Ad Hoc Scrutiny Review into Foundation Trust Status (Calderdale and Huddersfield NHS Trust)

Date: November 2003

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2. Background

Introduction to Overview and Scrutiny
The Local Government Act 2000 required local authorities to be more efficient, transparent and accountable in the way their political arrangements operate.

Overview and scrutiny gives an important role to all councillors who do not hold cabinet posts by enabling them to challenge the decision-making of the cabinet, hold it to account, monitor the quality of service delivery, review policy and contribute to its development. It is now a crucial part of the democratic system of local government.

In Kirklees overview and scrutiny is constructive to ensure that the best decision is taken first time. Scrutiny involvement at the very early stages in developing policies, plans or decisions enables concerns to be addressed before a formal decision is proposed.

What are ad hoc review panels?
Ad hoc overview and scrutiny panels investigate in-depth aspects of policy and services that may not be working as well as they should be as well as issues of concern to residents of Kirklees.

Anyone can request that an ad hoc review panel be set up to look into a particular issue and this includes residents, voluntary and community groups, individual councillors, and council officers. Issues can also be identified by the standing overview and scrutiny panels.

The panels investigate and make recommendations on how services, council or local NHS policy could be improved in the future. Reviews generally last between three and six months and work within agreed terms of reference to reach conclusions and recommendations based firmly on the evidence received.

Overview and Scrutiny of Health
Overview and Scrutiny can review any matter relating to the planning, provision and operation of health services in its area. This includes services which promote health or prevent ill health as well as those providing treatment for individual patients.

Health scrutiny is part of the local authority's role of community leadership and aims to encourage improvement and focus on issues of local concern where objective review will help progress to be made.

Calderdale and Huddersfield NHS Trust
Calderdale and Huddersfield NHS Trust is a 3-star trust formed in April 2001. This followed the merger of Calderdale Healthcare NHS Trust and the Huddersfield Healthcare Services NHS Trust.

The trust provides 24 hour acute healthcare services to more than 420,000 people, and has around 5,300 staff. They have an operating budget of just over £200 million, mainly provided by local primary care trusts who commission their services.

NHS Foundation Trusts
NHS foundation trusts are a key part of the government's 'NHS Plan', a 10 year programme of investment and reform for the NHS.

NHS foundation trusts are part of a new Health and Social Care (Community Health and Standards) Bill being taken before Parliament. Subject to parliamentary approval, the first set of NHS foundation trusts are anticipated to be up and running from April 2004.

Foundation status will allow top performing hospitals access to a range of management freedoms and release from direct Whitehall control; they would for example have more leeway to borrow money for capital investment.

Foundation trusts will be established in law as legally independent organisations called public benefit corporations modelled on co-operative and mutual traditions.

The NHS Plan

Published in July 2000 - the NHS Plan aims to deliver a health service fit for the 21st century with services designed around the needs of patients and improved health outcomes, particularly for the poorest in our society.

The NHS plan is a radical action plan for the next ten years; it sets out a vision of prompt, convenient, high quality services. It promises an investment of £19 billion by 2005 and:

- More power and information for patients
- More hospitals and beds
- More doctors and nurses
- Much shorter waiting times for hospital and doctor appointments
- Cleaner wards, better food and facilities in hospitals
- Improved care for older people
- Tougher standards for NHS organisations and better rewards for the best trusts

The Role of the Health and Social Care Board (HSCB) in Kirklees

The development of joint commissioning represents a great opportunity for Kirklees to be at the forefront of health and social care and to make fundamental changes to the way in which we support vulnerable people.

The HSCB vision is about "widening the mainstream". This is about vulnerable people in Kirklees being part of a vibrant economic, social and cultural life and a healthy community for all.

People with health and social care needs will be supported in being part of the mainstream of life rather than being diverted into special services.

This will be achieved by:

- Health services that are local and maintain people with daily life (mainstream health activity)

- Tailored personal support for people with higher levels of need (social care)

- Helping people to stay in good health (public health)

The relationship between primary care trusts (PCTs) and acute trusts

PCTs directly control 75% of the total NHS budget. This means they are the NHS body that has responsibility for assessing local health needs and providing a wide range of health care services. These include primary care services and community health services such as district nursing, health visiting and community mental health. What they cannot deliver themselves they commission from other organisations. In the main these will be acute hospital services but also include services from the voluntary and private sectors. PCTs are also the principle NHS bodies responsible for delivering public health services as part of their overall health improvement function.

3. Terms of Reference

The purpose of this ad hoc scrutiny review was not to scrutinise the principal of foundation trusts, but to look at the implications for service users and residents - exploring the potential impacts the proposals could have for local people, how opportunities can be maximised and possible disbenefits minimised or overcome.

The review process was undertaken in a collaborative way and it is hoped that this process will be of benefit to all partners involved in the provision of health services in Kirklees.

The terms of reference were:

To identify, discuss and analyse the issues surrounding foundation trust status and to make such recommendations to cabinet, Council and other agencies as appropriate.

The scope of the Ad Hoc will include the following key issues:

- How would Foundation Trust status impact on the residents of Kirklees and Calderdale?
- How would Foundation Trust status affect how health services are provided, access to services, equity of provision and health inequalities?
- How effective are the proposed accountability and public and patient involvement arrangements?
- What are the potential impacts for democratic accountability and joint working between the Local Authority and the NHS?
- How would Foundation Trust status affect NHS commissioning arrangements and patient choice?
- What are the potential impacts of the freedoms and flexibilities associated with Foundation Trust status?

4. Methodology

The Panel Members were:

- Cllr Molly Walton (Chair)
- Cllr Imtiaz Ali Ameen
- Cllr Gulfam Asif
- Cllr Linda Wild
- Joe Calder (Dewsbury District Community Health Council)
- Katie Fairbank (Disability Rights Network Executive)
- Hazel Park (Huddersfield Community Health Council)

Officer support was provided by John Heneghan (Overview and Scrutiny Officer) and Feisal Jassat (Head of Health Policy). Cooptee support was provided by Nina Stansfield (Working in Partnership Team).

Mr Max Ellam a member of the public and a current user of the acute trust services attended every meeting and played a full part in the discussions and debate.

The Panel held 6 public meetings between September and November 2003 and heard evidence from the following organisations:

- Calderdale and Huddersfield NHS Trust
- Dame Pauline Green (Co-operative Union Ltd.)
- Huddersfield Central PCT
- John Emms (Solicitor to Kirklees Council)
- Mid Yorkshire Hospital Trust
- North Kirklees PCT
- South Huddersfield PCT
- South West Yorkshire Mental Health Trust
- UNISON
- West Yorkshire Strategic Health Authority

The Panel also drew on information from the following documents and publications:

- Calderdale and Huddersfield NHS Trust, NHS Foundation Trust Consultation Document, September 2003
- Democratic Health Network, The Health and Social Care (Community Health and Standards) Bill. Briefing for Peers on Foundation Trusts, September 2003
- Democratic Health Network Briefing, The Parliamentary Debate on Foundation Trusts, July 2003

- Democratic Health Network Policy Briefing, Audit Commission report on corporate governance: health implications, October 2003
- Department of Health, A Guide to NHS Foundation Trusts, December 2002
- Department of Health, The Government's Response to the Health Committee's Second Report of Session 2002-03 into NHS Foundation Trusts, July 2003
- Department of Health, NHS Foundation Trusts - A Guide to Developing Governance Arrangements, September 2003
- Department of Health, NHS Foundation Trusts - Eligibility Criteria and Timetable, July 2002
- Department of Health, Reforming NHS Financial Flows: Introducing Payment by Results, October 2002
- Health and Social Care (Community Health and Standards) Bill
- House of Commons Health Committee, Foundation Trusts: Report and Proceedings of the Committee, April 2003
- Local Government Association, MP's Briefing, April 2003
- UNISON, Foundation Hospitals and the NHS Plan, February 2003
- UNISON, Foundation Hospitals: A UNISON Branch Guide (Extract), August 2003
- UNISON, Seven Reasons why UNISON is opposed to Foundation Trusts, March 2003

5. The Evidence

The following provides a summary of evidence received by the panel via written reports, briefings, oral evidence and other supporting documents. Written reports considered by the panel in public session and minutes of the panel meetings are available from the Scrutiny Office.

Briefing provided for the panel by Calderdale and Huddersfield NHS Trust

The context from Calderdale and Huddersfield NHS Trusts perspective was presented as "not if, but when". Government has indicated that all trusts will be in a position to apply for foundation status by 2008. The foundation trust proposals are one of a number of key reforms intended to improve performance within the NHS.

Foundation trusts will remain part of the NHS and be bound to uphold its values and principles, including the provision of services to patients free at the point of use, according to need. The legislation (still in development at this stage) will make provision to ensure that national standards are protected and that inappropriate disposal of assets is prevented. Foundation trusts would, though, benefit from local control and greater freedom to run their own affairs.

This “lock on purpose” would ensure adherence to the values and integrity of the NHS. Foundation trusts will be controlled locally not nationally; freeing them from day to day Whitehall control and enabling greater local innovation in how services are delivered. Local control will be achieved by establishing foundation trusts as independent public benefit corporations.

Each foundation trust will have members represented on a board of governors to oversee and provide strategic direction to the board of directors. The governors will ensure that the trust complies with its objects and the terms of its licence and will be under a duty to raise concerns with the regulator. The governors will consult with members and advise the board on the business plan. They will elect the chairperson and non executive directors, approve the annual report and accounts and approve the appointment of the chief executive, other executive directors and the auditor.

The board of directors will be the executive body responsible for the operational management and conduct of the trust. They will be under a duty to consult the board of governors on the development of forward plans for the trust and about any significant changes to the existing business plan. The board of directors will include a non-executive chairman, a chief executive and finance director. Non-executive directors will constitute at least one third of the board. There would be separate audit and remuneration committees, both with non-executive director membership.

Calderdale and Huddersfield NHS Trust felt that the proposals would provide benefits for patients, the public, the organisation itself and for commissioners and other stakeholders. Additional freedoms would encourage innovation, ensure the provision of high quality services and would enable the trust to operate with much greater transparency. They would remain focused on the provision of NHS services for NHS patients.

The panel noted the commitment staff gave to the values and principles of the NHS and a dedication to maintaining these no matter what.

The Chief Executive pointed out the majority of staff groups were supportive of the move toward an NHS FT.

Links to other changes in NHS policy

Proposals to establish foundation trusts are one of a number of changes within the NHS policy framework. These include changes to the patient choice agenda and financial flows (how money flows through the system). These two areas of NHS policy are happening anyway, irrespective of the foundation trust proposal.

The patient choice agenda means that by December 2005 when patients are referred for treatment, they will be offered a choice of four or five providers at the point of referral. By the summer of 2004 all patients who have been on a waiting list for treatment for longer than six months will be offered a choice of at least one alternative provider (i.e. the choice to either stay on the waiting

list and have the treatment locally, or the opportunity to go elsewhere for treatment). This could result in patients moving around the system in a very different way than they do currently. How people will exercise that choice is difficult to determine - the early pilot schemes demonstrated that patients exercised choice in a different way to that which was originally expected.

How patients exercise choice will impact on how money flows through the system. If patients don't come to Calderdale and Huddersfield NHS Trust then the money doesn't come into the organisation. Conversely if lots of patients choose to come then waiting lists may increase which, in turn, may impact on how people exercise choice.

The issue relevant to this review is whether being a foundation trust would help the organisation to cope with changes in patient flows better than not being a foundation trust. Will foundation status make a difference, for example, in terms of local responsiveness?

In relation to the financial flows policy changes, foundation trusts will implement the introduction of financial flows earlier than other trusts. In effect this will mean that patients will be paid for on an individual basis, whereas at the moment they are not. The system of financial flows is based on the principal of 'payment by results' against a standard tariff. Together with the patient choice agenda, these reforms are intended to provide strong incentives for providers to focus on quality and increasing patient satisfaction as well as efficiency.

Foundation trusts have been promised money to help ensure the transition to foundation status; this could help to ensure that the implementation of financial flows will not destabilise the local system.

Management and Financial Freedoms

The Guide to NHS Foundation Trusts[1] sets out a number of proposed freedoms and flexibilities for foundation trusts:

- freedom from Secretary of State powers of direction (removing control from Whitehall and replacing it with greater local public ownership and accountability)
- freedom to develop new ways of working that reflect local needs and priorities (within the NHS framework of standards and inspection)
- flexibility to offer rewards and incentives to staff
- freedom to innovate in asset use (foundation trusts will be allowed to retain proceeds from asset disposals)
- more options to access capital funding (for example the ability to borrow money from private lenders)
- freedom to retain any operating surpluses

[1] Department of Health, December 2002

There are proposed safeguards and conditions attached to a number of these freedoms and flexibilities. The detail of the legislation is, at the time of writing, subject to change as the Bill proceeds through the legislative process.

Management freedoms

The panel questioned Calderdale and Huddersfield NHS Trust about how the proposed freedoms could potentially be used. How 'real' would they be and what would happen if local priorities clashed with national priorities?

It was acknowledged that government needs to "let go" to allow local flexibility to work. To what degree this will happen depends in part on the extent to which the legislation changes as it goes through the parliamentary process. There are concerns that if central guidance continues to be the same and expectations are raised around local flexibility and priorities then the process will not work. If the more than 500 national targets are maintained, plus local expectations, with no additional resources to respond this then the process would not succeed.

However, there would need to be time to allow local governance arrangements to develop and become more effective. This transitional period should see increasing influence locally and confidence to challenge some of the central directives. It was likely that initially there would still be a strong central influence but, as boards of governors develop, that balance will change.

The panel also sought information on the role of the new proposed independent regulator. The regulator will be responsible for ensuring that the terms of the licence are upheld. (The licence will set out requirements for foundation trusts to operate in the public interest; to meet national clinical standards; requirements relating to continuity of NHS services; and a duty to work in partnership with NHS and other relevant organisations etc.)

Calderdale and Huddersfield NHS Trust felt that the intention was that the regulator would be a "light touch". The trust would still be subject to scrutiny from other bodies in terms of audit and inspection.

The implications of the proposed accountability and inspection regime for foundation trusts were questioned. For example, could bureaucracy potentially increase if foundation trusts are accountable to an independent regulator, the primary care trusts and other commissioners of services, a board of governors and other inspection and audit processes?

Again, it was acknowledged that the centre needed to "let go" to avoid the system becoming over-complicated; however, there was no evidence to suggest that this wouldn't happen - why would government set this model up and not give it a chance to succeed? In the trusts view, they needed to demonstrate that they could "get it right" locally - interference from audit and inspection processes would be less for organisations who have demonstrated that they can deliver and make local freedoms work.

The foundation trust will be accountable to its board of governors. It will have legally binding service level agreements with commissioning bodies including the relevant primary care trusts and local authorities. Provided that s/he is satisfied that the trust is performing, the independent regulator should apply a light touch. This will encourage the feeling of local responsiveness.

Financial Freedoms

The panel heard evidence that many of the financial freedoms that were initially proposed had been eroded as the bill had proceeded through parliament. The ability to borrow money from building societies and banks to raise capital, for example, was now not included.

The current proposals are that foundation trusts will benefit from easier access to the NHS capital programme. The freedom to re-invest surplus is still included. This is an incentive to improve efficiency - any money saved by providing services more efficiently will be available for reinvestment in local services.

The trust were questioned as to whether the commissioners of services would act as guarantors in relation to acute trust borrowing. They were informed that commissioners would not act as guarantors as such; they were, however, crucial to the flow of finances. The trust would need to demonstrate that it had the income necessary to repay any borrowing and commissioners of services are the trusts source of that income. Part of the process of showing, for example, that a new capital scheme would be viable would be to demonstrate that the primary care trusts had been involved; developments of this kind would need a “whole systems” debate.

The panel questioned the trust on how the proposed five year legally binding service level agreements between the primary care trusts and the acute trust would fit in with the patient choice agenda. For example, how would it work if a primary care trust had a contract to purchase a high percentage of hip replacement operations from Calderdale and Huddersfield NHS Trust if the majority of patients chose to have their operations elsewhere?

It was reported that the primary care trusts would have a portfolio of contracts with different organisations. Contracts would have to be structured in such a way that they can offer choice - for example, by having a contact that included both a guarantee for core elements of a service and a more flexible element.

Freedoms to offer incentives and rewards to staff

The trust reported that that there are already variations in how staff are paid in the NHS at the moment. Even without foundation status the trust could set its own terms and conditions should it wish to do so. This is not something, however, that they would enter into lightly. All agencies needed to be sensitive to the needs of the system when considering pay and conditions; if you pay twice the going rate someone else will pay three times the going rate.

Undertaking private health work

The panel questioned the trust on the level of private work that could/would be undertaken should they receive foundation status. They were informed that the opportunity to generate private income is very limited. It is likely that there will be a cap on the amount of private work that a foundation trust could undertake, based on the amount of private income earned in the last year as an NHS trust.

The social ownership model / public and patient involvement

The Panel received the trusts initial thoughts on governance arrangements and were informed that the trust welcomed contributions and ideas from all stakeholders.

"Successful co-operative businesses require a large and widespread membership that is supportive of the broad principles of co-operation and the participation of an active, informed and representative elected membership".

Co-operative Commission Report, 2001

The panel were informed that the proposed governance arrangements would require the development of a clear membership strategy, and an understanding of members' needs. It would require appropriate resources in terms of people, time and materials; consideration would need to be given to recruitment and retention of members; and for valuing diversity and seeking out 'hard to reach' groups. It was also noted that it would be important to have clarity about what was expected from members.

The trust outlined the relevant consultation process undertaken to date to inform the development of the governance proposals, namely:

- Public Patient Involvement strategy (April 2001-2)
- 40,000 information leaflets to the public(May 2003)
- 6000 information leaflets to the staff (June 2003)
- 40 presentations to local stakeholders (Jan- Sept)
- 25 + presentations to staff (April – July 2003)
- Local health economy event (May 2003)
- 20+ stakeholder presentations (Sept – Dec 2003)
- Additional updates for staff (Sept- Dec 2003)
- large public and staff one day event (Oct 2003)

It was reported that a further consultation exercise was underway (Sept-Nov 2003) to elicit views on

- suggested governance arrangements
- short, medium and long term service vision
- membership issues

The response so far (September 2003) from members of staff and the public consulted on their interest in membership should foundation trust status be granted was reported as 514 responses, with 20+ arriving each day. Of these 60% had requested that they would like to become a member or requested further information.

The trusts initial thoughts on the composition of the board of governors were presented as (these were subject to the consultation process outlines above):

- Maximum of 30
- 16 Elected public governors (Term of office 3years?)
- Elected from the electoral areas covering the electoral wards x 48 wards
- Ensure ethnic, gender, age representation
- 15 staff and stakeholder governors
- 5 elected staff governors
- 3 PCTs
- 1 University
- 1 Voluntary sector
- 2 Local Authority (one from each affected local authority)
- 1 NHS partner organisation
- 1 StHA
- Possibility of co-opted representatives

The Panel received evidence from the three primary care trusts in Kirklees on their views in relation to the governance arrangements for foundation trusts. The following provides a summary of the evidence received:

It should be noted that the context to this evidence was that all the primary care trusts made very clear that they wanted to work with Calderdale and Huddersfield NHS Trust to make this process work for the benefit of all stakeholders; that there are good relationships and a strong history of partnership working between all the health agencies in Kirklees. The debate on governance arrangements was welcomed and it was acknowledged that there was no single solution to effective governance. There was also a strong recognition that the policy was likely to happen and that there would be benefits of being in the “first wave” of foundation trust applicants.

<u>Huddersfield Central PCT</u>

PCT public and patient involvement forums are still in their infancy; other mechanisms including Community Health Councils are still in existence. Concern was expressed that different elements of national policy were being developed that potentially conflicted and that a variety of different agencies would be attempting to engage the same group of people. As commissioners of services, PCTS have the responsibility to determine local health needs.

Concerns were raised about how the proposed governance arrangements would balance local versus national priorities when initiatives would still continue to be driven by a national agenda. This would be further

complicated by the patient choice agenda, which would have an impact on relationships between the PCTs and the acute trust. The pace of change in government policy (for example, national tariffs and financial flows) could complicate the job of a board of governors for a foundation trust.

North Kirklees PCT

If the proposed governance arrangements for Foundation Trusts were regarded as good, should not the PCTs be looking at similar mechanisms? It was felt, however, that there was merit in ensuring that the governance arrangements for PCTs and the hospital sector were separate. In addition, it was important to note other existing good examples of public engagement including Working in Partnership and the partnership boards. It was felt that the foundation trust process should engage a much wider range of public and patient involvement mechanisms.

It was also felt that because the debate has been focused on the hospital sector there was a danger that that emphasis would shift away from the public health agenda, and potentially undermine the importance of public health issues. It was acknowledged, however, that there would be advantages for the acute trust of being in the first wave of foundation trusts, as this would inevitably attract resources.

South Huddersfield PCT

Foundation trust status would provide an opportunity to have a fresh look at how we do things, to look at performance issues and to ensure that services are developed in a manner that is patient-centred and needs-driven.

However, there are still many unanswered questions. Numerous agencies potentially recruiting members and running elections; the need for effective training and education for the board of governors; cost and bureaucracy of these processes and how this will be perceived by the public (will resources be diverted away from patient care?).

It was also considered that 30 seats on the board of governors were too few, particularly that there may be a need for more representatives from the community and voluntary sectors.

The Cooperative Model

The panel received evidence from Dame Pauline Green, Chief Executive and Secretary of Cooperatives UK. Cooperatives UK is the apex organisation for cooperatives, which provides a strategic voice for cooperation and acts as a centre of excellence for the provision of services to cooperatives.

There is a diversity of types of cooperative that operate in the UK, from consumer owned retail cooperatives; worker cooperatives; community, agricultural and housing cooperatives; credit unions; and new forms such as multi-stakeholder leisure trusts and supporters' trusts.

Consumer cooperatives have a significant economic influence. They have a combined turnover of £12.5 billion, reserves of £3.7 billion and over 4,000 outlets in the UK.

Key features of the NHS foundation trusts governance model are that it is based on the principle of mutual ownership, with ownership vested in the patient, staff and stakeholder community; it provides a democratic basis for the organisation, with elections to the board of governors from the membership community; and it confers a stewardship role on the board of governors.

The potential benefits of this approach are increased patient engagement; an opportunity to work in a more open and transparent way and to develop a culture of trust; greater opportunities for staff involvement; management freedoms from Whitehall; an opportunity to increase community partnerships and citizenship; and freedom to innovate.

There are, however, potential pitfalls, particularly: exclusivity; hijacking of the board of governors by narrow interest groups; and lip service - “mutuals only work if you work at them”.

It was acknowledged that this would require a cultural change in the organisation, and that this would take time. It would require commitment and leadership, external advice and support, regular public communication and consultation with staff and the trades unions.

Cooperation with other health providers and mutuals would be essential, particularly the primary care trusts. Dame Green noted that in her evidence to the parliamentary select committee on foundation trust policy, it was her suggestion that foundation status should have been applied first to the primary care sector and not the acute sector.

Foundation trusts would have to engage in an “active membership policy”, to conduct an audit of skills amongst the board of governors and implement appropriate training for the board.

Implications for other health bodies in Kirklees

<u>The primary care trusts</u>

The primary care trusts were broadly supportive of an application by Calderdale and Huddersfield NHS Trust for foundation status. There was support in principle for the concept of health organisations being bedded in the local community. Increased public involvement in the governance of trust services was welcomed, as hospital based trusts were thought to have become separated from a direct input from the public on service quality issues.

It was also recognised that this is government policy that is “going to happen” and that there would likely be benefits of being in the first wave of applicants. The consensus was one of “let’s work to make it succeed”.

The PCTs did, however, highlight a number of areas of uncertainty and issues of concern which they felt needed to be resolved.

The main concerns about the *principle* of foundation trust status were that this policy has happened too quickly after the establishment of the primary care trusts; the PCTs felt that their sector should have been the starting point for foundation policy. It was also felt that because the debate has been focused on the hospital sector there was a danger that emphasis would shift away from the public health agenda, and potentially undermine the importance of public health issues.

One of the major achievements since the advent of primary care trusts was seen as the shifting of minor surgery and other service activity from the acute to the primary sector. While the PCTs have received verbal assurances that foundation trust status would not impact adversely on this, concerns were expressed that pressures on foundation trusts to increase their financial flows might do just that. It was also acknowledged that the new GP contract would increase pressure on GPs to provide enhanced services.

In practical terms, there were concerns over the cost and bureaucracy of administering elections and supporting the new governance structures. Although new foundation trusts would attract additional resources to conduct elections, there would be ongoing revenue costs.

The need to ensure agreement about the distinctiveness of the roles of the primary and acute sectors when consulting with or engaging the public in order to avoid confusion was highlighted. The primary care trusts felt strongly that it was their role to consult on local health needs to inform their commissioning arrangements. This is distinct from the foundation trusts role to consult on quality, performance, standards and non-clinical issues. The suggestion was made that the foundation trust could use this process, or undertake joint consultation, to avoid public confusion.

It was felt that the foundation trusts governance arrangements needed to be established within the whole systems context; and that there should be clear commitments to engage with and accept the influence of wider partnership working arrangements.

The maintenance of effective partnership working and the need to be clear about the PCTs commissioning role and how this would be balanced against foundation trust priorities was identified as an area which required further clarification from the acute trust.

Particular concern was expressed that the acute trust would not undertake its own commissioning, even at the margins of its activity. The primary care

trusts had received verbal assurances that this would not happen without their support.

The potential benefits of the financial freedoms associated with foundation trust status were acknowledged and welcomed by the primary care trusts. They were unclear, however, as to how the PCTs would be involved in underwriting the revenue implications of these capital projects. Similarly, if foundation trusts are able to retain surpluses at the end of each financial year to re-invest in local provision, was there a danger that this investment might be channelled towards the interests of the acute trust rather than the wider health economy? Verbal assurances had been received from Calderdale and Huddersfield NHS Trust that this would be undertaken as part of the general planning process with the PCTs.

While relationships between the primary care trusts and Calderdale and Huddersfield NHS Trust were positive, there was still concern that these important issues might be dealt with only by local, possibly even informal, agreement with no solid 'foundation'. It was felt that the Department of Health should address these issues at a national level.

Concern was also expressed by the primary care trusts that staff may migrate from neighbouring hospitals to the foundation trust and the consequences that this could have on the local and regional health economy. There was a perception that this was already happening to some degree, as a result of Calderdale and Huddersfield NHS Trusts' three-star status. However, this could potentially be exacerbated by the perception amongst medical professionals that first wave foundation trusts would receive extra resources and would not be allowed to 'fail'.

The primary care trusts were also concerned that foundation trusts would lie outside the local performance system and whether this could have consequences for whole systems working within the area. If the foundation trust is under pressure to deliver, could decisions be made which aren't in the best interests of the system as a whole?

The primary care trusts emphasised the importance of seeing the foundation trust proposal as an opportunity to challenge the effectiveness of current partnership arrangements and develop more effective integration and partnership working.

South West Yorkshire Mental Health Trust

The government's intention is that all trusts will, by 2008, achieve foundation status. In relation to SWYMHT, the organisation was currently zero rated but had aspirations to achieve a three-star rating within 18 months.

Mental health provision remained a 'Cinderella service', and is poorly developed in relation to baseline funding, infrastructure and workforce development. However, staff have been engaged via the Improving Working Lives Programme; in maintaining good staff moral it was felt important that the

foundation proposals do not result in other services being perceived as 'second class'.

The potential benefits of foundation status to the regional health economy were not clear yet. As a foundation trust, Calderdale and Huddersfield NHS Trust would be able to retain any surplus at year end - it may be possible to negotiate that this be used for mental health benefits. The acute trust is the 'host' organisation in terms of premises for SWYMHT so there could be potential benefits in terms of increased capital support for ongoing estate management. SWYMHTs position on the proposal was portrayed as 'not opposed but waiting to be convinced'.

SWYMHT had been advised that they would be offered a place on the foundation trust board of governors. The opportunity to 'have a place round the table' was welcomed. It was hoped that this would provide an opportunity to reconnect the various agendas and facilitate a more seamless planning process. It was acknowledged that the pressure might be for the acute trust to focus on national priorities set by Whitehall initially, with increased opportunity to look at local priorities coming later. The new governance arrangements associated with foundation status could provide an opportunity to broaden the agenda away from just acute sector work and develop a better understanding of community needs.

As a tenant of the acute trust, SWYMHT requires their support for estate management. Inspections in recent years have indicated deterioration in environmental quality. There was some uncertainty over how the foundation trust proposals could affect this landlord/tenant relationship. SWYMHT currently has service level agreements with the acute trust, for example, around the maintenance of premises. Foundation trust status would mean that these agreements would need to be tightened up; made more explicit.

The panel questioned the SWYMHT on how the foundation proposals might impact on cross boundary issues and whole systems working. It was reported that partnership working was essential at al levels in relation to mental health - with the acute trust but also others: the local authority (social services, housing and others) and the primary care trusts. The benefit of establishing the mental health trust was that it gave mental health issues a higher profile - it was hoped that foundation status would not detract from that. There were also opportunities for whole systems working - e.g. surpluses could be used to achieve maximum benefits for all stakeholders, used in a whole systems endeavour rather than simply addressing tertiary needs.

Kirklees Social Services

The Health and Social Care Board are responsible for the commissioning of services; social services also commission some services directly.

It was felt that a social services perspective on assessment and service delivery issues is essential. Social and primary care providers work on the interface with the acute sector, particularly on planning and discharge.

Getting that process right enables people to stay in their own homes and reduces the likelihood of re-admission. Whole systems working is vital. For example, keeping avoidable hospital admissions down enables hospitals to more effectively plan their admissions for elective work.

The panel queried whether foundation proposals might impact on bed blocking issues. Were there any dangers, for example, of people being prematurely discharged to increase financial flows? From the social services perspective it was considered unlikely that the change in status would have any affect in this regard. The implementation of the community discharges legislation is not affected by foundation status. However, the importance of continuing the current partnership arrangements was stressed. Clarity was also required by both the local authority and the primary care trusts about the allocation of any surpluses and the balance of those investments.

It was noted that foundation trusts would respond to commissioning in a different way. While there is no inherent difficulty around this change there is some uncertainty, for example, about how the new governance arrangements will work. Will it be consistent with the HSCB vision of service?

It was stressed that current arrangements with local health partners are very good and there has always been the ability to work through differing perspectives.

The panel questioned what the impact would be of the patient choice agenda on social services. For example, if a patient receives treatment in a hospital outside the Kirklees area how can we ensure they receive the right discharge package and people do not fall through the net?

It was confirmed that some people are already treated outside of area. In these cases, social workers from the area concerned would undertake any required assessment and would liaise with Kirklees social services. If there is likely to be a significant increase in this trend, then there may be a need to make arrangements directly with the alternative acute providers. It was also noted that the converse could occur - i.e. more people being treated by hospitals in Kirklees from outside our area.

It was stressed that social services needed to see first what the commissioners are asking for, in order to evaluate the consequential impact for social services.

<u>Mid Yorkshire Hospitals Trust</u>

The foundation trust proposal is one of a number of NHS policy initiatives. On the surface there are a number of potentially attractive features, although some of the reported freedoms and flexibilities have been seen in previous NHS reorganisations. For example, the financial freedoms are similar to those granted to health trusts in their inception in 1991. It was considered that the regulator would be likely to exercise control on the use of capital, to

scrutinise the nature of capital bids and their justification in the interests of economic macro management.

The proposed social ownership model could represent a major innovation for local involvement. Although there is significant additional work that could be undertaken by existing trusts to increase local involvement, the foundation trust proposals offer a structural framework for this. Caution was expressed, however, about whether the foundation trust governance arrangements would in themselves deliver a step change in how services are provided - the problems are still the same, irrespective of organisational change. The foundation trust agenda may not be as radical as it first appears.

Mid Yorkshire Hospitals Trust is already looking at ways to improve the relationship between the trust and the public by revitalising their public and patient involvement mechanisms, having more transparent and open engagement with local people.

The amount of work needed to bring about greater public and patient involvement should not be underestimated - experience suggests that many people only get involved at a time of crisis and not in relation to routine issues. There was also a danger that foundation trust governance arrangements may actually inhibit change rather than being a vehicle for innovation as the public can be resistant to changes in health service delivery. The board of governors of a foundation trust would require extensive training and skills development.

The panel questioned the Chief executive on staffing pressures and ward closures. There is already a very real pressure on staff recruitment. In the last two months the trust has lost six ward sisters from Dewsbury hospital to take up positions with primary care trusts. This is illustrative of what could happen if improved staff packages were to be offered by foundation trusts or any other NHS organisation for that matter. He pointed out that the hospital (Mid Yorkshire) has recently recruited a number of consultants to the area.

It was felt that West Yorkshire Strategic Health Authority or the regulator should have an overview of what happens in the labour market and intervene if necessary; although it was recognised that interventions would need to be carefully considered.

Irrespective of foundation trust status the nature of use of acute hospitals is changing. Communities are increasingly reliant on their local hospitals - e.g. A&E admissions at Dewsbury hospital are higher per capita than Leeds. As many as 40% admissions from A&E could potentially be avoided if more senior doctors were available to undertake assessments or if there was greater primary care infrastructure in the community.

Mid Yorkshire Hospitals Trust is currently rated as a one-star trust, due mainly to its financial situation. The trust does not expect to be above two-stars next year due to the financial backlog.

One positive feature of the foundation trust proposals are that service level agreements with primary care trusts will be legally binding contracts. This would enable trusts to sell only that capacity which they could deliver; whereas, at the moment the acute trust can be overwhelmed by demand that the trust can't service. However, improvements are already being made in the current system, such as redesigning consultants' acute care pathways (e.g. the Surgical Assessment Unit at Dewsbury hospital).

In response to a question about how the trust would be affected by patient choice, it was noted that there was support for patient choice in principle as far as the proposals are currently understood. A guarantee of reasonable waiting times was welcomed. Improvements in waiting times for Mid Yorkshire Hospital Trust were noted - e.g. the development in Pontefract of an elective surgical centre providing rapid access has reduced the length of stay for orthopaedic patients from 14 to 6 days. If trusts fail to address issues of access, then patients can and should go elsewhere, provided that patients are fully aware of quality standards both for their local hospital and for alternative providers.

However, if foundation trusts are able to increase investment to provide rapid access, this could potentially draw resources away from other trusts.

Mid Yorkshire Hospitals Trusts boards' view of the foundation trust proposals was reported as being mixed. There is a recognition, however, that the health service must evolve; that the NHS can't stand still.

It was felt that the regulator will undertake at least an equivalent role in relation to the performance management of foundation trusts as the strategic health authority for other trusts. Given the government commitment that all trusts will have foundation status by 2008, the continuing role of the strategic health authority is unclear.

<u>West Yorkshire Strategic Health Authority</u>

The panel received the following written submission from Richard Jeavons on behalf of West Yorkshire Strategic Health Authority:

Background

1. West Yorkshire Strategic Health Authority (WYSHA) has been asked to provide a written submission to the Scrutiny Panel, who are undertaking a review into Calderdale and Huddersfield NHS Trust's application for Foundation Trust status.

2. This paper sets out:

- The context for Foundation Trusts;
- The SHA's role in the application process; and
- Our current understanding of future performance management arrangements.

Context for Foundation Trusts

3. Foundation Trusts are a key element of NHS system reform. They are one element of change that should lead to:

- A service more responsive to patients;
- Devolved accountability within a clear framework of national standards; and
- A self-managed system, with a variety of incentives.

4. Foundation Trusts encourage innovative and responsive solutions developed locally – under new governance arrangements where Trusts will be more accountable to the local community. There will be common standards and independent inspection across all of the NHS (including National Service Framework standards; eg. cancer), including Foundation Trusts. The local governance arrangements should ensure local (and not national) control over service strategy and delivery. There will be public and staff membership on the Board of Governors, giving an opportunity to engage with local communities and staff. The 'constituency' of this arrangement can be defined locally – and there has been the opportunity to comment on Calderdale and Huddersfield Trust's proposed arrangements.

5. The benefits to Trusts include:

- Greater integration of health and social care;
- The ability to build bridges (using membership);
- Social ownership;
- Capitalise on local initiatives; and
- Financial freedoms (eg. retain surplus, access to capital, retention of asset disposal)

Calderdale and Huddersfield Trust's Application

6. The SHA supports in principle the aim of the Trust in applying for Foundation Trust status. The SHA now has a key role in the Trust's application process, and is being asked to feed views on aspects of the application to the Department of Health.

7. This involvement has several aspects:

- Views on the Trust's draft Service Delivery Strategy (early November). The SHA will comment on how much this 'fits' local strategic drivers and current business planning in both the local health economy and on a West Yorkshire basis;
- Work with the Trust to ensure that Local Delivery Planning with PCTs includes clarity of action required to address performance issues; and

- Views on the Trust's draft HR Strategy (early November) – again to feedback to the Department of Health.

8. The SHA sees this role alongside it's role to support improvement across all NHS organisations to gain 3 stars – and to have the opportunity to apply for Foundation Trust status.

Future Performance Monitoring/Management

9. The Department of Health is currently seeking views on how the performance management relationship will work in future with regard to Foundation Trusts. Until the Independent Regulator is established it is difficult to define this relationship in detail. In the meantime, the SHA continues to support PCTs to develop commissioning and performance management locally.

10. In West Yorkshire, all 3 early candidates for Foundation Trusts have been open in a willingness to continue to work closely with us and networks both locally and across West Yorkshire.

UNISON

The panel received the following written submission from UNISON. The panel would have liked to have met with UNISON to seek clarification on their evidence.

Thank you for inviting UNISON to attend and submit information to your Scrutiny Panel. I am sorry I was unable to attend your last meeting.

You asked if I could send any documents electronically, which I have tried to do. I thought it would be useful to direct you to UNISON's website – www.unison.co.uk/foundation . I have sent by post a copy of the documents I left at the meeting I attended. They are:

1. Research document produced for UNISON dated Feb 2003.
2. A document describing the Seven Reasons UNISON is opposed to Foundation Trusts. This is available on the website. http://www.unison.org.uk/acrobat/B799.pdf
3. An extract from UNISON's guidance booklet for branches. This document is available in full on UNISON's website. http://www.unison.org.uk/acrobat/13655.pdf

There are a number of other documents on UNISON's website all relating to Foundation Trusts. Many of these are campaign materials for our branches and whilst these are interesting, they are not specifically relevant to the questions under consideration. I have tried to pick out the documents that are most useful, without being too repetitive.

This page link is to UNISON's written evidence to the Health Select Committee, written in February 2003, www.unison.org.uk/acrobat/B826.pdf . I have also included a link to a speech made by Dave Prentis in July this year to the Kings Fund but I am not able to edit it down to be specific to Foundation Trusts, www.unison.org.uk/acrobat/B921.pdf .

I am aware that some of these documents were written some time ago. Whilst UNISON has had clarification on certain issues in the Bill, the concerns and points of opposition remain the same.

I would also like to add some further context to these documents which I hope you will find useful.

It is easy to believe from comments made by the Government and others that UNISON is a backward looking and purely "protectionist" Trade Union. This is clearly not the case. UNISON has worked in partnership with the DoH to bring about the smooth implementation of significant change within the NHS and we still are. We have been broadly supportive of the Government's modernisation agenda and the National Plan. We have supported the move away from the dominance of the secondary (acute) health sector in favour of primary care, the development of PCTs and the focus on local health economies.

UNISON believes that the introduction of Foundation Trusts is unnecessary and unhelpful. They will seriously undermine the progress that is being made towards improving the ability of the NHS to deliver the integrated health and social care we all want. The lack of accountability of Foundation Trusts to the Secretary of State, the Strategic Health Authorities or the PCTs begs the question as to how inequalities in provision will be avoided in the future.

The documents I have sent and referred you to above make these points in more detail. They also draw out the key concerns about Governance and the dubious claims about public involvement and ownership.

I am aware that the Committee has the power to refer an issue to the Secretary of State for Health where it considers that a substantial variation in services or the development of services is not in the best interests of the health service.

It is UNISON's view that the development of Foundation Trusts is not in the best interests of the health service. We ask the Committee to support this view and refer the proposal to the Secretary of State.

I hope you find this information useful. Please do contact me if you would like any further information or clarification. Once again, thank you for giving UNISON the opportunity to have an input into your considerations.

WHY FOUNDATION TRUSTS WILL NOT IMPROVEMENT PUBLIC INVOLVEMENT AND LOCAL ACCOUNTABILITY

The proposed governance system for foundation trusts is fundamentally flawed and will not improve local accountability

- Foundation trusts will be able to draw up their own constitutions, and decide the constituencies from which their public members will be drawn. Foundation trusts will be able to alter their constitutions without consultation with local communities or the local NHS.

- Foundation trust members will be self-selecting, creating the potential for under-representation of particular ethnic or social groups. Foundation trust members may include private patients.

- Governors will have a right to be consulted by the Board of Directors concerning Foundation Trusts' forward plans, but will not be able to veto decisions made by the Board of Directors.

- There will be no statutory duty on Governors to consult with foundation trust members. Neither will the Governors be under any statutory duty to notify the Independent Regulator if the Board of Directors takes an action that is inconsistent with a Foundation Trusts' licence.

- If Trusts choose, PFI contractors can have a seat on the Board of Governors. This is for example a proposal that has been floated as part of the Nuffield Orthopaedic Centre's Foundation Trust consultation document.

- It is not clear how easy it will be to recruit Governors. Recruitment difficulties for school governors are well known, with vacancy rates up to 20% especially in inner city areas. OFSTED has found that in deprived areas school governance tends to be less effective.

- Administering the governance system for Foundation Trusts will be extremely expensive. Foundation Trusts will be required to maintain lists of members, to send members information and to organise elections to the Board of Governors. Already, each applicant trust has been allocated £100,000 by the Department of Health to help it develop its constitution and voting arrangements.

Foundation Trusts are being forced on local communities

- Foundation trusts are supposed to be about giving patients and local people a say in the way in which their hospital services are provided. Yet it is clear that, on the question of whether to submit an application for foundation status, local people and staff are not being given a say, with consultation being limited to how foundation status should be implemented.

- This is illustrated by the following two quotations taken from consultation documents produced by Trusts on their applications for foundation status:

- '*Trusts are an established part of NHS policy and there will be an NHS Trust in Sunderland. The primary aim of this consultation therefore is to ensure that each NHS Foundation Trust has an appropriate governance structure.'* (City Hospitals Sunderland.)
- *'Some things have already been decided for example that we will put forward a proposal to be an NHS Foundation Trust for the Secretary of State to consider.'* (Gloucestershire Hospitals NHS Trust.)

Foundation Trusts will cut across existing systems of patient and public involvement

- Unlike NHS Trusts, Foundation Trusts will not have their own Patient Forums, it being left solely to Primary Care Trust Patient Forums to provide an independent voice for patients on the services provided by Foundation Trusts. This flies in the face of one of the original justifications for Patient Forums, which was to implement the recommendation of the Kennedy inquiry into the events at Bristol Royal Infirmary: 'The involvement of the public in the NHS must be embedded in its structures: the perspectives of patients and of the public must be heard and taken into account wherever decisions affecting the provision of healthcare are made.' In practical terms, it would clearly be difficult for somebody who is seriously ill in hospital to raise concerns about a Foundation Trusts' services through a PCT Patient Forum, whereas a Patient Forum based in the Foundation Trust itself might prove more accessible.

- Whilst Primary Care Trust Patient Forums will have the power to enter and inspect Foundation Trusts' premises for the purpose of carrying out their duties, they will not be able to oblige Foundation Trusts to respond to any recommendations they make.

- When an NHS Trust become a Foundation Trust, this will mean scrapping a Patient Forum that may in many cases only very recently have been set up, unless the Trust agrees to retain it voluntarily. This will be an enormous waste of public funds.

- Quotation from the report of the Health Select Committee, *Patient and Public Involvement in the NHS*, 3 July 2003: 'We are left with the impression that some policy within the Department of Health is formulated in total isolation from other policy, leading to the ridiculous situation that the NHS and its patients are now faced with the introduction of two parallel but entirely different systems of patient and public involvement within the NHS within one year.'

Foundation trusts will be regulated by an unaccountable regulator

- Foundation Trusts will be licensed and regulated by an independent regulator, who will be largely unaccountable to the Government, Parliament or the public for his or her actions.

- The Independent Regulator will not be obliged to consult with local people on how he or she fulfils his or her role in relation to foundation trusts, on the content of a trust's licence, the property it must not sell off or the services it must provide.

- Neither is the Independent Regulator obliged to consult with Primary Care Trusts, whose role is to plan and buy services to meet the health needs of their local communities, or Strategic Health Authorities who are responsible for ensuring that specialist services such as intensive care and child and adolescent mental health are maintained.

The legal duties of the Independent Regulator are unclear and fail to place a legal obligation on the Regulator to act in accordance with the values and principles of the NHS. In particular, there is no legal duty on the regulator to safeguard the principle of equality of access of treatment, for instance by preventing Foundation Trusts from cherry- picking patients.

Medical Professional Staff

The local medical staff representative was invited to give evidence but did not attend the meeting.

Meeting to clarify issues with Calderdale and Huddersfield NHS Trust

After receiving evidence from relevant stakeholders, the panel arranged a further meeting with Calderdale and Huddersfield NHS Trust to explore issues of concern or clarification that has been raised by the agencies concerned. The following provides a summary of this discussion:

Audit and Inspection Arrangements

The panel questioned whether foundation trusts would benefit from any freedoms in relation to audit and inspection arrangements. They were informed that foundation trusts would be monitored in relation to compliance with the terms of the license agreement by the newly appointed regulator. The Board of Governors would be under a duty to report any concerns about non-compliance with the license to the regulator. Performance would also be monitored by an independent body, like the Commission for Healthcare Audit and Inspection (CHAI), although the detail of the relationship between CHAI and the regulator has not yet been made clear.

Maintaining an Active Membership Policy

The panel questioned the resource implications of maintaining an 'active membership policy'. They were informed that Calderdale and Huddersfield NHS Trust had sought advice from experts in the field of social ownership both in the UK and internationally. On the basis of this advice they estimated that costs would be in the order of £4 per member.

It was also confirmed that first-wave foundation trusts would receive extra resources (estimated at £100k) to establish the membership strategy.

The panel questioned whether any consideration had been given to making the maintenance of an active membership strategy a specific role of one of the board members. It was reported that the trust have been investigating good practice in this regard - including the role of Company Secretary to service the board and the interests of the wider membership. The PCTs could also be involved in a sub-group responsible for the membership strategy.

It was confirmed that the current proposals were for a board of governors consisting of 30 people, 16 of whom would be members of the public. Five or six of the appointed governors would be from the staff base and staff are being consulted as to how a fair staff representation might be achieved. It is possible, for example, that staff could vote for their clinical representatives. It was recognised that ancillary and clerical staff needed representation to reflect the important roles that they play in the organisation.

There will be 3 PCT representatives but their role will not be to represent their own PCT. The proposals are for one local authority representative from each affected local authority, and it would be up to each local authority to determine their representative.

Transitional Arrangements

The panel questioned what transitional arrangements between the current and new governance arrangements were anticipated; for example, should the existing non executive directors maintain their positions for a period of time?

It was confirmed that the bill is now more explicit regarding transitional arrangements- existing non executive directors would continue for up to 12 months or until their natural contracts run out, to ensure continuity.

Cooptees

It was confirmed that the trust are considering how best to ensure that the board have access to external skills and experience. The potential value of cooptees with non voting rights was being given careful consideration.

Public and Patient Involvement

The panel questioned whether there would be any coordination with other health bodies in relation to recruitment to public and patient involvement mechanisms.

It was confirmed that the membership strategy must engage the existing local infrastructure.

Finance Issues

The trusts service vision (including a financial appraisal carried out by Price Waterhouse) was being considered by an external reference group. This includes historical financial records, cash release inefficiencies savings, the recovery plan and outturn figures for next year and beyond.

Foundation trusts would have to report their financial position annually to Companies House, the regulator and the Board of Governors (and wider membership).

In relation to accessing capital for health service improvements, it was confirmed that this would only be undertaken in consultation with partners (including the PCTs and the local authority) about the broad areas of investment. The strategic overview by the Board of Governors would provide a framework to ensure investment was in the interests of the local health economy.

Payment by Results

The panel questioned what difference foundation trust status would have on implementing payment by results. They were informed that payment by results would be implemented irrespective of foundation trust status, but foundation trusts would be early implementers (from 1st April 2004). The trust has already had to agree service level agreements with commissioners as a shadow exercise, which includes built in checks and balances in relation to additional activity or under-achievement.

The 3-year Local delivery Plan (LDP) has now gone through its first year, but will require refreshing for year 2 and beyond. This process is unaffected by foundation trust status.

Impact for other Acute Trusts

The trust was questioned about whether foundation trust status could adversely impact neighbouring trusts, for example, in relation to staff recruitment and retention.

It was reported that the terms of authorisation of the trust would include an obligation not to destabilise other health partners. In relation to recruitment, NHS trusts already have the ability under 'agenda for change' to recruit against a higher pay spine for consultants that are difficult to source.

6. Conclusions and Recommendations

What Did the Scrutiny Review want to Investigate?

The Scrutiny Review into NHS Foundation Trust `s (NHS FT's) was established to investigate the implications NHS FT status would have on communities, patients, and the wider health and social care family in Kirklees.

It was not about examining government policy on NHS FT's which continues its progress through the parliamentary process before it reaches royal assent and becomes legislation sometime in the new year.

Difficulties associated with the legislative timescale.

To a certain extent the scrutiny review worked in a legislative vacuum, accepting that the detail on NHS FT's would change as the new "Health and Social Care (Community Health and Standards) Bill" progresses through the House of Lords and the House of Commons.

At its last reading in the House of Lords up to a hundred amendments were tabled (7 October 2003). This in effect means that NHS FT have been removed from the Bill.

The third reading of the bill is scheduled in the House of Lords on 17 November. Once the third reading has been complete it will make its way to the House of Commons.

If the House of Commons votes in favour of re establishing NHS FT many commentators anticipate that the House of Lords will not insist on removing NHS FT from the Bill and it will be included in the Act.

What does the evidence suggest?

"…..not if but when…..NHS FT will happen anyway……."

(Diane Whitingham Chief Executive CHT giving evidence to the Scrutiny Review)

The evidence received suggests little opposition in principle (with the exception of UNISON) amongst key stakeholders towards Calderdale and Huddersfield NHS Trusts application for NHS FT status.

While each key stakeholder identified areas for concern, most assumed the position that this was something that was going to happen irrespective of any resistance to change and would be brought in by legislation currently progressing through the parliamentary process.

The Governments view is that by 2008 all NHS hospital trusts in England will become Foundation Trust's.

It was argued that it was best to be "in at the beginning" and "part of the first wave" effectively managing any uncertainties than to join at a later stage, when there would be less financial support and guidance available.

NHS FT's will receive 4 years transitional funding to support implementation of the policy.

Who can apply to become an NHS Foundation Trust?

The Department of Health's (DOH) Guide on NHS FT's (Dec 02) says that the first foundation trusts will be drawn from existing 3 star acute and specialist trusts emphasising that NHS FT status will only be available to health care providers that are considered likely to deliver the benefits to patients that come with the greater freedom that the status offers.

Key stakeholders were keen to stress that given the climate of change in the NHS those NHS organisations who adapted quickly to the governments agenda of "modernisation" were most likely to receive benefits, freedoms and flexibilities to support the continued provision of high quality health care and responsiveness to patient needs.

NHS Trusts are assessed on how they are performing and then given a star rating to reflect their position. This rating is determined by their effectiveness in keys areas of responsibility that range from managing resources to delivering patient care. 3 star trust therefore will be ranked as one that is a high performing organisation.

CHT is a 3 star rated Trust.

So what about organisations with zero to two star rating?

The Government have emphasised that gaining 3 star status is the pre-condition for granting NHS Foundation Trust status.

The panel heard evidence that a range of measures are in place to improve the performance across the whole NHS. These include extra resources and external help from the NHS Modernisation Agency to assist poor performing Trusts get to a level that would enable them to gain 3 star status and move towards becoming an NHS FT.

Concern was raised about a two tier system. The evidence suggests that with central government support a process of levelling up is likely to take place, thereby alleviating any disparity.

What is the difference between an NHS Trust and an NHS Foundation Trust?

The scrutiny panel wanted to find out what difference if any an NHS FT would have on patients and their families using acute services provided by CHT.

The panels findings based on the evidence received, are that the main difference between an NHS (acute) Trust and an NHS FT is that NHS FT's will be required to:

- establish Governance arrangements based on principles of social ownership;
- be allowed to borrow from the public and private sector purse to improve facilities and services;
- be allowed to reinvest any surpluses made at the end of the financial year in line with the licence agreement.

These changes in themselves will not necessarily result in direct changes to service users. Effects will be indirect and are likely to be seen over the medium to longer term.

So what did the Scrutiny Review conclude?

The evidence received by the scrutiny review is presented under the heading of each of its terms of reference.

1. HOW WOULD FOUNDATION TRUST STATUS IMPACT ON THE RESIDENTS OF KIRKLEES AND CALDERDALE?

A) GOVERNANCE ARRANGEMENTS:

The Scrutiny Review received evidence that the major impact NHS FT `s will have on communities in Kirklees is that there will be a new governance structure to reflect the freedom from Whitehall central control with greater accountability to the local community.

A model of social ownership underpinned by an NHS that is patient centred, responsive to the needs of communities and delivering appropriate high quality services in partnership with other key stakeholders and communities is what is desired.

The review heard that this vision of a patient centred NHS is part of the governments 10 year plan "The NHS Plan - a plan for investment, reform and delivery" designed around the patient that builds on the very bases of which the NHS was founded in 1948, a service that delivers health care at the point of need, irrespective of the ability to pay.

Board of Governors and the Independent Regulator

The Review heard that each foundation trust will have members represented on a board of governors to oversee and provide strategic direction to the board of directors. The governors will ensure that the trust complies with its objects and the terms of its licence and will be under a duty to raise concerns with a regulator. The governors will consult with members and advise the board on the business plan. They will elect the chairperson and non executive directors, approve the annual report and accounts and approve the appointment of the chief executive, other executive directors and the auditor.

NHS FT`s would be granted a license to operate by a new Independent Regulator who will be accountable to Parliament. The Regulator will act on the advise of parliamentary select committees.

The regulator will be responsible for ensuring that the terms of the licence are upheld. For example the licence will set out requirements for foundation trusts to operate in the public interest; to meet national clinical standards; requirements relating to continuity of NHS services; and a duty to work in partnership with NHS and other relevant organisations etc. The license will include an explicit requirement on an NHS FT to uphold NHS standards and to operate according to NHS values.

The Scrutiny Review did not receive any detailed evidence on the licensing agreement, nor the constitution, or how the regulator would operate accept that he/she would adopt a “light touch”. It is understood that the Regulator would intervene if CHT did not abide by the terms of Authorisation (the license agreement).

The review note though that an NHS FT would still be open to scrutiny, inspection and audit through other bodies such as the Commission for Health Care Audit and Inspection and the Councils very own Overview and Scrutiny function.

The review note that the relationship between the regulator and CHAI is yet to be finalised.

An NHS Foundation Trust's constitution describes what type of body it is and its primary purpose, as well as defining its membership and its address. Key offices/staff groups may also be defined under the constitution. The constitution may also set out the internal governance arrangements.

The scrutiny panel recommends that CHT share its draft constitution with key stakeholders at the earliest opportunity to allow for detailed consultation before it is finalised. (The panel recognise the time pressures associated with the current application timetable for FT status. One way to ensure that all stakeholders have the opportunity to contribute to the detailed development of the draft constitution is to ensure that the draft constitution submitted with the application for FT status includes only the mandatory minimum elements. This would allow further time for more detailed

consultation on the make-up and role of the board of governors, provisions to guarantee a balance of representation and other issues).

The panel also recommend that the terms of the license agreement with the regulator are publicised and shared with key stakeholders should the application for FT status be successful

Board of Governors and the Social Ownership Model

The review heard that NHS FT will herald a new form of social ownership where health services are owned by and accountable to local people rather than to central Government. That local people patients and staff will be invited to become members and will elect representatives onto a Board of Governors.

The Scrutiny review accepts that there are several benefits to the model of social ownership and that this is a major change to the way the NHS has worked in the past.

The review heard evidence that the key feature of this model is that it is based on the principle of mutual ownership, with ownership vested in the patient, staff and stakeholder community; it provides a democratic basis for the organisation, with elections to the board of governors from the membership community; and it confers a stewardship role on the board of governors.

The benefits of this approach are to do with:

- increased patient engagement,
- an opportunity for the organisation to work in a more transparent way,
- developing a culture of trust;
- greater opportunities for staff involvement;
- management freedoms from Whitehall;
- an opportunity to increase community partnerships and citizenship;
- and freedom to innovate.

However the review is mindful that there are several pitfalls to this approach and that careful consideration and planning for how to manage the pitfalls must be a priority for an NHS FT.

The pitfalls are likely to do with issues of exclusivity, hijacking of the board of governors by narrow interest groups, the size of the board of governors and the potential lack of representation from a community and geographical basis, lack of transparency and fairness.

The review accept that these issues are not confined to the NHS FT but are difficulties most organisations experience with this type of free and fair democratic system.

The Review heard that the CHT had been supported by mutual and cooperative organisations in developing a governance model that would be as inclusive as is possible.

The Review understand that the model for governance arrangements has been discussed by an “external reference group” set up to support first wave Trust move to becoming NHS FT .

The Scrutiny review welcomes the principle of social ownership but notes that there are several pitfalls to this model.

The scrutiny panel recommend that CHT consult with key stakeholders on the detailed proposed governance arrangements before they are finalised.

The Review concludes and recommends that an essential requirement for the Board of an NHS Foundation trust will be to develop and maintain an “active membership policy”.

Representation, Roles, Responsibilities and Continuity of the Board of Governors

The Review heard that the Board of Governors will oversee and provide strategic direction to the Board of Directors
The Board of Directors will be the executive body responsible for the operational management and conduct of the trust
The Board of Governors will ensure that the trust complies with its objects and the terms of its licence and will be under a duty to raise concerns with the Regulator.
The governors will consult with members and advise the Board on the business plan.
They will elect the chairperson and non executive directors, approve the annual report and accounts and approve the appointment of the chief executive, other executive directors and the auditor.

The Board of Directors will be under a duty to consult the Board of Governors on the development of forward plans for the trust and about any significant changes to the existing business plan.
The Board of Directors will include a non-executive chairman, a chief executive and finance director.
Non-executive directors will constitute at least one third of the Board of Directors.
There would be separate audit and remuneration committees, both with non-executive director membership.

Representation

The panel received an outline of CHT’s current thinking with regard to the size and representation on the board of governors. It is understood that the proposed board would consist of 30 governors with 14 being appointed and 16 elected by the membership. Appointed governors would include one representative from each of the local authorities, the primary care trusts, the voluntary sector and South West Yorkshire Mental Health Trust (SWYMHT).

The panel welcomes the intent to ensure representation on the board of governors from all key stakeholders and considers this to be in the best interests of continued partnership working and consistent with a 'whole systems' approach to local health and social care provision. However, as noted above, the panel recommend that CHT consult with key stakeholders on the detailed proposed governance arrangements before they are finalised. Notwithstanding the outcomes of such a consultation, the panel would make the following initial recommendation in relation to appointed governors:

- **That two places are allocated for each participating Local Authority; one specifically for Social Services supporting work toward a more integrated and seamless service; and the other providing for the local authority's community leadership role.**

Elected Governors –

The Review heard that people elected to the board of Governors will be eligible to serve for a term of up to 3 years and stand for re-election subject to serving for a maximum of 9 years in total.

That the applicant NHS FT to arrange the election process in whatever way fits its local circumstances.

The panel recommends that the trust consider differential periods of appointment for public and staff governors so that they do not all come up for re-election at the same time.

The panel recommends that the trust consider limiting the maximum period a governor can serve to three consecutive terms, in line with the Commissioner for Public Appointment's guidance on terms of office.

The review was informed that the cost to maintain an active membership would be approximately £4.00 per member.

The review notes that the Trust has sort national and international views from health providers and other organisations on how to resource and support a board of governors and its membership community.
While it is acknowledged that there will be an approximate cost of £4 per member associated with setting up and maintenance of new governance arrangements it could be argued that this sum is unrealistic.

Considering that many board members may need additional support and that the membership community itself will require regular communication and information on a range of health matters what exactly will the £4.00 pay for?

The review would like to see the wider health and social care family contribute to information and communication processes.

The panel was informed that the cost to maintain an active membership would be approximately £4.00 per member.

The panel notes that the Trust has sought national and international views from health providers and other organisations on how to resource and support a board of governors and its membership community.

However, the panel consider that a cost of £4 per annum per member may be unrealistic to maintain an active membership community. One of the roles of the Board of Governors will be to provide a steer on how the NHS Foundation Trust can carry out its business in ways consistent with the needs of the members and the wider community. This will necessitate regular consultation on issues with the wider membership, which can be costly and time-consuming.

The panel feel that there are opportunities for joint working between CHT and the wider health and social care family, e.g. through the provision of joint information or by jointly undertaking consultations. As well as being more cost effective, this would reduce confusion, help support the perception of whole systems working and help to increase community engagement.

The panel recommends that a joint approach to community consultation and information provision be agreed between key health and social care providers in Kirklees.

The panel would welcome clarification that the change in governance arrangements associated with foundation trust status will not result in a reduction in resources available for patient care.

Continuity

The Review feel strongly for reasons of stability and continuity that a newly established board of governors required to ensure that the Trust operates in a way that fits with its statement of purpose and complies with the licence conditions will not be able to “hit the ground running” and contribute effectively to its remit.

The scrutiny review recommends that existing non - executive directors of the present CHT board be invited onto the Board of Governors for a period of no more than 12 months to provide continuity and stability supporting the consolidation for an effective board of governors.

B) Financial Freedoms

The panel was told that an NHS FT will be granted a wide range of financial freedoms. These freedoms will apply to decisions on managing the assets already vested in the organisation and allow access to a wide range of funding to improve and expand services and support innovation.

The freedoms will cover three key areas:

- retention of proceeds from assets disposals;
- retention of operating surpluses;
- access to capital based on financial performance and ability to meet any liabilities incurred as a result of borrowing.

Financial Management

The review heard that CHT had a managed a deficit budget over the last 2 years bringing the budget down from about £5 million to just £1.2 million.

Price Waterhouse and associates acting as an external reference group had undertaken a financial scrutiny to assess the financial viability of the trusts application to become an NHS FT.

The outcome of this process is not yet known.

The review heard from the CHT Chief Executive that she would only be confident in submitting an application to become an NHS FT if the Trust received a clean bill of health from the external reference group that were examining the Trusts financial position. That said she pointed out that the trust had worked hard to develop a financial recovery plan demonstrating a downward trend in managing an overspend.

The Scrutiny Review congratulates the CHT on managing effectively a deficit budget and receiving 3-star status.

Borrowing/Reinvesting surpluses

An NHS FT will be given the opportunity to access capital from the public and /or private sectors at appropriate rates of interest.

An NHS FT will also be allowed to keep any year end financial surpluses subject to the requirement that they are reinvested in ways consistent with its primary purpose as set out in the licence.

The review heard that the trust would need to demonstrate that it had the income necessary to repay any borrowing. It was noted that the principal source of revenue will come from legally binding contracts with PCT`s in the main as the commissioners of services.

It was also noted that clinical services will be driven by a standard national tariff based on the principle of payment by results. The standard tariff system across the NHS it was argued is designed to ensure that the NHS does not return to the internal market competition on price but it is driven by incentives that raise standards, outputs and activity.

This new system is seen as part of a reform programme that will increase patient choice and provide strong incentives for providers to focus on quality and increasing patient satisfaction as well as efficiency.

The review wanted to know who would be involved in making the decision on reinvesting any surpluses.

The review was informed that the Primary Care Trusts would be involved in discussions of this kind and that it would need a “whole systems” debate that brought in other key stakeholders.

The Scrutiny Review recommends that reinvestment of surpluses in line with the license agreement namely “…...health related activity carried out in the public interest set out in the license….” is decided on the basis of community health and social needs and in discussion with the wider health and social care family.

2. HOW WOULD FOUNDATION TRUST STATUS AFFECT HOW HEALTH SERVICES ARE PROVIDED, ACCESS TO SERVICES, EQUITY OF PROVISION AND HEALTH INEQUALITIES?

The evidence suggests that the main difference between an NHS Trust and an NHS FT is primarily the governance arrangements and ability to borrow and reinvest surpluses.

The evidence suggests that there will be no change in the way health services are provided, access to services or equity of provision that does not exist already or is being planned for.

NHS FT like all other NHS Trusts will need to respond to government policy set out in the NHS Plan to deliver a better deal for patients and staff.
The idea is to deliver faster treatment, higher clinical standards and a better patient experience with the patient at the centre.

To support implementation of the NHS Plan a number of initiatives exist that support patients to exercise choice of treatment referred to as the “patient choice” agenda linked to a system of how treatment is paid though a system of financial flow called “payment by results” set against a standard tariff.

These two areas of NHS policy will be implemented across all NHS acute trusts irrespective of whether there are an NHS FT or not.

A third “Agenda for change” will impact on pay and conditions.

NHS FT`s will implement the policy sooner than other trusts with the intention of providing strong incentives for providers to focus on quality and thereby increasing patient satisfaction and efficiency.

Patient Choice

The patient choice agenda means that by December 2005 when patients are referred for treatment, they will be offered a choice of four or five providers at the point of referral.

By the summer of 2004 all patients who have been on a waiting list for treatment for longer than six months will be offered a choice of at least one alternative provider (i.e. the choice to either stay on the waiting list and have the treatment locally, or the opportunity to go elsewhere for treatment). This could result in patients moving around the system in a very different way than they do currently.

How people will exercise that choice is difficult to determine –the early pilot (London) schemes demonstrated that patients exercised choice in a different way to that which was originally expected. A small number of patients were expected to respond however a large % (figure not known) exercised choice as part of the pilot.

How patients exercise choice will impact on how money flows through the system. If patients don't come to Calderdale and Huddersfield NHS Trust then the money doesn't come into the organisation. Conversely if lots of patients choose to come then waiting lists may increase which, in turn, may impact on how people exercise choice.

Payment by Results

As indicated earlier from 2003/04 the NHS will begin to introduce a system of financial flows based on the principle of payment by results against a standard tariff. The intention we told is that the national tariff system should be fully operational no later than the end of 2007/08 and that 90% of NHS Trust and NHS FT clinical activity will be paid for under the tariff. The tariff will apply to all providers of health care to NHS patients.

(The DOH guide to NHS FT defines tariff – the fixed price that organisations can charge NHS Commissioners in relation to services for NHS patients)

NHS FT will implement the introduction of financial flows earlier than other trusts. In effect this will mean that patients will be paid for on an individual basis, whereas at the moment they are not.

The system of financial flows is based on the principal of 'payment by results' against a standard tariff. Together with the patient choice agenda, these reforms are intended to provide strong incentives for providers to focus on quality and increasing patient satisfaction as well as efficiency.

The review notes that Foundation trusts have been promised money to help ensure the transition to foundation status. This could help to ensure that the implementation of financial flows will not destabilise the local system.

The scrutiny panel conclude that in relation to the provision of health care services all NHS organisations must respond to the Governments 10 year Plan "The NHS Plan" and note the extra resource for NHS FT and non FT`s to support successful implementation.

Agenda for Change –

Agenda for change is about the new pay system and conditions of service for all NHS staff.

The panel notes concerns raised about NHS FT`s "poaching" staff from other NHS trusts by offering high rates of pay and better conditions of service.

The evidence received points to "agenda for change" as the policy framework setting the criteria nationally for pay and working conditions across all the NHS.

The panel heard from the CHT that there are already variations in how staff are paid in the NHS at the moment. Staff move for all sorts of reasons including family reasons, promotion, better pay and working conditions etc. Even without foundation status the trust could set its own terms and conditions should it wish to do so.

Mid Yorkshire Hospitals Trust pointed to the pressure there are experiencing at the moment with staff recruitment and retention. It was pointed out to the review that in the last two months the trust (Mid Yorkshire Hospital) had lost six ward sisters from Dewsbury hospital to take up positions with primary care trusts.

This is illustrative of what could happen if improved staff packages were to be offered by foundation trusts.

The scrutiny panel heard that workforce planning was a shared responsibility between the PCT's and NHS Trusts reported on in the Local Delivery Plan (NHS strategic planning document also used for performance management purposes by the West Yorkshire Strategic Health Authority). The review note and would like to seek clarification on who has the responsibility to regulate and have an overview of the labour market across an NHS health economy.

The scrutiny panel request that the West Yorkshire Strategic Health Authority and/or the NHS Workforce Confederation comment on how an NHS labour market is regulated so that issues of capacity and workforce planning are managed strategically for a health economy.

3. HOW EFFECTIVE ARE THE PROPOSED ACCOUNTABILITY AND PUBLIC AND PATIENT INVOLVEMENT ARRANGEMENTS?

Accountability –

The review heard that an NHS FT will be subject to a legal regime that replaces accountability to Whitehall with accountability to local people.

That in terms of governance arrangements its accountability to local communities will be defined by the Board of Governors.

Its license will be issued and monitored by an Independent Regulator who will report to Parliament and be required to uphold NHS values and standards.

Inspection will come through the Commission of Health Care Audit and inspection as well as an annual performance assessment to ensure standards are met which will be reported on to the Independent Regulator.

Primary Care Trusts in their role as commissioners of health services will put in place Service Level Agreements with the NHS FT and monitor these .

PCT`s will continue to be performance managed by the West Yorkshire Strategic Health Authority and will need to include in their Local Delivery Plan information on how the Service Level agreements are performing.

A Public and Patients Forum will be established for each NHS Trust and NHS FT. The role of the Forum will be to look at service delivery and service planning issues in the interest of local communities.

Public and Patient Forums will have the power to refer issues of concern to the local authority Overview and Scrutiny Committees.

The Council through its Overview and Scrutiny role will liaise closely with Public and Patient Forums investigating areas of concern.

The scrutiny panel concludes that it is satisfied with the proposed accountability arrangements ranging from the Board of Governors and through to the Councils power on Health Overview and Scrutiny.

Public and Patient Involvement –

The Review notes the evidence expressed by all of the importance of engaging the community, public and patients in service delivery and service planning in the NHS. Public and Patient Involvement Forums (PPIF) are seen as the vehicle to deliver on this agenda with one PPIF for each NHS organisation.

The evidence received from the PCT `s suggested that it would make sense to harness the often scarce community/ public resource that is encouraged to become involved in the PPIF and other involvement issues.

The review accepts the argument made by the PCT`s of the importance to work strategically and in a whole systems way to ensure a more coordinated approach on issues of consultation and involvement across the partnership structures and whole health and social care system.

It was argued that we may not have enough local people who are dedicated, have the commitment and capacity to become involved in the numerous PPI mechanisms including being governors on a NHS FT.

Given that all of the health organisations in Kirklees are seeking to involve, engage and communicate with the same pool of people it would seem sensible to try to co-ordinate this activity. For example, by developing one streamlined PPI recruitment process for NHS FT members and patients' fora.

The scrutiny panel recommends that CT and the Health and Social Care Board Develop and implement a joint strategy for public and patient involvement

4. WHAT ARE THE POTENTIAL IMPACTS FOR DEMOCRATIC ACCOUNTABILITY AND JOINT WORKING BETWEEN THE LOCAL AUTHORITY AND THE NHS?

The Scrutiny review is satisfied that the governance arrangements provide an opportunity for local authority's to exercise their role as a community leaders working on behalf of patients and the wider community to develop services that are patient centred.

The Overview and Scrutiny role will hold NHS FT and the wider NHS to account.

NHS FT does not change any of this but only strengthens opportunities for democratically accountability as discussed already.

The Scrutiny Review concludes that the partnership arrangements under the auspices of the Local Strategic Partnership and Health and Social Care Board are adequately robust and working.

The panel welcome the opportunity for the Council to exercise its Community Leadership role by becoming actively involved in the Board of Governors and the continued power to undertake Health Scrutiny.

5. HOW WOULD FOUNDATION TRUST STATUS AFFECT NHS COMMISSIONING ARRANGEMENTS AND PATIENT CHOICE?

NHS Commissioning –

The primary care trusts were broadly supportive of an application by Calderdale and Huddersfield NHS Trust for foundation status.
There was support in principle for the concept of health organisations being bedded in the local community. Increased public involvement in the governance of trust services was welcomed, as hospital based trusts were thought to have become separated from a direct input from the public on service quality issues.

In their role as commissioners of services for NHS patients Primary Care Trusts have an important responsibility to ensure that provider organisations can be held to account for the services provided to patients. PCT`s control the majority of NHS resources they need to ensure that the services commissioned represent best value for public money.

NHS FT will take full responsibility for the outcomes it achieves in terms of volume, quality and responsiveness to patients. Outputs will need to be agreed with PCT`s and formalised under legally binding contracts.

The review heard of the importance of working in partnership between the PCT`s and the Councils Social services department to meet the needs of the patient and the community at large. That this approach of joined up commissioning, integrated delivery and pooling resources to support delivery is a requirement under the Health Act 1999 and well established in Kirklees.

The PCT`s and the Cooperative movement in particular were very keen to emphasis that the principle of Foundation trusts should have started with PCT`s as they are the commissioners of services and work to identify the health needs of local communities through a process of engagement and involvement.

The principles of social ownership would sit better with PCT`s who it could be argued would cascade the model of social ownership via their commissioning process and therefore be more strategic in dealing with issues of local democracy.

All witnesses who gave evidence spoke of the need to develop a “whole systems” way of working with the patient /public at the centre, commissioning developed jointly, involvement mechanisms better co-ordinated, surpluses reinvested into the system and shared across the health and social care family and the maximisation of scarce resources targeted at areas of greatest need.

Ironically no one organisation explained how they are working towards this or planning for it accepting that partnership arrangements exist though the Health and Social Care Board.

The scrutiny panel recommends that the HSCB commission partner organisations to present proposals on how to implement a whole systems way of working for the health and social care family in Kirklees including CHT as an NHS FT.

Patient Choice –

This area of national policy has been discussed elsewhere in the report.

6. WHAT ARE THE POTENTIAL IMPACTS OF THE FREEDOMS AND FLEXIBILITIES ASSOCIATED WITH FOUNDATION TRUST STATUS?

The Guide to NHS Foundation Trusts[2] sets out a number of proposed freedoms and flexibilities for foundation trusts:

[2] Department of Health, December 2002

- freedom from Secretary of State powers of direction (removing control from Whitehall and replacing it with greater local public ownership and accountability)
- freedom to develop new ways of working that reflect local needs and priorities (within the NHS framework of standards and inspection)
- flexibility to offer rewards and incentives to staff
- freedom to innovate in asset use (foundation trusts will be allowed to retain proceeds from asset disposals)
- more options to access capital funding (for example the ability to borrow money from private lenders)
- freedom to retain any operating surpluses

There are proposed safeguards and conditions attached to a number of these freedoms and flexibilities. The detail of the legislation is, at the time of writing, subject to change as the Bill proceeds through the legislative process.

SUMMARY

In the final analysis NHS FT will happen.

They will however encourage and support the NHS move towards a patient centred organisation in line with the NHS Plan. The patient will be in the driving seat.

The lessons learnt from first wave applicants would be invaluable for other NHS trusts wanting to become NHS FT.

NHS FT will continue to work to the principles and values enshrined in the NHS and deliver services commissioned by the Primary Care Trust.

Inspection and Audit processes will make sure that the organisation is held to account.

An NHS FT will have to work to a licence and constitution agreed by the Independent Regulator accountable to Parliament.

An NHS FT will be able to borrow and reinvest any surpluses in line with its license.

The NHS family are supportive in principle of the CHT becoming an NHS FT The review notes the government's commitment to make all NHS Trusts Foundation Trust by 2008.

The scrutiny panel makes a number of recommendations - for example, that the applicant share its Governance, Human Resource strategy and Service vision at the earliest opportunity and before they are submitted as part of the application.

The panel concludes based on the evidence it has received that the main difference between an NHS Trust and an NHS Foundation Trust is to do with

the social ownership model and associated governance arrangements, the ability to borrow money and the opportunity to reinvest any surplus back into the health care economy.

The panel accept that the range of policy initiatives such as Patient Choice, Payment by Results and Agenda for Change will impact on all NHS Trust organisations as part of the governments modernisation agenda identified in the NHS Plan.

Cllr Molly Walton
Chair of the Ad Hoc Scrutiny review into NHS Foundation Trusts (Calderdale and Huddersfield NHS Trust)
November 2003.

7. Action Plan

Recommendation	Responsibility	Agreed (Yes / No / Already Happening / Further Work Needed)	Proposed Actions	Date
R1. That CHT share its draft constitution with key stakeholders at the earliest opportunity to allow for detailed consultation before it is finalised.				
R2. That the terms of the license agreement with the regulator are publicised and shared with key stakeholders should the application for FT status be successful				
R3. That CHT consult with key stakeholders on the detailed proposed governance arrangements before they are finalised.				
R4. That two places are allocated for each participating Local Authority; one specifically for Social Services supporting work toward a more integrated and seamless service; and the other providing for the local authority's community leadership role.				
R5. That the trust consider differential periods of appointment for public and staff governors so that they do not all come up for re-election at the same time.				
R6. That the trust considers limiting the maximum period a governor can serve to three consecutive terms, in line with the Commissioner for Public Appointment's guidance on terms of office.				

Recommendation	Responsibility	Agreed (Yes / No / Already Happening / Further Work Needed)	Proposed Actions	Date
R7. That a joint approach to community consultation and information provision be agreed between key health and social care providers in Kirklees.				
R8. The panel would welcome clarification that the change in governance arrangements associated with foundation trust status will not result in a reduction in resources available for patient care.				
R9. That existing non - executive directors of the present CHT board be invited onto the Board of Governors for a period of no more than 12 months to provide continuity and stability supporting the consolidation for an effective board of governors.				
R10. That reinvestment of surpluses in line with the license agreement namely "…...health related activity carried out in the public interest set out in the license…." is decided on the basis of community health and social needs and in discussion with the wider health and social care family.				
R11. That the West Yorkshire Strategic Health Authority and/or the NHS Workforce Confederation comment on how an NHS labour market is regulated so that issues of capacity and workforce planning are managed strategically for a health economy.				
R12. That CHT and the Health and Social Care Board Develop and implement a joint strategy for public and patient involvement				
R13. That the HSCB commission partner organisations to present proposals on how to implement a whole systems way of working for the health and social care family in Kirklees including CHT as an NHS FT.				