we are clearer about what the commissioners need. I do not think you should regard £1.7 billion as the profits, if you like, or the surpluses; that is the cash on the balance sheet. The figure of surplus is £500 million.

Q68 Dr Stoate: Certainly the assertions you have made do seem reasonable, but our evidence is that they are very lacking in evidence. Research, for example, at the University of York has pointed out that actually the Foundation Trust policy has not made a significant difference to financial management. We are very lacking in evidence; we have a lot of anecdotes and lots of feel good factors but not much hard evidence.
Dr Moyes: I am a little inhibited in talking about the University of York's research with Professor Maynard listening in; I hope you will forgive me if I make one or two comments on it. As I recall that research focussed purely on 2004–05 which was the first year we had Foundation Trusts. That was the year when we had two or three financial problems beginning to emerge; Bradford was beginning to emerge and UCLH was beginning to emerge. I am pretty confident that we can give you very good evidence that financial management is much sharper in Foundation Trusts than in non-Foundation Trusts.

Q69 Dr Stoate: If you have any actual evidence we would love to see it because one of the whole problems with this inquiry is that we are very long on anecdotes and very short on hard facts. If you have any actual evidence we would very much like to see it.
Dr Moyes: I can quote UCLH, for example, where financial problems were turned around. A financial deficit of £36 million which, at its worse, became £50

million, was turned into a surplus in two years while at the same time the trust delivered the targets and standards required of it. We can give you a number of other examples; there are some in our annual report. I am happy to provide the Committee with a note on this if it would be useful.

Q70 Dr Stoate: That would be useful. What we have is that the Foundation Trusts were picked as being the very best of the best before they were allowed to be Foundation Trusts anyway and it is often said that these were long term trends that would have happened anyway, and it is not specifically due to Foundation Trust status that these trusts which were already exceptionally have got simply better. What we are looking for is evidence that the actual Foundation Trust status itself has made the difference or would they simply have done what they were doing anyway?
Dr Moyes: One might say that about the early applicants, but we now have 100 Foundation Trusts which is about half the hospital system. A third of applicants do not get authorised at first attempt and yet the only things we look for are strong finances and good governance. I slightly resist the proposition that we are dealing with just the best of the hospital sector. We have some very good hospitals but we also have some hospitals that were definitely in the middle of the pack. I think that there is good evidence that the responsibility and the accountability for the finances that rests at board level, the financial regime within which they operate and the ability to see a purpose in managing the finances well to build up surplus and then invest, those things taken together I think are producing much sharper financial management and I genuinely do not believe that this would have happened if there had been no change in the status.

Q71 Dr Taylor: Turning to borrowing, Bill, how much can Foundation Trusts borrow collectively?
Dr Moyes: Collectively they can borrow today about £3.2 billion.

Q72 Dr Taylor: How has that figure been fixed?
Dr Moyes: The legislation provides for Monitor to control the borrowing of Foundation Trusts. We published about three years ago a prudential borrowing code where the level of borrowing permitted is determined by a number of tests including the financial strength of the Foundation Trust, so the higher your financial risk rating the more you can borrow. Again, if you want an explanation, we can provide that to you quite easily.

Q73 Dr Taylor: We have been told by the Audit Commission's report that when the limit was £2.5 billion only about £100 million of that was actually accessed.
Dr Moyes: Yes, that is correct.

Q74 Dr Taylor: Why was that?
Dr Moyes: As at the end of March the borrowing capacity was £3.2 billion and the total actually borrowed was £172 million. There are a number of reasons for that. One is what we have been discussing. The trusts are not clear where investment is needed. The second reason is that a lot of them are now planning investment in a piecemeal fashion; they are not looking to re-build the whole hospital but hospitals like Bradford, for example, in the heart of England are publishing ten year investment plans that can be done in chunks and they can largely raise the finance to do that from their own resources, from the surpluses they are generating. I think the need for borrowing is less in the system at the moment than could be allowed.

Q75 Dr Taylor: How does somebody like Richard cope, who has told us his hospital is 25 years old and he is going to need a new one? PFIs have gone by the board, so how are you going to do it? Are you going to save up surpluses all the time? What collateral do you have to borrow on?
Mr Gregory: We do not need to borrow; we are using our surplus generation in a staged way to actually hit the capital investment needs that we can identify. At the moment I am quite comfortable. The only problem we would have would be if the nature of the tariff changed to disadvantage district generals. If that happened and reduced our surplus then it may not be completely affordable out of our service generation. At the moment on our present timeline horizons I am pretty comfortable that we do not need to borrow. In fact I would not want to go anywhere near borrowing on the refurbishment of the estate. I would be interested in using the borrowing facility if it was an agreed new interesting initiative for the benefit of the local health community with the Primary Care Trusts that we could actually help finance. I would be interested in using our financial powers that way but not actually in terms of going to borrow for the estate.

Q76 Dr Taylor: To be absolutely clear, out of your accumulated surpluses you are confident that you can do all you need to do to keep your hospital.
Mr Gregory: At present, depending upon the changes in the tariff later on this year.

Q77 Dr Taylor: Do you have anything to add?
Mr Firn: I would give a similar story that at the moment we do not feel the need to borrow because we have the cash that I have already mentioned and because there is still uncertainty about where that could be best invested in the interests of the local health economy. It is not that we are not doing anything around this. Howard knows the local health economy around area very clearly and there are some very large deficits in the local acute trusts and the local health economy. We are meeting with the Acute Trust and the Family Care Trust on a fortnightly basis, discussing with them what might be the future of that acute hospital site, whether that would have new services on there, whether there will be a polyclinic; there are GP-led clinical round tables that our commissioners are sitting on looking at improved pathways of care around things like strokes and where we may go into that. We are absolutely clear that that cash that we are holding

and our potential borrowing limit could be utilised if it is in the interests of the health economy but also enables us to continue as a viable concern.

Dr Moyes: Dr Taylor, you referred to PFI; that is the other thing that we should not forget. In the last ten years a huge amount of capital investment has been transferred into revenue so hospitals like Newcastle Sherwood Forest Foundation Trust will not borrow because they are re-building themselves but they are doing it through PFI.

Q78 Dr Taylor: Remembering the first inquiry we did in 2002–03 into Foundation Trusts, I think I remember that the ability to borrow was going to be one of the most important features of Foundation Trusts and yet you are not using it much.

Dr Moyes: It is not being used because it is not required. I think I would really caution the Committee that we are at a very early stage in the development of Foundation Trusts. If one looks to much longer term, having the ability to borrow from the commercial markets and being exposed to the discipline of the commercial market I think will be a good thing for Foundation Trusts and I think it will happen.

Q79 Chairman: Bill, you said that the Trusts were not sure where investment was needed. Could you just explain that a bit further and tell me why?

Dr Moyes: It comes back to all the work that has been done in the last 12 to 18 months or so to try to clarify commissioning, the work that Lord Darzi led initially in London and now nationally. Stephen mentioned earlier on polyclinics; we had the concept of polyclinics advanced by Lord Darzi but what we do not know today is exactly how many, exactly where, what scale, what type of services and all those types of things. Lord Darzi, in his London work, identified a need to concentrate certain services, stroke and cardiac in particular. Again, I think there is a lot of good work being done in London and around the country to start to refine that and to start to work out where we want stroke services to be, how do we resource stroke services, what kind of scanning equipment, diagnostic equipment and so on. I do not think many Foundation Trusts today—even those like University College Hospital London that does have surpluses and is ready and keen to invest—could say to you, "We are absolutely confident that we can make an investment of this nature and be absolutely sure that that this what our commissioner would want". I think that is a key requirement, to get to the stage now where commissioning can describe the pattern of services that they think is required to deliver the services the population needs.

Q80 Chairman: Would it be fair to say in the past that they would have built the unit and then looked for the patients to go into it?

Dr Moyes: I would not want to generalise.

Q81 Chairman: No, I do not want to either, but I am too tempted not to ask you the question.

Dr Moyes: When we had our financial problems with Bradford in 2004 that was part of the reason. They built a modular theatre and, if I remember rightly, they took on something like 300 staff, but there was no commitment from the commissioners to transfer patients to the hospital to use those facilities. That was part of the underlying reason why Bradford got itself into real financial difficulty and in getting itself out of that difficulty it had, if I remember correctly, to rationalise services, move in-patient facilities from St Luke onto the main Bradford Royal Infirmary to use those facilities they had created. Personally, having been there, I think it is a better service to patients so I am relatively relaxed about the outcome of that, but you are absolutely right, that was a good example of creating a facility and expecting the commissioners to send the patients.

Q82 Chairman: I meant that in general terms about what has happened in the National Health Service for the last 60 years.

Dr Moyes: You will forgive me if I confine my response to the last four years.

Q83 Chairman: The other thing of course is that there are very low levels of borrowing at the moment but if things were different and if income going into the health service budget was less than now, it might not be the case at all and those barriers that you want for borrowing might be a bit nearer. Would you have access to capital markets under those circumstances? If you needed major investment or a new hospital in Chesterfield or whatever, would you have access to capital markets and what would be any restrictions that you may or may not have in accessing capital markets?

Dr Moyes: I think from our contacts with the commercial banks there is undoubtedly appetite in the commercial banks to lend to the sector, but of course at the moment the Department still provides loan funding and other dividend capital at well below the prices the commercial markets would set. I think there is a question of working out what is the capital regime for the future. I think the banks are very keen and I do not think from our contacts with them that the banks would be looking for any particularly onerous conditions or anything novel. But why would a Foundation Trust go to the commercial markets when they can get cheaper money from Richmond House?

Q84 Chairman: Of course there would be the issue as you have described with Bradford, the actually commissioners decide on what the income is likely to be over time. Would that in any way, do you think—talking about the future here—restrict people in terms of loaning money into the building new hospital sector? Could it do?

Dr Moyes: I think the banks will have to work out how they assess the credit of different types of Foundation Trusts and depending on the state of the world economy at the time that this happens they might be more or less adventurous. I would expect them to start by exploring very carefully the long

term future of the hospitals they are lending to. Our contacts with them suggest that they would want to understand in some detail how Monitor would behave if a Foundation Trust that was a borrower got itself into financial trouble. Yes, I think they would take a very, very detailed view of the hospital's prospects but I think that is to be welcomed.

Q85 Dr Naysmith: Good morning, Bill. I want to ask you about the private income cap for Trusts which, as you know, varies quite considerably. I want to know if that is a problem and if there is any rationale behind it and, if it is a problem, what should be done about it?
Dr Moyes: It does vary considerably and it does because that is the way the legislation is structured. The 2003 legislation defined the cap and in essence what it does is that it fixes the proportion of private income to the level that it was in 2002/03. Therefore those trusts in 2002/03 who had a high proportion of private income can retain that and those that did not cannot. I feel slightly inhibited in talking about whether that is a problem or not because, as you may know, Monitor has started consulting on the private patient cap. The way the legislation is framed, Parliament has expressed a principle that private income should not grow unless NHS funding income grows, but it has largely left it to Monitor to sort out what the rules are. We thought we had done that but Unison has challenged us and is now pursuing judicial review of our process which, of course, they are entitled to do. That led us to think that we ought to set out the complexity of this issue in a consultation document and seek views from a wide range of not just Foundation Trusts but all sorts of people. We published that two or three weeks ago and the consultation closes in early September. If you do not mind, I would rather not speculate on the outcome of that consultation.

Q86 Dr Naysmith: Could I just ask you a specific question, do you think there is a demand from some of the Foundation Trusts which have a historical low base to increase it, or is that too difficult to answer in the circumstances?
Dr Moyes: What I can say is that I do not believe that Foundation Trusts find the rules that we have written out of the private patient cap to be restrictions, but they might find restrictive some other interpretations of the rules. That is what I think I can say.
Mr Firn: It is a specific problem for Mental Health Trusts because, I think I am right in saying, everyone who has been authorised so far has had the private patient cap set at zero because that was the position in 2002. It is something of an absurdity because if we were not a Foundation Trust we could set up services that have private patient income, but because we are a Foundation Trust we cannot. I have worked in the NHS for 27 years and I agree with all the principles about care being free at the point of delivery, but I know from all the work we have recently been doing with employers, that the support we could provide to employers about getting people back into work and retaining people in work and getting income from them would meet some of the Government's policies around keeping people in work and recovery, we cannot take forward because it would count as private income at the moment. There are other things around psychological therapies where we could set up units with free access for people on the NHS but we could part fund it by having private patients; we are not in a position to do that. I think it is actually inhibiting us from taking forward some key policies but also getting income to improve other NHS care.

Q87 Dr Naysmith: You have raised a very interesting point there which is not really a part of this inquiry but can I just ask you about it? There are known to be, all over the country, long waiting lists or longer lists than there should be for psychological therapy. If this problem you are describing could be solved would it help to make psychology more available?
Mr Firn: I think it would be one part of the jigsaw, yes.

Q88 Dr Naysmith: Bill, returning to joint ventures with the private sector is something that is suggested will increase NHS efficiency (and it probably will). Will Foundation Trusts' capacity to enter such arrangements be restricted by some of the things we have been talking about and would this not be a failure to ensure a level playing field for the National Health Service and for Foundation Trusts and for private providers?
Dr Moyes: Depending on the consultation and depending on whether the judicial review proceeds to a hearing, and depending on whether or not the outcome of that is that our roles are supported or overturned in the court, we could find that there are circumstances in which joint ventures and other types of cooperation between the Foundation Trusts and the private sector are inhibited. It is very hard to answer the question at the moment, I am afraid, until we get to the point where either the judicial review has come to a conclusion or something else has happened. I am speculating really.

Q89 Dr Naysmith: Richard, much has been made of the new autonomy that is granted to Foundation Trusts. What is different now you are a Foundation Trust? There are obviously quite a few difference, but what are the main ones?
Mr Gregory: I think, as I said earlier, the ability to try to shape your own future, to prioritise and the speed of decision making.

Q90 Dr Naysmith: Some people would argue that that could have happened before, prioritisation and speed of decision making.
Mr Gregory: When I joined back in 2006 one of the first major items on the board agenda was the business plan for the new children's development that we are building in Chesterfield, bringing services that are currently delivered in rather dilapidated buildings in the town centre onto the site of the Royal (which is a large site) and having an integrated set of services and an improvement to

those services. We had the board meeting and I noticed after we gave the business plan approval the chief executive and the financial director and a few others were smiling at each other. I asked what I was missing and they said, "You don't realise, Richard, but what we have just done in two months would have taken at least two years to achieve before".

Q91 Dr Naysmith: What was it specifically about the Foundation Trust that enabled that to happen?
Mr Gregory: We could make the decisions. We did not need to bid into a central pot. We had the resource, we put forward a proper analysis on clinical and financial criteria and we debated it rigorously and we decided to approve it. We did that within our own boardroom; it took as long as the process took which was probably less than two months actually. Apparently these things took an awful lot longer before.

Q92 Dr Naysmith: Stephen, what have you done that you could not have done before?
Mr Firn: I think there are a couple of examples, first around money and then around the work with governors. We are a Mental Health Trust, as I alluded to before and do not have a tariff, we just have block contracts. Prior to being a Foundation Trust there was no incentive to make or declare a surplus because we were essentially given a block of money on the first of April and you were expected to have spent it all by 31 March otherwise the risk—and often the reality—was that any left over was used to cover problems elsewhere in the health economy. Now that there is a recognition that if we work with commissioners and work with our commissioners to generate a surplus and we can carry that over and invest it in ways that are agreed with governors and commissioners that has made a huge difference. This year, as I have alluded to, we have put part of it into developing a personality disorder day hospital which is part funded by commissioners but part funded out of our surplus. That would not have happened; we would not have been able to do that. We have increased the level of psychological therapies through funding through our surplus because this is what governors said was the highest priority amongst local people. That has been a big difference and, as I said before, we have set up something called an opportunity fund where any of our clinicians can now say, "I can see a good service that we could develop; if you can give us non-recurrent funding we can demonstrate that it works to commissioners and then hopefully they will pick up the funding". We can get that approved within a month. The example last month were some commissioners from our child and adolescent mental health service who wanted to develop a service in a number of schools providing advice and education and counselling to young people. We were able to fund that. Already one of the schools has said that they will pick up the funding in the future. In that sense we are much more able to look at the money we have, work with clinicians and work with commissioners to re-invest it in a way that we were not able to before. The other big difference is the governors. As a Mental Health Trust we have often been used to involving users in care and having things like user councils that we have had for many years, but actually the Council of Governors which has 12 elected members of the public, 12 elected patients and six elected members of staff really are now holding us to account and making us focus much more on patient quality, sitting in on serious incident investigations and being part of those panels, and they are coming to our board strategy days to help us plan the future and approve our plans. That really has shifted our focus onto what are the local needs, to look outwards rather than look upwards. If I give one further example around the governors, we appointed onto the Council of Governors people from partner organisations who had not really been involved with us before, so representatives say from JobCentre Plus, from the Chamber of Commerce and through those new links we have been able to do things like set up employment schemes where we have been able to get our service users into jobs and supported, we have a lot of events with local employers showing how we can support them to employ our staff, and we have set up a partnership with Charlton Athletic where they have had us on the pitch giving messages about mental health. I could go on, but I think those are the two big things: the flexibility around the money and being able to invest it locally, and the work with the Council of Governors.

Q93 Dr Naysmith: Playing the devil's advocate, an awful lot of what you have said about the governors helping you to make contacts in the local community could have been done before through things like Community Health Councils and the new Links organisation. Or is that just not feasible?
Mr Firn: I do not think we would have been able to do all this within the last two years. I think the fact that if you ask somebody to be a governor you are asking them to give up a certain amount of time but you are also asking them to carry out a very important job (appointing non-executive directors, approving annual plans, holding me and the organisation accountable for our performance) and when people come onto that Council of Governors it gives them an investment that they want to see something coming out of and being involved. It does open up those new links and opportunities. For Charlton Athletic, for example, one of their footballers was the first member; he signed on the football pitch and that was the kick start to a lot of other things we have done. That would not have happened if we had just gone and knocked on the door and said, "We're your local Mental Health Trust; we would like to work with you". It gives you levers that you do not have otherwise.

Q94 Dr Naysmith: You are obviously very enthusiastic about this?
Mr Firn: Yes.

Q95 Dr Naysmith: Finally, Bill, on this autonomy section you have had a rather well-publicised discussion about autonomy, particularly over MRSA. Is this an area that you think has now been solved and resolved or is it still lingering around?
Dr Moyes: I am not going to say that it will never happen again in the sense that the issue will never come up again. We underestimate the scale of change moving to Foundation Trusts. The Department, for 60 years, has seen itself in essence as corporate headquarters of a corporate hospital system and with Foundation Trusts they are no longer in that position, whereas they are the headquarters of a commissioning system. The issue that David and I were debating—I think it is a debate amongst people who are trying to make this happen rather than a personal difficulty between us—was: how can the Government express absolutely legitimate points of view from ministers saying that they are worried about cleanliness in hospitals and what is being done about it? But how can ministers convey the desire to see something done through commissioning rather than through issuing operational instructions to hospitals? That is the issue I was really opening up with David, that we have to try to find a way to use commissioning, the power of commissioning and the language of commissioning to convey legitimate political aspirations rather than revert to saying that the secretary of state wishes this to be done. That is a huge change and I suspect we will still uncover examples in the future where we have to round that territory again and work out how we could have done it better. It is not in any sense a running dispute; it is something that he and the permanent secretary and I have talked about and I think we are pretty clear that this is an important issue that has to be tackled.

Q96 Dr Naysmith: Have you managed to get the MRSA issue into commissioning to your satisfaction?
Dr Moyes: No, I do not think I do see it as being in commissioning to my satisfaction. It still remains in the Foundation Trusts an issue that was largely being dealt with through regulation, through our compliance system rather than through discussions between commissioners and suppliers. My aspiration for the future for C.difficile, for example, would be that much of the discussion about whether C.difficile performance has been delivered or not will be between the commissioners and the Foundation Trusts and that we will only get involved in the most extreme cases of difficulty.

Q97 Sandra Gidley: Going back to innovation, the recent HCC/Audit Commission report concluded that "On a national level . . . Foundation Trust status does not yet seem to be empowering organisations to deliver innovative models of patient care". I have to say that in the submissions received there did not seem to be any specific examples of improvements in patient care, so I just wondered whether Richard or Stephen might be able to put some meat on the bones really.
Mr Gregory: I think we are now at the point in time after the Darzi report and the discussions about how Foundation Trusts can engage with their commissioners not simply in terms of negotiating the traditional bones of the activity and payment structure, but in actual fact trying to reshape services to improve them for the benefit of the patients in the local community. Those challenges that were laid out a few days ago will enable Foundation Trusts and commissioners, hopefully, to engage in some innovation. At the moment our innovative capability and capacity from where I sit is constrained by the quality of the contract and by the quality of the dialogue between the commissioner and the provider. That needs to be opened up and one of my personal concerns and priorities is that we need to escape our organisational barriers here and engage intelligently over and above the contract negotiation in terms of delivering change to the benefit of the patient.

Q98 Sandra Gidley: Surely you did not have to wait for Darzi.
Mr Gregory: I have not seen much evidence of an enabling framework for us to be able to do that from my perspective.

Q99 Sandra Gidley: So this sentence in your submission when it says that this is what you have achieved, "an altering vehicle model, goes everywhere, does everything, unrestricted by the usual boundaries" is not true because you have just mentioned boundaries that are in place.
Mr Gregory: I think there is a boundary. Yes, it is an exaggeration if you take that literally. I think that we have got the ability to deliver that; I think we have got the ability to be very flexible and innovative in the future, but we do need the right conditions. It is not simply about the contract, it is about the key individuals, it is the relationships. For example, yesterday we had a Council of Governors meeting at Chesterfield and we had the chairman, the chief executive and the director of corporate strategy from our PCT—Derbyshire County PCT—to actually present the Derbyshire vision following the Darzi work streams. We asked and they agreed for the implementation issues and the questions in those implementation issues to be consulted upon by 12,000 public members. We are beginning now to see evidence of like minded individuals in both camps actually putting their heads together to try to achieve this. The real trick is to enable the clinicians and the patients through their public elected members, the governors, to exert some leverage on that process. I am not unhopeful that we can deliver innovation; I would like to deliver innovation and I think we are at an interesting moment in time now.

Q100 Sandra Gidley: Stephen, have you managed to do any better?
Mr Firn: I cannot comment in relation to Richard, obviously. I mentioned a few of the initiatives earlier. What I think I can confidently say we have been able to do—I am sure if all my clinicians were here they would back this up—is innovate locally to

do the types of services that we were providing better, to increase access and to improve quality. I think we can show we have done that from our patient survey; we can show we have done that around expanding psychological therapies and indeed our governors said that in their submissions. As we said before, we are hindered by two things, one is having this block contract so that there are no means for a Mental Health Trust to do something really exciting and innovating with the money following the patient; it has to be a commissioning decision and the commissioners have to say "Yes, we will fund that". At the moment we are still in this position where we have a lack of clarity around how Darzi will actually play out in the way that services are delivered in local areas and it will be different in local areas. In terms of innovating into major service change, not yet. However, I think that the fact that we have Foundation Trusts and the fact that Foundation Trusts have the surpluses or the cash balances that we talked about will be a critical element of making things like Darzi happen. As I have said, we are already engaged in discussions around things like polyclinics et cetera. We are not quite there yet in terms of major service change.

Q101 Sandra Gidley: Dr Moyes, from Monitor's perspective do you have any mechanisms to identify innovation? If so, how would you evaluate what is going on and maybe spread best practice which is something the health service does not do well in any area?
Dr Moyes: I do not see that as Monitor's role. I think the Healthcare Commission and the Care Quality Commission are the bodies that ought to be interested in how clinical care is delivered and how it might be improved. We do try to keep Monitor focussed on particular areas and I have not so far seen Monitor as having a role in analysing innovative models of care and spreading best practice.

Q102 Sandra Gidley: So it is not something you even have any desire to do.
Dr Moyes: I think if we started to do that we would be easily open to the criticism that we were allowing our mission to creep and regulations were coming overburdensome. I am always very conscious of those things and I do try to keep Monitor focussed on the things that I think we were set up to do.

Q103 Sandra Gidley: Moving on, in your draft annual report you state that "as the financial stability and strength of the sector has grown, increasingly the issues are different kinds of service failures—breaches of national waiting time targets and more recently failures to secure sustained reductions in the rate of MRSA infections". Is it perhaps possible that improved financial performance is being gained at the expense of quality?
Dr Moyes: I do not think there is any evidence to demonstrate that. I think in the early days of Foundation Trusts the focus was very much on the financial performance but more recently, as deadlines for targets have come up—things like 18 weeks, MRSA—inevitably Foundation Trusts and our own focus has switched to ask questions about whether these things are or are not going to be delivered. As we list in the draft annual report that you have we have tackled this year a number of financial issues in Foundation Trusts but I think we have spent more time on non-financial issues than we have one financial issues, reflecting the kinds of problems that are emerging.

Q104 Sandra Gidley: You have the flexibility in-built to do that, it is just the way the systems work.
Dr Moyes: Yes.
Mr Gregory: To give you an example, without any pressure from Monitor or anybody else we were concerned back at the beginning of 2007 about our C.diff rates and as a board and as a Council of Governors we were determined to do something about it. We spent half a million pounds of hard earned revenue gain so directly impacting our bottom line on a whole range of measures that achieved over the next 12 months a very dramatic reduction in our C.diff rates, 53% down. We did not need to do that; we were absolutely determined to get hold of that issue and I have always said that it is the quality of what we do that is the most important thing. Finance enables you to make decisions; it is not going to be the key determinant and driver at Chesterfield Royal, it is about the quality of what we do and that has to be the priority. Going forward I think we all need to focus on the opportunities that we have just been talking about recently about how we can carry on doing that.

Q105 Dr Taylor: I am just wondering if it is coincidence that we have two of the very best Foundation Trusts here because looking at the glorious technicolour diagrams at the back Chesterfield is green all the way across for governance risk ratings and number five all the way across for financial risk. Oxleas is likewise green all the way across and steady fours for financial risk. I wonder if that was coincidence or by design. There are 25 trusts who governance risk ratings have remained for the last year at either amber or red and when we did our first report on Foundation Trusts we were worried that there were going to be adequate incentives in place to ensure that trusts improve or even maintain high levels of performance. Are there incentives to improve or maintain when we are talking about quality particularly?
Dr Moyes: I think there are, Dr Taylor. I cannot really speak for Primary Care Trusts and how they monitor performance against the contract, but I think Monitor's compliance system and its focus not just on finance but also on governance does provide very real pressures on the Foundation Trusts to first of all recognise that they have problems, so go and find the problem in the trust; the board has to self-certify to us when they provide their annual plan and then every quarter whether or not they are delivering national standards and targets. That means that we expect the board to know what their performance is

and to forecast their performance so there is a pressure to look ahead as well as just to tell us what is happening today. Foundation Trusts know that if they have a persistent problem and it is obvious that they are not tackling it, that Monitor will intervene, initially informally but if that does not produce a result then we will use our formal powers. I think Foundation Trusts are extremely conscious that we do have very, very tough powers and we can use them.

Q106 Dr Taylor: What happens if a trust remains on red for a long time?
Dr Moyes: If a trust remains on red for more than two quarters we would certainly call in the board. By that stage we probably would have concluded that they were in significant breach of their authorisation. We would try to establish whether the board understood the nature of the problem or not. If we had any doubts about that we would commission advisors to work with the organisation to make sure that we were tackling the right problem. We are very unwilling to go for quick fixes; we try to find out what is the real nature of this problem: is it the quality of the board? Is it the quality of the management? It is something about clinical quality? We try to get an advisory team in depending on the nature of the problem to describe to us the true nature of the problem. We have done that with five organisations in relation to MRSA. Having done that we make a judgment as to whether we think the hospital can or cannot, with the existing board and the existing team, solve its problems. If we think that they can then we make sure there is an action plan in place. We meet them monthly; we tend to want monthly reports against the action plan to try to make sure that they are delivering. If we came to the conclusion that the board or the management team or a combination of the two simply could not solve this problem then we would use our powers, if necessary to remove the board or the chief executive or the clinical director and find people who could solve the problems. That is an option we try not to use very often.

Q107 Dr Taylor: So you would remove the board before banishing them from the elite of Foundation Trusts.
Dr Moyes: We cannot do that. Once they are Foundation Trusts they are authorised forever; that is the legislation. The idea of withdrawing the authorisation and handing them back to the secretary of state is not an option.

Q108 Dr Taylor: One of our witnesses in the first session did say that he thought there were financial instruments to drive quality, for example that the commissioners could pay more for high quality services than for lower quality. I think one of you said you could use the power of commissioning to improve services.
Dr Moyes: Lord Darzi has recommended a system of paying for performance and a pilot scheme has been run in the Northwest using a model developed in America by Premier Healthcare to have a very small pot of money—it is not an enormous amount of money—and to use that small pot of money to reward trusts (not just Foundation Trusts, but all trusts) for delivering above and beyond the minimum contracted levels. I think the pilot in the Northwest has been held to be a successful pilot and Lord Darzi has recommended that it is adopted as a feature of the tariff going forward, which we would certainly support; we think it is a good idea.

Q109 Dr Taylor: Did you approve of Cheltenham giving all their staff a bonus of £100 for their achievements?
Dr Moyes: It is not for me to approve or disapprove but personally I think it is not a bad thing. I think the staff worked extremely hard and it was justified, but it is not a matter that comes to me at all.

Q110 Dr Stoate: I would like to talk about governance and democratic accountability. Richard, there has not been much evidence that we have seen on the costs of governance and accountability but some figures have put it around about £200,000. How much does it cost to run your governance arrangements?
Mr Gregory: The costs of running our membership, our public events, the newsletters, the elections and a whole range of associated things, the Chesterfield Royal is about £200,000 a year.

Q111 Dr Stoate: Is that good value for money?
Mr Gregory: Yes, I think it is very good value for money. I think we have to be careful long term about the targets that are given to us on total membership because every election, for example, costs about £35,000. If we have a catchment area of 375,000 I dread to think what it would cost to actually mail out to all 375,000 residents in North Derbyshire. There would be cost implications if it went to the end of the extreme. What we are looking for really in engagement; we are looking for a two way relationship so that is going to be more costly.

Q112 Dr Stoate: Can you explain what specific things your governors and your membership have added to your trust that you were not able to do beforehand? Can you give us examples?
Mr Gregory: I would be delighted to. I think if I give you the specifics of area—that is in the public and patient area, PPI—I could tell you an awful lot about what we have done to try to make our governance more effective. It was a concern of mine when I arrived that the model was thin on good principles and on detail. What we have done—when I say "we" I mean the executive, the board, management and governors—is to give far more of an effective role for the governors within the Trust. One key output or example of that is our PPI arrangements. The governors have their own PPI Committee and they have the ability to look at all aspects of our patient care. That means mystery shopping type visits to the wards, evidence based checking system on whether it is cleaner, whether the food is good enough, whether the levels of care are good enough. This is a properly documented

Committee where the board asks for the executive to not be defensive but to make sure that we are doing this to add value to the system. I am absolutely delighted with the way our executive has engaged with this. It is a positive, internal, constructive challenge and we would not have got that any other way. They are putting pressure on the system all the time. Our cleaning regime has changed; we are spending more on it. We are doing things in a different way; we have brought housekeepers back onto the wards, we have re-introduced matrons; we are looking at bringing our food sourcing into the locality rather than importing it from South Wales. We are doing a lot of things on all aspects of patient care. We would be doing them anyway to a degree but absolutely hand on heart I think we are doing them harder and faster because of the pressure that the governors are exerting on the system. We have only been running that for about 18 months and it is paying off a lot of rewards. I think the focus is on quality that Alan Johnson, Lord Darzi, Bill and David Nicholson have spoken about on many occasions over the last six months; I think we are into a new regime of focussing really hard on quality, not just on waiting time reductions and infection control rates, but really about the quality of everything we do. That is absolutely our mandate at Chesterfield.

Q113 Dr Stoate: Stephen, are there any specific challenges in terms of governance for a Mental Health Trust or is it broadly the same picture?
Mr Firn: It is more of a challenge. As I said before, even though we had a user council the fact that we now have governors with these formal roles, at every three monthly meeting I am on my feet for about an hour and a half taking questions principally from the public and patient governors about all aspects of the organisation. This is challenging enough but the Council of Governors is really a critical grilling and they really do hold us to account.

Q114 Dr Stoate: Does it improve the way you do things?
Mr Firn: Absolutely. It is in the forefront of our minds: "What are our governors going to think about this? What are they going to think about our staff survey? What are they going to think about our patient survey? What are they going to think about this serious or untoward incident?" So it is there now, it is right in front of us. They also do site visits like in Richard's trust and if we do have a serious incident, such as a suicide or very, very occasionally a homicide, then they will sit on the inquiry panel and they will be a full member of that inquiry panel and will give their views and judgments alongside the professionals. So there is that clear feedback. I think the real challenge for mental health is that whilst we have a very active set of governors it is building a large membership and that is a real challenge because most of our membership—which is only around 4500, which is not typical I do not think for Mental Health Trusts—have some contact with the organisation or family or friends. If you want to get people interested in a mental health organisation you should tell them you want to build something in their local area; that is often the only reason why they get very agitated and involved, otherwise if things are seen to be going fine it is very hard to get people interested. That is our biggest challenge I think, engaging with a wider membership. One of the things we wanted to do as a Foundation Trust is to actually start to make mental health something people discuss, know about and talk about it in the way we talk about other health problems. That is the challenge.

Q115 Dr Naysmith: Stephen, what happens if you and your team find yourselves in disagreement with what the governors and members want? Has it ever happened?
Mr Firn: There has not been a major disagreement, no. This has come up mainly around our annual plan in which we agree our priorities and we have to agree where we are going to invest our surpluses, so they are actually involved in making decisions about money. I think what the legislation says—certainly what our constitution says—is that the governors are required to take a view. They have asked me directly what that means and I have said that if they do not agree with something we are saying we will invest in or if we are refusing to do something that they think is very important, then we have a serious problem and I would be very silly to ignore them, given the powers they have.

Q116 Dr Naysmith: So you talk them round.
Mr Firn: We have not had major problems. One of the things we were worried about that has not come up is that we would have people who had completely off the wall views, but most people's concerns are the same as ours: what are we doing to support patients' care and improve things like psychological therapies? The agenda is similar, they just challenge and hold us to account.

Q117 Dr Naysmith: The question I want to ask you, Bill, is that this year for the first time you mentioned in your annual report that you are going to offer guidance to governors in the discharge of their key responsibilities. There has been a lot of evidence over the last two or three years—reports published and even one recently unpublished but some people know what is in it—suggesting that governors are very confused sometimes about their roles. Why has it taken you so long to offer this guidance?
Dr Moyes: We wanted to let the system settle down. It is a new approach and it is not something that we came to with a recipe book that said that we know exactly what governors are going to do and this is how they should do it. We thought it was very important that governors and members had a chance to think for themselves a bit. We did a survey of governors earlier this year; that gave us some useful information. We got Ipsos MORI to do the work for us. We held a series of four regional events where we invited governors in; we had about 100 to 150 at each one. That gave us quite a lot of intelligence about the issues that they faced. I think the conclusion we reached was that there is actually

quite a lot going on but governors have some very specific statutory duties but not always a very clear idea of how those duties should be discharged. They appoint the chair, they appoint the non-executives, they approve the terms at which a chief executive is appointed; they appoint the auditors, they receive the audit report, those kinds of things. One can infer that from that Parliament probably intended them to have some basis for making the appointments, so some kind of performance assessment process. We think probably the time has come where we understand enough the issues that governors face and the questions they have to start expressing some views about what would be very good practice and what might not be such good practice. That is where we are heading at the moment.

Q118 Dr Naysmith: Are you going to take it to some of the lower performers in this area and start with them first?
Dr Moyes: What we are going to do is to write from our experience and from the experience of other people and it think it is a guide to best practice; I do not really have it in my head yet because we are just starting work but I think it is a guide to best practice. It certainly will be something we will consult on. Then we hope out of that will come a consensus, purely in relation to the statutory functions of governors, what is a good way to do the job and what are the things we should discourage governors from doing. I think the other thing that we will try and bring out is that the board of directors have to support the governors to discharge their statutory duties. It is not two separate camps; there are a lot of things the board has to do and we want to make sure the board recognises this.
Mr Gregory: There is a national association for governors, the FTN, which works very closely with the governors on a national and a regional basis. The chairs do spend a lot of time encouraging governors to meet with each other and talk with each other, so there is a lot of best practice developing. We are on a journey and I think the journey as new trusts are authorised, the more mature trusts are offering facilities and help and the FTN does a great job doing that and we do an awful lot of it in Chesterfield.

Q119 Dr Taylor: Going back to Monitor and Dr Moyes, it has been suggested to us that your organisation's success is very closely tied to Foundation Trusts' success and that therefore you may have an interest in being something of a cheerleader for Foundation Trusts in general, emphasising the good points rather than necessarily focussing on those towards the bottom of the tables. How would you respond to that?
Dr Moyes: I think in our early days Monitor wanted to establish in people's minds that this was a system that could be made to work and work well. However, I think if you talk to hospitals like Bradford or UCLH or some of the more recent hospitals where we have intervened either formally or informally they would say that when we are not happy our unhappiness is extremely apparent and that they are expected to make us happy. I think overall we are very conscious of the issue and we are trying very hard not to be a cheerleader. We try very hard to be a constructive regulator and to let the Foundation Trust Network do the cheerleading because that is their role.

Q120 Dr Taylor: Going back to our first report again, one of the recommendations was: "In line with the general move towards rationalising inspection and regulation in healthcare we recommend that CHAI" (as it was then) "and the proposed independent regulator act in a complementary way integrating their work". Is that actually happening? We had Maria Goddard as a witness who gave written evidence at that time and she has written, I gather, in September's *Health Policy Matters* that there is a rather crowded regulatory environment covering economic regulation, quality and public safety. Is it crowded or are you working with the Healthcare Commission or the Care Quality Commission as it comes?
Dr Moyes: With the Healthcare Commission we have a very good relationship and I think we are both very clear about our respective roles. We work together; I see Anna Walker regularly, my team see her team regularly. Where we have problems in a Foundation Trust we will ask for their advice. Where they identify problems with quality or with service delivery that is serious enough, they will refer these things to us. I think there our respective roles are very clear and the legislation underpins that. My ambition is to develop a similarly clear and good relationship with the Care Quality Commission and similar clarity of role. The Care Quality Commission is a very different animal with a much wider remit. One of the things that Baroness Young and I have started to talk about is how do we make sure that the fact that they have a degree of intervention power in relation to registration does not produce two regulators trying to do either different or the same things to the same trust. We recognise the issue and we have just started to talk to each other about how is that issue going to manifest itself and what are we going to do about it.

Q121 Dr Taylor: Without you listening, Bill, have the other two been more frightened of you or of the Healthcare Commission, or has that not come into it?
Mr Gregory: I do not want this to sound arrogant but I am not afraid of either Monitor or the Healthcare Trust.
Mr Firn: I am afraid of the consequences of both if we get things wrong because they both have significant powers and so have our commissioners. Speaking on behalf of Mental Health Trusts we fully recognise Monitor's desire and reasons for strengthening the quality indicators in the compliance framework for Mental Health Trusts which Monitor has done this year, but it set some very challenging targets, particularly around an area of delayed discharges. We want to be reassured that the Healthcare Commission will adopt the same

indicators and that we are not at risk of double jeopardy. That is why I am reassured to hear that they are talking.

Q122 Dr Taylor: So your talks are absolutely vital. Can you give us a rough idea of the costs of regulation?
Dr Moyes: I cannot really, no. We had some work done for us by Dr Foster in 2005 once we had authorised the first 25 Foundation Trusts. At that stage the feedback we had from the trusts was that on the whole they were absorbing the costs of our compliance system within their overheads, that the information we were asking for of a financial and non-financial nature was not requiring any special work that they did not do anyway for themselves. We have not repeated that work since maybe because the cost question has not really come to us as a particular issue that Foundation Trusts are anxious about and I think if they were they would tell us. I cannot give you a figure I am afraid.

Q123 Mr Syms: The research conducted by the University of York (Marini et al) analysed year on data for a small subset of trusts. Subsequent performance analysis of performance was prevented by Monitor being unable to facilitate the access to that particular data. How would you respond to the argument that decentralisation in the NHS may deny researchers the essential data to investigate performance and thereby reduce accountability? Is it just part of the decentralised process that there are not going to be the figures available for research?
Dr Moyes: It is a new idea; I have not heard that said before. However, I would say that Monitor is more transparent, we publish more and maybe in a better format. Things like our quarterly reports, for example, our consolidated accounts and our annual report. I have not come across researchers saying that they cannot get the data. They may have to do a little bit more collating themselves because we are very punctilious about what we get from Foundation Trusts; we are trying very hard to reduce the burdens on them. I do not myself believe that researchers cannot get the data. As I say, they may have to do a little bit more collating themselves but I do not think that data is being concealed; I think there is more information around than there has ever been.

Q124 Dr Naysmith: Figures suggest there has been a lot of activity in Foundation Trusts—it has gone up quite considerably over the last two or three years—and yet this has been happening at a time when care is supposed to be being transferred into the primary sector. Do you think you are working hard enough to fulfil that agenda from the Department of Health which is moving care into the primary sector?
Dr Moyes: Again I think this is for the commissioners. I do understand the question but I think what we need to see is commissioners creating the capacity in the community to make transfers of care and then in their contracts with Foundation Trusts making sure that they limit the activity in Foundation Trusts to what they want to see there. I would not say in Monitor we have a lot of evidence of this, but what I can say is that the income of Foundation Trusts is not that much higher than their planned levels of income. It is not as if we are seeing 5 or 10% increases in activity as reflected in the income; it is 2 or 3%, and that is within the error of parameters of the kind of planning that Foundation Trusts do. I am not sure there is evidence of a lot more activity taking place in Foundation Trusts than was planned and I do think commissioners are the mechanism by which we shift activity from hospitals to the community.

Q125 Dr Naysmith: Richard, how is it in your area?
Mr Gregory: We would like to engage in more primary care activity. This is the recurring theme when I meet with the chair of the Primary Care Trust and I really hope that the changes that have recently been flagged give us the opportunity to do that. Chesterfield is very close to its community; it is a small community in many ways and it makes absolute sense to deliver our services in the most effective way for the patient. Looking at integrated care is the obvious thing to do so I really hope we make progress on that front over the next 12 months.

Q126 Dr Naysmith: Stephen, you are involved with your community, I am sure.
Mr Firn: Yes. I would be surprised if that level of activity applied to Mental Health Trusts because, as you know, if we do more expensive interventions like admit people to hospital we do not get any more money for that so it is not in out interests financially and it is often not in the patients' interest either. A lot of the way in which we generate its surpluses has been by reducing our occupancy levels, providing more home treatments, providing more crisis treatments and working more closely with GPs to try to both respond quickly to their referrals but also transfer people back to GP care whenever possible. That is what we have been working on and we will continue to do so.
Chairman: Could I thank all three of you very much indeed for coming along and providing evidence in this session. Clearly there will be no report coming out of this inquiry but I have no doubt that the things that have been said this morning are going to be commented on. Thank you very much indeed.

Written evidence

Memorandum by Dr Pauline Allen (FTM 01)

RESEARCH FOR NIHR SDO R&D PROGRAMME ON FOUNDATION TRUSTS

The London School of Hygiene & Tropical Medicine (in partnership with Leeds University and York University) has been funded by the NIHR Service Delivery & Organisation R&D programme to carry out a research project. The research is about Foundation Trusts, which are a new form of NHS healthcare organisation.

The aim of the project is to investigate how NHS Foundation Trusts (FTs) function, and what difference it makes that they have new ways of being governed, both in terms of their internal structures (as they have members and governors) and how they are regulated from outside. We are interested to find out the degree to which decision making has been devolved to FTs, whether FTs are able to be more responsive to local needs and how FTs work with other local health and social care organisations. We plan to identify the lessons learnt from looking at FTs and suggest how these might be used to improve the governance of all NHS trusts (whether FTs or not).

We plan to study four FTs to understand the effect of the new governance regime. Two will be in the London and home counties area, and two in northern England. The burden on the FTs we study will not be great. Over a period of two years, we will come to the hospital on a small number of occasions to interview a small number of senior managerial and professional staff, and also to hold two focus groups with patients. We plan to use two specialties as examples of how FT status is affecting the delivery of care and patients' relationships with the hospital: these are orthopaedics and diabetes.

The insights we derive from in-depth investigation in each case study FT will be explored and triangulated using the York database. The team has access to this large database held at the Centre for Health Economics, University of York. The database consists of English hospital-level data for all acute and specialist hospitals. There are approximately 400 variables that measure such things as expenditure and income, activity and capacity, patient characteristics, speciality and staffing details, organisational culture, and dimensions of access, quality and performance. The data are derived from a variety of sources including: CIPFA, NHS Information Authority, Healthcare Commission, Hospital Episode Statistics, Department of Health websites, Dr Foster Good Hospital guide, Monitor and specific data that has been collected through CHE's research projects. The data cover non FTs and FTs.

The research team is experienced in studying NHS organisations and their relationships with other care providers. Previous studies resulted in several publications and important lessons, and did not have negative consequences for the organisations involved. We were careful to preserve their anonymity and to respect the confidentiality of sensitive information communicated to us. Similar assurances of anonymity and confidentiality will be given to participants in this study.

Research Team

LSHTM: Dr Pauline Allen, Mr Andrew Hutchings, Dr Stuart Anderson, Dr John Wright
Leeds: Professor Justin Keen, Professor Peter Vincent-Jones, Ms Jean Townsend, Dr Paul Dempster
York: Dr Andrew Street and Professor Maria Goddard

June 2008

Memorandum by Professor Alan Maynard (FTM 02)

FOUNDATION TRUSTS

Alan Maynard is a Professor of Health Economics, Department of Health Sciences, University of York. He is Chair of York Hospitals NHS Foundation Trust and has been involved in NHS management since 1983. He is a member of the Department of Health's External Advisory Board on Payment by Results, an Adjunct Professor in the Centre for Health Economics Research and Evaluation (CHERE), Technology University, Sydney, Australia and a Fellow of the Academy of Medical Sciences.

Introduction

There are currently 99 Foundation Trusts in the English NHS, mostly acute facilities and more recently, including some mental health units. They are allegedly the result of a visit to Spain by Alan Milburn, who was much impressed by local (isolated and unevaluated) developments and asked his civil servants to develop a similar regime here. They were vigorously opposed by some members of the Labour party, especially by Frank Dobson who regarded them as departing from NHS principles, in particular by enabling trusts to make surpluses (profits) from trading in the NHS.

The concept involves quasi-autonomy from the NHS, a more commercial financial regime, increased focus on "quality" and an attempt to improve "democratic accountability". The principal objective of FTs is to improve efficiency by allowing some freedoms within a tight regulatory structure.

Financial Issues

Foundation Trusts (FTs) have greater financial flexibility than other Trusts and are tightly managed by Monitor, their public regulator. Monitor evaluates the performance of each applicant both with its own resources and by using accounting firms to audit financial robustness, probity and governance. There is a Board to Board interrogation in which Monitor assesses not just the robustness of written reports but also assesses how the Board operates and whether there are appropriate skills in the executive team and amongst the non-executive directors. Subject to success in this application process (some trusts have had to apply several times), Monitor issues a licence with documentation setting out the FT's obligations. Monthly and quarterly returns on finance and performance are rigorously scrutinised and deviation from plan can lead to changes in the "traffic light" performance indicators. Deterioration in performance leads to increased scrutiny, visits and enforcement to ensure plans are created and implemented to correct deviations from plans. Monitor is generally more visible to hospitals than the Health Care Commission.

The principal theoretical attractions of FT status are:

1. An obligation on PCTs to pay FTs at tariff (payment by results) for the volume of services delivered. This obligation can be enforced at law.
2. A rolling three year financial cycle which is carefully planned with negative deviation from path leading to swift intervention by Monitor? This regulatory system involves careful risk rating of the FTs performance with swift "traffic light" signalling and management scrutiny.
3. An expectation that annual trading will generate surpluses that can be carried forward to fund future investments.
4. Access to private capital markets to develop local services.
5. Capped private income.

But issues have arisen:

1. To stay in balance PCTs should introduce demand management that diverts patients from hospitals in primary and community care. Whilst the theory of this is intuitively attractive (eg anticipatory care maintaining the chronically ill in their homes), PCTs have had limited impact with such policies. This is unsurprising as they have insufficient leverage to moderate hospital activity and switch care into the community. Consequently they have great pressure on their finances.

   FTs have an incentive to attract patients as increased activity creates increased income and their status requires payment at tariff rates for work done. It has been alleged that hospitals allow erosion of conversion criteria to increase patient flow eg reducing treatment thresholds and converting more out-patients into in-patients. The original rhetoric of "payment for services delivered" has now been watered down by strong DH advice that FTs and their PCTs should collaborate on agreeing volume levels so as to cap by mutual agreement the open ended nature of the PCT liability. DH rhetoric about "world class commissioning" is supposed to assist this process but PCTs, generally with weak management and poor use of comparative quantitative data, continue to find difficult the tasks of capping hospital activity and switching resources to a "primary care led" approach.
2. The regulation of the financial performance of FTs is detailed and generally appears to be of high quality. Of course given the initial tranches of FTs were carefully selected and high performing, financial discipline was expected and generally has been delivered. The exception was the poor performance of the Bradford FT which led to the removal of the Chair and Chief Executive and significant management changes. The costs of the regulatory regime are typically underplayed.
3. Trading profits have been unequally distributed but are significant. Currently they are circa £1.7 billion, a large nominal amount but in relation to their trading volumes, quite modest. However, with this considerable sum sitting in the bank, there is little gain to the NHS. Can these sums be managed more efficiently?
4. Access to private capital markets remains a problem. FTs generally cannot access NHS capital and the PFI programme of recent decades is fading into insignificance. In theory FTs should be able to borrow and finance repayment and interest out of trading surpluses. However hospital tariffs are in a continuous state of flux as DH seeks to fine-tune the policy and use tariff manipulation to induce cost savings and improved benefits for patients. The consequence of this hospital tariff policy is that FTs have very uncertain income flows and surpluses are either not spent or are used to fund one off small capital projects, eg improving car parking. FTs have as a result large unused licence capacity to borrow and there is great uncertainty about how FT capital development will be carried out to improve service quality.

Democratic Accountability

Each FT is encouraged to recruit as large a membership as is possible, and recent Prime Ministerial statements have advocated a doubling of membership. Members elect governors through secret ballot. The size of the Council of Governors varies and is made up of people elected by the members and nominated members from local authorities and medical schools.

The governors' powers are limited:

1. They appoint the Chair of the FT (The Chair of the FT chairs both the Council of Governors and the Board of Directors of the FT).
2. They appoint non-executive directors to the Board.
3. They can dismiss the Chief Executive (with a 75% vote) (The other Executive members of the Board are appointed by the non-executive directors with professional support from the Chief Executive and an independent external assessor).

There are two FT members' organisation: the Foundation Trust Network whose chief executive is Sue Slipman, and the Foundation Trust Governors' Association (which is run out of the Kings Fund), whose chair is Sharon Carr-Brown.

Some issues of democratic accountability have also arisen:

1. The training and involvement of governors has been demonstrated to be very variable (eg the FT Governors' Association publication "Snapshot membership survey" April 2008 showed considerable variations in FT investments in induction, training, and meetings with Boards and to consider performance).
2. Monitor has also surveyed governors' roles and activities in two recent publications: "Developing the role of FT governors" (May, 2008) and the results of a Mori investigation "Survey of Foundation Trust Governors" (January 2008). Monitor is now much more focused on the membership issues as a result of the "democratic deficit" debate.
3. There has been little evaluation of the costs of the FT governance mechanism. With the need to manage member and governor inquiries, to communicate and meet with the latter regularly and to manage registers of members and governors and regular elections, a "guesstimate" of the cost per FT might be £250,000 per year ie £20–£25million per year for all FTs.
4. The recent discussion of a "democratic deficit" in public bodies such as the NHS has led to some suggestions of reform eg involving local government in NHS governance. This also raises questions of why Foundation status was not initiated with commissioners rather than providers, as PCTs might be expected to be more locally accountable in allocating purchasing funds.
5. The policy issue arising from the recent debate on governors and members is whether these arrangements are efficient or not. The Health Service Journal reports that "there are huge obstacles to making foundation trust membership anything other than a fig leaf of accountability" (HSJ editorial 5 June 2008.in response to the January Mori survey for Monitor).

Quality Regulation

It is only in recent years that the focus of Monitor has shifted from finance to what is done with the money in terms of the quality of patient care. Monitor now complements the Health Care Commission (HCC) with performance targets, some slightly differently defined (eg using moving averages or monthly performance to judge achievement of the four hour wait for A&E).

Monitor's recent publications on quality, and their advice to the Darzi review reflects their awareness of the difference between processes of care and patient outcomes. This is consistent with the evolving Department of Health agenda—for example, Sir Bruce Keogh's increasing pressure not only to improve outcome measurement but also incentivise it with financial incentives.

While the quality agenda remains central to Monitor's governance of FTs, it accepts in a recent paper to the Darzi review that the Health Care Commission and its successor will be the primary vehicle for this work. A nice issue is how Monitor and HCC bring their metrics into line and collaborate to ensure both early warning of problems and their prompt resolution.

Areas for Investigation

The work of Monitor and the scrutiny of the performance of FTs have been quite limited. In part this is a reflection of how the early tranches of hospitals being awarded FT status were high performers in terms of finance and service performance. With nearly 100 FTs now licensed, the following issues need investigating both in the Select Committee hearing and by future research:

1. Who is responsible if an FT goes bankrupt? Is the division of responsibility between Monitor (Bill Moyes) and the Department of Health (David Nicholson) clear and unambiguous?

2. Has efficiency improved as a result of Foundation status being awarded to hospitals? The Marini *et al* paper[1] analyses year one data for a small subset of trusts. When seeking data for subsequent years to extend their analysis, they were told Monitor no longer collected the data and access to data could only be acquired by application to individual FTs. "Decentralisation" in the NHS may deny researchers of essential data to investigate performance, thereby reducing accountability.
3. How can policy continue to incentivise more efficiencies in FTs once they have achieved a surplus? Are "cost improvement targets" sufficiently ambitious?
4. How can PCTs demand more for their money from FTs? Will they be allowed to pursue even greater value? Are they capable of practicing greater vigour in the pursuit of improved efficiency from FTs? How can Monitor help them do this or is this not their role?
5. How robust is the FT application process? With the recent rapid increase in FT numbers, is the quality of these processes still fit for purpose? How much does an average application cost Monitor?
6. What is the cost of Monitor? What is the average cost to applicants of applying for FT status?
7. If Monitor's budget was increased by 10% how would the increased funding be spent?
8. If Monitor's funding was cut by 10% where would expenditure be reduced?
9. What is the capacity to borrow of all FTs and how much of this capacity is used? Why is utilisation of borrowing powers limited? How should FTs fund ambitious capital developments when PbR tariff revenues are uncertain?
10. The private income cap for Trusts varies considerably. How should this be managed in the future? Joint ventures with the private sector may increase NHS efficiency. Will FTs capacity to enter such arrangements be restricted and is not this a failure to ensure a level playing field for NHS and private providers?
11. Finally there is the long running issue of achieving a "primary care led NHS". This has been a central part of Government rhetoric for decades but the translation of intention into change has been very modest. There are groups of patients who should not be in hospital and are admitted because of the weaknesses of primary and community care. For instance if community monitoring and support of patients with chronic obstructive pulmonary disease (COPD), heart failure, asthma and diabetes is provided earlier in an episode of illness patients would not need to be admitted to hospital as emergency cases. The system of payment by results (PbR) rewards hospitals for activity and thus even though hospital admission may be an inferior solution to prevention with community care, they welcome the revenue flow.

    Government has recognised this perverse incentive by introducing a two part tariff with hospitals paid for emergencies up to some agreed level at full tariff, and paid at only 50% of tariff above the contracted volume. In the absence of a primary care led NHS and investment in community based preventive care, government might manipulate the PbR tariff further. They could do this by, for instance, not inflating the current contracted volume of emergency care annually so that the 50% tariff kicks in sooner or it could be more radical and pay less than 50% (eg 10–20%) of the tariff for volumes in excess of the contracted amount. This would leave PCTs with more cash to invest in preventive community care and would incentivise hospitals to collaborate closely with PCTs and local authorities to ensure that emergency admission volumes are at the contracted level. The failure of policies to address these issues has enabled trusts to generate money from the avoidable misery of patients who may be better cared for in the community.

June 2008

Memorandum by Dr Mark Exworthy (FTM 03)

NHS FOUNDATION TRUSTS

1. Summary

Foundation Trusts (FTs) represent a significant phase in the decentralisation of the NHS. Allied to other reforms, FT status offers (high performing) Trusts the opportunity for greater autonomy in various functions from the Department of Health (DH)/centre. Here, autonomy can be seen (i) as "freedom from" the centre as well as "freedom to" be innovative and responsive, and (ii) as a key factor with incentives in promoting further improved performance (crudely, autonomy + incentives = higher performance).

[1] Marini, G *et al*, Foundation Trusts in the NHS: does more freedom make a difference? Health Policy Matters, 13, 2007, University of York.

The willingness and ability of FTs to exercise their autonomy will determine the impact they have both within their organisations and the wider NHS. Currently, the evidence suggests that they have yet to exercise fully this autonomy but have the potential to do (given their current evolutionary path and supporting policy developments).

2. Lack of Evidence

In general, there is a lack of (research) evidence on the work and impact of FTs, given their significance to English health policy. The reports by the Health Select Committee (2003), Day and Klein (2005), Healthcare Commission (2005) and the Audit Commission (2008) are the major sources of evidence. Some studies have been conducted into specific aspects which relate to FTs, such as Payment by Results (PbR). Anecdotal evidence is much more prevalent.

3. Synthesis of Evidence

This synthesis is informed by the provisional findings from our research (see 4).

2a. Macro-level: Autonomy from the Centre:

Recent reforms have transformed by the role of the "centre" in that the DH is no longer the sole agency. For example, the Secretary of State no longer retains residual powers. Instead, Monitor (as regulator) has a key role in ensuring performance standards of FTs and acting as a buffer between DH and FTs. Generally, Monitor is well regarded by FTs. The role of the Strategic Health Authorities (SHAs) in relation to FTs has also changed given the removal of performance management function. The number of FTs by SHA area varies considerably and may imply a key role for SHAs in fostering FT development. However, the DH and SHA also require a change in attitude and behaviour to reflect the changed landscape of FTs and their activities.

2b. Meso-level: FTs in the local health economy:

Despite autonomy, FTs' actions are constrained to varying degrees by the context of the local health economy (or community). For example, PCT deficits or "competition" from other providers might constrain service developments of or related to FTs. Provisional evidence suggests that FTs are "picking and choosing" the issues on which they are cooperating (especially if it is in their self-interest). There are some perceptions that FTs have secured an unfair advantage in the LHE (for example, as a result transitional relief arrangements associated with PbR). PCTs still remain generally weak (in capability and intelligence) compared to FTs, comprising the strategic perspective of PCTs.

2b. Micro-level: FT attitudes and behaviour:

FTs have been the "high performing Trusts"; this was the criteria for their approval. This biased sample indicates that their performance might also be strong as FTs but initial evidence suggests no significant improvements as a result of FT status. The willingness and ability of FTs to exercise their autonomy is debatable. Generally, they are able to exercise autonomy (under their new status as public benefit corporations) although FT status demands that senior staff change their skills and attitudes. Equally, FTs appear less willing to exercise autonomy to a great extent, as they are still acquiring legitimacy as organizations in their LHE and internally. This unwillingness might reflect their view of risk (aversion to it) given their greater degree of financial exposure, the uncertainty associated with the new policy environment (including on-going features of centralisation) and the impact that their decisions might have upon other local organizations. New governance arrangements are seen as an important development but have yet to translate into meaningful change. The relationship between the FT Governors and the Board still require further development.

4. Funding

Our current research is funded by the National Institute of Health Research (Service, Delivery and Organisation R&D programme): "Decentralisation and performance: autonomy and incentives in local health economies" (2006–09) http://www.sdo.nihr.ac.uk/sdo1252006.html (Lay and scientific summaries are available on this web address).

The research project involves a collaboration between Dr Mark Exworthy (Royal Holloway, University of London (principal investigator), Francesca Frosini (RHUL), Lorelei Jones (London School of Hygiene and Tropical Medicine), Stephen Peckham (LSHTM), Prof Martin Powell (Birmingham University), Dr Ian Greener (Durham University), Dr Jacky Holloway (Open University) and Dr Paul Anand (Open University).

June 2008

Memorandum by the Foundation Trust Network (FTM 04)

FOUNDATION TRUSTS

Foundation Trust Achievements

Since their establishment foundation trusts have become leaders in the NHS for financial performance, quality, innovation, local accountability and staff engagement. Set out below is an overview of what the foundation trust sector has achieved over the past four years.

- *Growing the sector*: In April 2004 there were just 10 foundation trusts. By the end of June 2008 the sector will have grown to 100 authorised foundation trusts. This constitutes substantial and consistent growth of this new sector within the system.
- *Finances*: Foundation trusts continue to be strong performers financially. As Monitor recently reported the sector's revenues were £566 million ahead of plan, and the net surplus stood at £514 million. Cash balances amounted to £2.3 billion. Foundation trusts are reinvesting these surpluses to improve the patient experience—by upgrading their existing estate, new build or service improvements. For example:
  - South Essex Partnership Trust reinvested its surplus to build and open a brand new mental health hospital at Rochford and a six bed psychology unit for young people.
  - Aintree Foundation Trust has set significant money aside this year for investment in clinical services: £2.2 million to improve nurse staffing level on wards and plans for £2.1 million going into radiology.

Foundation trust boards of governors play a key role in influencing each foundation trust's strategy and its high level investment plans.

- *Quality*: The results of this year's Annual Healthcheck demonstrate the progress that foundation trusts are making on the quality of services they deliver:
  - Nineteen trusts were scored "excellent" for quality of service and "excellent" for use of resources—all 19 were foundation trusts.
  - Eighty per cent of all foundation trusts scored "excellent" or "good" for quality of service. Our analysis of these results also shows the performance transformation that can take place during the foundation trust authorisation process.
  - Of the 20 foundation trusts authorised in 2006, nine showed an improvement in both quality and resources scores, and 18 showed an improvement in one of these scores on their 2005–06 results (pre-authorisation).
- *Staff satisfaction*: Foundation trusts are making a real impact on staff satisfaction levels. The results of the 2007 NHS staff survey showed that on measures of the extent of positive feeling within the organisation, eight out of ten of the top performers are foundation trusts and of all the trusts scoring above average 50% of them are FTs. This picture is repeated on job satisfaction measures with FTs making up 40% of all trusts above average, and within that 13 out of 20 top performers are foundation trusts.

This year's survey results show similar positive results for foundation trusts. In response to the statement "care of patients or service users is my trust's top priority", 55% of those working in acute foundation trusts agreed or strongly agreed, compared to 44% in non-foundation trusts. In response to the statement "senior managers try to involve staff in important decisions" 24% of those working in acute foundation trusts agreed or strongly agreed, compared to 21% in non-foundation trusts. This difference was more sharply defined in specialist FTs where 31% agreed or strongly agreed, compared to 25% in non-FT specialist trusts.

- *Innovation*: foundation trusts are able to pioneer new approaches and use their freedoms to innovate to improve services for the patients in their trusts and the wider NHS, and, on occasions, make advances in medical technology. Set out below are two examples of this:

  Gloucestershire Hospitals NHS Foundation Trust has pulled off a national first in a partnership deal with a local charity, Hope for Tomorrow, to provide a mobile chemotherapy team across three counties where many residents live in isolated communities. The foundation trust was free to make the decision when the charity approached it—proving that good ideas can happen quickly in an FT. In Gloucestershire chemotherapy was provided in a secondary setting, and the FT wanted to push out the service so that a safe, quality assured infection free service could get to where the patients were. The FT wanted to cover all three counties—not just their own. This innovation was about looking at the way the FT provided services from the standpoint of the patient and then finding ways to do things differently. And the FT had the financial freedom to deliver part of the cost without referral to other bodies.

  Salisbury NHS Foundation Trust "spin off" company—Odstock Medical Limited makes and market electronic devices that help disabled patients to walk by stimulating paralysed muscles. OML is the first "spin off" company to be created and owned by the NHS. Salisbury NHS FT has taken the innovative route of creating their own company so that the income generated by the

device can be used to further research and create new developments to help NHS patients. Salisbury maintains majority ownership of the company—68%—with the hospital charity owning 18%. The only other shareholders are staff and Bournemouth University. As the FT has the majority share it can ensure that the philosophy of the company remains dedicated to putting patient care first. Salisbury has used the financial flexibility afforded by FT status to grow the company and has renovated the hospital's old burns unit to house it. Its medical physics department has been developing and producing the devices for 20 years. However until now operating constraints within the NHS severely limited their availability to patients outside the Salisbury area.

Local Accountability and Membership

With close to a million members and over 2,000 governors, foundation trusts are taking the NHS into a new era of local accountability and engagement. The level of membership in FTs is greater than the membership of the three political parties combined. The government is pushing for three million members by 2010. The FTN is supporting this push—and at the same time focusing on building foundation trust accountabilities by ensuring that memberships are diverse, and representative of the communities and groups they serve.

Although the governance arrangements in foundation trusts are new, and are taking time to establish themselves, it is clear that they offer enhanced responsiveness to and engagement with local communities, patients and service users. The governance model, involving members and governors, means there is now an independent voice at every level to emphasise the views of the patient and carer. These quotes from a foundation trust chair, chief executive, and governor, underline this:

- "It is partly a recognition of the Governors' perceptions that our priorities for next year are patient safety, the patient experience and underpinning information systems". Dr Mary Archer, Chair of Cambridge University Hospitals NHS Foundation Trust.
- "We are much more focused on what the public are looking for. We now have vehicle for talking directly to the public, whom we serve". Angela Pedder, Chief Executive of Royal Devon and Exeter NHS Foundation Trust.
- "As governors on the high quality patient care group we have really championed the quality agenda and the need for the Trust to both listen to and learn from patients". Veronica Beechey patient governor at University College London Hospitals NHS Foundation Trust.

Part of the FTN's recent survey of governors demonstrates how governors are engaged in shaping the future strategy of foundation trusts, and holding the trust to account through its challenge role. The survey had a response rate of 67%, and of these:

- 89% of governors said they were both involved in the FT's strategy and working on the business plan.
- 89% saw their role as making the foundation trust more patient focused.
- 85% saw their role as influencing FT policies and priorities.
- 63% saw it as challenging policy decisions of the board.
- 83% feel involved in the strategic decisions of the board.
- 91% saw their role as recruiting members.
- 76% saw their role as devising member engagement programmes.

The results of this survey mirror the results of the survey of foundation trust governors carried out by Monitor.

About the FTN

The FTN is the voice of foundation trusts. We were established four years ago to represent authorised foundation trusts as well as those trusts preparing for foundation trust status. We currently have 180 members, and that number is growing all the time. Our membership includes 96% of authorised foundation trusts (both acute and mental health), as well as 84 aspirant trusts in a range of sectors—acute, mental health, ambulance trusts, NHS Direct and most recently aspirant community foundation trusts.

Our aim is to improve the system for patients, services users and staff by raising the profile of the issues facing existing and aspirant foundation trusts and strengthening the influence of FTN members. The FTN has an independent board elected by our members, made up of chairs and chief executives of foundation trusts.

Our work programme is organised around three priority areas:

- Representing views—as the national voice for foundation trusts, we provide the point of contact for those wanting to know more about the foundation trust movement.

— Shaping policy—our policy agenda focuses not just on the immediate issues facing foundation trusts but on the changes needed to ensure the success of wider NHS reforms.

— Sharing learning—part of our mission is to enable foundation trusts to share innovation and learning within the FT movement and across the health services.

Alongside this we also run a preparation programme, funded by the Department of Health, to help NHS organisations prepare for foundation trust status.

As this brief overview has shown, foundation trusts are taking the NHS in a new direction—in terms of financial performance, quality, innovation, local accountability and staff engagement. As the representative voice of foundation trusts, the Foundation Trust Network is in a position to provide an accurate insight into the progress of the whole sector, the learning undertaken and the challenges ahead.

June 2008

Memorandum by the Chesterfield Royal Hospital NHS Foundation Trust (FTM 05)

PROGRESS AND IMPACT OF NHS FOUNDATION TRUSTS

1. Background

Profile

Serving North Derbyshire's population of around 375,000, Chesterfield Royal Hospital NHS Foundation Trust provides a full range of acute services—plus 24-hour accident and emergency care and specialist children's services based in the community (including family therapy services, child and adolescent mental health, children's physiotherapy and school nursing). The Trust also manages a small maternity centre in Darley, near Matlock.

1.1 **Organisational facts and figures 2008–09**

— Employs approximately 3,400 staff.

— Budget £160 million.

— Around 560 beds and 8 beds at Darley Birth Centre.

— More than 115,000 x-rays and 26,000 physiotherapy appointments.

— 250,000 out-patients in 10 out-patient suites.

— 25,000 patients admitted in an emergency.

— 30,000 patients cared for on our wards.

— 58,000 A&E attendances expected.

— 12,000 community members, 3,200 staff members.

— Council of governors—17 public (elected governors), 4 staff (elected governors) and 8 partner (appointed governors).

1.2 **Achievements 2007–08**

— Rated a double excellent by the Healthcare Commission (use of resources and quality of services). Only organisation in East Midlands to achieve this.

— Rated a "best performer" by Healthcare Commission for maternity services (one of only 38 hospitals in the country).

— Rated "excellent" by mothers surveyed by the Healthcare Commission in 2007.

— Achieved 18-week referral to treatment target by December 31 2007 (a year early)—one of only six hospitals to do so.

2. Benefits

Foundation trust status has allowed Chesterfield Royal Hospital NHS Foundation trust to achieve:

— An enhanced board of directors—bringing in vital skills and experience and higher quality.

— Speedier decision making.

— "Surplus with a purpose"—developing long-term investment strategies.

— Greater investment in facilities and services (three-fold increase in capital expenditure).

— Improved governance systems—setting strategy, targets and long-term plans.

— Engaged governors representing the community.
— Engaged members—involved with the trust.
— Wider and leading role in the community—supporting business and partnerships.
— The opportunity to lead change.
— An "all terrain vehicle" model—goes everywhere, does everything, unrestricted by the usual boundaries.
— Democracy within its systems and processes.
— Improved risk management across the organisation—from the clinical and environmental perspectives.

3. Progress

Working with governors, members and the local community:

Seeks views, opinions and ideas on key plans and developments from the Council of Governors before the Board of Directors (to influence, inform and shape strategy and decision making).

Creates meaningful roles for governors, for example:

— developing the patient and public involvement agenda—being involved in all aspects of patient care, cleanliness, food etc and "mystery shopping" checks;
— supporting membership engagement through an outreach committee;
— advising the trust on site strategy and capital developments;
— appraising the chairman and non-executive directors; and
— representing the community on a joint board and council corporate sustainability committee—working to reduce the trust's carbon footprint and exploring opportunities for local sustainability.

Consults with governors and members on issues that will affect the local community—visiting hours, capital schemes and health issues.

Informs and educates members through literature, open evenings, events.

Backs local business through a discount scheme for members.

Creates local business opportunities through contracts for services.

Offers opportunities for wider public engagement with its members—for example, working with Derbyshire County Primary Care Trust to consult governors and members on their proposals through Darzi.

4. Statements

Bernard Everett, public governor:

> "Foundation trusts are a movement in the opposite direction that governments have been going in for generations; they are returning power back to the community, rather than aggregating it all to Whitehall, and that really interested me. The NHS is something we all care about—being a governor means local people can influence decisions on matters that affect their healthcare".

Sheila Smith, public governor:

> "Those who have been governors for longer are more confident in the role, they are able to foresee problems and articulate how things can be resolved. When we started, I think most of us saw it as a rubber stamping exercise, but now as we're growing into the role and developing committees and systems we realise we're making a genuine contribution.
>
> "I'm starting to find that my trust is a lot more experienced at this than most other foundation trusts, the event hosted by Monitor really highlighted that. It was the first time since I became a governor that I felt more experienced than others. We were one of the first foundation trusts and we weren't sure how we'd fit into this new role. But now, if governors go to events, such as those hosted by Monitor, there is likely to be somebody who can pass on experience that might help. It's certainly something we would have liked at the beginning when there were so few of us. As new foundation trusts are being authorised on a monthly basis there are a lot of comparatively new governors about".

Richard Gregory OBE
Chairman

June 2008

Memorandum by Clatterbridge Centre for Oncology (FTM 06)

OUR EXPERIENCE OF FOUNDATION TRUST STATUS

Introduction

1. Clatterbridge Centre for Oncology NHS Foundation Trust (CCO) welcomes the Health Select Committee's session on Foundation Trusts and the opportunity to provide input on this topic.

2. CCO is one of the largest cancer centres in the UK serving a population of 2.3 million covering Merseyside, Cheshire, North Wales, the Isle of Man and South Lancashire.

3. In 2006 CCO became a Foundation Trust following a process to test the business planning and financial systems to ensure the Centre was "Fit for Purpose".

4. The Wirral-based Trust employs 650 staff, provides specialist radiotherapy and chemotherapy services and delivers more than 112,000 treatments to patients every year. Visiting medical and nursing teams also deliver specialist cancer services at hospitals across the region.

5. The Trust has state of the art imaging services to detect and plan treatment together with supportive care from nursing and allied health professionals to address the palliative aspects of care and needs of family supporters. This is greatly assisted by our Macmillan Information Centre.

6. Most patients are treated as out-patients or day cases and much of the chemotherapy is delivered at the associated general hospitals that are nearest to the patients.

7. CCO is a Trust that understands the importance of living by its values. Our vision is to provide world class cancer care, this is backed up with our values: putting people first; achieving excellence; passionate about what we do; always improving our care; committed to our future.

8. Our people shaped our values and by demonstrating that we use these to inform how we conduct our business there is a real, shared energy across the Trust. This is evidenced by our staff and patient surveys that scored CCO within the top 20% best performing Trusts in 2007.

9. We provide involvement opportunities for service users, carers, staff, and members of the public through a membership scheme. We currently have almost 6,000 members.

10. For the final quarter of 2007–08 the Independent Regulator, risk rated CCO as "Green" for Governance, "Green" for Mandatory Services and "5" for finances.

The Foundation Trust Status Difference at CCO

11. Foundation Trust status has enabled us to change the way that we think and work. We believe that three drivers have been important in doing this:

11.1 **Assessment to become a Foundation Trust**—the assessment process in becoming a Foundation Trust is meant to ensure that your system, processes and Board are fit for purpose. We found this assessment very helpful not only as a one off check but in challenging the way that we think and operate on an ongoing basis.

11.2 **Local involvement**—members and especially Governors are there to ensure that as a Foundation Trust we listen to local views and have in place active processes to seek such views. We have found this very helpful in shaping our overall strategy and especially useful in agreeing our plans for a satellite radiotherapy unit (discussed below).

11.3 **Knowing that success is down to us**—Foundation Trust status brings freedoms and responsibilities. We believe that success or failure is down to ourselves as we are not only more accountable for day to day delivery but are also able to take a greater role in determining our future. For us this has been achieved by working in partnership with our local commissioners and other NHS organisations in the Cheshire and Merseyside Cancer Network. We now better understand our ability to improve the care provided for our patients by influencing the cancer network as a whole and the people who sit around its table.

Achievements as a Foundation Trust

12. We now have more financial freedom to develop our services in the way we want. We closed this year with a £3.4 million surplus and we intend to invest part of that in a major refurbishment of our wards, including the development of a dedicated teenage cancer unit and the refurbishment of our outpatient facility with improved privacy for patients, increased numbers of clinic rooms and additional consultant offices.

13. New accommodation has been provided to support the research and development directorate and to bring them into one place within the Trust.

14. From a quality perspective we are one of only a few Trusts in the country to be awarded the ISO:9001:2000 registration across all departments and we are only the second Trust in the country to have been awarded NHSLA level 3, which assesses our policies and systems.

15. We have agreed plans to develop a £16m satellite radiotherapy facility in Aintree. The proposed development will house three radiotherapy treatment machines and a range of support services to benefit the wider Merseyside community.

16. The Aintree development will bring enormous benefits to our patients. For example, a patient living in Southport currently faces a 60 mile round trip when receiving treatment at CCO. The centre at Aintree would cut the journey time in half and save patients' travel costs. We are on course to have the new centre in operation by December 2010—for us, Foundation Trust status has meant that good ideas can become a reality quickly.

17. By investing surpluses and using our borrowing freedoms as a Foundation Trust we have been able to progress our plans for the radiotherapy satellite facility more quickly than we would otherwise have been able to. One major benefit is that we can now raise our own funding by utilising Foundation Trust prudential borrowing. Using this approach also means that we can build the facility using the Procure 21 process, meaning that we will own the facility, rather than PFI where we would not.

18. Our success has created greater confidence in our ability to deliver and this in turn has produced a further commitment from Primary Care Trusts to provide CCO with an additional £15 million to provide a second radiotherapy satellite centre in central Liverpool. Taken together this means over £30 million of investment and up to six new linear accelerators (these are the machines used to treat cancer using radiotherapy).

19. The ability to reinvest surpluses in local priorities means that there is a tangible incentive for Foundation Trust Boards and Governors to deliver strong financial control and NHS targets. This means that good financial control has, for us, led to improved quality through our ability to reinvest.

20. However, we know that our freedoms come with greater responsibilities and the need to manage risk effectively. As a result our Board is focused not only on our long term strategy but on what patients expect us to deliver today. To help with this we have produced a new Delivery Plan which has been launched with staff and we are now busily re-aligning our reporting structures around this.

21. On a final point our Governors were involved in both the appointment of a Non Executive Director and our Chief Executive. They have also been involved in the selection of our new external auditors.

THE FUTURE

22. We see Foundation Trust status not as badge but as a journey. There are things that we need to work on and improve, especially around engagement with our members—as we are new to being a mutual organisation we are still learning. Four key themes in our journey are:

22.1 Using strong external partnerships and clear internal values to improve our services to patients.

22.2 Improving how we involve staff, Governors and the wider membership to shape priorities and change front line services.

22.3 Using our freedoms as a Foundation Trust and our fundraising as a cancer charity to supplement our core services and add extra value—what we call internally "service plus".

22.4 Utilising new technology to improve patient outcomes—We are the UK's only proton therapy centre with over 20 years experience in treating eye cancers. We have ambitions to use this expertise and bid for new high energy equipment which will enable us to establish a UK proton service for the treatment of cancer in children. (Proton Therapy is less damaging to surrounding tissue than radiotherapy. When used to treat children it reduces the risk of secondary cancers in later life.)

June 2008

Memorandum by the Royal College of Nursing (FTM 07)

FOUNDATION TRUSTS AND MONITOR

1. EXECUTIVE SUMMARY

Our submission focuses on a survey conducted in 2007 by the RCN. The results of the survey of RCN members recommended the following:

— RCN members view local control of an NHS Foundation Trusts (NHSFT), with the full engagement of community and staff constituencies in their governance, as one of the greatest benefits of Foundation Trust (FT) status. Many NHSFTs have made significant improvements in membership engagement.

— However, there is also a strongly expressed concern that too much emphasis on a "big business ethos" could squeeze out patient, public and professional engagement.

— As NHS FTs reach critical mass, discreet policy interventions are required to strengthen governance arrangements, promote best practice public patient involvement and encourage partnership working.

— Strategic Health Authorities and Local Authority Oversight and Scrutiny Committees may need a much clearer role and authority if they are to have constructive relationships with NHSFTs in which essential information is shared openly and local agreements on priority services are developed in partnership.

— RCN and other staff side organisations have a role to play in encouraging more members to get involved as Governors. That would ensure stronger relationships between Governors and staff side organisation representatives. As NHSFTs grow and the market matures the RCN believes that there will be an increasing need to ensure the integrity of democratic representation within these organisations and within the wider NHS.

— NHSFTs with their early exposure to Payment by Results (PbR) and a more rigorous financial framework have led to more consistent financial information and a better balance of income/expenditure. This has brought an increasing awareness of the costs activity, although there is concern that the full contribution of nursing remains largely invisible.

— Many respondents saw benefits from adopting a more business like approach to organisational development and service management. However, where NHSFTs were disproportionately focused on costs, this had a detrimental impact on staff morale and clinical engagement.

— The emerging potential for successful NHSFTs to merge with and takeover failing NHS Trusts holds the prospect for creating provider organisations whose size and revenue will far exceed anything that we have previously seen in the NHS.

— The RCN remains concerned that competition between providers and the emergence of FT systems within community services will present opportunities to dispose of and re-provide services in a manner which prioritises short term income above the sustainability and quality of services.

2. Introduction

With a membership of over 390,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations. The RCN welcomes the opportunity to make a written submission to the inquiry of the Health Select Committee.

2.1 Since the inception of NHS Foundation Trusts (NHSFTs), the RCN has adopted the view that each application for Foundation Trust (FT) status should be considered on its merits.

2.2 Following on from previous work with members and staff in FTs, the RCN carried out a survey on the progress of NHSFTs between June and July of 2007. The survey had two distinct parts:

— Firstly, a questionnaire on a range of issues related to the development and operation of NHSFTs was made available to RCN activists and members through the RCN website.

— Secondly, semi structured interviews with RCN activists and staff were conducted based on the issues raised within the questionnaire. In combination, this approach gathered evidence from 46 of the 54 NHS Foundation Trusts that were authorised when the survey commenced.

2.3 Based upon this evidence the RCN is able to identify some key trends and issues which we believe should be considered and addressed as part of the future development of these crucial NHS provider organisations. These key trends are divided into the four areas outlined below.

3. Governance and Engagement

Given the size and potential influence of NHSFTs the RCN believes that there is an increasing need to ensure the integrity of democratic representation within these organisations and within the wider NHS. In a very real way, RCN members view local control of an NHSFT, with the full engagement of community and staff constituencies in their governance, as one of the greatest benefits of FT status.

3.1 There is also a strongly expressed concern that too much emphasis on a "big business ethos" could squeeze out patient, public and professional engagement. Some suggest that NHS values are being squeezed in a similar manner. As NHS FTs reach critical mass, discreet policy interventions are required to strengthen governance arrangements, promote best practice public patient involvement and encourage partnership working.

3.2 SHAs and Local Authority Oversight and Scrutiny Committees may need a much clearer role and authority if they are to have constructive relationships with NHSFTs in which essential information is shared openly and local agreements on priority services are developed in partnership RCN and other staff side organisations have a role to play in encouraging more members to get involved as Governors. That would ensure stronger relationships between Governors and staff side organisation representatives. As NHSFTs grow and the market matures RCN believes that there will be an increasing need to ensure the integrity of democratic representation within these organisations and within the wider NHS.

4. Effects of Prioritising Financial Performance

NHSFTs with their early exposure to PbR and a more rigorous financial framework have led to more consistent financial information and a better balance of income/expenditure. This has brought an increasing awareness of the costs activity although there is concern that the full contribution of nursing remains largely invisible. Many respondents saw benefits from adopting a more business like approach to organisational development and service management. However, where NHSFTs were disproportionately focused on costs, this had a detrimental impact on staff morale and clinical engagement.

4.1 The Department of Health have given a strong commitment to achieving 100% provision of secondary NHS services through Foundation Trusts by 2009. By October 2007, only 30% of the NHS Trusts eligible to become NHSFTs had done so. At the same time, 10% of applications had failed across England but in some areas that figure is higher. For example, in the West Midlands SHA area 30 % of applications have "failed" and in the East Midlands SHA area 25% of applications have "failed".[2]

4.2 Monitor have published guidance on "mergers" and "takeovers" of "failing" organisations by NHSFTs and the first mergers have already been authorised. In Birmingham, for instance, the Heart of England NHSFT took over the failing Good Hope Hospital in the first merger to take place under the provisions of the Monitor guidelines in early 2007. The RCN has noted the growing potential for "takeovers" and "mergers" as a means of overcoming "failure" in NHS provider organisations.

4.3 This potential appears to be mainly focussed upon the activities and freedoms of NHSFTs and their capacity to drive the financial performance of the NHS. At the same time, as the numbers and rates of failure in NHSFT applications rise there will be an increasing potential for the Department of Health to keep to their commitment to achieve a 100% NHSFT economy in secondary care by 2009 through mergers and takeovers. RCN Policy Unit forecast the probability of this scenario in a publication from January 2007.[3]

4.4 It is the view of Monitor that financial performance in NHSFTs is strong in comparison with their equivalent NHS Trusts and that this is borne out by the results of the Healthcare Commission's Annual Health Check ratings for 20073. The RCN believe that this is largely attributable to the process by which NHSFTs are selected and the investment in them in order to improve their financial management systems to meet the diagnostic requirements of Monitor.

4.5 RCN members who responded to our survey believed that this had led to a trend whereby there is an increasing and inevitable gap in financial performance between NHSFTs and NHS Trusts. Respondents suggested that the greater "freedoms" of these more modern organisations may have a detrimental effect upon traditional NHS Trusts who are at a disadvantage in an increasingly competitive provider market. The survey also portrayed a growing hierarchy within NHSFTs whilst those at the bottom end of the continuum are becoming increasingly pressured to raise their financial performance or face a worrying and uncertain future.

5. Payment by Results and the Drive for Increasing Efficiency

Payment by results (PbR) is a casemix based activity payment system which rewards providers "in year" for patient activity.[4] Foundation Trusts were the first providers to pilot the tariff system and the related Healthcare Resource Groups (HRGs) and were able to model the impact of this system on income and business stability although one of PbR's prime objectives was to act as a focus for improving the quality of care.

5.1 In its recent consultation on the future of PbR, there was a heavy focus on the importance of clinical engagement for the future development of PbR. Clinical engagement is essential to ensure that the powerful incentives within PbR are focused on improving care pathways and not simply used as a means of reducing costs.[5]

5.2 There were a high proportion of respondents who said that they did not know what impact PbR was having upon their services. It is of great concern if such a high number of respondents did not understand PbR or its stated objectives, particularly given its important links to financially incentivising certain care

[2] NHS North West, *Avoiding Failure in the Application Process*, September 2007.
[3] http://www.rcn.org.uk/__data/assets/pdf_file/0012/24024/mergers_markets_and_monitor.pdf
[4] RCN Policy Briefing (2005) Glossary of terms.
[5] http://www.rcn.org.uk/__data/assets/pdf_file/0009/21213/pbr_update_and_discussion.pdf

pathways. Without clinical engagement in the collection of activity data; in the analysis of care costs; or in the development of a strategic response to Trust activity data, PbR becomes a focus for cost cutting rather than improving the patient experience and the quality of care.

5.3 Moreover, failure to engage clinicians can lead to poor data quality and inaccurate reporting of activity on the basis that it may be seen to be a finance driven agenda rather than an opportunity to innovate in care delivery. Respondents cited several reasons for this lack of familiarity with PbR in their follow up comments, including:

— Their NHSFT was only recently authorised and had not been part of the PbR pilot scheme.

— There had been little or no communication from managers regarding PbR and national tariffs and their relevance to patient services.

— Financial information, including PbR issues was not readily shared with clinical teams, FT members or staff side organisations because of the sensitive nature of such information and the business interests of the NHSFT.

Respondents generally felt that none of these reasons offered an acceptable explanation of the lack of understanding that exists about PbR and the implications for the NHS.

6. Developing New Services

Our survey showed that RCN members have serious concerns that too many NHSFTs do not effectively communicate their service plans to nurses, patients and FT members. Our members do, however, accept the need for FTs to generate financial surplus and to meet cost improvement targets.

6.1 NHSFTs have exceeded expectations in terms of achieving cost reduction targets. National tariffs established under Payment by Results assumed a cost improvement saving of 2.5% per year, yet in 2006 the NHS Foundation Trusts had achieved a cost improvement saving of 3.0% of operating costs.[6] Achieving these efficiency targets is clearly crucial to NHSFTs and any NHS Trusts that aspire to Foundation status. Our survey showed that RCN members felt that planning to achieve these targets was an activity which took place at Board level, whereas the process of achieving cost efficiency savings depended almost entirely on the activity of nurses, managers and practitioners at clinical team level.

6.2 The overall impression amongst RCN members was that this fact was insufficiently appreciated at Board of Director level. As a result, although RCN members reported improvements in the sharing of operational planning and service development plans, they did not believe that most NHSFTs engaged sufficiently with stakeholders on issues relating to cost improvement plans (CIPs). Issues that were raised by respondents included:

— Service development plans are generally more transparent, accessible and more readily available than financial performance information within most NHSFTs.

— RCN members are concerned about lack of practitioner engagement in the development and planning process of CIPs and the organisational levels at which crucial decisions are being made in NHSFTs. This creates a potential for "top-down" management in achieving cost savings and efficiency targets with little or no ownership at clinical team level.

— Where CIPs generate increasing levels of financial surplus, RCN members believe that these monies should be invested in developing services and that NHSFTs have a responsibility to communicate their investment plans more clearly to their members.

Royal College of Nursing

June 2008

Memorandum from Professor Maria Goddard (FTM 08)

I am writing to follow-up the issue described below by Professor Alan Maynard.

In trying to undertake independent evaluation of the impact of FTs, we encountered some problems in the availability of data from FTs. In the past, all NHS trusts have been required to submit financial returns to the Dept of Health in a common format (known as TFRs—Trust Financial Returns) and these are available in the public domain. However, as part of the freedoms given to FTs they are no longer required to submit this data. As we were trying to compare the financial performance of non FTs and FTs, this was problematic so we contacted Monitor to ask whether the returns they collect from FTs would contain the appropriate information. Although there was only partial matching of the data, Monitor said that some of their returns would contain information we were seeking but that they were unable to let us have this data because it was confidential. Their suggestion was that we seek permission from every FT in order that the data could be released. As you may appreciate, that is rather time consuming and not conducive to the

[6] Monitor, *NHS Foundation Trusts: annual plans for 2007–08*, page 3 (2007)

conduct of independent evaluation. Ultimately we were able to get the Foundation Trust Network to assist us in getting permission but it was made clear that if we wished to update the analysis with more recent financial data we would be required to approach each FT directly.

It has also become apparent that the increasing mis-match between the format and nature of the data provided by the FTs and non-FTs makes proper comparisons impossible. In addition, I understand that CIPFA has cut down the data series they have usefully produced on Trusts over many years.

Our own rich series of data on NHS Trusts which we have assembled in the Centre for Health Economics over many years (covering input, output and process variables), which has facilitated a range of useful research projects, has also fallen down because of the lack of FT data held in the public domain. As more Trusts become FTs, less and less information will be available for research purposes. As FTs remain public sector organisations spending public funds, it is worrying that independent scrutiny of some fundamental issues is made difficult, or even impossible, by rules that seem to protect them as commercial concerns.

I hope this is helpful.

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