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Foundation trusts and Monitor

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Report, together with formal minutes

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The Health Committee

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Footnotes

In the footnotes of this Report, references to oral evidence are indicated by 'Q' followed by the question number, and these can be found in HC 833-II. Written evidence is cited by reference in the form FTM x for evidence to be published in HC 833-II, Session 2007-8.

Contents

Report	<i>Page</i>
Summary	3
1 Introduction	5
2 Impact of foundation status on foundation trusts	6
Introduction	6
Finance	6
Surpluses	7
Borrowing from private capital markets	10
Future capital requirements	11
Cap on private sector income	11
Quality	12
Innovation	15
Governance and local accountability	19
Conclusions	22
3 Impact of foundation status on wider health communities	24
Introduction	24
Relationships within local health communities	25
Surpluses	26
Shift to primary care	29
Commissioning and 'Darzi blight'	30
4 Autonomy and regulation	33
Autonomy	33
The result of FTs' autonomy	33
The Department of Health and the boundaries of FTs' autonomy	35
Regulation	35
The FT application process	36
Regulation	36
5 Conclusions	39
Conclusions and recommendations	40
Annex A – Background to Foundation Trusts	45
Annex B - further reading	47
Annex C – geographical distribution of FTs	48
Annex D – Healthcare Commission ratings	50
Annex E – Monitor Risk Ratings	62

Formal Minutes	64
Witnesses	65
List of written evidence	65
Reports from the Health Committee	66

Summary

In 2004, a new type of NHS organisation was established—the NHS foundation trust—which was to benefit from a greater degree of financial and management freedom and different arrangements to improve local accountability. Since then, over 100 NHS trusts have successfully undergone the application process.

Before foundation trusts (FTs) were established, there was considerable debate about whether the supposed benefits of these new trusts would materialise and about what the impact of these trusts would be on the wider NHS. Since surprisingly little systematic and objective evaluation of FTs' performance has been carried out, we decided to hold a one-off evidence session on FTs and their regulator, and to publish a short report on our findings.

FTs have some proven strengths. They have performed well financially and generated surpluses. They have been high performers in routine NHS process quality measures. However, much is unknown. It is not clear whether their high-performance is the result of their changed status, or simply a continuation of long term trends, since the best trusts have become FTs. Key aims of FTs were the promotion of innovation and greater public involvement. While we were provided with examples of good practice in both of these areas, again there was a lack of objective evidence. We therefore recommend that the Government commission research to assess all aspects of FTs' performance objectively so that best practice can be shared with other FTs, and with the NHS more widely.

It seems that some of the fears about FTs' impact on local health economies have not been borne out; however, they have made little contribution towards the Government's aim of delivering more NHS care outside hospitals with the interesting exception of mental health trusts. This situation is not solely attributable to FTs themselves; rather it is a consequence of the introduction of Payment by Results and inadequate collaboration between PCTs and FTs to manage demand for acute care. FTs' slowness to innovate and invest was ascribed by many to failure on the part of PCTs to provide strategic guidance. The Government is clearly aware of these deficiencies and has announced plans to strengthen PCTs' commissioning skills through its *World Class Commissioning* programme; however, it is unfortunate that this has come after the establishment of powerful FTs in the acute sector and not before.

While FTs do not appear to have yet exploited the full potential of their autonomy, witnesses from FTs told us that the ability to make decisions more quickly was important and made a 'tangible' difference to the dynamic of their organisations, which we welcome. Unfortunately, concerns persist about what level of Government intervention in FTs' affairs is legitimate, and the Government must clarify what the appropriate levels of intervention are.

Finally, Monitor's application process and regulatory regime seems to be well regarded. However, a complex regulatory environment of other organisations also surrounds FTs, and in particular there is potential duplication between the Healthcare Commission and Monitor both of which evaluate the quality of FTs' services.

1 Introduction

1. On 3rd July 2008 the Health Committee held a single evidence session on foundation trusts (FTs). Witnesses included Monitor, the regulator of FTs, a selection of representatives from FTs and NHS organisations that work with them, and academic commentators. Coming shortly after Monitor announced the establishment of the 100th FT, taking the proportion of FTs to 43% of all NHS acute trusts and 52% of mental health trusts¹, this seemed an opportune time to examine both the impact of the FT programme and their regulator.

2. Unlike the Committee's usual inquiries, this one-off evidence session was not accompanied by formal terms of reference or a call for written evidence, although we received a number of written submissions. The scale and scope of our inquiry was therefore necessarily limited. However, given the importance of this set of reforms to the performance of the NHS as a whole, and given the surprising lack of published research evidence in this area, we have decided to publish a brief report outlining our findings. Alongside this report we are also publishing the written and oral evidence we received together with a list of further reading.²

3. We took oral evidence from Dr Mark Exworthy, Reader in Public Management and Policy, School of Management, Royal Holloway, University of London; Dr John Carrier, Chairman, Camden PCT; Keith Palmer, Chairman, Barts and the London NHS Trust; Richard Gregory, Chairman, Chesterfield Royal NHS Foundation Trust; Stephen Firn, Chief Executive, Oxleas NHS Foundation Trust; and Dr Bill Moyes, Executive Chairman, Monitor. We are extremely grateful to our witnesses and to all those who submitted written evidence. We are also indebted to Alan Maynard, our Specialist Adviser, for his advice.

4. In our questioning of witnesses, our main focus was on the impact of FT status, first on those trusts that have achieved FT status, and secondly on the wider NHS. Thirdly, and linked to both these questions, we considered FTs' accountability and autonomy, and the role of Monitor. This short report is divided into these three sections.

1 <http://www.regulator-nhsft.gov.uk/news.php?id=1144>

2 We have also made use of the small amount of relevant research in this area, including 'Foundation Trusts in the NHS: does more freedom make a difference?' Marini *et al*, *Health Policy*, University of York, 2007 and Healthcare Commission and Audit Commission, *Is the Treatment Working*, May 2008

2 Impact of foundation status on foundation trusts

Introduction

5. Foundation trusts (FTs) were established as part of the Government's 'earned autonomy' policy for the NHS, offering high-performing NHS trusts greater financial and management freedoms coupled with new, more locally accountable governance arrangements, with the aim of improving quality and financial performance. Annex A provides more information about the introduction of FTs, how they differ from traditional NHS trusts, and other relevant reforms that have occurred at the same time. In this chapter, we examine the impact of FT status on trusts' performance in a number of areas. These are:

- finance;
- quality;
- innovation; and
- governance and local accountability.

Finance

6. FTs have greater financial flexibility than other trusts and their finances are closely scrutinised by Monitor, their public regulator. The chief differences of the FT financial regime are:

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

7. Our written and oral evidence addressed the last three points, which are discussed below.

³ As an incentive to reduce unnecessary secondary care treatment, any emergency care provided which is over and above the volume stipulated in contracts is only reimbursed at 50% of tariff. This applies to all NHS acute trusts.

Surpluses

8. FTs have demonstrated good financial control with a few exceptions. The recent Healthcare Commission and Audit Commission report *Is the Treatment Working?* suggests that FTs are providing more care than other NHS trusts, and are providing it more efficiently:

Both FTs and non-FTs have increased their overall activity levels between 2003/04 to 2006/07, although the increase was greater for FTs by almost 3 per cent. For FTs, this increase has been steady, although slightly higher in 2005/06, possibly as a reaction to PbR⁴, which was introduced in 2004. FTs experienced activity growth for all types of care, with the exception of non-elective short-stay admissions. However, between 2004/05 and 2006/07, the increase in activity was greater in FTs for all types of care, including non-elective short-stay admissions. Therefore, second and third wave FTs have seen the highest level of activity growth of the three groups over this period, and this has been more noticeable since 2004/05.

Between 2003/04 and 2006/07, FTs have continued to be lower cost providers, and their relative cost position has been less subject to change than other trusts. However, FTs were authorised partly on the basis of their efficiency, and it should not be surprising that the majority are still relatively more efficient than the average NHS trust.⁵

9. Monitor argues that FT status and its rigorous regulatory system has enabled some trusts to deal more clearly and effectively with financial deficits when they arise.

10. FTs have generated significant cash surpluses, in the order of £1.7 billion, unequally distributed amongst FTs. Although this is a large nominal amount, it has been pointed out that in relation to their trading volumes, this sum is quite modest.⁶

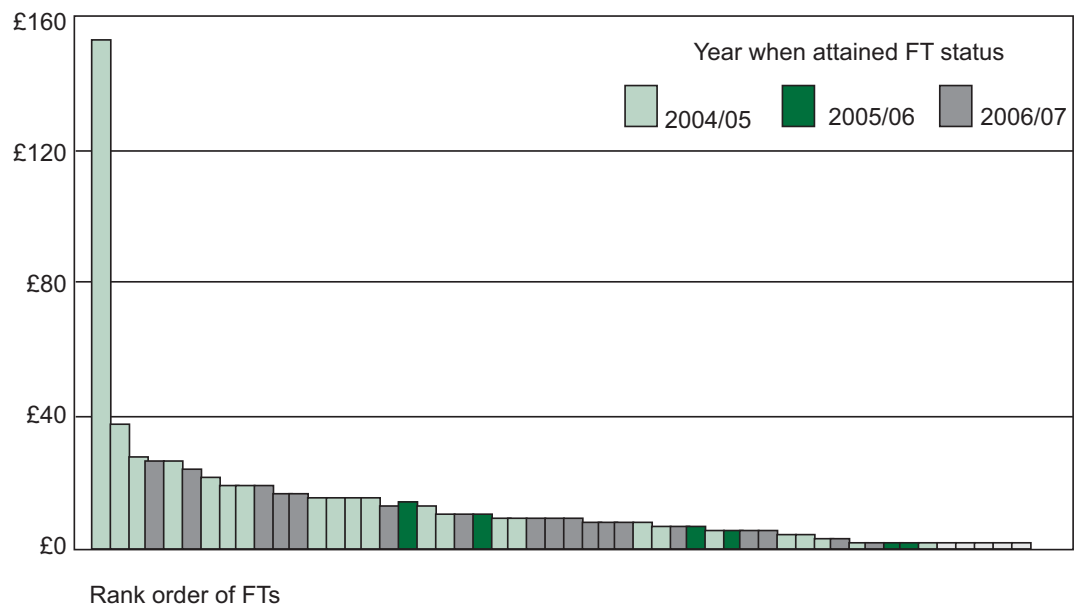
4 Payment by Results (PbR) is a payment system introduced into the NHS in 2003–04, whereby providers are paid for the activity they undertake according to a tariff derived from national reference costs.

5 Healthcare Commission and Audit Commission, *Is the Treatment Working?*, May 2008

6 The net surplus (before exceptional items) for 2007–8 for the 89 Foundation Trusts authorised as at 31 March 2008 was £514 million (after public dividend capital dividends of £352 million, but before exceptional charges of £120 million). This represents 3.1% of FTs' total revenue for the year (£16.3 billion).

FT cash surplus (2006/07)

Cash surplus (£ million)



Source: Audit Commission and Healthcare Commission (data from FT accounts)

11. The Healthcare Commission and Audit Commission provide more detail:

In the three years that FTs have been operational, their cash surplus has increased to £1.5 billion as at the end of the first six months of 2007/08 and is expected to continue to rise. This represents about 38 days of operating expenses, and is an increase of approximately £0.6 billion from the end of 2006/07. In addition, FTs have access to approximately £900 million of unused overdraft facilities. FTs are set up as independent bodies and are free to retain any surpluses they generate. FTs are also motivated to generate a reasonable surplus to achieve a low risk rating with Monitor and to be able to borrow monies for investment.

There is a clear link between income growth and FT status. This is unsurprising given that the FT application is built upon financial viability. The early FTs were, historically, low cost trusts, and stood to gain income under PbR through a higher national tariff than local prices. They also had a faster transition than other trusts to the new higher prices. However, increasing income is a contributing factor to both FT and non-FT surpluses. Of the 11 acute and specialist trusts that made over 45 per cent income gain between 2003/04 and 2006/07, just under half are FTs. One NHS trust, now an FT, made almost 60 per cent income gain over this period, and only one trust made a loss.

Income growth overall has been a significant contributor to the FT net surplus before exceptional items, which in 2006/07 amounted to £134.4 million, and their cash surplus, which amounted to £995 million. Efficiency gains have also contributed to their improved financial position.⁷

12. Witnesses from FTs were clear that the ability to retain surpluses was a crucial aspect of the attractiveness of FTs. When asked what difference FT status had made in practice to the trust he worked in, Keith Palmer, Chairman of Barts and the London NHS Trust, told us that “the fact that that foundation trusts are allowed to keep the surplus that they generate through efficiency improvements is a really important driver of behaviour within the hospital trust”.⁸

13. Our evidence raised two main concerns about FTs generating and retaining surpluses. First, is this policy harmful to the rest of the NHS? This is discussed in the next chapter of this report. Secondly, has FT status itself helped trusts generate surpluses, or is this the result of long-term financial trends?

14. It is clear that FTs are demonstrating improved financial performance. However, it is not clear whether these improvements are directly attributable to FT status or whether, as Marini *et al* concluded, this should instead be attributed to long term trends—i.e. that these high performing trusts would have continued to demonstrate improved financial performance even without the supposed advantages of FT status. Using data on retained surpluses and the Reference Cost Index (an activity weighted average of a Trust’s casemix costs⁹ relative to the national average) Marini *et al* conclude that:

It is very common to read that FTs are “outperforming” non foundation trusts (NFTs) financially. However, this is usually based on very superficial comparisons. There is very little empirical evidence relating to the financial management and performance of FTs. Our own research is the first to shed light on the comparative performance of FTs and NFTs using robust methods.

The evidence on the extent to which the potential benefits of FTs have been achieved in practice is not, so far, particularly promising. Although of course, it is early days for FTs and we might expect such changes to take time to appear.... Evidence on the comparative financial management and efficiency of FTs has not previously been produced aside from superficial comparisons which lack robustness. Our research ... suggests that, rather than the FT policy suddenly having brought about a change in behaviour, there seem to be longstanding differential trends between these different groups of Trusts. The FT policy per se has not made a significant difference to their financial management.¹⁰

15. Marini *et al* go on to question whether this level of financial performance will be sustainable in future as increasing numbers of NHS trusts gain FT status, and indeed whether this can continue to be achieved without detriment to quality:

Whether these long-standing trends are sustained as the policy is rolled out to additional hospitals, or whether improved financial performance is gained at the expense of quality, is a matter for future study.

8 Q8

9 Casemix is the range and type of patients treated by a hospital or health service.

10 ‘Foundation Trusts in the NHS: does more freedom make a difference?’ Marini *et al*, *Health Policy*, University of York, 2007

16. We questioned Dr Bill Moyes, Executive Chairman of Monitor, about the research presented by Marini *et al.* He argued that FT status is now no longer limited to the best of the hospital sector, but now includes some hospitals that ‘were definitely in the middle of the pack’. He told us that in his view, “there is good evidence that the responsibility and the accountability for the finances that rests at board level, the financial regime within which they operate and the ability to see a purpose in managing the finances well to build up surplus and then invest, those things taken together I think are producing much sharper financial management and I genuinely do not believe that this would have happened if there had been no change in the status.”¹¹

Borrowing from private capital markets

17. In the view of Professor Alan Maynard, although access to private capital markets is one of the theoretical financial benefits for FTs, in practice accessing these markets remains a problem. He stated:

FTs generally cannot access NHS capital and the PFI programme of recent decades is fading into insignificance. In theory FTs should be able to borrow and finance repayment and interest out of trading surpluses. However hospital tariffs are in a continuous state of flux as DH seeks to fine-tune the policy and use tariff manipulation to induce cost savings and improved benefits for patients. The consequence of this hospital tariff policy is that FTs have very uncertain income flows and surpluses are either not spent or are used to fund one off small capital projects, e.g. improving car parking. FTs have as a result large unused licence capacity to borrow and there is great uncertainty about how FT capital development will be carried out to improve service quality.¹²

It is not being used because it is not required. I think I would really caution the Committee that we are at a very early stage in the development of foundation trusts. If one looks to the much longer term, having the ability to borrow from the commercial markets and being exposed to the discipline of the commercial market I think will be a good thing for foundation trusts and I think it will happen¹³

18. *Is the Treatment Working?* also notes that FTs are not taking full advantage of their borrowing freedoms:

Monitor ... has found that FTs are not taking full advantage of their borrowing freedoms and have accessed only £100 million out of £2.5 billion available, partly because many were already undertaking or had recently completed significant capital investments before becoming an FT.¹⁴

19. However, according to our witnesses from FTs, FTs do not currently need to access private capital as their current investment plans can be financed through their own surpluses and there is not a need for large scale investment. It also seems that FTs may be

11 Q70

12 FTM 02, Alan Maynard

13 Q78

14 Healthcare Commission and Audit Commission, *Is the Treatment Working?*, May 2008

holding back from large scale investment programmes because of uncertainty about future funding streams, and uncertainty about what services commissioners want—this is discussed more fully in Chapter 3. Dr Moyes gave more detail on both of these points:

As at the end of March the borrowing capacity was £3.2 billion and the total actually borrowed was £172 million. There are a number of reasons for that. One is what we have been discussing. The trusts are not clear where investment is needed. The second reason is that a lot of them are now planning investment in a piecemeal fashion; they are not looking to re-build the whole hospital but hospitals like Bradford, for example, in the heart of England are publishing ten year investment plans that can be done in chunks and they can largely raise the finance to do that from their own resources, from the surpluses they are generating. I think the need for borrowing is less in the system at the moment than could be allowed.¹⁵

Future capital requirements

20. It is clear from the analysis of Marini *et al* that most FTs had low reference costs¹⁶ when foundation status was granted. However, analysis of reference cost trends since they achieved FT status has been poor. If their reference costs have gone up relative to the tariff since they became FTs, or if this happens in future it will lead to a reduction in the surpluses available to FTs. Equally, if the Department of Health readjusts the PbR tariff downwards to achieve greater cost efficiencies—as it is expected to do in 2010-11—this could also reduce or even eradicate FT surpluses. This raises important questions about where FTs would get their capital from, as they would not have surpluses to reinvest, and equally a lack of surplus would make banks less likely to lend to FTs.

Cap on private sector income

21. Finally, Stephen Firn, Chief Executive of Oxleas Foundation Trust, informed us that the fact that the private sector cap has been set at zero for mental health trusts, was hampering their efforts to use their financial freedoms to improve services:

It is a specific problem for Mental Health Trusts because, I think I am right in saying, everyone who has been authorised so far has had the private patient cap set at zero because that was the position in 2002. It is something of an absurdity because if we were not a foundation trust we could set up services that have private patient income, but because we are a foundation trust we cannot. I have worked in the NHS for 27 years and I agree with all the principles about care being free at the point of delivery, but I know from all the work we have recently been doing with employers, that the support we could provide to employers about getting people back into work and retaining people in work and getting income from them would meet some of the Government's policies around keeping people in work and recovery, we cannot take forward because it would count as private income at the moment. There are other things around psychological therapies where we could set up units with free access for people on the NHS but we could part fund it by having private patients; we are

15 Q74

16 Reference costs itemise the cost of every treatment provided in a trust

not in a position to do that. I think it is actually inhibiting us from taking forward some key policies but also getting income to improve other NHS care.¹⁷

22. FTs have shown good financial performance; according to the Healthcare Commission and Audit Commission they are delivering more care and may be doing so more efficiently. FTs have generated cash surpluses to the order of £1.7 billion. It is not possible to conclude, however, whether this is largely attributable to the introduction of the FT system with its new flexibilities and rigorous financial monitoring, or whether it is simply the continuation of long-term trends amongst high-performing trusts in a Payment by Results system.

23. We were told that FTs are holding back both from investing their surpluses and from making full use of their borrowing powers because of a lack of direction from commissioners; this issue is discussed more fully in the following section.

24. A further difficulty is that the private sector cap for mental health FTs currently set at zero. We have not examined the relationship between NHS FTs and the private sector in depth in this inquiry. However, it seems inequitable that mental health trusts should not have the same freedoms as other trusts, and we recommend that the Government reconsider this policy.

Quality

25. ‘Quality’ is a term used within the NHS to cover many aspects of service provision, including waiting times for treatment, convenience and accessibility, cleanliness of facilities, and patient involvement, as well as the quality and effectiveness of clinical care. It is defined by Lord Darzi as care which is “clinically effective, personal and safe”.¹⁸ In measuring quality of services and care, ideally both process and outcome measures¹⁹ should be used to ensure that adherence good processes (for example using NICE guidelines, or specifying a maximum waiting time for treatment) is actually leading to good outcomes (for example, reduced mortality rates, or patient reported outcome measures).

26. Looking at comparative data from the Healthcare Commission’s Annual Healthcheck, it is clear that FTs outperform non-foundation trusts. Comparative performance tables are included as Annex D to this report. The Healthcare Commission and Audit Commission note these trends in their recent report, but sound a strong caveat that FTs were selected as high-performing organisations, and so, as we noted above, are starting from a position of advantage. Moreover, they conclude that ‘there is no significant evidence yet that FTs are delivering higher quality care as a result of their status’:

There is some evidence, through the annual health check, that FTs are becoming even stronger organisations when compared with other acute trusts. But it is important to note that they were deliberately selected for foundation status on the

17 Q86

18 *High quality care for all: NHS Next Stage Review final report*, Department of Health, June 2008

19 Process measures, such as waiting times, test whether parts of a system are working as planned; outcome measures, such as whether health is improving, test the results of a system.

strength of their service delivery track record, financial standing and financial management arrangements

However, an important test is whether the autonomy that accompanies FT status results in higher quality services being provided. Although FTs tend to be higher performers in the quality of service ratings in the annual health check, there is no significant evidence yet that FTs are delivering higher quality of care as a result of their status. FTs generally started from a better financial position. The great majority of current FTs were also scoring highly on quality of service before the introduction of FT status. This changed with the new assessment system but the response does not appear to depend appreciably on when FT status was obtained. Analysis of the Healthcare Commission's annual health check quality of service scores found no clear indication that FTs improved their quality of service at the time they achieved their FT status. The changes in the scoring system in 2005/6 (the introduction of the annual health check to replace star ratings) meant that a large proportion of current FTs suffered a reduction in their score from the highest level, so it is difficult to disentangle any effect of FT status from the change in scores.

In FTs, the DH has succeeded in creating more autonomous, locally accountable bodies. The FT concept has driven change more quickly in NHS organisations and improved financial control, including for those organisations that are still preparing for FT status. The freedom and flexibilities of FT status give frontline healthcare professionals and local managers the incentive to improve services and innovate in response to the needs of their patients and local populations. However, the changes resulting from this are not striking. We found no evidence of significant innovation in our research for this study or from the detailed service reviews undertaken by the Healthcare Commission. Annual health check data suggest that FTs are generally higher performers, but they started from a better position in terms of service delivery, efficiency and financial standing.²⁰

27. Interestingly, comparative data from the Healthcare Commission (HCC) (see Annex D) suggests that some FTs' performance fell from 3 star to 2 star after they received authorisation²¹, and a small number are amongst the worst performers in the NHS according to HCC ratings, although changes in the HCC's measuring systems make comparisons difficult. Although the proportion of poor performers amongst FTs is far lower than the proportion of NHS Trusts performing poorly, the fact that they exist at all is noteworthy given FTs' selection and reputation as an elite part of the NHS.

28. Mr Palmer, Chair of Barts and the London NHS Trust, agreed with the conclusions of the Healthcare Commission/ Audit Commission's recent report, telling us that in his view quality had not been sufficiently prioritised anywhere—but that this was not a problem unique to FTs:

This is nothing whatsoever to do with foundation trust status but the dynamics to improve quality of care have not been very strong and I welcome the very recent

20 Healthcare Commission and Audit Commission, *Is the Treatment Working?*, May 2008

21 NB the star rating system has since been superseded

announcements by Darzi *et al* for a renewed focus on quality but if that is to be achieved we need instruments that will drive it better than we currently have. I think those instruments should apply to everybody, not just to foundation trusts.²²

29. Dr Moyes told us about a scheme currently being piloted to reward trusts for delivery higher quality services:

Lord Darzi has recommended a system of paying for performance and a pilot scheme has been run in the North West using a model developed in America by Premier Healthcare to have a very small pot of money—it is not an enormous amount of money—and to use that small pot of money to reward trusts (not just foundation trusts, but all trusts) for delivering above and beyond the minimum contracted levels. I think the pilot in the North West has been held to be a successful pilot and Lord Darzi has recommended that it is adopted as a feature of the tariff going forward, which we would certainly support; we think it is a good idea.²³

30. As well as rating financial risk, Monitor also rates ‘governance’ risk, which assesses the quality of services and management. Monitor considers seven elements when assessing the governance risk that an NHS FT may face over the coming year, including service performance, clinical quality and membership and board structures. Governance risk is rated using a traffic-light system, where green indicates low risk and red indicates high risk:

- Green - NHS FT’s governance complies with terms of authorisation
- Amber - Concerns about one or more aspects of governance
- Red - Concern that issue(s) significantly breach(es) Terms of Authorisation

31. At the time of our inquiry, the most recent report (see Annex E) suggested that five trusts had improved their governance risk rating in the last quarter, but that the governance risk rating of 8 trusts had got worse, and 30 trusts’ ratings remained at amber or red. It was also apparent that a total of 25 trusts have remained on an amber or red risk rating for the whole of the past financial year.²⁴ Monitor told us that it would instigate proceedings, including meeting with the Board of the FT, and if necessary commission external advisers to work with the FT if a trust remained on a red rating for more than two quarters.²⁵

32. FTs are generally high performers in routine NHS process quality measures. However, despite the fact that they are widely believed to be a high performing elite, the performance of some FTs has fallen, and a small number are amongst the worst performers for some measures. A significant minority also fall within the ‘amber’ or ‘red’ categories on Monitor’s governance ratings, with some showing no improvement across a whole financial year. This suggests that FTs can afford no complacency about the quality of services.

22 Q16

23 Q108

24 http://www.monitor-nhsft.gov.uk/documents/Q4_report_June_08.pdf

25 Q106

33. We commend the Department of Health for piloting a scheme to reward trusts financially for delivering a quality of service beyond the minimum contracted levels. We recommend that such schemes should be extended and conversely schemes to punish low quality care as evidenced by unacceptable complaints from patients or their relatives should be considered.

Innovation

34. One of the chief attractions of FT status was that the freedoms afforded to FTs would enable them to innovate more effectively than normal trusts could. According to the Department of Health:

NHS foundation trusts will be at the cutting edge of the Government's commitment to devolution and decentralisation in the public services. They will not be subject to direction from Whitehall. Local managers and staff working with local people—rather than remote civil servants—will have the freedom to innovate and develop services tailored to the particular needs of their local communities.²⁶

35. The Foundation Trust Network, the membership group of all FTs, cites several examples of what it views to be innovative practice:

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

Salisbury NHS Foundation trust 'spin off' company – Odstock Medical Limited makes and market electronic devices that help disabled patients to walk by stimulating paralysed muscles. OML is the first 'spin off' company to be created and owned by the NHS. Salisbury NHS FT has taken the innovative route of creating their own company so that the income generated by the device can be used to further research and create new developments to help NHS patients. Salisbury maintains majority ownership of the company—68%—with the hospital charity owning 18%. The only other shareholders are staff and Bournemouth University. As the FT has the majority share it can ensure that the philosophy of the company remains dedicated to putting patient care first. Salisbury has used the financial flexibility afforded by FT status to grow the company and has renovated the hospital's old burns unit to house it. Its medical physics department has been developing and

²⁶ Department of Health, *A Short Guide to Foundation trusts*, 2003
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4050483

producing the devices for 20 years. However until now operating constraints within the NHS severely limited their availability to patients outside the Salisbury area.

South Essex Partnership Trust is reinvesting surplus funds into the building of a brand new mental health hospital at Rochford (pictured) and a six bed psychology unit for young people. The hospital will benefit the local community by providing state of the art accommodation for people experiencing mental health problems.

Other FTs are investing surplus from their budgets and using their borrowing freedoms to enhance services to patients or to speed up existing plans, as these examples demonstrate:

- **Stockport** has opened a £25 million cardiology and surgery unit, invested in a £3 million scheme to upgrade all wards and opened a £5 million car park.
- **UCLH** has sold its Middlesex Hospital site for £175 million to invest in a new cardiac centre
- **Moorfields Eye Hospital** is launching a new specialist drugs manufacturing unit.
- **Queen Victoria Hospital**, East Grinstead, is planning to accumulate £12 million to redevelop the hospital and has already opened a new £1m critical care unit and a day surgery unit
- **Liverpool Women's hospital** has gone into partnership with a private company to start new IVF service for NHS and private patients.
- **Homerton University Hospital** has borrowed £2 million to add to a £1 million gift to build a new teaching centre.
- **Doncaster and Bassetlaw** has opened a new dialysis unit.²⁷

36. However, it is difficult to disentangle which of these are examples of innovative practice that have occurred as a direct result of FT status, and which are examples of good practice that might be expected from any high-performing trust. The Healthcare Commission and Audit Commission report is clear that innovative models of patient care have not yet emerged from FTs:

On a national level, despite the improved quality of services, FT status does not yet seem to be empowering organisations to deliver innovative models of patient care.²⁸

37. This view was endorsed by Dr Mark Exworthy, who is leading the NHS Service Delivery and Organisation Programme research into the impact of system reform in four health communities:

Sandra Gidley: Are there any practical examples or independent evidence that foundation trusts are actually delivering care more innovatively or efficiently?

27 FTM 04, Foundation Trust Network

28 Healthcare Commission and Audit Commission, *Is the Treatment Working?*, May 2008

Dr Exworthy: I think you are right to point out that there is relatively little evidence of this so a lot of it does rely on the sort of reports that you have mentioned which clearly have a “vested interest” in some of these issues so independent research or independent evaluations tend to be rather scarce ... Probably there are two points to make, one is that these were high performing, largely innovative, dynamic organisations so, as it were, much of that has continued in the direction that you would expect it to, so what difference would foundation trust status over and above that bring? Some of the evidence seems to be a little bit weak in that regard.²⁹

38. According to John Carrier, Chairman of Camden PCT which has had a close commissioning relationship with one of the first and largest FTs, UCLH, since its establishment four years ago, it is perhaps too soon to be expecting FTs to deliver innovative practice:

One of the issues that was always raised was the accounts, the finance. Innovation, I think, would have been pushing it for the first couple of years. They were the first wave.³⁰

39. Mr Palmer agreed. He noted that FTs have to work with other health organisations which are still subject to the traditional NHS performance management regime and have less freedom to innovate themselves:

You can only change models of care by interacting across the whole network. You have to deal with organisations which are not foundation trusts and who are subject to direction by the SHA. I think it has been slow but my observation would be that there is a degree of freedom now and the fact that Guys and St Thomas’s plan to use those surpluses is really quite interesting. It would be a shame, I think, to stop the experiment now, but if you do not see some action over the next couple of years then you should be asking the question why.³¹

40. Dr Exworthy told us that FTs’ slowness to innovate may be because they are still adapting to the freedom from central control that they now have. He also suggested that the public discipline of FTs’ new financial regime may make them more cautious about spending on innovative service models:

Their willingness in a way is being compromised not so much in the sense that they are being told what to do but there is a cultural change that is involved. In some ways many of these foundation trust organisations have grown up in an NHS that has traditionally been centralised so to some extent they have always been looking up, hence David Nicholson’s advice to look outwards and not upwards, but clearly those traditional patterns still persist. Also I think the rules of the game are still a little unclear for foundation trusts in the sense that this is such a new departure and represents such a significant change in health policy that their willingness to extend into new areas—innovations, service developments, capital spending et cetera—exposes them in a much more visible way financially and publicly which you could

29 Q6

30 Q5

31 Q9

say is a good thing but clearly, as you are exposed a little more, your willingness to do so leads to a certain caution or a certain carefulness which again might be a good thing but perhaps it starts to explain why, although they are very able and capable, they have not always been willing to exert that.³²

41. FTs themselves told us that innovation was being constrained because they were not getting a steer from PCTs and local health communities about what new services are needed:

Mr Gregory: At the moment our innovative capability and capacity from where I sit is constrained by the quality of the contract and by the quality of the dialogue between the commissioner and the provider. That needs to be opened up and one of my personal concerns and priorities is that we need to escape our organisational barriers here and engage intelligently over and above the contract negotiation in terms of delivering change to the benefit of the patientI have not seen much evidence of an enabling framework for us to be able to do that from my perspective.

Sandra Gidley: So this sentence in your submission when it says that this is what you have achieved, “an all terrain vehicle model, goes everywhere, does everything, unrestricted by the usual boundaries” is not true because you have just mentioned boundaries that are in place.

Mr Gregory: I think there is a boundary. Yes, it is an exaggeration if you take that literally. I think that we have got the ability to deliver that; I think we have got the ability to be very flexible and innovative in the future, but we do need the right conditions. It is not simply about the contract, it is about the key individuals, it is the relationships.³³

42. Monitor does not believe that it is its role to identify innovation and spread best practice. It argues that the Healthcare Commission and its successor the Care Quality Commission are the bodies that ought to monitor innovations in how clinical care is delivered. However they do not appear to do this regularly at present.

43. Freedom for the NHS to develop innovative models of care unencumbered by bureaucracy was widely seen to be one of the chief attractions of FT status; however while we have seen some examples of innovative practice, there seems to be little robust evidence to suggest FTs are using their new status to innovate in a significant way. Some witnesses thought it was too soon for FTs to be expected to be generating major innovations when they were still concentrating on achieving and maintaining financial stability; others considered that FTs’ ability to innovate was being constrained by commissioners.

44. We were surprised and concerned that no organisation seems to have a clear remit to assess objectively whether or not FTs are becoming more innovative, which makes it difficult to evaluate whether or not there are sufficient incentives for FTs to innovate. Given that innovation is meant to be an important part of the ‘value added’ by FT

32 Q3

33 Qq 97–99

status, and given the potential benefits to the rest of the NHS from sharing best practice, the Government should commission objective evaluation in this area.

Governance and local accountability

45. The governance arrangements for FTs have three main elements:

- a **membership community** comprising local people, patients and staff, including patients and carers living outside the area if the Trust chooses to make them eligible for membership
- a **board of governors** made up of members elected from the membership community as well as people appointed by primary care trusts and local authorities. Foundation trusts with a medical or dental school are also required to have at least one university governor. There may also be other partnership governors to represent local partner organisations. Governors elected by public and patient constituencies must be in a majority
- a **board of directors** made up of a Chair and non-executive directors appointed by the governors, a chief executive appointed by the non-executive directors with the approval of the governors, and executive directors appointed by the chief executive and non-executive directors.

46. The Chair of the board of directors also serves as the Chair of the board of governors. The Deputy Chair of the board of directors is also a governor.

47. The governors' powers are limited:

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

48. Within this framework, each FT is able to determine its own governance arrangements, and the detail of these arrangements varies.

49. The Health Committee's inquiry into FTs in 2003, before their inception, noted 'considerable confusion' surrounding arrangements for local accountability and governance. Many witnesses expressed concern that FTs would end up merely 'going through the motions'.³⁴

50. A recent *Health Service Journal* editorial reported that “there are huge obstacles to making foundation trust membership anything other than a fig leaf of accountability”.³⁵ Marini *et al* agree that:

greater local accountability has not, as yet, been adequately demonstrated. Public and patient membership of boards is low and even where it exists, does not seem to be “active” in terms of producing high turn-outs for board elections”

51. However, they noted that

there are signs of improvement in terms of the numbers of people becoming members of FTs, although the degree to which they are representative of the community is not known.³⁶

52. The Healthcare Commission and Audit Commission found that:

FTs were also positive about their governance arrangements and the greater connection with the local community, through the governors and the membership. They reported that clinical services are now starting to be planned in discussion with the membership, rather than in isolation. FT governors reported that they felt engaged, had assisted with recent board appointments and had sat on working groups in the FT. However, the extent to which they were informing local priorities was not clear. It was apparent that there can be frustration on both sides where governors seek to get involved in operational issues, which is outside their remit. Our qualitative research did not find significant evidence that FT governors were having a clear and identifiable impact on FT development. Indeed, we identified some instance of confusion of roles between the governors and board of FTs.³⁷

53. Research carried out for the Department of Health by Chris Ham and Peter Hunt of Mutuo is more positive:

The evidence we have gathered suggests that the unusual hybrid governance model adopted for NHS foundation trusts is working increasingly effectively. There is greater clarity than in the initial stages about the role of the board of governors and how the knowledge and skills of governors can be used to best advantage. The statutory powers of governors have helped to ensure that they are taken seriously and are not treated as rubber stamps.

There is less clarity on the role of the membership community and the most effective way of governors relating to members. Foundation trusts are communicating with members in various ways but recognise that more needs to be done to become

35 *Health Service Journal*, 5 June 2008

36 ‘Foundation Trusts in the NHS: does more freedom make a difference?’ Marini *et al*, *Health Policy*, University of York, 2007

37 Healthcare Commission and Audit Commission, *Is the Treatment Working?*, May 2008

membership organisations. The experience of the mutual sector needs to be drawn on to enable foundation trusts to make further progress in this area.³⁸

54. Our witnesses from FTs provided us with some examples of good practice where the involvement of governors and members had had a positive impact, and generally believed that the approximate £200,000 annual cost to their organisations of running the new governance structures was good value for money:

We appointed onto the Council of Governors people from partner organisations who had not really been involved with us before, so representatives say from JobCentre Plus, from the Chamber of Commerce and through those new links we have been able to do things like set up employment schemes where we have been able to get our service users into jobs and supported, we have a lot of events with local employers showing how we can support them to employ our staff, and we have set up a partnership with Charlton Athletic where they have had us on the pitch giving messages about mental health. I could go on, but I think those are the two big things: the flexibility around the money and being able to invest it locally, and the work with the Council of Governors.³⁹

Our cleaning regime has changed; we are spending more on it. We are doing things in a different way; we have brought housekeepers back onto the wards, we have re-introduced matrons; we are looking at bringing our food sourcing into the locality rather than importing it from South Wales.⁴⁰

55. However, Mark Exworthy argued that there was certainly room for further improvement with regard to the performance of governors:

I think there is some evidence that the governors have failed to identify their role in a sufficiently well-defined sense. In a way that was my implication about this further development in that area. I think also there are areas to test between the board of governors and the executive team in the sense of on what occasions has that role been exercised in audits, appointments et cetera. Maybe they have not entered into that territory yet.⁴¹

56. Surprisingly, Monitor has only recently issued guidance to governors, despite the fact that several reports over the last five years have identified the need for this, starting with the then Health Committee which recommended the establishment of a national training system for Governors in 2003.

57. The Involvement of members seems less well developed than that of governors. This may be caused by a number of factors, including duplication of public involvement in NHS services by other bodies, including patient and public involvement bodies and Overview

38 Mutuo and University of Birmingham, *Membership Governance in NHS Foundation Trusts: A Review for the Department of Health*, 2008; available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086374

39 Q92, Stephen Firn

40 Qq 110–111, Richard Gregory

41 Q19

and Scrutiny Committees.⁴² Mark Exworthy summarised his observations on progress to date in this area:

I think that the focus—or priority if you like—has not been on [public membership and governance] so far, it has been about getting financial stability, robustness and making sure that their operation as a Trust (usually it is a hospital) is efficient and effective. There are signs that they are moving into developing better relationships with their memberships but I think there is a danger that initially at least these efforts have been focussed on people who might have been engaging with those Trusts anyway and extending it out to a broader membership is traditionally very difficult so foundation trusts would encounter similar problems.

58. Dr Exworthy did find cause for optimism that this could improve:

However, I think there are signs of much more outward focus; I mentioned that, rather than looking upwards, looking outwards. There are signs that they are taking that on board, entering into dialogue with all the various stakeholders that have been mentioned—local authorities, other NHS trusts, the public in all its dimensions.⁴³

59. On the other hand, Dr Exworthy thought that new tensions may arise if, as suggested in the Darzi report, PCTs rename themselves to become, for example, ‘NHS Derbyshire’, in an attempt to better engage with their local populations, and find themselves vying with local FTs for the affiliation of the people they serve, when clearly there are not enough evenings in the week for people to attend all of these public meetings.⁴⁴

60. While we saw some examples of good practice in FTs’ new governance arrangements, in general they seem to be slow to deliver benefits and despite numerous small studies, there remains a lack of robust evidence of their effectiveness. The governance process currently costs *circa* £200,000 per trust, giving a total of around £20 million per annum. We recommend that the Department of Health make it a priority to evaluate rigorously the FT governance system and to give guidance on best practice so that public money as well as members’ and governors’ time can be used as effectively as possible to improve services.

61. We are also surprised and concerned that Monitor did not issue guidance to governors until shortly before our evidence session took place, despite several reports over the last five years having identified the need for this, starting with the Health Committee which recommended the establishment of a national training system for Governors as long ago as 2003.

Conclusions

62. In considering the impact of FT status on FTs themselves, a recurring theme has been a lack of firm evidence that FT status is yet conferring the benefits hoped for. While it is clear that the majority of FTs are high performers in terms of finance and

42 Q22, John Carrier

43 Q18

44 Q21

quality as measured by Healthcare Commission ratings, these were high-performing organisations prior to becoming FTs, and so it is difficult to ascribe this high performance to FT status per se. Two other major aims were to give trusts the freedom to invest in innovation and to promote better local engagement with the public and other health providers through new governance systems. Evidence of benefit on both of these scores is also thin. Systematic and independent evaluation is needed. The Department of Health should make it a priority to commission research to measure FTs' progress objectively, and to disseminate their successes more widely.

3 Impact of foundation status on wider health communities

Introduction

63. Like other hospitals, foundation trusts (FTs) operate within health communities and are contracted by PCTs, so a degree of engagement with other local health organisations is essential to their survival. Dr Moyes told us that where FTs have got into financial difficulties, poor engagement with PCTs was in one case a key factor, highlighting the importance of good collaborative working:

When we had our financial problems with Bradford in 2004 that was part of the reason. They built a modular theatre and, if I remember rightly, they took on something like 300 staff, but there was no commitment from the commissioners to transfer patients to the hospital to use those facilities.⁴⁵

64. Perhaps the most vocally expressed concerns before the introduction of FTs related to their wider impact on local health communities and on the rest of the NHS. Concerns included:

- a) Staff poaching and wage inflation
- b) Unequal distribution of funds and services
- c) Barriers to the development of care pathways and ‘whole systems working’
- d) Barriers to delivering more care in a primary care setting

65. So have these concerns proved justified? Some have not materialised: according to Marini *et al*, one important threat that does not seem to have materialised is that of FTs poaching staff from other trusts: “contrary to some predictions there have been no reports of widespread poaching of staff by FTs from other Trusts”.⁴⁶ The key concerns expressed in our evidence have been:

- the relationships within local health communities;
- surpluses
- the impact on shifting care to primary care settings; and
- the role of commissioning.

45 Q81

46 ‘Foundation Trusts in the NHS: does more freedom make a difference?’ Marini *et al*, *Health Policy*, University of York, 2007

Relationships within local health communities

66. The Healthcare Commission's 2005 review of FTs reported little change in local relationships between FTs and other organisations, with those that had always been good remaining so; those that were poor have shown few signs of improvement. However, according to Mark Exworthy,

Provisional evidence suggests that FTs are 'picking and choosing' the issues on which they are cooperating (especially if it is in their self-interest). There are some perceptions that FTs have secured an unfair advantage in the Local Health Economy (for example, as a result of transitional relief arrangements associated with PbR). PCTs still remain generally weak (in capability and intelligence) compared to FTs, comprising the strategic perspective of PCTs.⁴⁷

67. In oral evidence he gave more detail, arguing that the degree of collaborative working was likely to depend on historic relationships:

Clearly foundation trusts have been given a set of incentives in which they are much more responsible for their own activities and affairs and, as we have just heard, surpluses as well. So clearly there is a much greater focus on their internal processes and decision pathways if you like and that clearly sets up a self interest type model that they are responsible for the boundaries of their trust and outside that is an externality; it is beyond their responsibility. Clearly in terms of some of the activities that might be going on in the local health community they are deciding the degree to which they might cooperate. Clearly there are areas in the country where there has been a history of collaboration and foundation trust status does not immediately change that; there has been an on-going network, many people will have worked in similar organisations, their friends and colleagues work similarly. There is a level of trust often between foundation trusts and non-foundation trusts in the local health community in the development of HR policies or clinical networks et cetera.

There might be some places where the foundation trust status sets up a difference of position, responsibility and interest such that there is...more of a silo mentality. That has created not just the acquisition of their foundation trust status but some of the central rules and implementation of those rules that set up a degree of resentment between foundation trusts and non-foundation trusts. That might hinder future collaboration. Some of the specific examples where they might wish to collaborate, for example in some of the big service reconfigurations that have been going on and are likely to continue, in the sense that it is very much in their long term interests for foundation trusts to get involved in these decisions. Helping shape that debate locally within the county, city or whatever is part of their interest. As we have heard surpluses might be retained which might set up a kind of tension, the degree to which they are seen to be retaining the surpluses and/or hindering or hampering local service developments. I think it will be very different in different places depending on the history and culture of collaboration.⁴⁸

47 FTM 03, Mark Exworthy

48 Q39

68. However Keith Palmer, who has served on the boards of both FTs and non- foundation trusts, argued that tensions were more related to the system of Payment by Results, and it made little difference whether a hospital was an FT or not, as long as it was high performing and in financial surplus:

I do not think that the tensions in the system about service re-design and cross-organisations makes very much difference whether they are foundation trusts involved or not. I am now at Barts and the London; we are a high performing, financially in surplus major teaching hospital trying to do re-configuration with clinically less high-performing, financially very troubled DGHs. I think that situation creates enormous tensions in trying to do things that are good for patients that the losers will sign off on and losers will usually be the district general hospitals. I see that exactly the same in the Northeast where we do not have foundation trusts as it was in the Southeast where they have the same issues. I think they are inherent in service re-design and the way that payment by results works more than whether you are engaging with a foundation trust or not.⁴⁹

69. Before their establishment a number of fears were voiced about the impact FTs might have on wider health communities. There is little evidence that FTs have poached staff from other trusts. Evidence from Dr Mark Exworthy and the Healthcare Commission suggests that in local health communities where collaborative working has historically been good this has continued to be the case; Dr Exworthy did suggest that in other areas the presence of FTs may be generating tensions and resentment. However, others felt that tensions exist between high-performing and less well performing trusts regardless of their status because of the system of Payment by Results.

Surpluses

70. As discussed in the previous chapter, FTs are able to keep any operating surpluses they generate and re-invest them as they choose. FTs are keen to keep surpluses and report that they are a motivating factor for clinicians and managers and enable them to invest in things quickly:

Prior to being a foundation trust there was no incentive to make or declare a surplus because we were essentially given a block of money on the first of April and you were expected to have spent it all by 31 March otherwise the risk—and often the reality—was that any left over was used to cover problems elsewhere in the health economy. Now that there is a recognition that if we work with commissioners and work with our commissioners to generate a surplus and we can carry that over and invest it in ways that are agreed with governors and commissioners that has made a huge difference. This year... we have put part of it into developing a personality disorder day hospital which is part funded by commissioners but part funded out of our surplus. That would not have happened; we would not have been able to do that.⁵⁰

49 Q42

50 Q92, Stephen Firn

We have submitted evidence that shows that we have nearly tripled our capital expenditure since being a foundation trust. To be able to plan for that and prioritise for that you need to build up surpluses ...it is surplus with a purpose...The surplus and the cash balance give us flexibility to be able to react, whether it is a short term issue or a long term issue. For me it absolutely underpins the principle of foundation trusts.⁵¹

71. However, at the time of our inquiry £1.7 billion was being held by FTs collectively, raising questions firstly about whether it is equitable for FTs to have full control over how these resources are invested, and, if so, whether there should be a mechanism for sharing and using resources more efficiently in the short term. In their recent report, *Is the Treatment Working?*, the Healthcare Commission and Audit Commission highlighted these problems:

FTs have been successful in generating surpluses. However, there is clearly an issue with the size of unused but available funds for FTs. Some FTs said that they felt unable to invest in services due to a lack of clarity about future commissioning intentions. Other FTs wanted to build up funds to cope with the anticipated decrease in the growth of health funding from 2008/09 and uncertainty around the national tariff. Some have also only recently moved to FT status. With the improving financial position of the NHS overall, large surpluses may also disincentivise innovation and the achievement of further efficiency gains.

Taxpayers and patients have a reasonable expectation that FTs will not retain large cash balances over prolonged periods. FTs in such a position must set out clearly how they intend to use these balances ... In order to achieve this, PCTs need to clarify their commissioning intentions on a timely basis.⁵²

72. The Healthcare Commission and Audit Commission went on to argue that:

To ensure that money is spent on patient care, PCTs need to be clearer about their future plans and FTs need to engage in these discussions, despite their concerns over the lack clarity about PCT commissioning intentions following the 2006 PCT reorganisation.

73. They also suggested a role for Monitor in this area:

Monitor should also consider whether the performance management and regulatory systems for FTs should ensure that where there is such a balance, it is used for the benefit of patients.

74. Monitor did not agree with this, arguing that “in the first instance we are looking to commissioners to be clear about what they need to see by way of investment by foundation trusts.”⁵³ Dr Moyes told us that if FTs were building up surpluses at too high a level despite

51 Q62, Richard Gregory

52 Healthcare Commission and Audit Commission, *Is the Treatment Working?*, May 2008

53 Q63

making necessary investments, that might indicate that PCTs were paying too much and that contracts and tariffs needed revision.

75. Unfortunately, the evidence we received suggested that PCTs are not yet in a position to give FTs the guidance they need to invest their surpluses. Dr Moyes argued that:

I do not think many foundation trusts today—even those like University College Hospital London that does have surpluses and is ready and keen to invest—could say to you, “We are absolutely confident that we can make an investment of this nature and be absolutely sure that that this what our commissioner would want”. I think that is a key requirement, to get to the stage now where commissioning can describe the pattern of services that they think is required to deliver the services the population needs.⁵⁴

76. John Carrier, Chairman of Camden PCT, told us that for his PCT the issue of FTs’ surpluses and how best to invest them was not yet a priority issue:

In a sense that surplus is a hidden iceberg and what we are constantly debating with them are issues like coding of procedures and whether the returns we get quarterly are accurate and validated and so on. So there is that very administrative financial detail and we tend not to look at that big issue of the surplus and tax payers’ money. We tend as a PCT not to think about the surpluses; we tend to argue about our bottom line and us coming in on budget.⁵⁵

77. He did, however, agree that in a tighter financial climate where PCT budgets had stopped growing, FT surpluses might be more cause for concern for him.

78. Mark Exworthy pointed out that there are differences between short and long term investments of surpluses, and that funding long term projects would obviously necessitate some build up of surplus capital:

there is a difference between, as it were, short term improvements you might be able to make and say, capital expenditure which might take several years of surpluses to accrue. Building a new wing of a hospital or even a new hospital would clearly be on a different scale than, for example, I know from the Darzi report one of the foundation trusts in Gloucestershire paid £100 to each member of staff as a bonus. There is a short term/long term issue.⁵⁶

79. The ability to retain surpluses was a key element of the FT reform, and FTs are now building up surpluses. FTs report that they are looking to PCT commissioners to collaborate on how these surpluses should be reinvested to improve patient care, but that PCTs are not in a position to give this guidance. We did not see any evidence that PCTs are thinking strategically about how FT surpluses might best be reinvested in their local health communities, a situation which we find extremely worrying. We recommend that the Department of Health takes steps to ensure that PCTs are able to

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play the strategic planning role urgently required of them; without this, public money risks sitting idle or being invested without proper strategic planning.

Shift to primary care

80. A 'primary care led NHS' has been a frequently cited aspiration of Government policy over the last six years. However at the time of FTs' inception considerable worries were expressed that this reform would in fact tip resources and power more firmly in favour of the acute sector. The evidence we received has not shown that FTs have helped shift any more traditionally acute care into the community, with Mark Exworthy arguing that so far it has proved a 'hindrance'⁵⁷:

Given my earlier comments about their self interest, they have a clear interest in looking at acute care.⁵⁸

81. John Carrier suggested that incentives were pulling in different directions:

My own feeling is that there is a paradox here and the paradox is that the centre wants more and more care out of hospitals and while we are trying to support centres of excellence which are these hospitals in the middle of London there is a real demand management question here which is quite tense I think.⁵⁹

82. It is perhaps unsurprising that FTs have not contributed to the drive to deliver more care in a primary care setting, as the PbR payment system gives them strong incentives against doing so. Monitor did not see that helping move more healthcare care out of hospital settings was part of its role, instead looking to commissioners to create capacity in the community and ensure FTs' activity is appropriately limited.⁶⁰

83. An interesting exception is that of mental health, where Payment by Results has not yet been introduced. This, coupled with foundation status, has actually provided a strong incentive to get more patients treated in the community, as Stephen Firn, the Chief Executive of Oxleas trust, described:

If we do more expensive interventions like admit people to hospital we do not get any more money for that so it is not in our interests financially and it is often not in the patients' interest either. A lot of the way in which we generate its surpluses has been by reducing our occupancy levels, providing more home treatments, providing more crisis treatments and working more closely with GPs to try to both respond quickly to their referrals but also transfer people back to GP care whenever possible. That is what we have been working on and we will continue to do so.⁶¹

84. In future the planned introduction of PbR into the mental health sector may, however, undermine this.

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59 Q14

60 Q124

61 Q126

85. Mark Exworthy believed that there was the potential for FTs to move into providing primary care services themselves—and Richard Gregory told us that this was certainly an aspiration for his FT—but this itself raises a different set of issues surrounding the gatekeeper function and monopoly provision.⁶² GPs are the ‘gateway’ to NHS hospital services, with patients needing a referral from a GP before they can access more specialist care at an NHS hospital. This helps prevent inappropriate referrals, saving the NHS money, and acts as an important counterbalance to acute trusts which, under Payment by Results, have an incentive to treat as many patients as possible to maximise their income. If a FT provided both primary and secondary care services, the gatekeeper demand management function, currently provided by GPs who are independent of hospitals, would be lost.

86. A major concern at the inception of FTs was that they, together with Payment by Results, would strengthen the acute sector to the detriment of primary care services. This seems to be the case, although it is probably more because of introduction of Payment by Results than the introduction of FTs. By this stage we might have hoped for better collaboration within health economies, particularly with a view to providing more care in the community. Mental health provides an interesting contrast: mental health FTs, which are not subject to the Payment by Results regime, argue that they have a strong incentive to get more patients treated in the community in order to generate surpluses. This Committee is very concerned that PbR is to be extended to mental health and community care in the next two years. We recommend that the Government address this issue.

Commissioning and ‘Darzi blight’

87. Weakness in PCTs’ commissioning was cited by witnesses as the cause of many perceived problems relating to FT status, including FTs not investing their surpluses, FTs not being able to innovate, and the lack of shift to primary care. Bill Moyes was emphatic on this point:

I think the Committee has to recognise that foundation trusts need their commissioners to be clear about what investment they want to see made: investment in buildings, investment in equipment, investing in some new staff to deliver new services. As commissioning becomes a stronger function with a greater degree of clarity about what they want to see—Lord Darzi’s report obviously [gives] them a platform to do that—then we will see foundation trusts respond to that. My sense of foundation trusts is that they are anxious to make investments; they recognise the issue that you are putting to me and they are anxious to respond. However, what they do not want to do is to make investments that do not meet the needs of their commissioners.⁶³

88. Richard Gregory agreed:

62 Q125

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At the moment our innovative capability and capacity from where I sit is constrained by the quality of the contract and by the quality of the dialogue between the commissioner and the provider.

89. Several of our witnesses described what has been termed elsewhere as ‘Darzi blight’—organisations delaying their forward planning and investment pending the publication of the Darzi report, which was published on 30 June 2008:

My hope and my expectation is that when the operating framework is published in the autumn, after Lord Darzi, we will start to see in that a clearer description of what the Department of Health is looking to commissioners to create and that will flow into their own local commissioning plans.⁶⁴

I think we are now at the point in time after the Darzi report and the discussions about how Foundation Trusts can engage with their commissioners not simply in terms of negotiating the traditional bones of the activity and payment structure, but in actual fact trying to reshape services to improve them for the benefit of the patients in the local community. Those challenges that were laid out a few days ago will enable Foundation Trusts and commissioners, hopefully, to engage in some innovation.⁶⁵

90. It appears that even now the final report has been published uncertainty still persists:

At the moment we are still in this position where we have a lack of clarity around how Darzi will actually play out in the way that services are delivered in local areas and it will be different in local areas.⁶⁶

91. While some degree of delay may be attributable to ‘Darzi blight’, it seems that PCTs themselves must be held responsible for not providing sufficient strategic planning. The recent report on system reform by the Healthcare Commission and Audit Commission is clear that “despite the intention to move care out of hospitals and into a primary or community care setting, limited progress appears to have been made.” They argue that the reason for this lies with commissioning organisations:

Commissioning and contracting skills are not yet strong enough to drive this agenda, although some PCTs can point to successes. PbR also needs further refinement to facilitate care transfers more effectively.

Improving commissioning capacity and capability is critical to the success of the reform programme. Given the 2006 reorganisation, PCTs need time to progress this agenda. More work is needed to strengthen commissioning and without this, the reform programme will not provide the necessary balance of power between primary and secondary care.⁶⁷

64 Q63, Moyes

65 Q97, Gregory

66 Q100, Firm

67 Healthcare Commission and Audit Commission, *Is the Treatment Working?*, May 2008

92. Alan Maynard gave a stark description of the scale of the challenge faced by PCTs in managing demand when commissioning from FTs:

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

FTs have an incentive to attract patients as increased activity creates increased income and their status requires payment at tariff rates for work done. It has been alleged that hospitals allow erosion of conversion criteria to increase patient flow e.g. reducing treatment thresholds and converting more out-patients into in-patients. The original rhetoric of “payment for services delivered” has now been watered down by strong DH advice that FTs and their PCTs should collaborate on agreeing volume levels so as to cap by mutual agreement the open ended nature of the PCT liability. DH rhetoric about “world class commissioning” is supposed to assist this process but PCTs, generally with weak management and poor use of comparative quantitative data, continue to find difficult the tasks of capping hospital activity and switching resources to a “primary care led” approach.⁶⁸

93. Professor Maynard suggested that one way to encourage commissioners and providers to develop alternatives to hospital care would be to adjust the two part tariff for emergency care.

94. Weakness in PCTs’ commissioning was cited by witnesses to this inquiry as the cause of many perceived problems relating to FT status, including FTs not investing their surpluses, FTs not being able to innovate, and the lack of shift to primary care. We note that the Government is now developing a specific support package to enable PCTs to become ‘world class’ commissioning organisations; however in our view focusing on provider side reforms, including payment by results and the introduction of FTs, before PCTs were ready to meet the challenges set before them was ill-judged.

95. As part of its ‘World Class Commissioning’ initiative, we recommend that the Government sharpens incentives for acute trusts to ensure they are fully engaged in keeping people who could be treated in the community out of hospitals. One option would be further adjustment of the two part tariff for emergency care, thereby increasing incentives to commissioners and providers to develop more rapidly alternatives to hospital care.

4 Autonomy and regulation

96. One of the main concerns expressed by witnesses to the Health Committee's 2003 inquiry into Foundation Trusts (FTs) was that promised management freedoms would not translate into real autonomy and that FTs would be more encumbered by regulation than their predecessors.

Autonomy

The result of FTs' autonomy

97. How real the autonomy FTs have is, and how far they have managed to use it to improve services in ways that would not be possible to non-foundation trusts is difficult to measure. According to Mark Exworthy, FTs autonomy will be key to their success, but has not yet been demonstrated:

The willingness and ability of FTs to exercise their autonomy will determine the impact they have both within their organisations and the wider NHS. Currently, the evidence suggests that they have yet to exercise fully this autonomy but have the potential to do (given their current evolutionary path and supporting policy developments).⁶⁹

98. Dr Exworthy considers that the reasons for this may include the attitudes of the DH and of SHAs, as well as FTs' risk aversion given their greater degree of financial exposure:

The DH and SHA also require a change in attitude and behaviour to reflect the changed landscape of FTs and their activities.

The willingness and ability of FTs to exercise their autonomy is debatable. Generally, they are able to exercise autonomy (under their new status as public benefit corporations) although FT status demands that senior staff change their skills and attitudes. Equally, FTs appear less willing to exercise autonomy to a great extent, as they are still acquiring legitimacy as organizations in their LHE and internally. This unwillingness might reflect their view of risk (aversion to it) given their greater degree of financial exposure, the uncertainty associated with the new policy environment (including on-going features of centralisation) the impact that their decisions might have upon other local organizations.

99. Autonomy seems to have been good for staff morale, and helped FTs secure good Non-Executive Directors:

A study undertaken in the early days of the FT process, reported that when asked about autonomy, managers were highly motivated by the thought of having increased discretion in order to provide high quality and responsive services.⁷⁰

69 FTM 03, Mark Exworthy

70 'Foundation Trusts in the NHS: does more freedom make a difference?' Marini *et al*, *Health Policy*, University of York, 2007

FTs in our study welcomed the autonomy that they had to attract and appoint more experienced and able non-executive directors to the board. This gave trusts' management greater challenge, although the Appointments Commission is seeking to secure similar high calibre non-executives to NHS trusts.⁷¹

100. When we asked our witnesses to give practical examples of how they have used their autonomy, their answers related to greater speed and freedom to make decisions:

Mr Palmer: I think it is difficult to pick something out. The behaviour of the board of directors at Guys and St Thomas's has been different in the sense that they have felt free to take certain decisions which otherwise they would have been directed when they were an NHS Trust. Things like how to conclude negotiations with the commissioners, how to engage with the sector about the changing models of care, there is a sense of empowerment that there is a right to carry on those discussions which simply was not there before. I am absolutely sure in my mind, having been both an NHS trust and a foundation trust, it feels very, very different on the board of an NHS Trust—which is where I am back again—because you really have to ask permission all the time. It is a different dynamic and it is quite difficult for me to give you a particular instance, but it is tangible and real.⁷²

Mr Gregory: I think, as I said earlier, the ability to try to shape your own future, to prioritise and the speed of decision making ... When I joined back in 2006 one of the first major items on the board agenda was the business plan for the new children's development that we are building in Chesterfield, bringing services that are currently delivered in rather dilapidated buildings in the town centre onto the site of the Royal (which is a large site) and having an integrated set of services and an improvement to those services. We had the board meeting and I noticed after we gave the business plan approval the chief executive and the financial director and a few others were smiling at each other. I asked what I was missing and they said, "You don't realise, Richard, but what we have just done in two months would have taken at least two years to achieve before".

Dr Naysmith: What was it specifically about the foundation trust that enabled that to happen?

Mr Gregory: We could make the decisions. We did not need to bid into a central pot. We had the resource, we put forward a proper analysis on clinical and financial criteria and we debated it rigorously and we decided to approve it. We did that within our own boardroom; it took as long as the process took which was probably less than two months actually. Apparently these things took an awful lot longer before.⁷³

71 Healthcare Commission and Audit Commission, *Is the Treatment Working?*, May 2008

72 Q10

73 Qq89–91

The Department of Health and the boundaries of FTs' autonomy

101. However, it appears that the boundaries of FTs' autonomy are still under negotiation. In February of this year the *Health Service Journal* reported a disagreement between Bill Moyes and NHS Chief Executive David Nicholson, after the former sent a letter to FTs outlining policy on infection control, deep cleaning and matrons following the infection control scandal at Tunbridge Wells. Bill Moyes expressed his discomfort over the "directive" and "instructive" tone of letters from the Department of Health to FTs, which he said were in contravention of legislation. He said that the circulars "could only be interpreted as issuing instructions" and that the circulars implied FTs were "in a line management accountability relationship with the DH".⁷⁴ When we asked Dr Moyes if these discussions had been resolved, he told us that the challenge of moving away from central control should not be underestimated:

I am not going to say that it will never happen again in the sense that the issue will never come up again. We underestimate the scale of change moving to foundation trusts. The Department, for 60 years, has seen itself in essence as corporate headquarters of a corporate hospital system and with foundation trusts they are no longer in that position, whereas they are the headquarters of a commissioning system. The issue that David and I were debating—I think it is a debate amongst people who are trying to make this happen rather than a personal difficulty between us—was: how can the Government express absolutely legitimate points of view from ministers saying that they are worried about cleanliness in hospitals and what is being done about it? But how can ministers convey the desire to see something done through commissioning rather than through issuing operational instructions to hospitals?⁷⁵

102. While FTs do not appear to have yet exploited the full potential of their autonomy, witnesses from FTs told us they were free to make decisions more quickly, and that there was a 'tangible' difference to the dynamic of their organisations, which we welcome. FTs' use of their autonomy should be included in the evaluation of FTs' progress which we have recommended that the Government commissions.

103. The recent disagreement between Monitor and the Department of Health suggests that boundaries are still being negotiated between the Department of Health and Monitor about what level of government intervention in FTs' affairs is legitimate. The Government should take steps to clarify this.

Regulation

104. While FTs have autonomy from the Department of Health, they are still subject to strict regulation. Marini *et al* comment that:

74 'Monitor challenges DH on freedoms', *Health Service Journal*, 22 February 2008

75 Q95

Although central regulation of FTs has been loosened in some areas, they are still subject to a great deal of central control in a rather crowded regulatory environment, covering economic regulation, quality and public safety.⁷⁶

The FT application process

105. Monitor demands both strong finances and governance from successful applicants. The FT application process was described by one Trust director as a ‘huge effort’, although the costs of the FT application process are difficult to quantify:

There is a very structured process that Monitor runs; there are very high standards in terms of compliance with their requirements and I would say at Guys and St Thomas’s it caused us at least 12 months to take our eye off the ball; not take our eye off the ball because actually you cannot do that because you cannot become a foundation trust if you slip from meeting all the targets. People had to work much, much harder simply to get through an additional major agenda which is the foundation trust application process ...The front end cost is really measured in the time and energy that staff have to put in; the actual cash on the table is not that great.⁷⁷

106. According to the Healthcare Commission and Audit Commission, the FT authorisation process is of itself a useful exercise for trusts to scrutinise their internal processes:

Our research identified that undergoing the FT application process has made a significant difference to the internal processes of both successful and unsuccessful applicants. The health economies felt that FT application has led to a better understanding of both the current trust business and how the organisation would function in the future. Legally binding contracts, which cannot be broken by either side, force NHS organisations to operate in a more business-like way.⁷⁸

Regulation

107. Following authorisation, FTs are subject to monitoring of finance and performance by Monitor:

Monthly and quarterly returns on finance and performance are rigorously scrutinised and deviation from plan can lead to changes in the “traffic light” performance indicators. Deterioration in performance leads to increased scrutiny, visits and enforcement to ensure plans are created and implemented to correct deviations from plans.⁷⁹

76 ‘Foundation Trusts in the NHS: does more freedom make a difference?’ Marini *et al*, *Health Policy*, University of York, 2007

77 Q53

78 Healthcare Commission and Audit Commission, *Is the Treatment Working?*, May 2008

79 FTM 02, Alan Maynard

108. In addition to this, FTs must also report data to the Healthcare Commission’s Annual Healthcheck in the same way as other NHS trusts. According to Alan Maynard, Monitor seems well regarded, and “is generally more visible to hospitals than the Healthcare Commission.”⁸⁰ Monitor recognises the importance of good relations with the HCC and now discussing how it will work with the CQC. However, questions remain about whether it is necessary for FTs to be subject to quality monitoring by two separate regulators. A further layer of complexity will be added by the proposed establishment of a further regulator, the Competition and Collaboration Commission, which will act as an ‘OFT’ equivalent for the NHS. With Monitor alone costing around £13m per annum⁸¹, not taking account of the costs of regulation to NHS trusts, whether these regulatory bodies are providing the necessary regulatory support to the NHS as efficiently as possible requires close scrutiny.

109. A further concern about the way in which FTs are regulated is that less information is centrally collected under current system, and so less information on FTs may be available for the purposes of public scrutiny and research. Marini *et al* report difficulties in their research on the impact of FTs. Professor Goddard informed us that :

In trying to undertake independent evaluation of the impact of FTs, we encountered some problems in the availability of data from FTs. In the past, all NHS trusts have been required to submit financial returns to the Dept of Health in a common format (known as TFRs—Trust Financial Returns) and these are available in the public domain. However, as part of the freedoms given to FTs they are no longer required to submit this data ... Monitor said that some of their returns would contain information we were seeking but that they were unable to let us have this data because it was confidential. Their suggestion was that we seek permission from every FT in order that the data could be released... that is rather time consuming and not conducive to the conduct of independent evaluation. Ultimately we were able to get the Foundation Trust Network to assist us in getting permission but it was made clear that if we wished to update the analysis with more recent financial data we would be required to approach each FT directly.

The increasing mis-match between the format and nature of the data provided by the FTs and non-FTs makes proper comparisons impossible ... CIPFA⁸² has cut down the data series they have usefully produced on Trusts over many years. Our own rich series of data on NHS Trusts which we have assembled in the Centre for Health Economics over many years (covering input, output and process variables), which has facilitated a range of useful research projects, has also fallen down because of the lack of FT data held in the public domain. As more Trusts become FTs, less and less information will be available for research purposes. As FTs remain public sector organisations spending public funds, it is worrying that independent scrutiny of some fundamental issues is made difficult, or even impossible, by rules that seem to protect them as commercial concerns.⁸³

80 FTM 02, Alan Maynard

81 http://www.monitor-nhsft.gov.uk/documents/Annual_Report_0708.pdf

82 The Chartered Institute of Public Finance and Accountability

83 FTM 08, Professor Goddard

110. When we put the researchers' concerns to Dr Moyes, he replied that data was still accessible, but conceded that it was more difficult for researchers to put together than previously.⁸⁴

111. The FT application process and regulatory regime seems to be well regarded, but concerns have been expressed about the availability of information on FTs for the purposes of public scrutiny and research. There also seems to be potential duplication between Monitor and the Healthcare Commission in terms of regulating quality, and the regulatory landscape will soon be further complicated with the addition of a new body, the Competition and Collaboration Commission.

5 Conclusions

112. FTs have some proven strengths, but much is unknown. In general, robust evidence is lacking. It is not clear whether their high performance in terms of finance and quality is the result of their changed status, or simply a continuation of long term trends, since the best trusts have become FTs. Key aims of FTs were the promotion of innovation and greater public involvement, but, again, there is a lack of objective evidence about what improvements, if any, FTs have produced.

113. The lack of objective evidence about, and evaluation of, FTs' performance is surprising given the importance of this policy. With over half of NHS trusts now FTs, the time is right to begin systematic and independent evaluation. The Department of Health should, as a priority, commission research to assess FTs' performance objectively. This will require access to FT data. Researchers have found it difficult to access such data. This should be centrally collected by Monitor and published.

114. It seems that many fears about FTs' impact on local health economies have not been borne out; however, they have made little contribution towards the government's aim of delivering more NHS care outside hospitals with the interesting exception of mental health trusts. This is not solely attributable to FTs themselves; rather it is a consequence of payment by results and inadequate collaboration between PCTs and FTs, notably their failure to reduce emergency admissions to hospitals.

115. In this inquiry the deficiencies of PCTs were also seen as contributing to other failings. In particular, FTs' slowness to innovate and invest was seen as a failure on the part of PCTs to provide strategic guidance. The Government is clearly aware of these deficiencies and has announced plans to strengthen PCTs' commissioning skills through its *World Class Commissioning* programme; however, it is unfortunate that this has come after the establishment of FTs and not before.

116. A major advantage of FT status is the autonomy it gives trusts. While FTs do not appear to have yet exploited the full potential of their autonomy, witnesses from FTs argued that the ability to make decisions more quickly was important and made a 'tangible' difference to the dynamic of their organisations, which we welcome. Unfortunately, there are persisting concerns about what level of government intervention in FTs' affairs is legitimate. We recommend that the Government clarify what the appropriate levels of intervention are.

117. FTs' use of their autonomy and the relationship between FTs, their regulator, and Government should be included in the Department of Health's evaluation of FTs' progress which we have recommend above.

118. Monitor's application process and regulatory regime seems to be well regarded. However, a complex regulatory environment of other organisations also surrounds FTs, and in particular there is potential duplication between the Healthcare Commission and Monitor both of which evaluate the quality of FTs' services.

Conclusions and recommendations

1. FTs have shown good financial performance; according to the Healthcare Commission and Audit Commission they are delivering more care and may be doing so more efficiently. FTs have generated cash surpluses to the order of £1.7 billion. It is not possible to conclude, however, whether this is largely attributable to the introduction of the FT system with its new flexibilities and rigorous financial monitoring, or whether it is simply the continuation of long-term trends amongst high-performing trusts in a Payment by Results system. (Paragraph 22)
2. We were told that FTs are holding back both from investing their surpluses and from making full use of their borrowing powers because of a lack of direction from commissioners. (Paragraph 23)
3. A further difficulty is that the private sector cap for mental health FTs currently set at zero. We have not examined the relationship between NHS FTs and the private sector in depth in this inquiry. However, it seems inequitable that mental health trusts should not have the same freedoms as other trusts, and we recommend that the Government reconsider this policy. (Paragraph 24)
4. FTs are generally high performers in routine NHS process quality measures. However, despite the fact that they are widely believed to be a high performing elite, the performance of some FTs has fallen, and a small number are amongst the worst performers for some measures. A significant minority also fall within the ‘amber’ or ‘red’ categories on Monitor’s governance ratings, with some showing no improvement across a whole financial year. This suggests that FTs can afford no complacency about the quality of services. (Paragraph 32)
5. We commend the Department of Health for piloting a scheme to reward trusts financially for delivering a quality of service beyond the minimum contracted levels. We recommend that such schemes should be extended and conversely schemes to punish low quality care as evidenced by unacceptable complaints from patients or their relatives should be considered. (Paragraph 33)
6. Freedom for the NHS to develop innovative models of care unencumbered by bureaucracy was widely seen to be one of the chief attractions of FT status; however while we have seen some examples of innovative practice, there seems to be little robust evidence to suggest FTs are using their new status to innovate in a significant way. Some witnesses thought it was too soon for FTs to be expected to be generating major innovations when they were still concentrating on achieving and maintaining financial stability; others considered that FTs’ ability to innovate was being constrained by commissioners. (Paragraph 43)
7. We were surprised and concerned that no organisation seems to have a clear remit to assess objectively whether or not FTs are becoming more innovative, which makes it difficult to evaluate whether or not there are sufficient incentives for FTs to innovate. Given that innovation is meant to be an important part of the ‘value added’ by FT status, and given the potential benefits to the rest of the NHS from sharing best

practice, the Government should commission objective evaluation in this area. (Paragraph 44)

8. While we saw some examples of good practice in FTs' new governance arrangements, in general they seem to be slow to deliver benefits and despite numerous small studies, there remains a lack of robust evidence of their effectiveness. The governance process currently costs circa £200,000 per trust, giving a total of around £20 million per annum. We recommend that the Department of Health make it a priority to evaluate rigorously the FT governance system and to give guidance on best practice so that public money as well as members' and governors' time can be used as effectively as possible to improve services. (Paragraph 60)
9. We are also surprised and concerned that Monitor did not issue guidance to governors until shortly before our evidence session took place, despite several reports over the last five years having identified the need for this, starting with the Health Committee which recommended the establishment of a national training system for Governors as long ago as 2003. (Paragraph 61)
10. In considering the impact of FT status on FTs themselves, a recurring theme has been a lack of firm evidence that FT status is yet conferring the benefits hoped for. While it is clear that the majority of FTs are high performers in terms of finance and quality as measured by Healthcare Commission ratings, these were high-performing organisations prior to becoming FTs, and so it is difficult to ascribe this high performance to FT status per se. Two other major aims were to give trusts the freedom to invest in innovation and to promote better local engagement with the public and other health providers through new governance systems. Evidence of benefit on both of these scores is also thin. Systematic and independent evaluation is needed. The Department of Health should make it a priority to commission research to measure FTs' progress objectively, and to disseminate their successes more widely. (Paragraph 62)
11. Before their establishment a number of fears were voiced about the impact FTs might have on wider health communities. There is little evidence that FTs have poached staff from other trusts. Evidence from Dr Mark Exworthy and the Healthcare Commission suggests that in local health communities where collaborative working has historically been good this has continued to be the case; Dr Exworthy did suggest that in other areas the presence of FTs may be generating tensions and resentment. However, others felt that tensions exist between high-performing and less well performing trusts regardless of their status because of the system of Payment by Results. (Paragraph 69)
12. The ability to retain surpluses was a key element of the FT reform, and FTs are now building up surpluses. FTs report that they are looking to PCT commissioners to collaborate on how these surpluses should be reinvested to improve patient care, but that PCTs are not in a position to give this guidance. We did not see any evidence that PCTs are thinking strategically about how FT surpluses might best be reinvested in their local health communities, a situation which we find extremely worrying. We recommend that the Department of Health takes steps to ensure that PCTs are able to play the strategic planning role urgently required of them; without this, public

money risks sitting idle or being invested without proper strategic planning. (Paragraph 79)

13. A major concern at the inception of FTs was that they, together with Payment by Results, would strengthen the acute sector to the detriment of primary care services. This seems to be the case, although it is probably more because of introduction of Payment by Results than the introduction of FTs. By this stage we might have hoped for better collaboration within health economies, particularly with a view to providing more care in the community. Mental health provides an interesting contrast: mental health FTs, which are not subject to the Payment by Results regime, argue that they have a strong incentive to get more patients treated in the community in order to generate surpluses. This Committee is very concerned that PbR is to be extended to mental health and community care in the next two years. We recommend that the Government address this issue. (Paragraph 86)
14. Weakness in PCTs' commissioning was cited by witnesses to this inquiry as the cause of many perceived problems relating to FT status, including FTs not investing their surpluses, FTs not being able to innovate, and the lack of shift to primary care. We note that the Government is now developing a specific support package to enable PCTs to become 'world class' commissioning organisations; however in our view focusing on provider side reforms, including payment by results and the introduction of FTs, before PCTs were ready to meet the challenges set before them was ill-judged. (Paragraph 94)
15. As part of its 'World Class Commissioning' initiative, we recommend that the Government sharpens incentives for acute trusts to ensure they are fully engaged in keeping people who could be treated in the community out of hospitals. One option would be further adjustment of the two part tariff for emergency care, thereby increasing incentives to commissioners and providers to develop more rapidly alternatives to hospital care. (Paragraph 95)
16. While FTs do not appear to have yet exploited the full potential of their autonomy, witnesses from FTs told us they were free to make decisions more quickly, and that there was a 'tangible' difference to the dynamic of their organisations, which we welcome. FTs' use of their autonomy should be included in the evaluation of FTs' progress which we have recommended that the Government commissions. (Paragraph 102)
17. The recent disagreement between Monitor and the Department of Health suggests that boundaries are still being negotiated between the Department of Health and Monitor about what level of government intervention in FTs' affairs is legitimate. The Government should take steps to clarify this. (Paragraph 103)
18. The FT application process and regulatory regime seems to be well regarded, but concerns have been expressed about the availability of information on FTs for the purposes of public scrutiny and research. There also seems to be potential duplication between Monitor and the Healthcare Commission in terms of regulating quality, and the regulatory landscape will soon be further complicated with the

addition of a new body, the Competition and Collaboration Commission. (Paragraph 111)

19. FTs have some proven strengths, but much is unknown. In general, robust evidence is lacking. It is not clear whether their high performance in terms of finance and quality is the result of their changed status, or simply a continuation of long term trends, since the best trusts have become FTs. Key aims of FTs were the promotion of innovation and greater public involvement, but, again, there is a lack of objective evidence about what improvements, if any, FTs have produced. (Paragraph 112)
20. The lack of objective evidence about, and evaluation of, FTs' performance is surprising given the importance of this policy. With over half of NHS trusts now FTs, the time is right to begin systematic and independent evaluation. The Department of Health should, as a priority, commission research to assess FTs' performance objectively. This will require access to FT data. Researchers have found it difficult to access such data. This should be centrally collected by Monitor and published. (Paragraph 113)
21. It seems that many fears about FTs' impact on local health economies have not been borne out; however, they have made little contribution towards the government's aim of delivering more NHS care outside hospitals with the interesting exception of mental health trusts. This is not solely attributable to FTs themselves; rather it is a consequence of payment by results and inadequate collaboration between PCTs and FTs, notably their failure to reduce emergency admissions to hospitals. (Paragraph 114)
22. In this inquiry the deficiencies of PCTs were also seen as contributing to other failings. In particular, FTs' slowness to innovate and invest was seen as a failure on the part of PCTs to provide strategic guidance. The Government is clearly aware of these deficiencies and has announced plans to strengthen PCTs' commissioning skills through its World Class Commissioning programme; however, it is unfortunate that this has come after the establishment of FTs and not before. (Paragraph 115)
23. A major advantage of FT status is the autonomy it gives trusts. While FTs do not appear to have yet exploited the full potential of their autonomy, witnesses from FTs argued that the ability to make decisions more quickly was important and made a 'tangible' difference to the dynamic of their organisations, which we welcome. Unfortunately, there are persisting concerns about what level of government intervention in FTs' affairs is legitimate. We recommend that the Government clarify what the appropriate levels of intervention are. (Paragraph 116)
24. FTs' use of their autonomy and the relationship between FTs, their regulator, and Government should be included in the Department of Health's evaluation of FTs' progress which we have recommend above. (Paragraph 117)
25. Monitor's application process and regulatory regime seems to be well regarded. However, a complex regulatory environment of other organisations also surrounds FTs, and in particular there is potential duplication between the Healthcare

Commission and Monitor both of which evaluate the quality of FTs' services.
(Paragraph 118)

Annex A – Background to Foundation Trusts

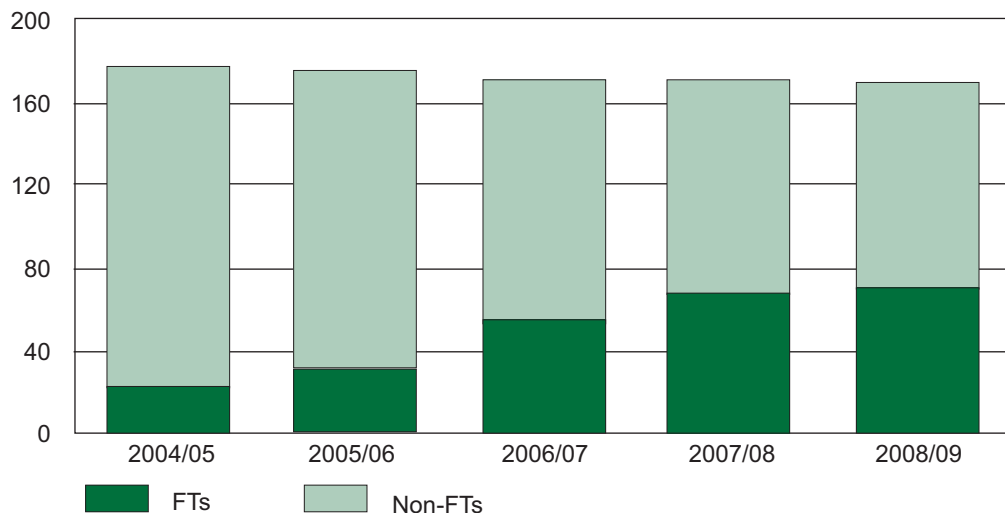
What are foundation trusts?

In 2003 the UK Parliament passed the Health and Social Care Act to create a new type of organisation transforming English NHS trusts into foundation trusts (FTs). FTs are independent not-for-profit public benefit corporations. They are required to meet national targets, like any other trust, but have more freedom to decide how they achieve these standards. There are currently 107 foundation trusts in the English NHS, mostly acute facilities and, more recently, including some mental health units. Foundation status is granted to high performing trusts after successfully completing an application process administered by Monitor, the independent regulator of foundation trusts.

The Government's original aim was that all NHS trusts would eventually become foundation trusts. However in late 2007, the DH recognised that some trusts would not reach the standard necessary to achieve FT status and that the target of all trusts having the opportunity to become FTs by 2008 would not be achieved. The DH now intends that, over the next three years, all acute and mental health services will be delivered by FTs, with the implication that FTs will merge with or buy out the remaining non-foundation hospitals. The following table shows how the proportion of acute and specialist trusts which have been granted foundation status has increased.

The number of FTs is increasing, but the aspiration to have 100 FTs by December 2007 was not met

Number of acute and specialist trusts



Note: 2008/09 figures correct at time of publication (June 2008). Data excludes mental health trusts

Source: Audit Commission and Healthcare Commission

Geographical distribution of FTs is shown at Annex C.

Foundation trusts differ from NHS Trusts in three key respects:

- Local accountability—as well as Boards of Directors, FTs have Boards of Governors, and members, drawn from staff and the local public, who participate in elections for boards of governors.
- Freedom from central control—FTs are not directly accountable to the Secretary of State, but instead to an independent regulator, Monitor.
- Financial freedoms; FTs:
 - have greater financial flexibility: FTs do not have to break even and are allowed to retain surpluses
 - can invest in buildings and new services
 - can manage their own assets
 - can borrow both from the public and the private sector
 - can recruit and reward staff with more competitive salaries

Foundation trusts have been introduced against a backdrop of system-wide reforms to the NHS including Payment by Results, patient choice and the introduction of Independent Sector Treatment Centres, all of which have been introduced as incentives to improve the quality and efficiency of secondary care. At the same time a desire to shift more traditionally secondary care services into primary care settings closer to people's homes was expressed in the *Our Health, Our Care, Our Say* White Paper, and this has been underpinned by the introduction of practice-based commissioning, alternative primary care providers, and the consideration of other models of primary-secondary care services delivery such as polyclinics. At the same time the period during which foundation trusts have been operating has also seen the NHS as a whole slide into and recover from major financial deficit, and a wholesale restructuring of PCTs, which are the organisations responsible for commissioning care from FTs and other providers.

Annex B - further reading

General

Is the Treatment Working? Summary; Chapter 4 – Healthcare Commission and Audit Commission, 2008

Monitor draft annual report 2007–08

NHS foundation trusts: Quarter 4 report, Monitor

Foundation trusts – the story so far - Foundation Trust Network, 2008

Foundation Trust Network Annual Report

Financial freedoms

Foundation trusts in the NHS: does more freedom make a difference? Marini et al, University of York, 2007

Governance and citizen involvement

Citizen and staff involvement in health service decision-making: have National Health Service foundation trusts in England given stakeholders a louder voice? Richard Lewis, Lisa Hinton, 2008

Review of membership plans for NHS Foundation trusts, Richard Lewis, Lisa Hinton, 2006

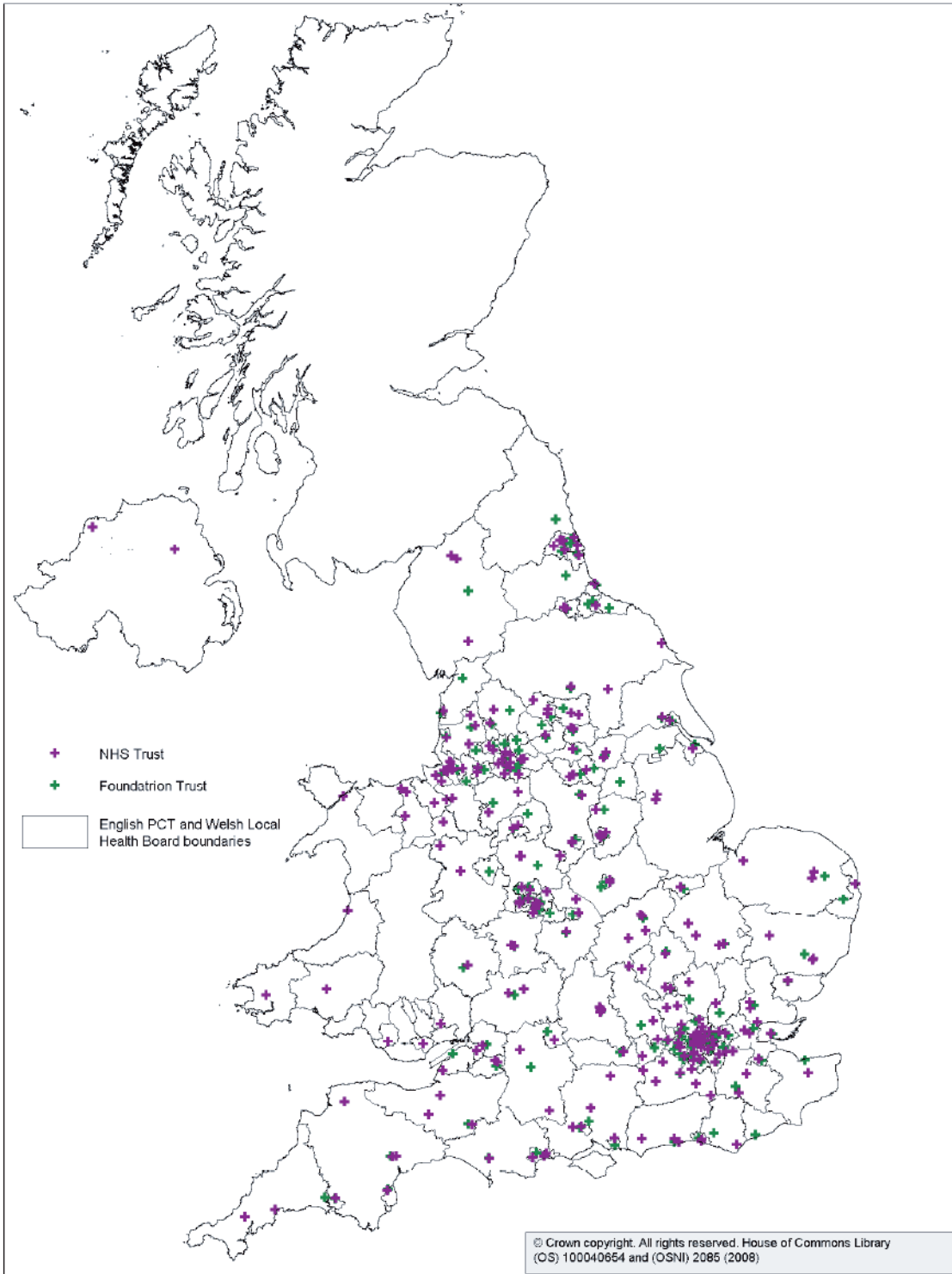
Developing the role of NHS foundation trust governors, Monitor, 2008

Membership Governance in NHS Foundation trusts – a review for the Department of Health; Peter Hunt, Chris Ham, 2008

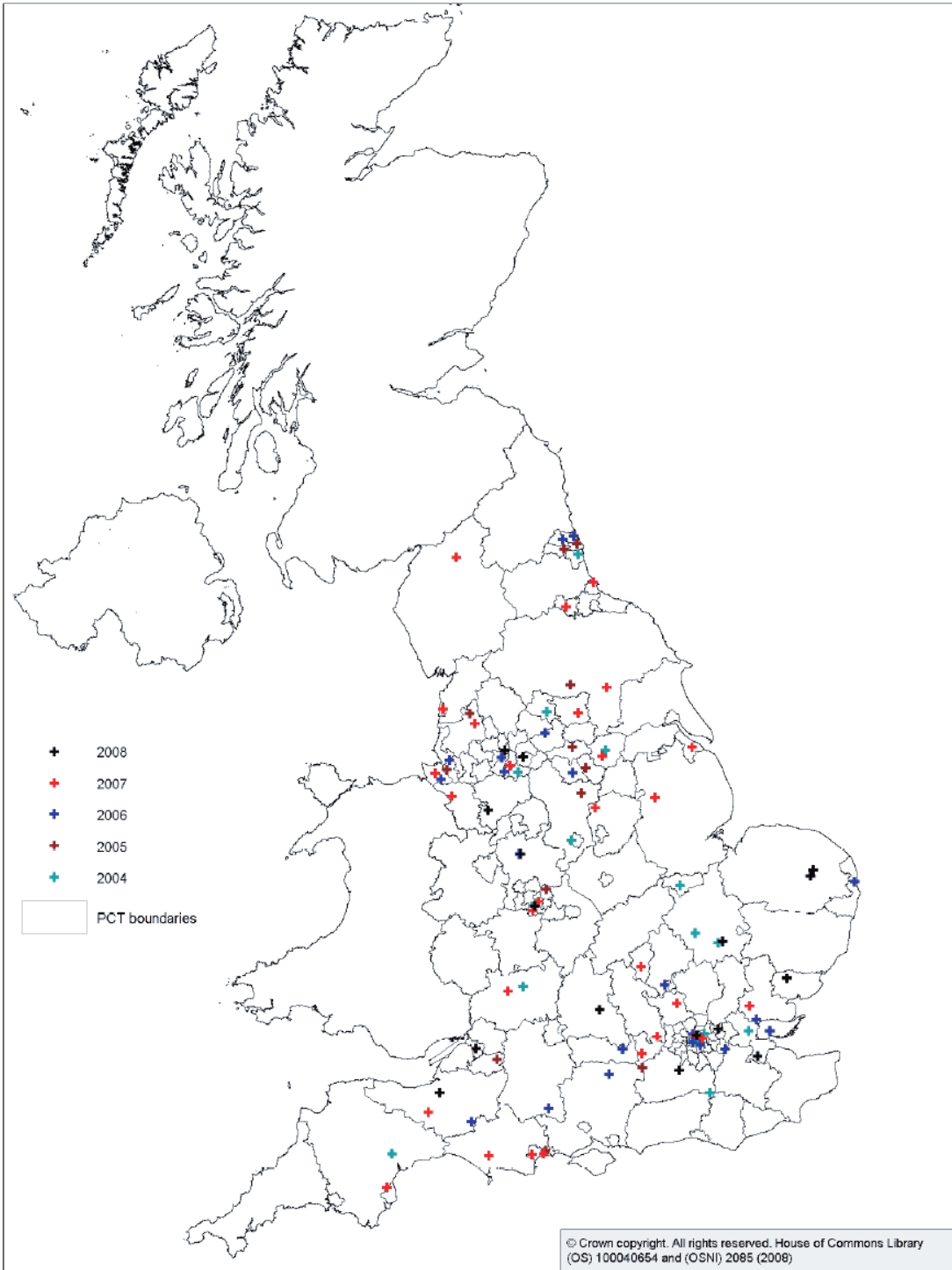
Better Governance, Stronger Voice – a survey of FT Governors, Foundation trust Network, 2007

Annex C – geographical distribution of FTs

Distribution of NHS and Foundation Trusts



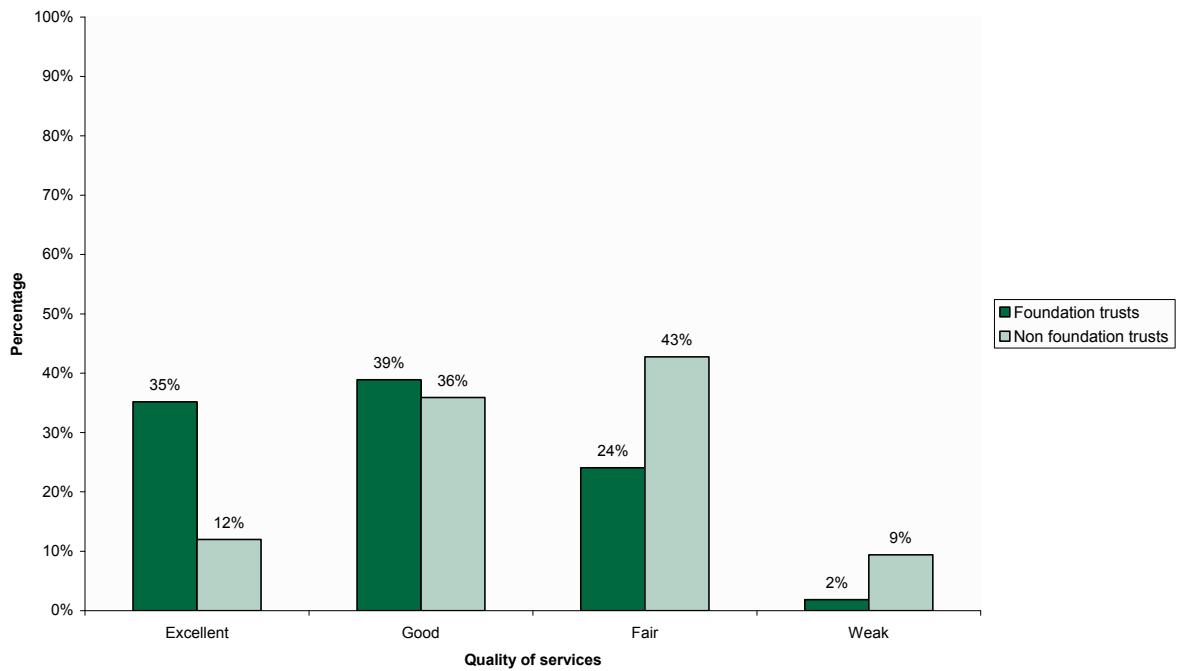
Foundation Trusts by year of authorisation



Annex D – Healthcare Commission ratings

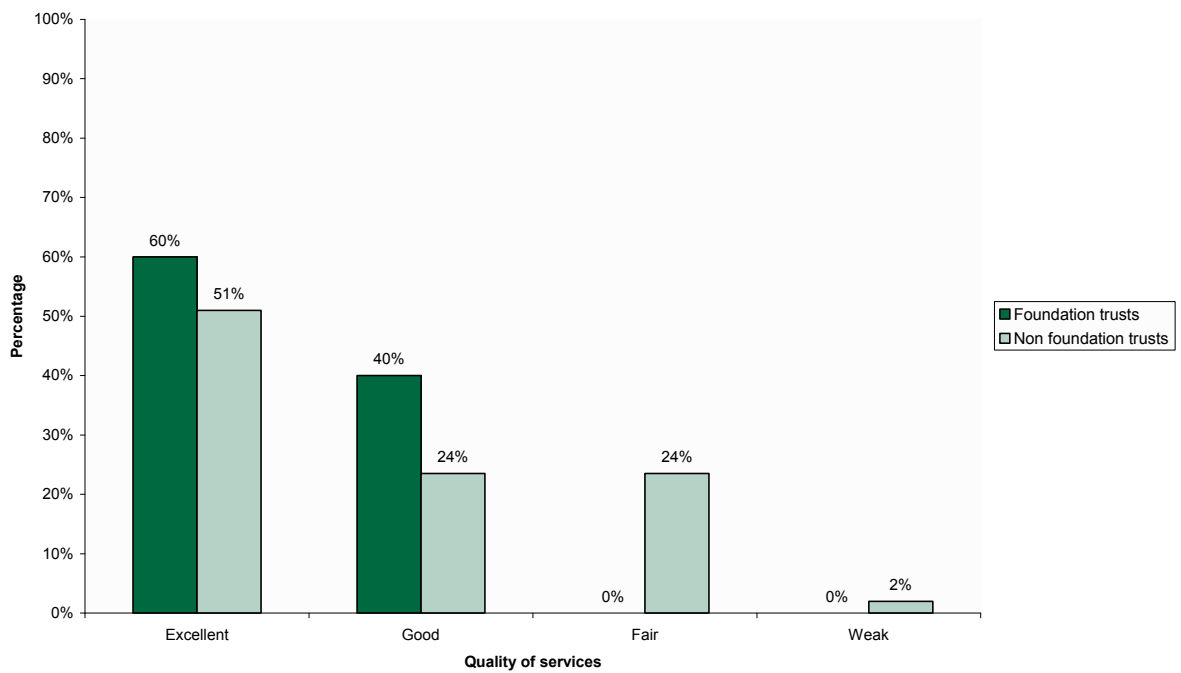
Foundation trust Statistics Scrutiny Unit

Figure 1 – Quality of services – Acute and Specialist Trusts



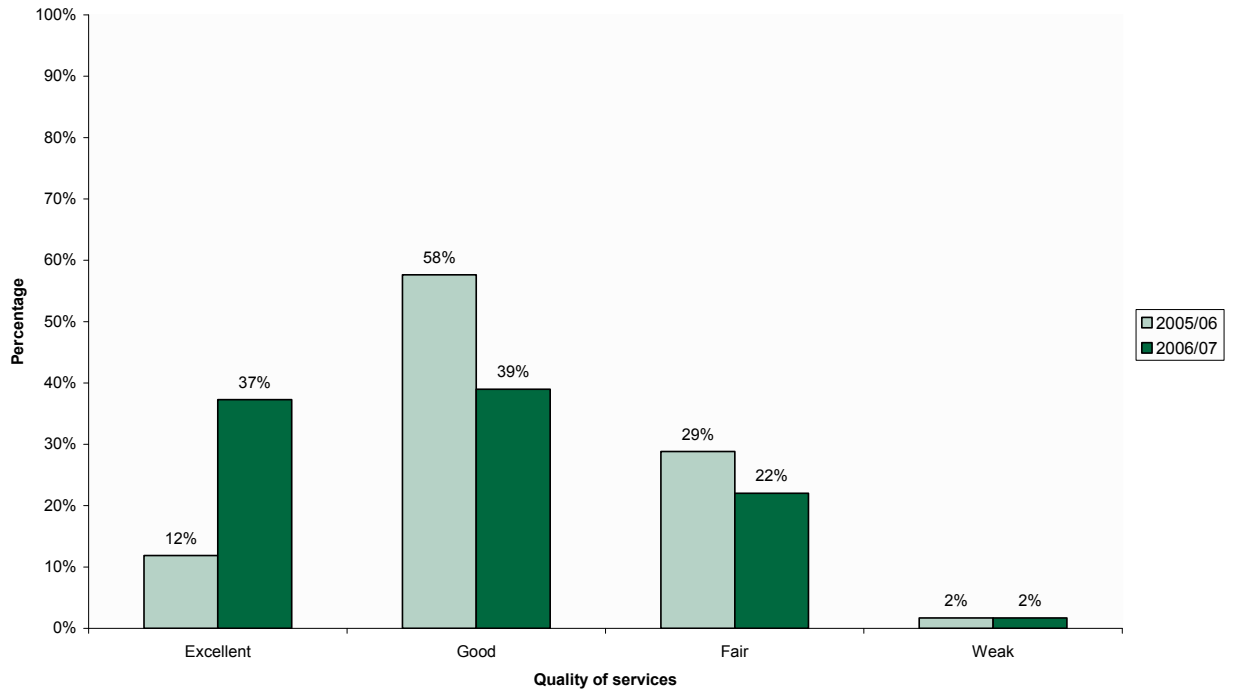
Source: Health Care Commission, 2007

Figure 2 – Quality of services – Mental Health Trusts



Source: Health Care Commission, 2007

Figure 3a – Quality of services – All Acute and Mental Health Foundation trusts 2005/06 compared to 2006/07



Source: Health Care Commission, 2007

Figure 3b – Change in quality of services rating for All Acute and Mental Health Foundation trusts from 2005/06 to 2006/07

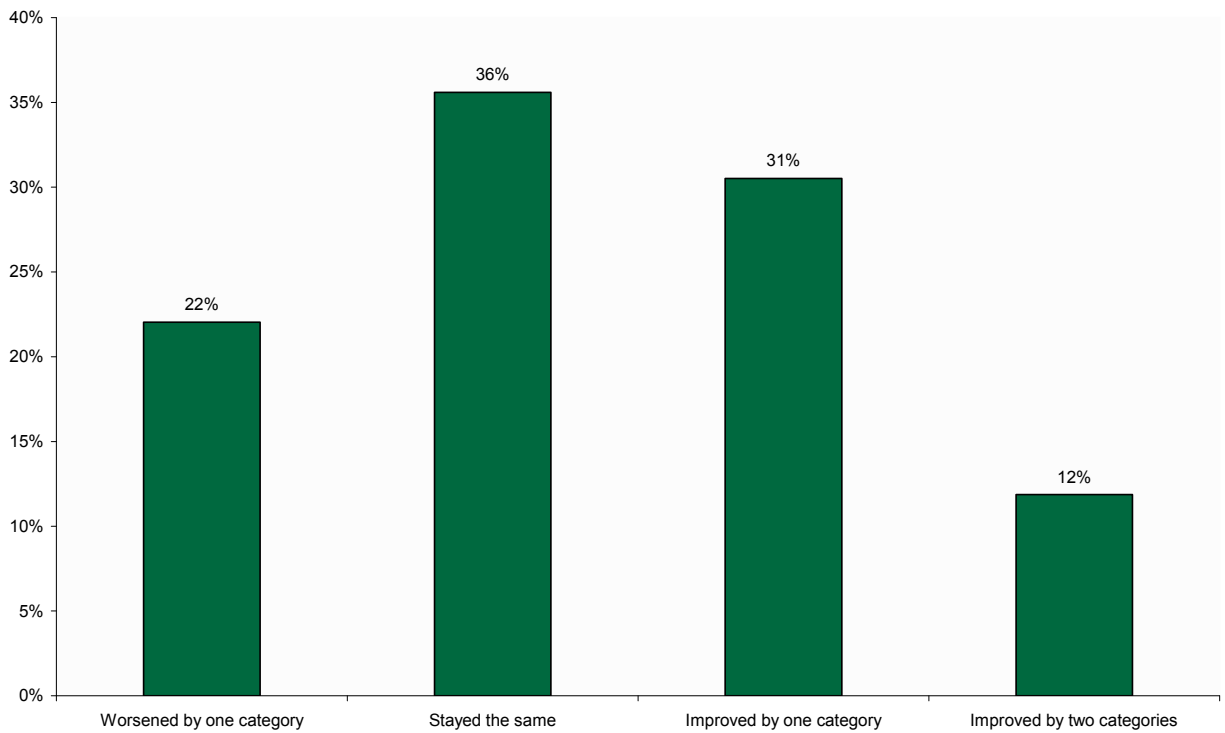


Figure 4 – Core standards – Acute and Specialist Trusts

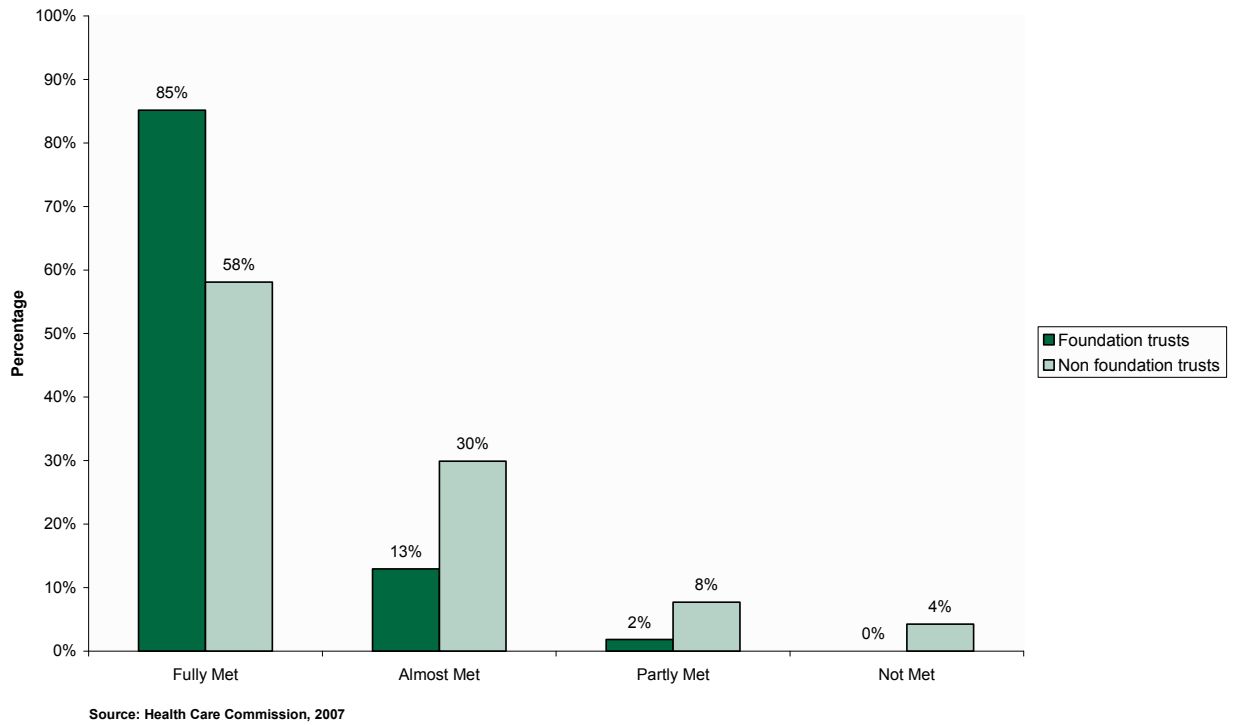


Figure 5 – Core standards – Mental Health Trusts

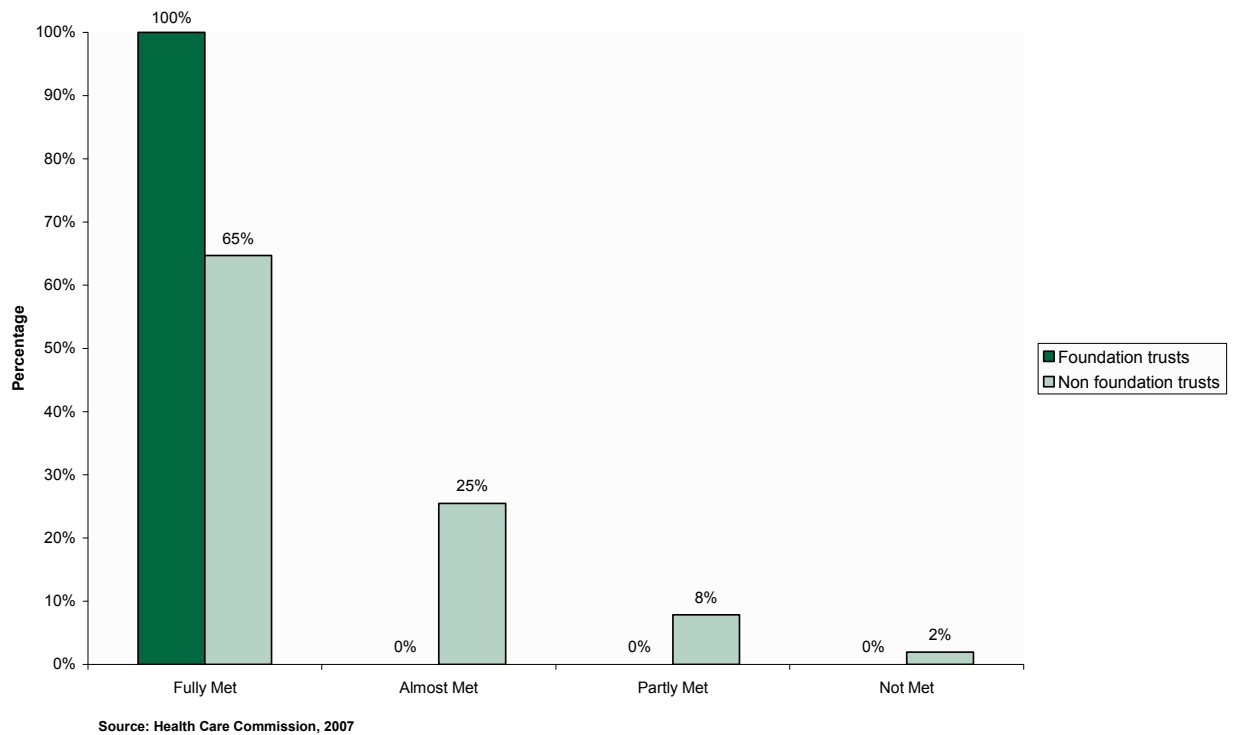


Figure 6 – Core standards – All Acute and Mental Health Foundation trusts 2005/06 compared to 2006/07

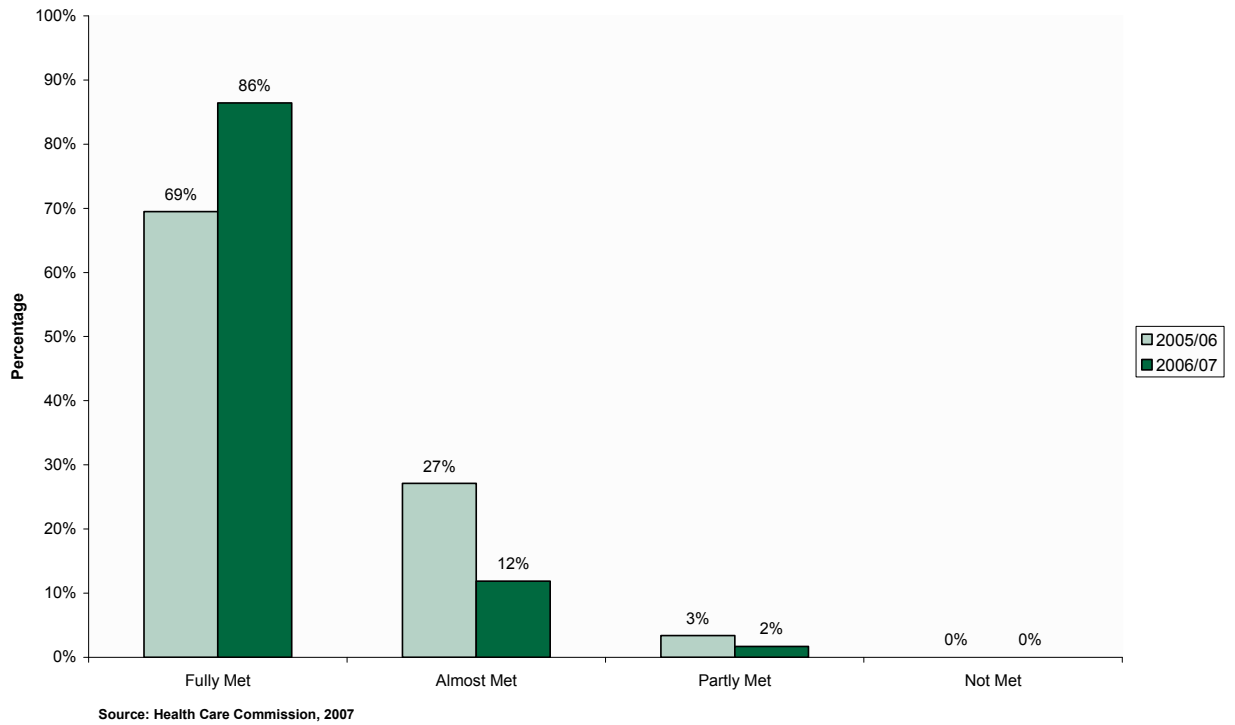


Figure 7 – Existing national targets – Acute and Specialist Trusts

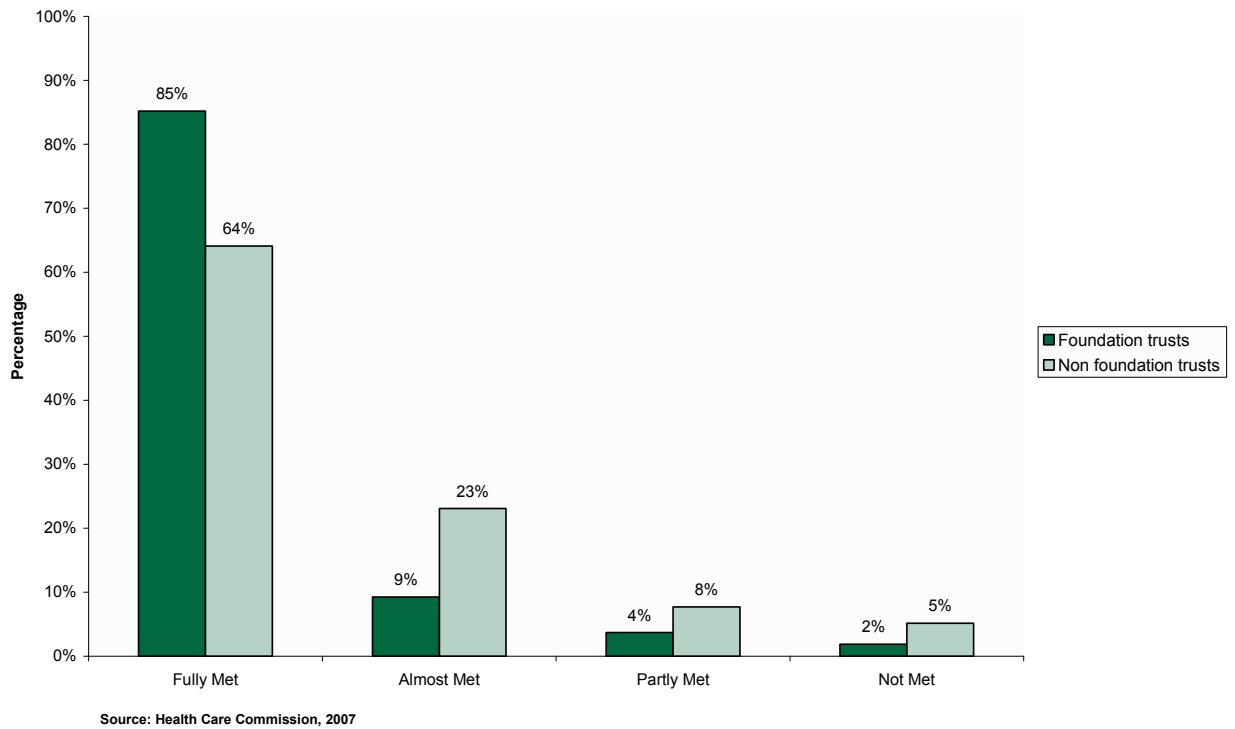


Figure 8 – Existing national targets – Mental Health Trusts

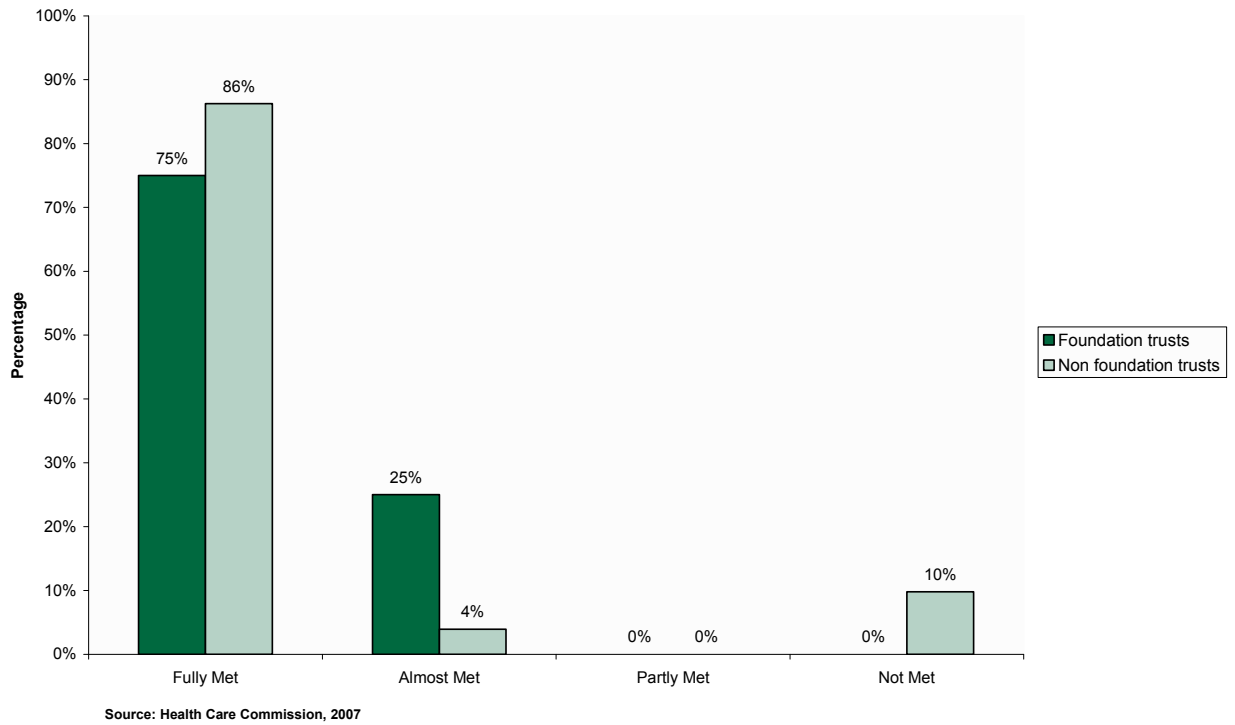


Figure 9 – Existing national targets – All Acute and Mental Health Foundation trusts 2005/06 compared to 2006/07

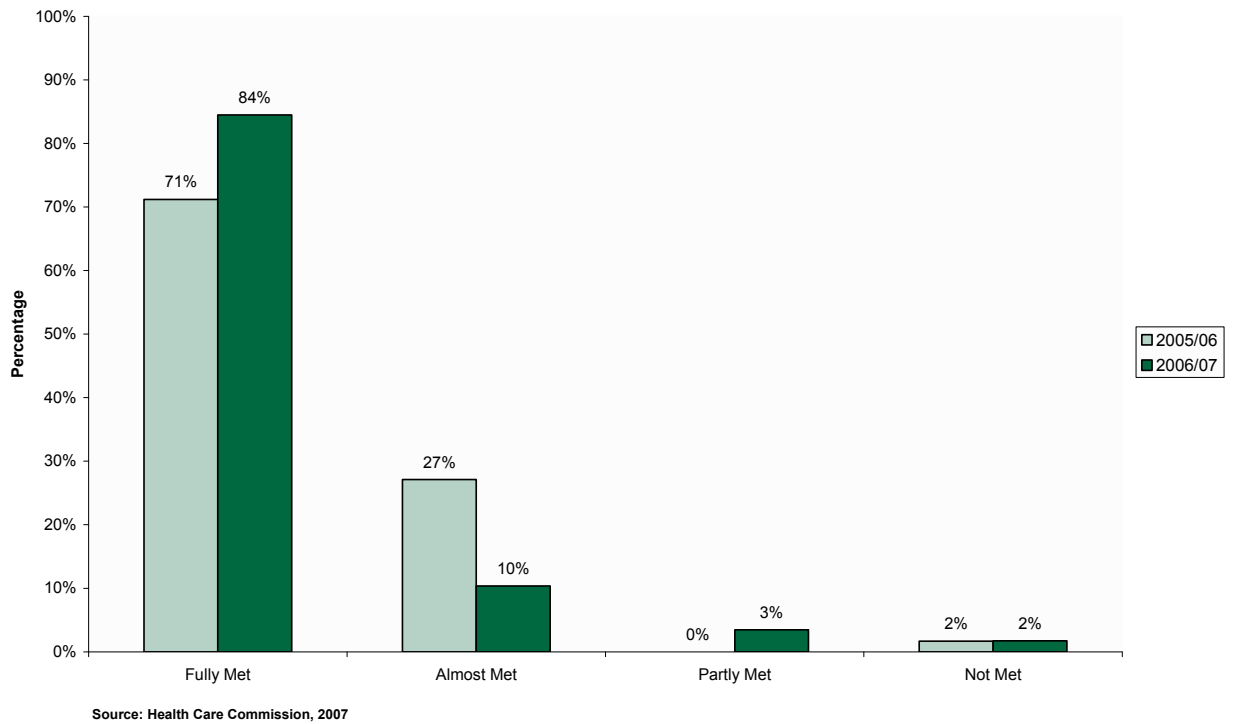


Figure 10 – New national targets – Acute and Specialist Trusts

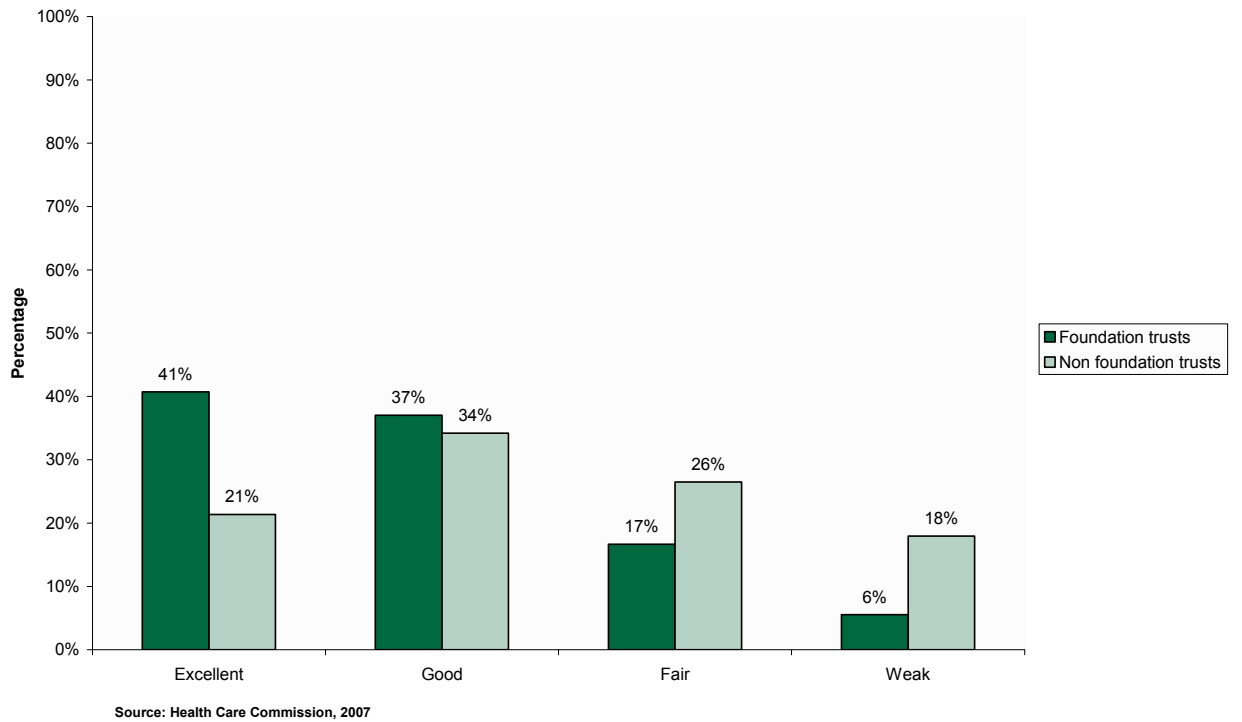


Figure 11 – New national targets – Mental Health Trusts

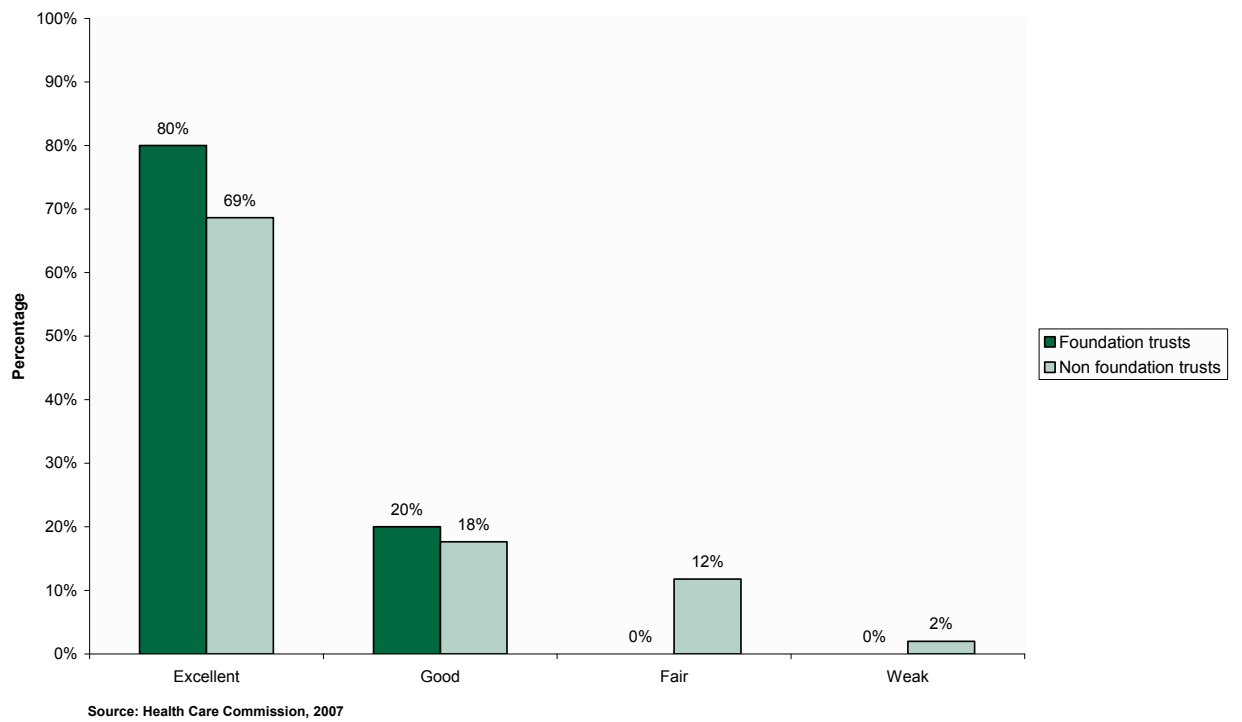


Figure 12 – New national targets – All Acute and Mental Health Foundation trusts 2005/06 compared to 2006/07

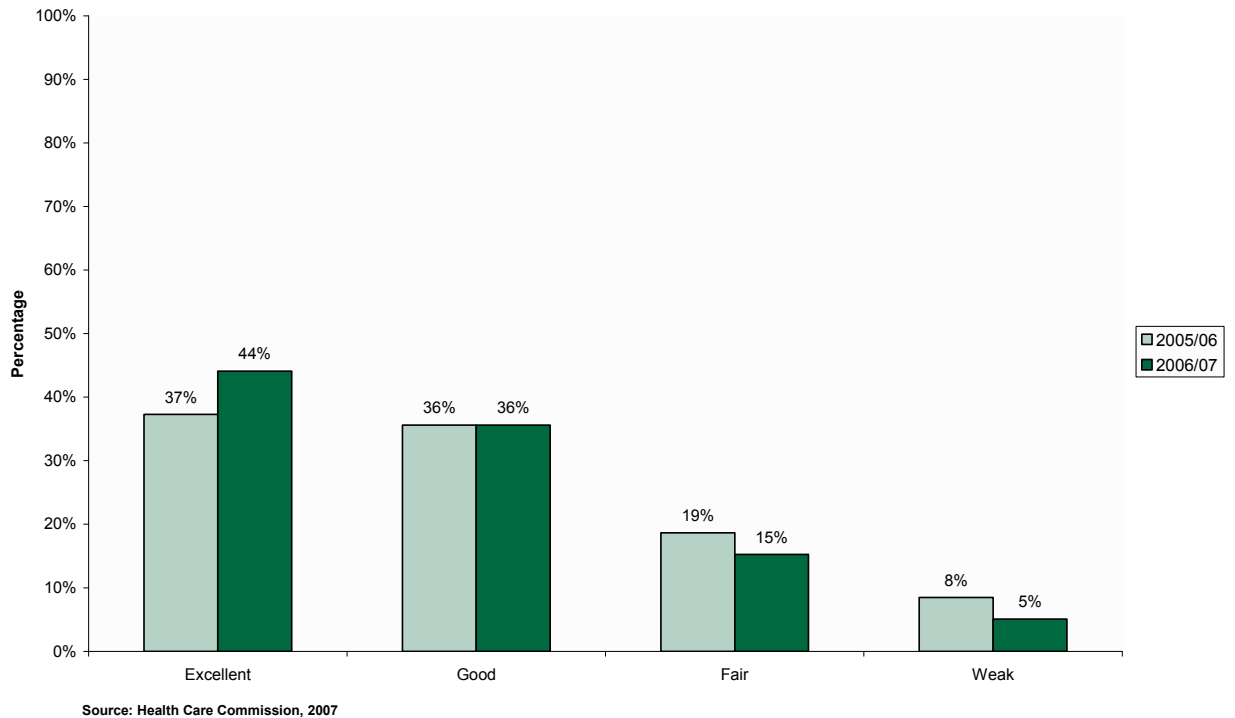


Figure 13 – Safety developmental standards, Acute and Specialist Trusts

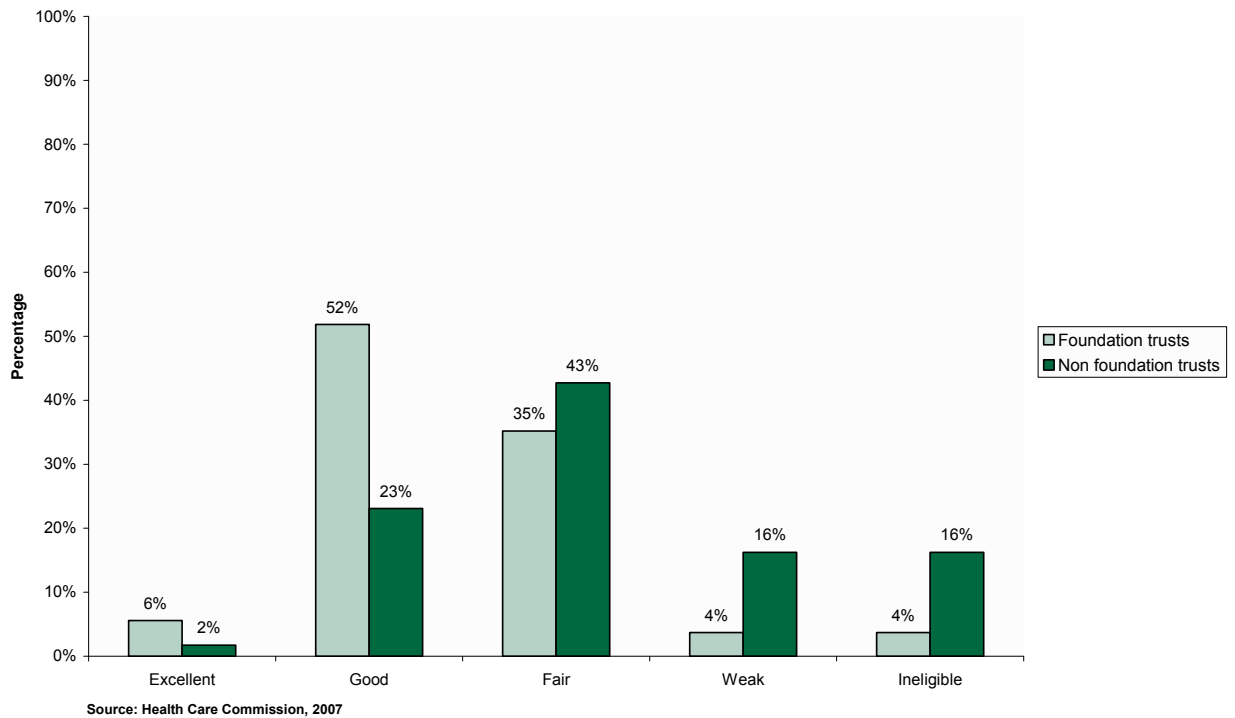


Figure 14 – Clinical and cost effectiveness, Acute and Specialist Trusts

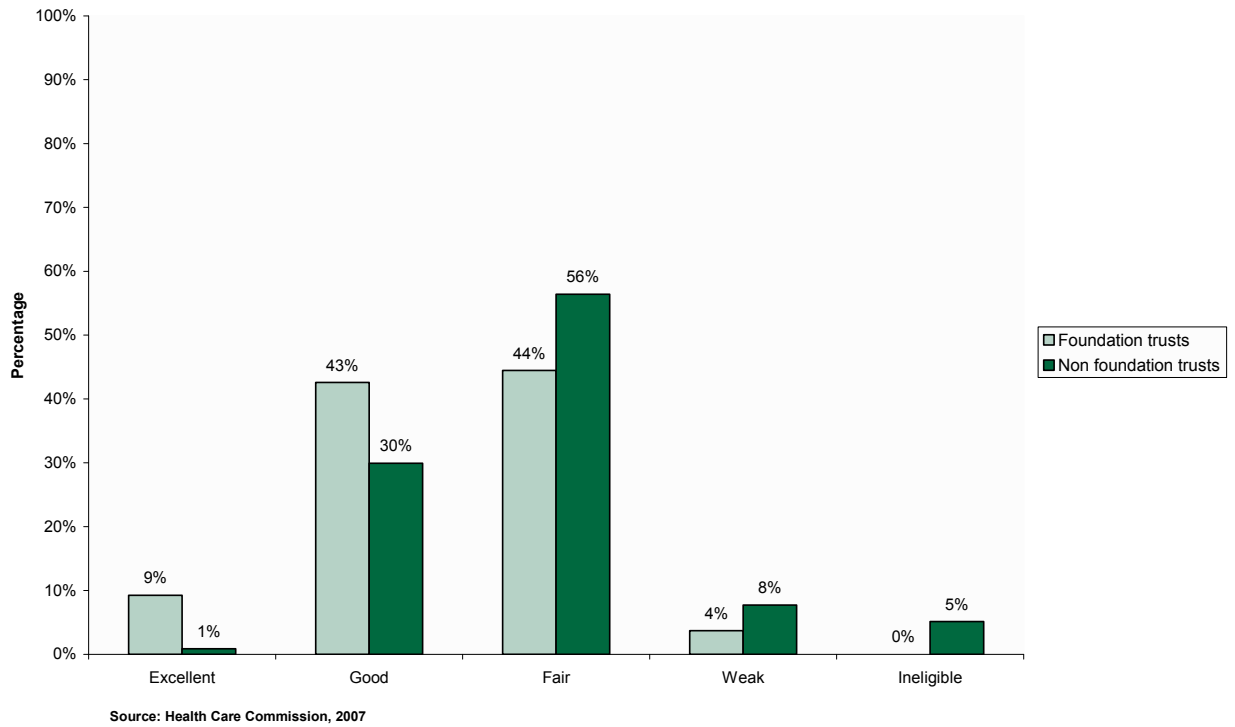


Figure 15 – Clinical and cost effectiveness, Mental Health Trusts

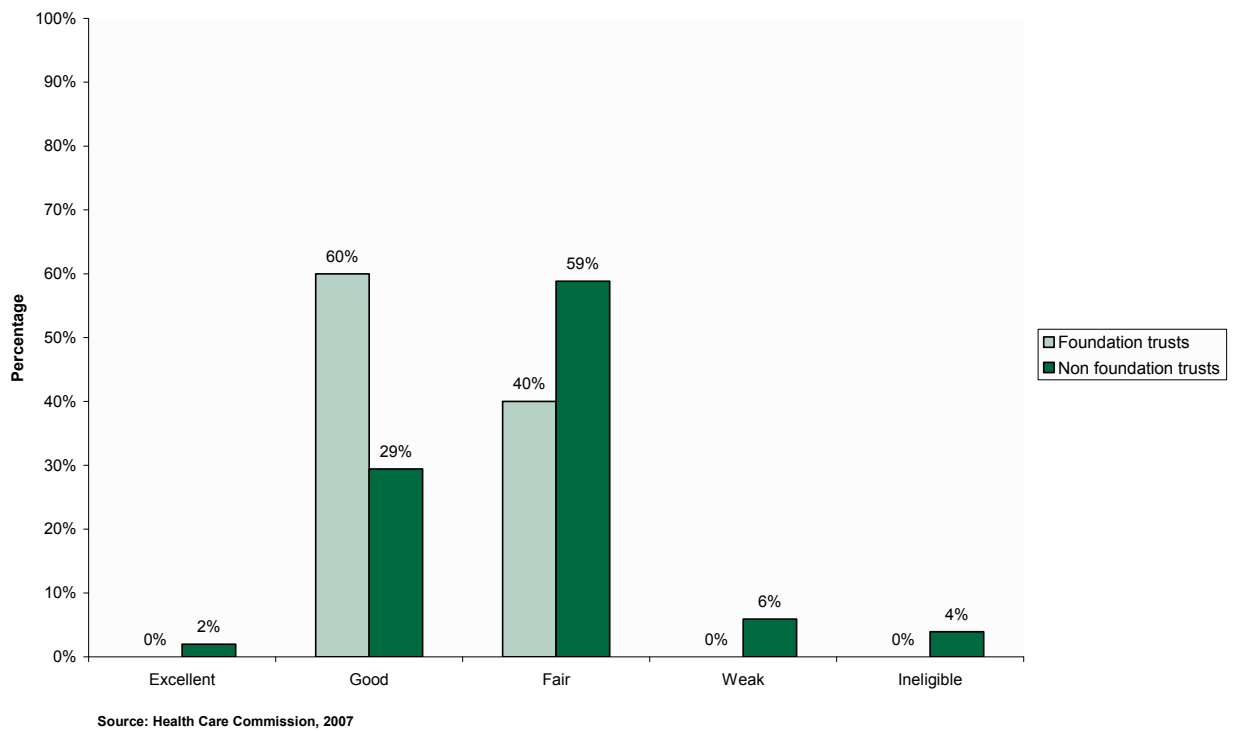
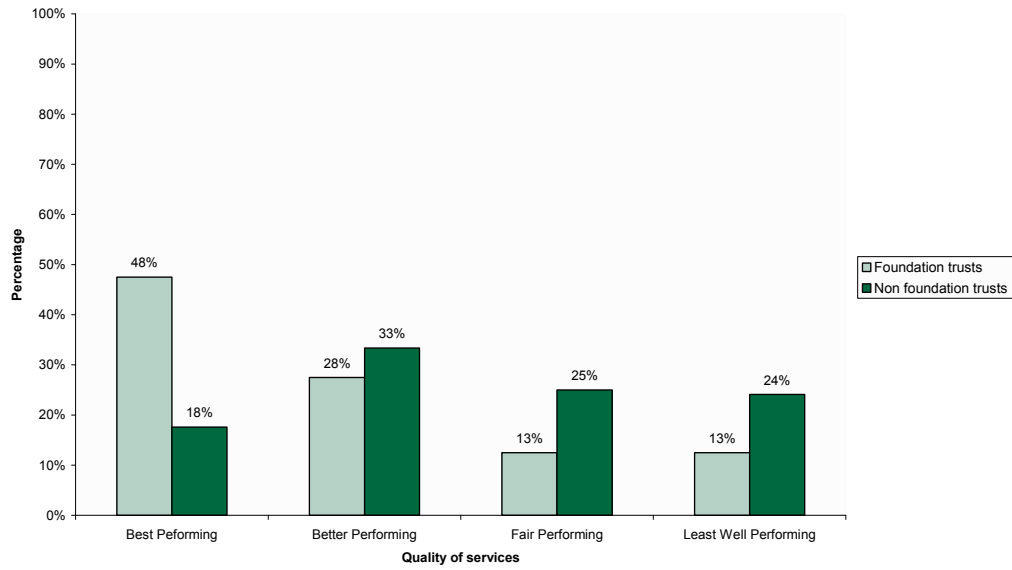
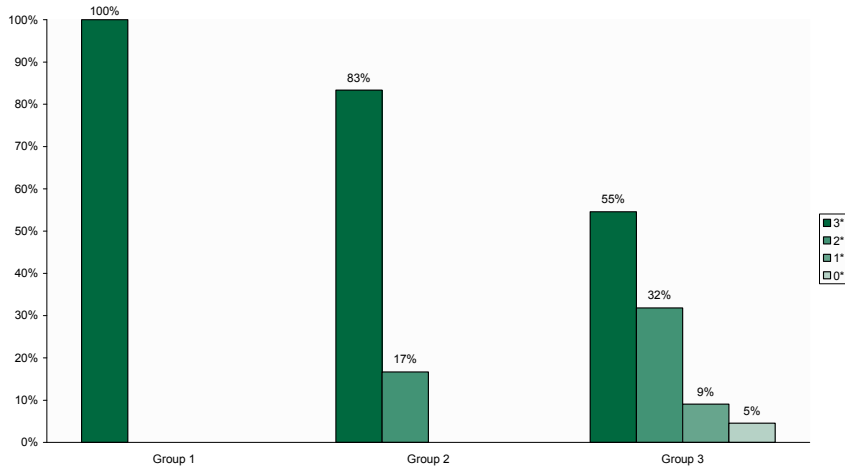


Figure 16 – Maternity service review, Acute and Specialist Trusts



Source: Health Care Commission, 2007

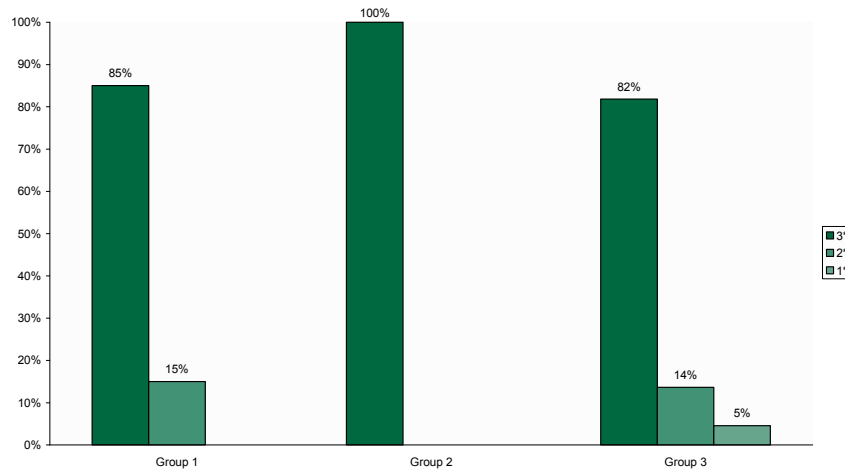
Figure 17a – Star ratings in 2003 by FT ‘group’



Note: Group 1 - designated as Foundation Trust in 2004; Group 2 - 2005; and Group 3 - 2006

Source: Health Care Commission, 2007

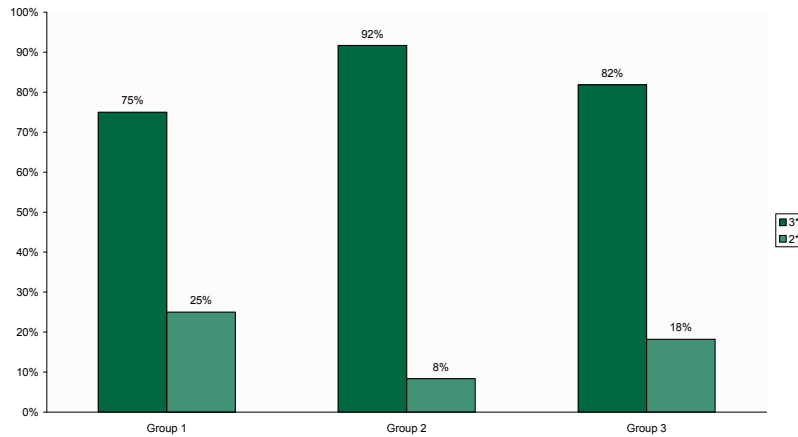
Figure 17b – Star ratings in 2004 by FT ‘group’



Note: Group 1 - designated as Foundation Trust in 2004; Group 2 - 2005; and Group 3 - 2006

Source: Health Care Commission, 2007

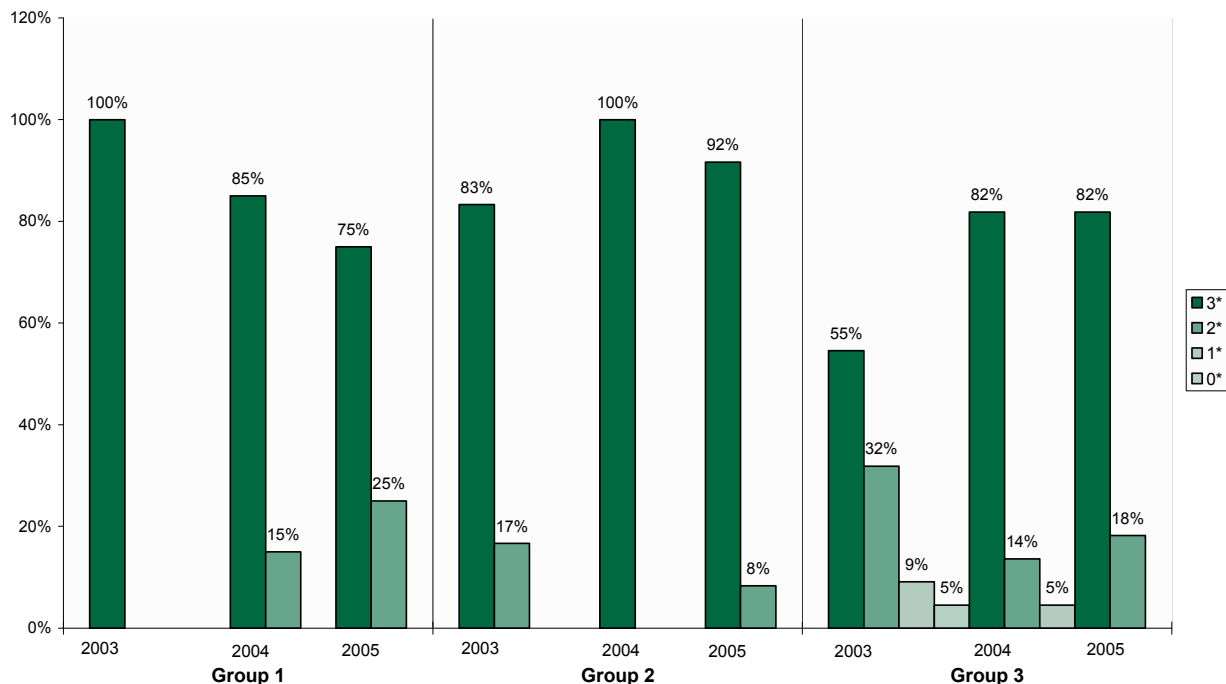
Figure 17c – Star ratings in 2005 by FT ‘group’



Note: Group 1 - designated as Foundation Trust in 2004; Group 2 - 2005; and Group 3 - 2006

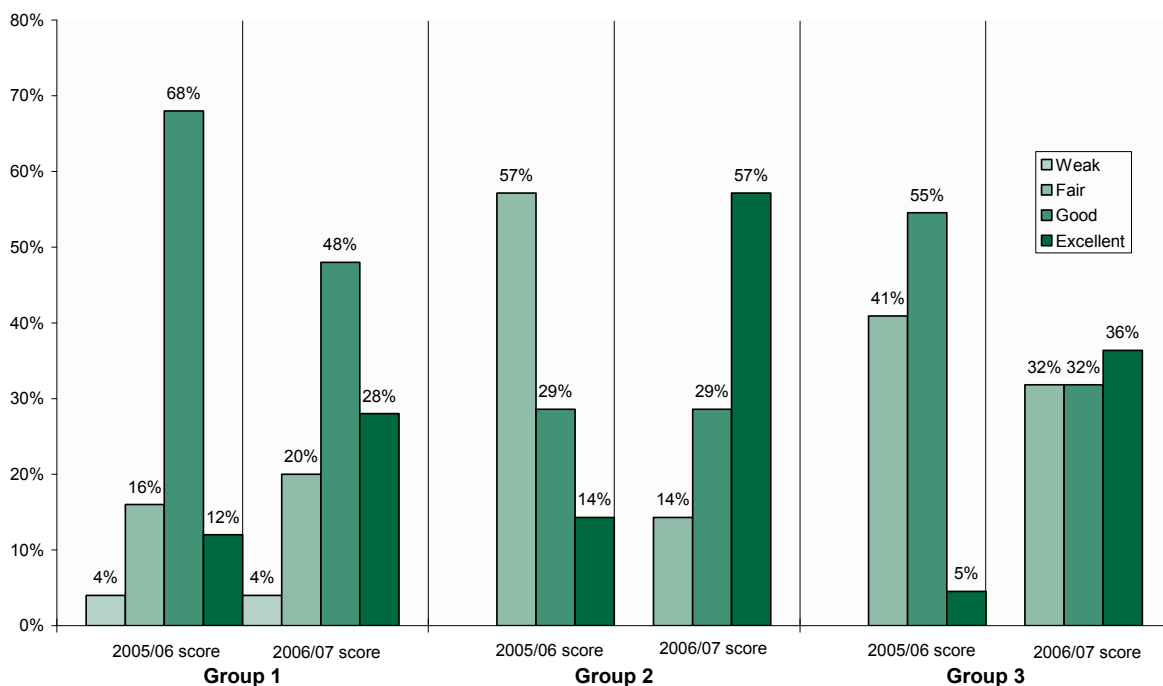
Source: Health Care Commission, 2007

Figure 17d – Star ratings over time by FT ‘group’



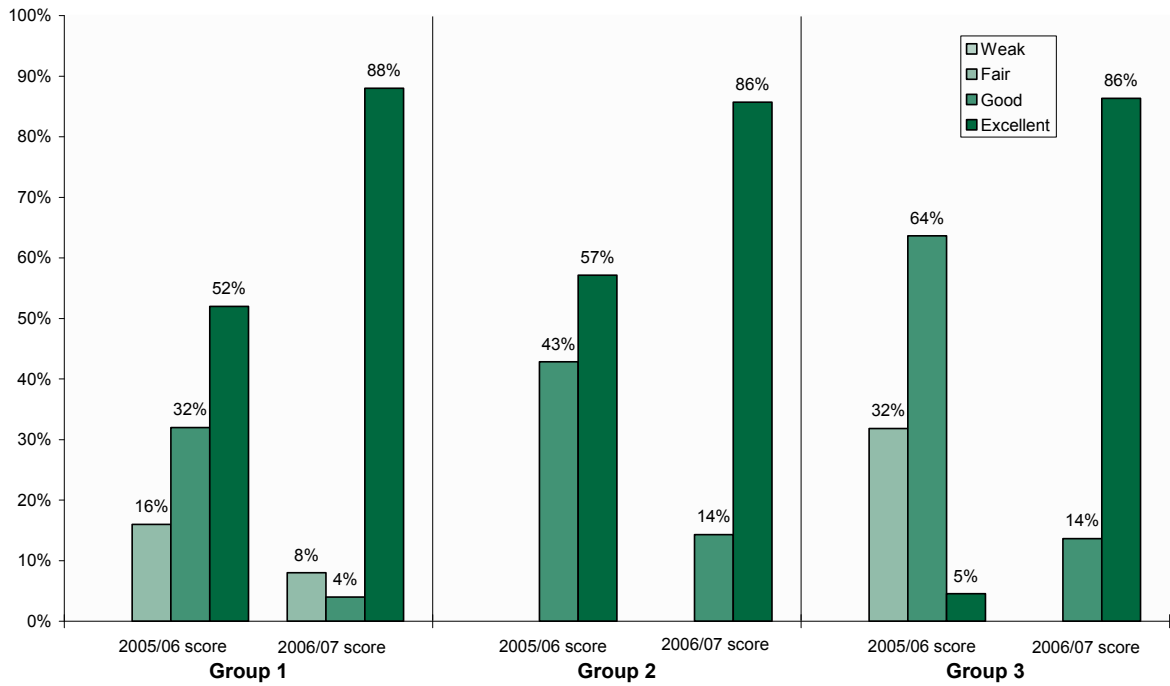
Note: Group 1 - designated as Foundation Trust in 2004; Group 2 - 2005; and Group 3 - 2006
 Source: Health Care Commission, 2007

Figure 18 – Acute Foundation trusts – Use of Resources rating by ‘group’



Note: Group 1 - Foundation Trust status achieved in 2004/05; Group 2 - 2005/06; Group 3 - 2006/07
 Source: Health Care Commission, 2007

Figure 19 – Acute Foundation trusts – Quality of Service rating by ‘group’



Note: Group 1 - Foundation Trust status achieved in 2004/05; Group 2 - 2005/06; Group 3 - 2006/07

Source: Health Care Commission, 2007

Annex E – Monitor Risk Ratings

NHS foundation trust	Governance risk rating (2007-08)				Financial risk rating (2007-08)				Mandatory goods and services risk rating Q4
	Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1	
2gether (formerly known as Gloucestershire Partnership)	●	●	●		4	4	4		●
Aintree University Hospitals	●	●	●	●	5	5	5	4	●
Barnsley Hospital	●	●	●	●	3	3	3	3	●
Basildon and Thurrock University Hospitals	●	●	●	●	4	4	4	4	●
Basingstoke and North Hampshire	●	●	●	●	5	5	4	4	●
Berkshire Healthcare	●	●	●	●	4	4	4	4	●
Birmingham Children's Hospital	●	●	●	●	4	4	3	3	●
Birmingham Women's	●				4				●
Blackpool Fylde and Wyre Hospitals	●	●			4	4			●
Bradford Teaching Hospitals	●	●	●	●	3	3	3	3	●
Calderdale and Huddersfield	●	●	●	●	4	4	4	4	●
Cambridge University Hospitals	●	●	●	●	4	5	4	5	●
Camden and Islington	●				4				●
Central and North West London	●	●	●	●	4	4	4	4	●
Chelsea and Westminster Hospital	●	●	●	●	5	5	4	4	●
Cheshire and Wirral Partnership	●	●	●		3	3	3		●
Chesterfield Royal Hospital	●	●	●	●	5	5	5	5	●
Christie Hospital	●	●	●	●	4	4	4	4	●
City Hospitals Sunderland	●	●	●	●	4	4	3	3	●
Clatterbridge Centre for Oncology	●	●	●	●	5	5	5	4	●
Countess of Chester Hospital	●	●	●	●	5	4	4	4	●
County Durham and Darlington	●	●	●	●	5	4	3	4	●
Cumbria Partnership	●	●			4	4			●
Derby Hospitals	●	●	●	●	4	4	4	3	●
Doncaster and Bassetlaw Hospitals	●	●	●	●	4	3	3	3	●
Dorset County Hospital	●	●	●	●	3	3	4	4	●
Dorset Healthcare	●	●	●	●	4	4	4	4	●
East London	●	●			4	4			●
Frimley Park Hospital	●	●	●	●	5	5	5	5	●
Gateshead Health	●	●	●	●	5	5	5	5	●
Gloucestershire Hospitals	●	●	●	●	5	5	4	3	●
Greater Manchester West Mental Health	●				4				●
Guy's and St Thomas'	●	●	●	●	5	5	5	5	●
Harrogate and District	●	●	●	●	4	4	5	5	●
Heart of England	●	●	●	●	5	5	5	5	●
Heatherwood and Wexham Park Hospitals	●	●	●	●	4	4	4	4	●
Hertfordshire Partnership	●	●	●		3	4	3		●
Homerton University Hospital	●	●	●	●	5	4	4	4	●
James Paget University Hospitals	●	●	●	●	4	4	4	4	●
King's College Hospital	●	●	●	●	4	4	3	3	●
Lancashire Care	●	●			4	4			●
Lancashire Teaching Hospitals	●	●	●	●	4	5	4	4	●
Leeds Partnerships	●	●	●		4	3	3		●
Lincolnshire Partnership	●	●			4	4			●
Liverpool Women's	●	●	●	●	5	5	4	4	●
Luton and Dunstable Hospital	●	●	●	●	4	4	4	4	●

	Governance risk rating (2007-08)				Financial risk rating (2007-08)				Mandatory goods and services risk rating Q4
	Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1	
Mid Staffordshire	●				3				●
Milton Keynes Hospital	●	●			4	4			●
Moorfields Eye Hospital	●	●	●	●	4	4	4	4	●
Norfolk and Waveney Mental Health	●				4				●
North Essex Partnership	●	●			4	4			●
North Tees and Hartlepool	●	●			4	4			●
Northern Lincolnshire and Goole Hospitals	●	●	●	●	4	4	4	4	●
Northumbria Healthcare	●	●	●	●	4	4	4	4	●
Oxleas	●	●	●	●	4	4	4	4	●
Papworth Hospital	●	●	●	●	5	5	5	4	●
Peterborough and Stamford Hospitals	●	●	●	●	5	5	4	4	●
Poole Hospital	●	●			3	3			●
Queen Victoria Hospital	●	●	●	●	5	5	5	5	●
Rotherham Doncaster and South Humber Mental Health	●	●	●		4	4	3		●
Royal Berkshire	●	●	●	●	4	4	5	5	●
Royal Devon and Exeter	●	●	●	●	4	5	5	5	●
Royal National Hospital for Rheumatic Diseases	●	●	●	●	2	3	3	3	●
Salford Royal	●	●	●	●	4	4	4	4	●
Salisbury	●	●	●	●	4	4	4	4	●
Sheffield Children's	●	●	●	●	5	5	4	4	●
Sheffield Teaching Hospitals	●	●	●	●	4	4	4	4	●
Sherwood Forest Hospitals	●	●	●	●	4	4	3	3	●
South Devon Healthcare	●	●	●	●	5	4	4	4	●
South Essex Partnership	●	●	●	●	5	5	5	5	●
South London and Maudsley	●	●	●	●	4	5	4	4	●
South Staffordshire and Shropshire Healthcare	●	●	●	●	4	4	4	3	●
South Tyneside	●	●	●	●	5	5	5	5	●
Southend University Hospital	●	●	●	●	5	5	5	5	●
Stockport	●	●	●	●	4	4	4	4	●
Tameside Hospital	●				4				●
Taunton and Somerset	●	●			4	3			●
Tavistock and Portman	●	●	●	●	3	3	2	2	●
The Newcastle Upon Tyne Hospitals	●	●	●	●	4	5	5	5	●
The Rotherham	●	●	●	●	4	4	4	3	●
The Royal Bournemouth and Christchurch Hospitals	●	●	●	●	5	5	5	4	●
The Royal Marsden	●	●	●	●	4	4	4	4	●
The Royal Orthopaedic Hospital	●	●	●	●	5	4	4	4	●
University College London Hospitals	●	●	●	●	4	4	3	2	●
University Hospital Birmingham	●	●	●	●	4	4	4	4	●
University Hospital of South Manchester	●	●	●	●	4	4	4	3	●
Wirral University Teaching Hospital	●	●	●	●	4	3	3		●
Yeovil District Hospital	●	●	●	●	4	5	5	5	●
York Hospitals	●	●	●	●	4	4	4	4	●

Formal Minutes

Wednesday 8 October 2008

Members present:

Mr Kevin Barron, in the Chair

Charlotte Atkins
Dr Doug Naysmith
Dr Howard Stoaite

Mr Robert Syms
Dr Richard Taylor

Draft Report (Foundation trusts and Monitor), proposed by the Chairman, brought up and read.

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

Paragraphs 1 to 118 read and agreed to.

Annexes and Summary agreed to.

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

Ordered, That the Chairman make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report.

[Adjourned till Thursday 16 October at 9.30 am

Witnesses

Thursday 3 July 2008

Dr Mark Exworthy, Reader in Public Management and Policy, Royal Holloway College, University of London, **John Carrier**, Chairman, Camden PCT, and **Keith Palmer**, Chairman, Barts and the London NHS Trust

Richard Gregory, Chairman, Chesterfield Royal Hospital NHS Foundation Trust, **Stephen Firn**, Chief Executive, Oxleas NHS Foundation Trust, and **Dr Bill Moyes**, Executive Chairman, Monitor

List of written evidence

- 1 Dr Pauline Allen, London School of Hygiene & Tropical Medicine
- 2 Professor Alan Maynard
- 3 Dr Mark Exworthy
- 4 Foundation Trust Network
- 5 Chesterfield Royal Hospital NHS Foundation Trust
- 6 Clatterbridge Centre for Oncology
- 7 Royal College of Nursing
- 8 Professor Maria Goddard, University of York

Reports from the Health Committee

The following reports have been produced by the Committee in this Parliament. The reference number of the Government's response to the Report is printed in brackets after the HC printing number.

Session 2007–08

First Report	National Institute for Health and Clinical Excellence	HC 27 (Cm 7331)
Second Report	Work of the Committee 2007	HC 337
Third Report	Modernising Medical Careers	HC 25 (Cm 7338)
Fourth Report	Appointment of the Chair of the Care Quality Commission	HC 545
Fifth Report	Dental Services	HC 289 (Cm 7470)

Session 2006–07

First Report	NHS Deficits	HC 73 (Cm 7028)
Second Report	Work of the Committee 2005–06	HC 297
Third Report	Patient and Public Involvement in the NHS	HC 278 (Cm 7128)
Fourth Report	Workforce Planning	HC 171 (Cm 7085)
Fifth Report	Audiology Services	HC 392 (Cm 7140)
Sixth Report	The Electronic Patient Record	HC 422 (Cm 7264)

Session 2005–06

First Report	Smoking in Public Places	HC 436 (Cm 6769)
Second Report	Changes to Primary Care Trusts	HC 646 (Cm 6760)
Third Report	NHS Charges	HC 815 (Cm 6922)
Fourth Report	Independent Sector Treatment Centres	HC 934 (Cm 6930)

The following reports have been produced by the Committee in the 2001–05 Parliament.

Session 2004–05

First Report	The Work of the Health Committee	HC 284
Second Report	The Prevention of Thromboembolism in Hospitalised Patients	HC 99 (Cm 6635)
Third Report	HIV/AIDS and Sexual Health	HC 252 (Cm 6649)
Fourth Report	The Influence of the Pharmaceutical Industry	HC 42 (Cm 6655)
Fifth Report	The Use of New Medical Technologies within the NHS	HC 398 (Cm 6656)
Sixth Report	NHS Continuing Care	HC 399 (Cm 6650)

Session 2003–04

First Report	The Work of the Health Committee	HC 95
Second Report	Elder Abuse	HC 111 (Cm 6270)
Third Report	Obesity	HC 23 (Cm 6438)
Fourth Report	Palliative Care	HC 454 (Cm 6327)
Fifth Report	GP Out-of-Hours Services	HC 697 (Cm 6352)
Sixth Report	The Provision of Allergy Services	HC 696 (Cm 6433)

Session 2002–03

First Report	The Work of the Health Committee	HC 261
Second Report	Foundation Trusts	HC 395 (Cm 5876)
Third Report	Sexual Health	HC 69 (Cm 5959)
Fourth Report	Provision of Maternity Services	HC 464 (Cm 6140)
Fifth Report	The Control of Entry Regulations and Retail Pharmacy Services in the UK	HC 571 (Cm 5896)
Sixth Report	The Victoria Climbié Inquiry Report	HC 570 (Cm 5992)
Seventh Report	Patient and Public Involvement in the NHS	HC 697 (Cm 6005)
Eight Report	Inequalities in Access to Maternity Services	HC 696 (Cm 6140)
Ninth Report	Choice in Maternity Services	HC 796 (Cm 6140)

Session 2001–02

First Report	The Role of the Private Sector in the NHS	HC 308 (Cm 5567)
Second Report	National Institute for Clinical Excellence	HC 515 (Cm 5611)
Third Report	Delayed Discharges	HC 617 (Cm 5645)