



House of Commons  
Committee of Public Accounts

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# Achievement of foundation trust status by NHS hospital trusts

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**Sixtieth Report of Session 2010–12**

*Report, together with formal minutes, oral and  
written evidence*

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## Committee of Public Accounts

The Committee of Public Accounts is appointed by the House of Commons to examine “the accounts showing the appropriation of the sums granted by Parliament to meet the public expenditure, and of such other accounts laid before Parliament as the committee may think fit” (Standing Order No 148).

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Mr Richard Bacon (*Conservative, South Norfolk*)  
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Dr Stella Creasy (*Labour/Cooperative, Walthamstow*)  
Justine Greening (*Conservative, Putney*)  
Eric Joyce (*Labour, Falkirk*)  
Rt Hon Mrs Anne McGuire (*Labour, Stirling*)

### Powers

The powers of the Committee are set out in House of Commons Standing Orders, principally in SO No 148. These are available on the internet via [www.parliament.uk](http://www.parliament.uk).

### Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the internet at [www.parliament.uk/pac](http://www.parliament.uk/pac). A list of Reports of the Committee in the present Parliament is at the back of this volume. Additional written evidence may be published on the internet only.

### Committee staff

The current staff of the Committee is Philip Aylett (Clerk), Lori Verwaerde (Senior Committee Assistant), Ian Blair and Michelle Garratty (Committee Assistants) and Alex Paterson (Media Officer).

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## Summary

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A vital component of a successful health service is that everybody wherever they live should have ready access to a high standard of care through a network of acute hospitals that are subject to strong clinical and financial governance. The Department of Health (the Department) sees self-governing foundation status as necessary if hospitals are to succeed in a financially demanding environment. Becoming a foundation trust requires strong governance, long-term financial viability, and a framework to secure delivery of quality services. NHS foundation trusts were first created in 2004 and, between then and the end of September 2011, 139 NHS trusts attained foundation status. The Government intends that the majority of the remaining 113 NHS trusts will become foundation trusts by April 2014. It is already clear that this will be extremely difficult to achieve.

The challenges facing those hospitals which have still to attain foundation status are more severe than previously thought. Four out of five now face financial difficulties; 78% say they have to tackle strategic issues; two thirds acknowledge they have performance and quality challenges and nearly 40% say they need to strengthen their governance and their leadership.

Creating a national network of hospital trusts which are autonomous and financially viable presents hugely difficult challenges. It remains unclear whether all the problems trusts have highlighted can be resolved. Making all trusts viable will involve reconfiguration of some services, including through mergers. It is critical that local communities are consulted on these decisions and benefit from them. Where changes are proposed, trusts will need to demonstrate how merging organisations will create healthcare benefits to local communities while addressing the root causes of the financial problems that exist. Many of these trusts are in deprived areas and solutions should not reduce access to services for vulnerable people, thereby exacerbating health inequalities.

We are particularly alarmed that the healthcare system in London has been allowed to deteriorate despite its problems having been known about for many years. At least half of the acute trusts in London are not viable in their current form. The Department reassured us that none of trusts' current plans involve closing hospitals, but some trusts are in such a poor financial state it is difficult to see why other organisations would want to take them on. The Chief Executive of the NHS is only "moderately confident" that London's hospital system can be turned round, and acknowledged the unique challenges and obstacles to be overcome.

Strong leadership is urgently needed if those trusts facing clinical and financial difficulties are to meet the challenge of achieving foundation status. The flow of trusts through the 'pipeline' towards foundation trust status is already behind schedule. Decisions about changes to services, need to be taken promptly but wisely, and some trusts are still putting off difficult decisions. A particular problem is the quality of leadership, but prolonged uncertainty makes it harder to recruit good board members and clinical staff. The Department has made an explicit commitment to intervene if trusts fail to tackle problems on their own.

The cost of private finance schemes is an additional challenge for a limited number of hospitals. Analysis commissioned by the Department has identified six trusts that are unviable largely because of their PFI charges. Long term Private Finance Initiatives (PFI) deals reduce the Department's ability to establish a level playing field of financially sustainable, autonomous trusts. In many cases efficiency savings alone will not be enough to make unviable trusts financially sustainable. The Department faces a particular dilemma about how to manage the debt of these hospitals as their long term financial commitments make reconfiguration more difficult.

On the basis of a report by the Comptroller and Auditor General,<sup>1</sup> we took evidence from the Department of Health and the Chief Executive of the NHS, and from the Chief Executives of Ealing Hospital NHS Trust, North Middlesex University Hospital NHS Trust, and Winchester and Eastleigh Healthcare NHS Trust, about the responsibility for dealing with this huge challenge, and what is being done to protect taxpayers and patients when trusts need external help.

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1 C&AG's report, *Achievement of foundation trust status by NHS hospital trusts*, HC (2010-12) 1516.

## Conclusions and recommendations

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1. **Twenty hospital trusts have declared themselves unviable in their current form.** In many cases, this is a consequence of a failure to face up to and resolve problems that have been evident for over a decade. Moreover, half of all trusts are not yet foundation trusts and more are likely to conclude they are unviable. A particular concern is what will happen to trusts that are unable to achieve foundation status but nevertheless provide an essential service to local people. In most of these cases, mergers and reconfigurations will be inevitable. The Department should require each trust in difficulty to provide the local community with a clear explanation of the problems it faces and what the proposed changes will mean for patients. Trusts must consult staff and the local community on how they intend to resolve these issues.
2. **Failure of trusts to meet the commitments in their TFAs is likely to damage their financial and clinical viability and make the achievement of foundation status more difficult.** Should a trust fail to carry out the actions agreed with the Department and SHAs they may be forced to shed services or to undertake mergers. Where such action is taken by necessity rather than design it seems inevitable that patients will suffer. Sir David Nicholson made a promise that SHAs and the Department would intervene if trusts failed to deliver the commitments made in their TFAs. We expect the Department to honour this promise, and to carefully monitor progress so that it can take timely and robust action to address risks to the provision of important services. The Department should report back to us by the end of 2012 on the progress of all trusts still in the pipeline and what further action it is taking to help those trusts which continue to be unviable.
3. **The situation in many parts of London is unacceptable and long-standing problems need to be tackled urgently.** At least half of non-specialist acute hospitals in London are not viable in their current form, with some heavily indebted trusts providing poor services. We remain to be convinced that combining struggling hospitals into larger trusts - as with South London - is a realistic way to create viable organisations which provide equal access to good quality healthcare to everybody. The Department and NHS London are aware of the difficulties facing London's healthcare system, but they cannot just leave this problem to individual trusts, and they need to develop a clear strategy and appropriate support for the creation of a sustainable, safe and efficiently delivered health system, and communicate it clearly to Londoners.
4. **Reconfiguration of local services could disproportionately affect vulnerable patients, particularly those who rely on public transport.** Reconfiguration will inevitably reduce the range of services provided by some hospitals. The Department will have to support otherwise unviable services in some parts of the country so that all local people have access to the healthcare they have a right to expect. In considering how to reconfigure services the Department and the SHAs should assess carefully the impact on the local population. They should ensure they protect the interests of vulnerable people for whom travelling to hospital is difficult, so that health inequalities are not exacerbated.

5. **PFI is an additional challenge facing a few hospitals and PFI service charges are contributing significantly to some trusts' financial problems.** Analysis commissioned by the Department has identified six trusts where their PFI contract is a major obstacle to them becoming financially viable. The Department recognises that those financial commitments need to be met, but has not yet explained how it will support these trusts without disadvantaging others. The Department will need to ensure the long term sustainability of these hospitals whilst at the same time minimising any extra financial support it offers.
6. **Nearly 40 % of trusts struggling to attain foundation trust status have identified leadership and governance as a key problem.** Strong leadership is vital for achieving foundation trust status.. The Department should report back to the Committee, by the end of April 2012 on:
  - what practical steps have been taken by successful foundation trusts to engage higher calibre non executives, and to put in place more robust accountability frameworks;
  - what action the 40 % of NHS trusts with acknowledged weaknesses have taken to address the leadership and governance problems they are facing; and
  - what impact the new toolkit has had in helping those trusts struggling to attain foundation status.

# 1 The problems trusts are facing in achieving foundation trust status

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1. Since the first NHS foundation trusts were created in 2004 it has been government policy that NHS hospitals should be more independent, running their own affairs and being accountable to local people and patients.<sup>2</sup> To achieve foundation status, trusts must be able to show they are financially and clinically sustainable over the next few years, and that their board and management have the skills to govern the trust as an autonomous body.<sup>3</sup> The Department of Health (the Department) believes that trusts need to attain foundation status to succeed in a highly constrained financial environment where past increases will not be continued.

2. By 1 October 2011 there were 139 NHS foundation trusts, and 113 NHS trusts at various stages in the 'pipeline' towards foundation trust status. Only 14 trusts have achieved foundation status since the end of 2009.<sup>4</sup> The Department expects the majority of trusts to achieve foundation trust status by 2014, but recognises that a small number may not do so before 2016.<sup>5</sup>

3. The development of the 'tripartite formal agreements' (TFAs) signed by trusts, Strategic Health Authorities (SHAs) and the Department has highlighted the extent of problems that some trusts face in achieving foundation trust status. These challenges are far more severe than trusts' and SHAs' initial assessment had suggested.<sup>6</sup> The proportion of trusts which stated that financial difficulties could be an obstacle to achieving foundation status, for example, has increased from 49% in 2010 to 80% in 2011. In addition, 78% of trusts need to tackle strategic issues, 65% have quality and performance issues; and 39% need to strengthen their governance and leadership.<sup>7</sup>

4. Twenty trusts have already identified themselves as not viable in their current form.<sup>8</sup> This number does not include some trusts, such as the South London Healthcare NHS Trust, already known to be facing serious difficulties, and others whose Private Finance Initiative (PFI) schemes have been identified by the Department's consultants as unaffordable.<sup>9</sup> The Department accepts that more trusts will need to be added to the list, but does not believe that the total number will grow because, as some trusts join, others will become viable following merger or acquisition.<sup>10</sup>

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2 C&AG's Report, Para 1

3 Q 100

4 C&AG's Report, Para 2

5 Qq 92-93

6 Qq 96-97

7 Q 96, C&AG's Report, Para 2.4 and Figure 7.

8 C&AG's Report, Para 9

9 Qq 94-95; 121-123

10 Qq 94 -95; Q 119

5. All NHS trusts have now agreed with their SHA and the Department the actions they need to take to achieve foundation status. Not all trusts have so far published their TFA documents or are prepared to release them when asked to do so. The Department maintained that TFAs are locally owned and that, as soon as they have been approved by trusts' boards, they will be published by each trust so that communities can see what has been agreed.<sup>11</sup> It is essential that local people should be involved in decisions about what services are available, and that trusts should gain the support of communities for the changes they are proposing.<sup>12</sup>

6. The Department told us that responsibility for achieving foundation status, which will depend on implementing the commitments set out in the TFAs, rests with the trust's own board. The SHA in its oversight role, and the Department in turn, nonetheless retain a responsibility to ensure that adequate support is in place to enable trusts to achieve foundation trust status.<sup>13</sup> The Department confirmed that it would not let trusts pursue strategies that were not viable, and would intervene to ensure that trusts reach foundation status, either in their own right or as part of a larger organisation. The range of actions included self-assessment tools to help trusts develop board capability, bringing new expertise into the organisation, drawing in clinicians and clinical leaders from other organisations and, if necessary, replacing the trust's leadership team.<sup>14</sup>

7. The quality of leadership at board level, and particularly the ability of non executive board members to hold the executive to account, is crucial to the trust's success.<sup>15</sup> The independent regulator, Monitor, has identified the lack of quality on boards as being a major impediment to applicants for foundation trust status, and 39% of trusts in the pipeline identified board capacity and capability as an obstacle they need to overcome.<sup>16</sup> Witnesses from three trusts also emphasised to us the importance of boards in providing clear leadership in difficult times, and in ensuring that patients and clinicians understand and support future plans.<sup>17</sup> The Department told us that from January all trusts would be expected to go through a process of board support and development which the Department was piloting.<sup>18</sup>

8. It is not clear why an organisation would want to merge with, or take over some of the most troubled trusts, some of which are very large and are facing severe financial problems, including debt as well as poor performance.<sup>19</sup> It is not a convincing solution that combining trusts which are already challenged or unviable will somehow create a more sustainable successor, without some form of further intervention.<sup>20</sup> Ultimately, the Secretary of State retains responsibility for ensuring the sustainability of healthcare services

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11 Qq 56-57; 177-178; Ev 22

12 Qq 68-70

13 Qq 98; 104

14 Qq 109-112; 114-115

15 Qq 72; 85; 184

16 Q 183, C&AG's report Para 2.23

17 Qq 43; 68-70, 72, 176, 213

18 Q183; C&AG's report, paras 2.25-2.26

19 Q 209

20 Qq 206, 210

provided to local communities, but the Department has not yet developed a failure regime to deal with trusts that prove unable to resolve their problems.<sup>21</sup>

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21 Qq 113; 190; C&AG's report, para 3.14

## 2 Protecting taxpayers and patients

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9. Where trusts merge they may not be able to continue to provide all their current services.<sup>22</sup> The Department argued that reorganising specialist services in particular can lead to much better provision and, for these, people may be prepared to travel further to access better care.<sup>23</sup> However, most services must always be accessible locally and, for people who are dependent on public transport, decisions about where services are provided are critical to whether they are able to access them. For example, some patients may be put off going to their hospital appointments if they are too far away and using public transport is expensive or difficult.<sup>24</sup> Inequality of access can only help to worsen the inequalities in health that currently exist.

10. Nearly half of acute trusts in the pipeline have concerns about their current financial position and nearly three quarters are concerned that they will not be able to achieve the level of efficiencies required of them.<sup>25</sup> Financial issues where trusts may need support from the Department fall into three categories: repayment of loans received from the Department; lack of cash to pay creditors or run day-to-day operations; and charges associated with PFI-financed capital schemes.<sup>26</sup> The current estimate of the amount of additional working capital that trusts might need is £376m, although the Department conceded that the eventual figure could be higher.<sup>27</sup>

11. The Private Finance Initiative (PFI) provided much needed replacement of antiquated hospital buildings and facilities<sup>28</sup> but the ongoing long-term cost to trusts, however, has been as high as 20% of income in some cases.<sup>29</sup> The Department's examination of twenty-two trusts with PFI debts has identified around six where, in addition to other financial difficulties, obligations under their PFI contract are a major obstacle to them becoming financially viable.<sup>30</sup> The Department and witnesses from NHS trusts told us that one reason for the problem was that, at the time PFI deals were signed, trusts had anticipated continued growth.<sup>31</sup> Long term PFI commitments can make reconfigurations more difficult, and the Department may have to offer support once other opportunities for efficiencies have been explored.<sup>32</sup>

12. There are wide regional variations in the proportion of hospitals which have become foundation trusts. By October 2011 all but one trust in the North East had achieved

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22 Qq 21

23 Qq 65, 177

24 Qq 27; 65; 174-177

25 C&AG's report, para 2.8 and Figure 8

26 Q 141

27 Qq 127-128; 130-131

28 Qq 135-7

29 C&AG's report, para 2.14

30 Qq 105-6, 121, 138-9

31 Qq 30; 105, 124-126

32 Qq 53; 106

foundation trust status, while in London 62% of trusts were not foundation trusts.<sup>33</sup> At least half of non-specialist acute hospitals in the capital cannot achieve foundation trust status in their current form.<sup>34</sup> The Chief Executive of the NHS explained that part of the problem in London was a relatively unproductive secondary care system, and an underdeveloped community system, which means that far more people go to hospital for relatively minor healthcare needs than in other parts of the country.<sup>35</sup> The Department gave assurances that planned solutions for London do not involve closing hospitals and would improve clinical services, but were not wholly confident that trusts would deliver on their plans.<sup>36</sup>

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33 C&AG's report, para 1.20

34 C&AG's report para 3.10

35 Q204

36 Qq 204-211

# Formal Minutes

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**Wednesday 7 December 2011**

Rt Hon Margaret Hodge, in the Chair

Mr Richard Bacon  
Stephen Barclay  
Matthew Hancock  
Chris Heaton-Harris  
Meg Hiller

Jo Johnson  
Austin Mitchell  
Nick Smith  
Ian Swales

Draft Report (*Achievement of foundation trust status by NHS hospital trusts*) proposed by the Chair, brought up and read.

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

Paragraphs 1 to 12 read and agreed to.

Conclusions and recommendations 1 to 6 read and agreed to.

Summary read and agreed to.

*Resolved*, That the Report be the Sixtieth Report of the Committee to the House.

*Ordered*, That the Chair 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 placing in the Library and Parliamentary Archives.

[Adjourned till Monday 12 December at 3.00pm]

## Witnesses

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### Wednesday 19 October 2011

Page

**Dr Chris Gordon**, Chief Executive, Winchester and Eastleigh Healthcare NHS Trust, **Julie Lowe**, Chief Executive, Ealing Hospital NHS Trust, and **Clare Panniker**, Chief Executive, North Middlesex University Hospital NHS Trust

Ev 1

**Sir David Nicholson KCB CBE**, Chief Executive of the NHS, and **Ian Dalton**, Managing Director of provider Development, Department of Health

Ev 8

## List of printed written evidence

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1 Chief Executive of the NHS

Ev 22

## List of Reports from the Committee during the current Parliament

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The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

### Session 2010–12

First Report	Support to incapacity benefits claimants through Pathways to Work	HC 404
Second Report	Delivering Multi-Role Tanker Aircraft Capability	HC 425
Third Report	Tackling inequalities in life expectancy in areas with the worst health and deprivation	HC 470
Fourth Report	Progress with VFM savings and lessons for cost reduction programmes	HC 440
Fifth Report	Increasing Passenger Rail Capacity	HC 471
Sixth Report	Cafcass's response to increased demand for its services	HC 439
Seventh Report	Funding the development of renewable energy technologies	HC 538
Eighth Report	Customer First Programme: Delivery of Student Finance	HC 424
Ninth Report	Financing PFI projects in the credit crisis and the Treasury's response	HC 553
Tenth Report	Managing the defence budget and estate	HC 503
Eleventh Report	Community Care Grant	HC 573
Twelfth Report	Central government's use of consultants and interims	HC 610
Thirteenth Report	Department for International Development's bilateral support to primary education	HC 594
Fourteenth Report	PFI in Housing and Hospitals	HC 631
Fifteenth Report	Educating the next generation of scientists	HC 632
Sixteenth Report	Ministry of Justice Financial Management	HC 574
Seventeenth Report	The Academies Programme	HC 552
Eighteenth Report	HM Revenue and Customs' 2009-10 Accounts	HC 502
Nineteenth Report	M25 Private Finance Contract	HC 651
Twentieth Report	Ofcom: the effectiveness of converged regulation	HC 688
Twenty-First Report	The youth justice system in England and Wales: reducing offending by young people	HC 721
Twenty-second Report	Excess Votes 2009-10	HC 801
Twenty-third Report	The Major Projects Report 2010	HC 687

Twenty-fourth Report	Delivering the Cancer Reform Strategy	HC 667
Twenty-fifth Report	Reducing errors in the benefit system	HC 668
Twenty-sixth Report	Management of NHS hospital productivity	HC 741
Twenty-seventh Report	HM Revenue and Customs: Managing civil tax investigations	HC 765
Twenty-eighth Report	Accountability for Public Money	HC 740
Twenty-ninth Report	The BBC's management of its Digital Media Initiative	HC 808
Thirtieth Report	Management of the Typhoon project	HC 860
Thirty-first Report	HM Treasury: The Asset Protection Scheme	HC 785
Thirty-second Report	Maintaining financial stability of UK banks: update on the support schemes	HC 973
Thirty-third Report	National Health Service Landscape Review	HC 764
Thirty-fourth Report	Immigration: the Points Based System – Work Routes	HC 913
Thirty-fifth Report	The procurement of consumables by National Health Service acute and Foundation Trusts	HC 875
Thirty-seventh Report	Departmental Business Planning	HC 650
Thirty-eighth Report	The impact of the 2007-08 changes to public service pensions	HC 833
Thirty-ninth Report	Department for Transport: The InterCity East Coast Passenger Rail Franchise	HC 1035
Fortieth Report	Information and Communications Technology in government	HC 1050
Forty-first Report	Office of Rail Regulation: Regulating Network Rail's efficiency	HC 1036
Forty-second Report	Getting value for money from the education of 16- to 18-year olds	HC 1116
Forty-third Report	The use of information to manage the defence logistics supply chain	HC 1202
Forty-fourth Report	Lessons from PFI and other projects	HC 1201
Forty-fifth Report	The National Programme for IT in the NHS: an update on the delivery of detailed care records	HC 1070
Forty-sixth report	Transforming NHS ambulance services	HC 1353
Forty-seventh Report	Reducing costs in the Department for Work and pensions	HC 1351
Forty-eighth Report	Spending reduction in the Foreign and Commonwealth Office	HC 1284
Forty-ninth Report	The Efficiency and Reform Group's role in improving public sector value for money	HC 1352
Fiftieth Report	The failure of the FiReControl project	HC 1397

Fifty-first Report	Independent Parliamentary Standards Authority	HC 1426
Fifty-second Report	DfID Financial Management	HC 1398
Fifty-third Report	Managing high value capital equipment	HC 1469
Fifty-fourth Report	Protecting Consumers – The system for enforcing consumer law	HC 1468
Fifty-fifth Report	Formula funding of local public services	HC 1502
Fifty-sixth Report	Providing the UK's Carrier Strike Capability	HC 1427
Fifty-seventh Report	Oversight of user choice and provider competition in care markets	HC 1530
Fifty-ninth Report	The cost-effective delivery of an armoured vehicle capability	HC 1444
Sixtieth Report	Achievement of foundation trust status by NHS hospital trusts	HC 1566

# Oral evidence

## Taken before the Committee of Public Accounts on Wednesday 19 October 2011

Members present:

Margaret Hodge (Chair)

Mr Richard Bacon  
Jackie Doyle-Price  
Joseph Johnson  
Mrs Anne McGuire

Austin Mitchell  
Ian Swales  
James Wharton

**Mark Davies**, Director of Health Value for Money Audit, NAO, **Marius Gallaher**, HM Treasury, Alternate Treasury Officer of Accounts, and **Amyas Morse**, Comptroller and Auditor General, were in attendance.

### REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

#### Achievement of Foundation Trust Status by NHS Providers of Secondary Care

##### Examination of Witnesses

*Witnesses:* **Dr Chris Gordon**, Chief Executive, Winchester and Eastleigh Healthcare NHS Trust, **Julie Lowe**, Chief Executive, Ealing Hospital NHS Trust, **Clare Panniker**, Chief Executive, North Middlesex University Hospital NHS Trust, gave evidence.

**Q1 Chair:** Our paperwork is not in the best of order this afternoon. Although I know who you are, usually we have a biography of each of you before we proceed with the questions. I wonder whether you would start, Julie Lowe, by telling us who you are and what your job is so that people have an awareness.

**Julie Lowe:** My name is Julie Lowe, and I am chief executive of Ealing Hospital NHS Trust, which also incorporates the community services of the boroughs of Brent, Harrow and Ealing.

**Dr Gordon:** I am Dr Chris Gordon, and I am acting chief executive of Winchester and Eastleigh NHS Trust.

**Clare Panniker:** I am Clare Panniker, and I am chief executive of North Middlesex University Hospital.

**Ian Swales:** Can I be clear whether these witnesses are from foundation trusts?

**Q2 Chair:** No, they are all in the group of 20 that have declared that they cannot be, in their current form—I chose them for that reason—but they are all doing slightly different things. I chose them because they are in the self-declared group of 20, but it is self-declared not assessed. This part of the afternoon will be a shortish part and we want to get as much information as we can out of you, but equally if you can be direct and succinct in your answers that would help the Committee enormously in our work. Can I ask, first of all, were you all briefed by the Department of Health before you came to us this afternoon?

**All witnesses:** Yes.

**Q3 Chair:** Why was that?

**Dr Gordon:** Why was there a briefing? I think to understand the functions of the Committee.

**Q4 Chair:** Or was it to ensure that you all spoke with one voice?

**Dr Gordon:** I can only speak with my own voice—

**Mr Bacon:** You can try to speak in everyone's voices; it might be quite interesting.

**Clare Panniker:** It was clear that we must give our own opinion, but that we should understand what the Committee is about.

**Q5 Chair:** Okay, but it was not in the context of sticking to Department of Health or Government policy.

**All witnesses:** No.

**Q6 Chair:** You have some independence from that. Yes? Good. You are all doing rather different things, so the reason I chose to have evidence from the three of you is that you are all in the group of 20 that have declared that they do not think they can achieve foundation trust status, but you are approaching it in very different ways. Can you briefly, starting with Julie Lowe, tell us how you are approaching it?

**Austin Mitchell:** Chair, why are they self-relegated? What is the problem in each case?

**Chair:** We can ask that. Let us find out who they are.

**Austin Mitchell:** We need to start with that.

**Chair:** I was going to give them the opportunity to speak, because they are all going in slightly different directions, and then you can come in on that. Just let them explain who they are.

**Julie Lowe:** It will probably come out when we explain where we are. Ealing hospital, as some of you may know, is a small district general hospital in west London. It was built about 30 years ago and serves a population of some 300,000, but a lot of that population look to our neighbours because it is quite a crowded pitch in north-west London. There are lots of hospitals.

19 October 2011 NHS Trust

As health care moves forward and becomes increasingly sub-specialised, and as we move into a world in which more care is delivered directly by consultants and very senior staff, rather than by junior doctors, we are struggling cost-effectively to provide such cover and such a level of specialism 24/7. We originally applied to be a foundation trust, but in discussion with our neighbours and NHS London—

**Q7 Chair:** You failed.

**Julie Lowe:** No, we didn't fail. We applied to be a foundation trust. We discussed what the long-term future, beyond four or five years, would look like, and we felt that on our own we would not be able to provide a high level, modern standard of health care as health care becomes increasingly sub-specialised, so we decided that we needed to do something different. The first thing we did that was different was to take on the management of the three community wings of the three boroughs, as I explained, because we believe that the future of health care is increasingly in providing care closer to people's homes and in community settings.

**Q8 Chair:** You are going to stop being a hospital—I am hurrying you up—that is my understanding.

**Julie Lowe:** Okay, so we have got the community services. We need, then, to look at what we do around our acute services, especially—

**Q9 Chair:** You are going to stop being a hospital.

**Julie Lowe:** No, we're not; we are going to work with North West London Hospitals to see whether a merger between us is viable so that we can continue to provide hospital services where appropriate for us to do so.

**Q10 Chair:** But the reason I have chosen you is that my understanding is that you are going to stop being a hospital and you are going to focus on community-based health services.

**Julie Lowe:** It would be wrong for us to stop being a hospital, because there is still a need for hospital-based services.

**Q11 Chair:** What are you going to provide that I and we would understand as a hospital?

**Julie Lowe:** We are working through what that will look like at the moment.

**Q12 Chair:** Give us some idea. What sort of things? If I were a resident in your area, in Ealing, what would I use you, as a hospital, for?

**Julie Lowe:** We are keen that there is a front door that—

**Q13 Chair:** Will you deliver babies?

**Julie Lowe:** At the moment, we deliver 3,000 babies a year—

**Q14 Chair:** What will you do?

**Julie Lowe:**—and we need to work through whether it is appropriate for us to continue to deliver babies in the long term.

**Q15 Chair:** Will you deliver babies? It sounds to me as though you won't.

**Julie Lowe:** We don't know that yet. We cannot categorically say whether we will or won't.

**Q16 Chair:** I understand that you are going to cease hospital services, and that is why you are here. Actually, you have taken a decision, more or less, just to do community-based services.

**Julie Lowe:** No. That is not the decision we have reached, because if it were, we would stop, at the point we are at, running three boroughs of community services and a hospital—

**Q17 Chair:** Are you going to have an A and E there?

**Julie Lowe:** We have an A and E at the moment, and North West London has two A and E departments. We are committed to providing 24/7 access to services on the site.

**Q18 Chair:** But what? As a walk-in centre, not as an A and E.

**Julie Lowe:** No, we have an A and E department that provides a full range of services.

**Q19 Chair:** I hope you are being honest with us—

**Julie Lowe:** I am being honest with you.

**Q20 Chair:**—because that was not my understanding of where you were at.

**Julie Lowe:** I am sorry about that, but we do have a 24/7 A and E department that provides a full range of services.

**Q21 Ian Swales:** But what will you have? That is the question the Chair is asking. It is not about what you have now; it is about what you will have.

**Julie Lowe:** Yes, and as I have said, I do not know that yet, because we have entered the next phase of our discussions, which are with North West London Hospitals, about whether, by coming together, we can provide a viable range of clinical services. The local population, particularly in Ealing, is a big user of hospital services and always has been, so we are keen to make sure that there is accessibility in that locality for them, because it would be difficult for them to travel to any of the immediate neighbours for the full range of services. What we cannot do is continue to provide everything. For example, we closed our stroke unit, because we were not—

**Q22 Chair:** I think this is getting too long; we have lots to get over.

**Dr Gordon:** Winchester and Eastleigh Trust, after a long period of consideration and a number of discussions with the SHA around achieving foundation trust status, has recognised that we were unable to get there on the ability to generate a five-year plan that produced a long-term recurrent surplus. So there was an ongoing financial issue.

Plus, because of the size of our organization, we need to start getting together with other organisations on a more consolidated basis so that we can account for future clinical development, sub-specialisations,

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junior doctors' rotas and various other things that we think will make it more difficult for hospitals of our size to provide a service in future. With the SHA and the PCT supporting us, we went to develop a clinical strategy, to look at our options, and to choose the sort of partners that we wanted. We have chosen Basingstoke and North Hampshire Foundation Trust as our future partner, and we are going to become a foundation trust by acquisition.

**Q23 Chair:** Okay. I understand that you are the most advanced in that development.

**Dr Gordon:** That is correct.

**Q24 Chair:** Does that mean that we will end up with three A and Es and three maternity units, or are you going to reduce that?

**Dr Gordon:** There will be two emergency departments and two maternity units.

**Q25 Chair:** From three to two.

**Dr Gordon:** No, there are only two at the moment. We have two district hospitals and a community hospital.

**Q26 Chair:** Why does the merger make you viable?

**Dr Gordon:** The merger makes us viable for a number of reasons. There are financial efficiencies from absorbing back-office costs from two organisations into one, which is really important, and estate rationalisations. We will be able to get procurement functions and greater critical mass; there is a simple financial efficiency. There are clinical efficiencies, because instead of there being seven radiologists on one site and six on the other, we now have 13 radiologists with which to provide a 24/7 sub-specialised rota. That goes through all the specialities. We are on two distinctive sites, so it is not quite as easy as it might seem, but we are also at increased clinical viability. We now subtend a population of around 500,000 to 600,000, which allows us to develop those ranges of services.

**Q27 Chair:** Even on two sites.

**Dr Gordon:** Even on the two sites, but with 250,000 each we would not be able to do that. Because of the geographies of our two sites, it will be important for us to continue to provide a wide range of acute services on both sites. That has been said by the acquiring foundation trust and by the current commissioners, NHS Hampshire.

**Q28 Chair:** Okay. Clare Panniker. Again, the reason I thought it would be interesting to hear from you is that you are talking to another hospital that the Secretary of State announced will no longer deliver either A and E or maternity services—Chase Farm.

**Clare Panniker:** That is right.

**Q29 Chair:** You are merging with a failing hospital, whereas Chris Gordon is merging with a working foundation trust?

**Clare Panniker:** Well, there are two distinct parts to this. One is the clinical strategy that was agreed and consulted upon publicly in 2007, which saw the reduction of service at Chase Farm, turning the A and

E into an urgent care centre and removing the consultant-led maternity services from there. That was agreed back in 2007 and significant amounts of that activity, because of the way the geography works, would flow into North Middlesex hospital. We have had some delays in implementing that strategy but, as the chair said, the Secretary of State in September agreed that we could go ahead. As a separate part of that decision, he also asked us to look at the feasibility of North Middlesex taking management responsibility for the Chase Farm site—that is, separating it from Barnet and coming under the wing of North Middlesex. That piece of work is currently under way and we will report back to the Secretary of State on 16 December.

**Q30 Chair:** Are you driven by the fact that you have a PFI, so to fund the PFI and North Middlesex you have had to merge with Chase Farm and close the services there?

**Clare Panniker:** At the time we agreed the contract for the PFI in 2007 we anticipated small amounts of growth. The economic climate and the care close to home—

**Q31 Chair:** Is it true? Is that driving the decision?

**Clare Panniker:** Decisions were made to invest in the North Middlesex site knowing that the Chase Farm site would downgrade, so the North Middlesex, with the current economic climate, needs that additional activity.

**Q32 Chair:** But to be fair, both the previous Secretary of State and this Secretary of State promised that they would not close Chase Farm.

**Clare Panniker:** Well, that is not my decision.

**Q33 Chair:** So you mean the decision was taken to put a PFI in—

**Clare Panniker:** In 2007.

**Q34 Chair:**—on the basis that you closed some services at Chase Farm. I know that you said that it will still be there, but it won't be in five years. But let us take that as given. Then both political parties—the previous Government and this Government—agreed to keep Chase Farm, knowing that the investment in North Middlesex was predicated on the closure of Chase Farm.

**Clare Panniker:** No. The decision to invest in the PFI in 2007 was made independently. There was no inference that Chase Farm needed to close to fund the PFI. But things have moved on since then and the care closer to home agenda has moved on. The economic climate has moved on. The overprovision of hospital services is a key factor in north London.

**Q35 Chair:** It is not the overprovision of services. What you have is the financial pressure emerging from a £137 million PFI.

**Clare Panniker:** There is a PFI on the site. That was a decision that was made some years ago. It provides state of the art health care provision. Neither Chase Farm nor the North Middlesex had sites that were fit

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for the future. They were both serving the population in crumbling buildings.

**Q36 Chair:** What is going to be different with two failing trusts to make them, when merged, a successful foundation trust?

**Clare Panniker:** Well, I would challenge the label “failing”. North Middlesex has delivered surpluses for the last five years and has continued to improve clinical quality, so I don’t regard North Middlesex as a failing organisation. There may be some merit in creating a hospital for Enfield people that is situated at North Middlesex and at Chase Farm that works closely with the Enfield commissioning group and with the Enfield local authority. There may be merit in that and that is what we are testing at the moment.

**Q37 Chair:** Okay. I just have to say that looking at the NHS’s own publication under the quality of services your performance is “under review”. Under maternity services, late 2010 showed that “trust rated worse than other trusts in nearly all categories.” In March, “trust was warned that its neonatal unit was dangerously understaffed” and under user experience, you are “underperforming”. It was reported in September that more than half of the patients seen at North Middlesex university hospital trust in June had waited more than 18 weeks for treatment.

**Clare Panniker:** In September, that position on waiting times fully recovered.

**Q38 Chair:** But that is not a very good record from the stuff that I have read out.

**Clare Panniker:** The issues that you identified are all related to patient experience. We know that we have some challenges in ensuring that we score well on patient surveys for our very ethnically diverse and mixed population. That is an agenda that the trust board is prioritising and taking very seriously.

**Q39 Chair:** It is not patient experience; it is quality issues.

**Clare Panniker:** Most of the drivers around that were related to patient experience.

**Q40 Chair:** What you are there for is to offer a service to patients. Whether it is maternity services, neonatal or seeing people within 18 weeks of treatment, you are not doing very well. That is a fact. You can call it patient experience, but you are there for patients to experience a good service.

**Q41 Austin Mitchell:** You are all in a state of uncertainty—Dr Gordon least of all—but in this state of uncertainty, while the future aims are decided, what is the effect on recruitment and staff morale? It must be disastrous to be in a hospital that has declared itself failing and which is going to merge or lose services. What is the effect?

**Julie Lowe:** Again, it is important to differentiate the words “failing” and “unviable in its current form”. All three of us have said that our current form is not the right form to take our services forward for the future. In the case of Ealing, one of the main drivers for us to explore a merger with North West London Hospitals is

the fact that our clinical staff have told us that they would feel happier in a bigger department in many cases where there is sufficient expertise to specialise.

**Q42 Austin Mitchell:** Yes, but if the staff want to get out, you must find it difficult to attract new staff.

**Julie Lowe:** Staff that are with us already are very keen to work with us to develop the opportunity to work in what will be a very big local organisation caring for our local population. Recruiting staff is always difficult when there is any uncertainty. One of the things that we are keen to do is to get through this—not as quickly as possible, but with due process—in good time so that we are not prolonging the period of time when there is uncertainty. You are correct in terms of recruiting new staff; it can be very difficult, particularly to attract senior staff, at a time of uncertainty.

**Q43 Austin Mitchell:** If I were employed there, I should be rushing to leave the sinking ship. Dr Gordon, what is your advice?

**Dr Gordon:** I think you would be making a mistake, Mr Mitchell. People are very loyal to their organisation. They hate uncertainty; they want to know what is going on. Once they know, they can start working to that model. As soon as my people understand that they are going to be working for a new foundation trust with a new geographical area and a new clinical model, they start working in their own heads to understand how that will work for them and for the patients they currently serve, so naturally our clinicians will look for opportunities.

We have concentrated really hard on looking at the opportunities that will come out of this, of which there are many, and people can see those opportunities. We have had fantastic support from our staff looking to the future. It has been a very brave thing that people have done—to be able to look above the parapet to see what the future is for a stand-alone organisation over the next five years and go for something that feels initially at risk, but actually will turn out to be something much better.

**Q44 Austin Mitchell:** Clare Panniker, any panickers on your staff?

**Clare Panniker:** Very good. No, they are not panicking at all because they see that the North Middlesex is a fixed point in terms of providing acute services to a very needy local population.

**Q45 Ian Swales:** I want to return to the PFI question. Have you all got PFI hospitals?

**Clare Panniker:** Yes.

**Dr Gordon:** No

**Julie Lowe:** No

**Q46 Ian Swales:** One of you has. In your area, you are self-declared as not being viable in your current form. What proportion of your income goes in servicing the PFI debt?

**Clare Panniker:** Eight per cent.

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**Q47 Ian Swales:** Okay. To what extent are your services tied into the PFI contract?

**Clare Panniker:** Only the hard estate management is tied into the PFI contract. We have separate contracts for all the other facilities management, such as cleaning and catering.

**Q48 Ian Swales:** You only have management of what—maintenance of the building?

**Clare Panniker:** Just maintenance of the building.

**Q49 Ian Swales:** On the estate. You do not have expensive contracts for other services?

**Clare Panniker:** No, we have separate contracts for the other services.

**Ian Swales:** Okay. That is shorter than I expected. Thank you.

**Q50 Joseph Johnson:** I want to ask each of the chief executives what their understanding of the failure regime is. If you do not make it by 2014 to foundation trust status, Ms Lowe, what will happen to you?

**Julie Lowe:** If we try to stay alone and we don't make it, we would get into a situation where we needed to be acquired by an NHS organisation that had achieved foundation trust status. We are trying to get into a merger and then through an FT process so that we are able to achieve FT in a new organisational form. That would be our preference.

**Q51 Joseph Johnson:** In other words, a shotgun marriage with any institution that will take you, come 2014.

**Julie Lowe:** That is one potential solution. The other thing that could happen us to locally is that we lose more and more services off the site.

**Q52 Joseph Johnson:** So you die on the vine. Dr Gordon?

**Dr Gordon:** As an organisation, we looked at the consequences of not moving a couple of years ago, and none of them looked particularly attractive. A gradual, progressive loss of services, worsening and worsening financial instability, with clinical crises that would follow—that is what has led us to this decision. We are not going to be seeing a failure regime, because very early in the new year we will be part of a foundation trust.

**Clare Panniker:** Our TFA process takes us through the various steps that we need to go through to determine the best future for us. We do not have one fixed point. We are exploring the “Enfield hospitals” possibility, and if that is not feasible, there are other options that we will look at—a range of other partners.

**Q53 Joseph Johnson:** Ultimately, if your plan does not work, you will be in the same position, potentially, as Ms Lowe: you will either have to find a foundation trust to take you on, or you will simply close.

**Clare Panniker:** It will be difficult to close, given that we have a long-term commitment around a PFI. It will be in everyone's interests for the local trust, with the support of the Department, to find a solution in advance of that.

**Q54 Joseph Johnson:** Very quickly, can you each say what your operating deficits are on an annual basis at the moment?

**Julie Lowe:** I do not think that any of us have operating deficits.

**Clare Panniker:** An operating surplus of £3 million last year.

**Q55 Joseph Johnson:** You do not have a deficit?

**Clare Panniker:** None of us has a deficit.

**Q56 Chair:** Julie Lowe, I could not get hold of your—what is this wonderful document called?—tripartite formal agreement. What words! Why have you not published yours?

**Julie Lowe:** Ours was signed with the SHA and the Department only very recently because of the discussions about the merger. It will be going to our trust board next Thursday and will appear on our website with our public trust board papers next week.

**Q57 Chair:** Yours was also signed recently, but you got it out.

**Clare Panniker:** It is published, yes.

**Q58 Mr Bacon:** I want to ask Dr Gordon one question arising out of what you said earlier. You made what sounded like a very persuasive case for the course of action that you are taking; you mentioned, just as an example, 13 radiologists being a lot better than six in one place and seven in another, and said that that went across all disciplines. It prompts the question: what is not to like? If you can do that and get so much more bang for your buck, why was this not done many years ago?

**Dr Gordon:** I think 21 miles of Hampshire is probably the main cause of not having done it many years ago.

**Q59 Mr Bacon:** Twenty-one miles? Is that all?

**Dr Gordon:** It is 21 miles of the M3. People are very proud of their organisations. We celebrated our 275th anniversary as a hospital yesterday, so I think that people like to retain their integrity. It takes a very brave organisation to look at its organisational future, and for a board to look at the possibility of voluntarily—

**Q60 Chair:** It is 21 miles between Winchester and Basingstoke?

**Dr Gordon:** Yes.

**Q61 Chair:** And Winchester and Andover?

**Dr Gordon:** 16 miles.

**Q62 Mr Bacon:** I represent a constituency in Norfolk, so these seem very small distances to me.

**Dr Gordon:** I think it depends on your world view to some extent, doesn't it? It leads to a big decision from any organisations, whether you are 20 miles, five miles or 100 miles apart, to say, “We are viable now, and we provide a really good quality of service now but, in a few years' time, that will be really difficult; what is best for our patients?”, and for the board to take the decision to go through a process that will dissolve itself.

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**Q63 Mr Bacon:** While I was asking my question a minute ago, a chap behind you was smiling and nodding sagely in agreement. At least I think he was.

**Dr Gordon:** That is my chairman.

**Q64 Mr Bacon:** That makes me wonder whether you think that it is probably fair to say—I think this is what you are saying, but perhaps you can confirm it—that were it not for local chauvinism with a small “c”, there are probably lots of things that could have been done, especially when a lot of extra money was going in, that might have improved service quite a lot some time ago. However, they were not done because we were not in a financial crisis. They were providing a good service, they had other pressures, and it was not top of mind, so it did not get done. It is rather like how very profitable companies do not necessarily think about how to become even more profitable when, if they looked at their costs very hard, they probably could be.

**Dr Gordon:** Sure. I do not think it is quite fair. I think it’s really important to be—

**Mr Bacon:** I am not trying to be unfair.

**Dr Gordon:** No. I think it is important to say that the world does not move in explosions too often, hopefully. It moves gradually, in the way that we change. If you think about the way that, over the past 10 years, we have come to look after cancer in networks; the way that, over the past five years, we have come to look after stroke through networks; and at the vascular trauma networks, on which we are going through a consultation process in Hampshire, it is all about networking across different organisations. It is a huge change in culture for many people. Organisations that evolved before the NHS, into the NHS and into the future are now grouping together and working together in networks. It is only natural that, for some organisations, that can be taken further, into an organisational union to support those services.

**Q65 Chair:** Some of us represent slightly different constituencies. It depends; if you have a car, you are okay and another 10 miles might not kill you, but if you are dependent on public transport, you are in trouble.

**Dr Gordon:** Public transport links are good up and down the M3 corridor. It is really important that local services are provided. You have to find the balance whereby you can provide local services to a local hospital, but where critical mass makes it important, for some services, people are sometimes prepared to travel a little bit further.

**Q66 Chair:** So you will reconfigure services in this new trust?

**Dr Gordon:** I cannot say that. There are no plans.

**Q67 Chair:** You will.

**Dr Gordon:** To take this back to the consultation around stroke services, for instance, the proposal in the public domain in the NHS Hampshire stroke consultation is that the hyper-acute service for north and mid-Hampshire will be centred for immediate care around Winchester, for the Winchester and Basingstoke area. For some extremely urgent things

where critical mass is really important, those processes are already happening.

**Q68 Mrs McGuire:** I should declare an interest: my husband was carted into the Royal Hampshire in the back of an ambulance—you do not look as though you recognise me, do you?—with a compound fracture in his ankle. I can only say that the treatment he received was excellent. I also have a niece and a nephew who were born in the Royal Hampshire. I do not know if that makes me biased. You might wonder why an MP from Scotland has that connection with Hampshire—

**Dr Gordon:** I was wondering about that Hampshire accent.

**Mrs McGuire:** I am happy to explain to you later.

I want to concentrate on the Winchester and Basingstoke area, partly because I know it, but partly because it replicates something that happened in my constituency. We had two district hospitals, which were effectively exporting medical cases and not attracting some specialisms into the hospitals because they could not provide the critical mass, training and so on. In many ways, although there was an issue about staff, the big issue was how to persuade the local communities that they would still get a service that met their needs.

Frankly, I think that people understand the need to travel for specialist services. If you need a brain surgeon or specialist cancer treatment, the chances are that you will have to travel, but most people’s interaction with a hospital is like the compound fracture of the ankle at 12 o’clock at night. What are you doing to ensure that you get the new “clinical model”, as I think you called it, into some sort of balance, so it is not just about the staff and their personal and professional development, but also about how the local community sees delivery of services nearby? Like Richard, I have a large constituency in which people travel more than 21 miles, but that does not undermine the rationale of my question.

**Dr Gordon:** Absolutely. You are absolutely right. There is a really important balance to be struck on where we put services, but also on how the public perceives what services might be available. If you are going to what is an acquisition, people might think that things are going to be moved away from an area. For some services, such as unscheduled care, a very large proportion of our patients over 80 are acutely unwell and need to come in through an emergency service in their local hospital, so it is important that we are very clear that we provide that. We have gone through this process with our current commissioners and with our future clinical commissioners—the GPCCs, as they were called at that stage.

**Q69 Mrs McGuire:** That might change in time.

**Dr Gordon:** They are CCGs now, or whatever. They have been on board with this model, and they have been involved in that process. We have also been in consultation with Hampshire county council’s health overview and scrutiny committee. My foundation trust colleagues and I have been to speak with Andover borough council, Test Valley borough council, Eastleigh borough council and Winchester borough council to understand what the population feel. There

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will still need to be an incredibly important engagement process to continue to inform the population as to what services are available at these hospitals.

**Q70 Mrs McGuire:** Can I flip this on its head? So far I have not heard people mentioned; I have heard about councils and authorities, but I will give you one word of advice that comes from my experience in the Forth valley area: if the authorities go out and consult with people on the ground—not the councils, not any intermediary—and actually try to have an understanding of what people are expecting from their hospital services, you get a better model. It would probably be one that is not that far removed from what you are proposing. People need to understand it and, frankly, I do not think that you can always work through intermediaries such as councils or MPs or whatever. Sometimes you actually need to meet real people.

**Dr Gordon:** I am sure that you are absolutely right. We talk to our patients a lot about this. We talk to the local populations about how we can get through to them. We are encouraging membership of the new foundation trust, which will be an important part of helping us to understand what patients want to experience.

**Q71 Jackie Doyle-Price:** I have a few reflections about leadership, because you, Dr Gordon, have outlined a good example of leadership, where the board has decided collectively on a course of action and engaged the public to deal with it. Obviously, going forward, the new trusts will have to depend much more on good-quality NEDs and senior management teams to take the institutions forward. It is interesting to pick out the characteristics of good leadership in this context. I want to ask each of you: do any of you have clinical backgrounds?

**Dr Gordon:** Yes.

**Clare Panniker:** Yes.

**Julie Lowe:** I do not.

**Q72 Jackie Doyle-Price:** You do not; okay. In terms of non-executive directors, could you, Dr Gordon, say how easy it has been to attract a full complement of NEDs of sufficient quality? Has that been a challenge? From my perspective, it is patchy in different areas of the country. With varying degrees of ease, do you get the right skill sets?

**Dr Gordon:** I entirely echo your sentiments about the need for leadership. Leadership at board level is crucial. I have to say, given the audience, that my chairman is a fantastic leader of our organisation. We have an excellent team of NEDs. Under his leadership we went through an awful lot of board development. It is really important that non-executive directors from a wide variety of places come together and really understand the machinations of the NHS, how a hospital works and the complexity of the organisation. It is important that the executives and chief executive—if they are clinical it makes it slightly easier—illustrate what the underlying meaning is for clinicians and what the strategy means for patients, the staff and the service going forward. We are going

to need to ensure that our non-executive directors are brought in carefully, inducted into the organisation and given the level of knowledge that they need—I should not say this—to be able to challenge the executives on the information that they are given, and to have provided the clarity of information that they need to be able to make a judgment.

**Q73 Jackie Doyle-Price:** How long have you been in post?

**Dr Gordon:** A year and a half.

**Q74 Jackie Doyle-Price:** And how long has your chairman been in post?

**Dr Gordon:** Four years.

**Q75 Chair:** Julie?

**Julie Lowe:** I have been in post for four years, and my chairman has been in post for three years, but he has been a non-exec on the board for much longer than that, because he was a non-exec before. I have been very fortunate, in that all of my non-execs have committed to staying with the process, subject to terms of office, and working with our staff, our patients and our local community to get us to our sustainable long-term future.

**Q76 Chair:** And Clare Panniker?

**Clare Panniker:** I have been in post for almost eight years, and the chair has been in post for almost five.

**Q77 Chair:** May I ask, in drawing this session to a close, how you have dealt with financial cuts in 2010–11? Starting with Clare, for a change, what did you cut? Were you forced to cut any front-line services or front-line workers—midwives and other workers whom we have been hearing about? This is in the context of the King's Fund publication, which suggested that a lot of front-line services were involved. Was that the case in your hospital?

**Clare Panniker:** On the contrary, actually; we have been recruiting midwives. We have had at least eight start in the past couple of months. We have also increased our substantive clinical staff—both doctors and nurses—over the past eight months or so. We have done that through reducing our vacancy rates, so that we have to depend far less on bank and agency. We have almost eliminated agency use within the organisation.

We have made our cost savings by reducing the premium that we spend on temporary staff, but also through implementing new models of care. Just this week, we have started a new ambulatory service, which means that patients can be treated as out-patients. Things that we might have kept people in hospital for—IV antibiotics, for example—for weeks on end, they can now come and have done in the hospital on more of an out-patient-type basis, which has reduced our need for some of our in-patient beds. We have looked very much at other areas of productivity and efficiency, such as theatres, out-patients and improving processes within hospitals.

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**Q78 Chair:** Thank you. Julie?

**Julie Lowe:** I do not want to repeat everything that Clare said, but we spend a lot of money, as many London trusts do, on agency staff, and we are reducing that right down. On procurement, we are buying things more efficiently. We are providing more care at home, and building on our community links to try to reduce length of stay.

**Q79 Chair:** Have you been forced to cut what would be commonly accepted as front-line services or staff working in front-line jobs?

**Julie Lowe:** No.

**Q80 Chair:** And Dr Gordon?

**Dr Gordon:** There is no cut in front-line staff. We have managed to make cost-efficiencies through back-office savings, a reduction in management costs, using our staff more efficiently by reducing agency use, and making extra payments to consultants for extra work. There are also all the things that make our work better, including joint teams with social services and community services to shorten length of stay and to improve patient flow.

**Q81 Chair:** So you are all denying, for your individual hospitals, the assertion from the King's Fund?

**Dr Gordon:** Absolutely.

**Q82 Chair:** Starting with Julie, do you feel more or less secure in the new world, where you will have to stand on your own feet, rather than being managed by David Nicholson? Well, you might still be managed by David Nicholson.

**Julie Lowe:** I think being a foundation trust is tremendously exciting for a trust chief executive, and for a community like the one that I work in. The opportunity to be part of a local community and to have greater community involvement will be a tremendous benefit.

**Q83 Chair:** Will you get more community involvement? I cannot see that with foundation trusts. How?

**Julie Lowe:** By having a council of governors and by having members, there is a real ability to engage.

**Q84 Chair:** Who are you getting in on that? Councillors? I think that was Anne's point.

**Julie Lowe:** When we started to go through the foundation process in 2007–08, thousands of local people signed up to be members and were really keen to be involved, and they have remained involved, despite the fact that we have not pursued FT status.

**Chair:** Do you want to add to that, Jackie?

**Q85 Jackie Doyle-Price:** This is where we get into the geographical discrepancies. Certainly with my local foundation trust, getting governors of the right quality to give appropriate accountability is a real challenge. To put all your eggs in that basket to monitor performance will not be enough; you will need to have better ways of community engagement. That will not be the panacea. Certainly, one issue for me is to make sure that Monitor hoists that into the system.

**Q86 Chair:** Clare, are you looking forward to the new world? The question was really whether you feel more or less secure.

**Clare Panniker:** There is a big journey ahead, and there is a lot to be done. The prize is worth having, because the journey around developing the governance and the financial control is—

**Q87 Chair:** You think you will get there, do you? You have the toughest challenge.

**Clare Panniker:** Yes, I think we will get there.

**Q88 Chair:** By 2014?

**Clare Panniker:** I think during 2014.

**Q89 Chair:** And Chris Gordon?

**Dr Gordon:** Yes, I am confident that the chief executive of foundation trusts in Basingstoke will have the skills necessary to carry my services forward. I look forward to handing them over to her in January.

**Q90 Mr Bacon:** What are you going to do?

**Dr Gordon:** That is a story yet to be told.

**Q91 Mr Bacon:** Will you come back and tell us?

**Dr Gordon:** I would love to.

**Chair:** Thank you very much, including for being very concise. We now have to move on.

### Examination of Witnesses

**Witnesses:** **Ian Dalton**, Managing Director of Provider Development, Department of Health, and **Sir David Nicholson**, Chief Executive of the NHS, gave evidence.

**Q92 Chair:** Sir David, welcome to yet another session, and welcome to Ian Dalton.

When I read the report—despite the very good evidence that we have just had—the thing that really shocked me was the massive size of the problem that you face and the highly risky nature of the endeavour on which you are engaged. Nearly half the trusts are not yet foundation trusts. You are going to end up running about half of those—about 60—and you will set up this NHS trust development agency. Twenty

trusts have also self-admitted to having difficulty in achieving foundation trust status. Is it realistic to think that you will get there by 2014?

**Sir David Nicholson:** You are absolutely right to point out the massive challenge that faces the NHS over the next few years. Irrespective of foundation trust status, the challenge, as you know, is great. We have never existed on small amounts of real-terms growth for an extended period. We have had the odd year of it, but it has never been over an extended period, so the

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challenge is absolutely great, irrespective of the foundation trust stuff.

We believe that we can get the bulk of foundation trusts in place by 2014. You will have seen the programme, and you will have seen the work that we are doing on all of that. Originally, when the White Paper was produced, we said that that was the date by which everybody would be a foundation trust and that we would abolish the status of NHS trust at that stage. I think we listened to the conversations that we had through the NHS Future Forum, and we looked at and amended the position to allow a bit more time for a certain number of trusts for which the challenge is so great. We talked about the possibility of 2016 for a small number.

**Q93 Chair:** 2016?

**Sir David Nicholson:** 2016.

**Q94 Chair:** Do you think the figure of 20 self-identified trusts will grow? We are thinking of South London Healthcare NHS Trust or Imperial College Healthcare NHS Trust, which is in a mess. Quite a lot of them are still in a mess. There are others that are not in that list that could well have been included, such as Portsmouth Hospitals NHS Trust or St George's Healthcare NHS Trust. I am just thinking of a few.

**Sir David Nicholson:** There may be trusts that come into that list, but there may also be trusts that go out.

**Q95 Chair:** Will the list grow?

**Sir David Nicholson:** We do not believe that the total number will grow. We think some will come in and some will come out, but it very much depends on the detailed work that is being done now. As you know—some of the organisations around PFI or the issue around South London Healthcare—all of those issues are being tackled at the moment. As we go forward, we will refine the list, but the point of doing the list is not to have a list; the point of the list is to focus our attention, support and action to support those organisations going forward.

**Q96 Chair:** I have great respect for you, but I looked at figure 7 on page 21 of the NAO Report, and you made an assessment—you and Mr Dalton no doubt—in November 2010 of the problems in the Department of Health assessment. Yet now, when we have these—I cannot bear this term. Can I call them TFAs? I do not know who invented it.

**Ian Dalton:** That is mine.

**Chair:** God almighty. Okay, TFAs. Once they were out, it was so ruddy wrong, and that was not after even a year. On financial, you are up 63%. On quality and performance, you have more than doubled—120%. On governance and leadership, the increase is nearly 120%, and we will come back to that, because no doubt Jackie will want to pursue it. On strategic issues, it is 32%. That is a huge difference. How could you get it so wrong? And I do respect you.

**Sir David Nicholson:** We are getting better at it, and we are getting more realistic.

**Q97 Chair:** But it is awful. When I think about the risk, I look at that and think, “Blimey, that is what they thought they had a year ago.” And, a year in, it is far worse than even they imagined.

**Ian Dalton:** A couple of different things are going on. The November 2010 exercise was in response to my letter asking chief executives of NHS trusts and SHAs for an informal view of the issues they faced at that stage. Since then we have had a year's worth of activity with those organisations, and they have spent a further year examining their position and understanding the realities of what foundation trust status means. We are, to a degree, comparing apples and pears. Figure 7 reflects a year's activity, and a lot of thinking in a lot of organisations, that has led them to that position. That is a positive in the sense that it identifies the issues that the organisations know they now need to deal with.

**Chair:** You might have known before.

**Q98 Joseph Johnson:** The Chair has explained that the list is self-identifying. The trusts have to say whether they think they will meet foundation trust status by 2014. Is that good enough? I am puzzled as to why South London Healthcare Trust is not on the list. It appears to have the largest annual operating deficit of any trust in the system. Surely that should be qualification enough.

**Ian Dalton:** Fundamentally, the whole exercise is about boards of NHS organisations, supported by the SHA and the Department of Health, leading the process of determining whether they are able to become a foundation trust and taking responsibility for that. Being a successful foundation trust is, in large measure, about having a board that is appropriately set up and appropriately run to govern its organisation. We start from a position in which the board has to take responsibility. Clearly, the SHA in its oversight role—and we in our oversight of SHAs—has to assure itself that the appropriate support is in place.

**Q99 Joseph Johnson:** South London Healthcare Trust doesn't even have a chairman.

**Ian Dalton:** In its process, South London Healthcare Trust has identified a decision point at the end of December and a second point at the end of March 2012, at which it will be clear whether the trust has a way through to foundation status. The trust has put that point to us in its TFA. We have signed up, and we and NHS London—particularly NHS London—will be working with the trust between now and 31 December to ensure that the assessment is sustainable and credible. We will see where that takes us. The range of options that come from that will then be determined.

**Q100 Joseph Johnson:** In your view, what are the key elements as to whether South London Healthcare Trust can achieve foundation trust status?

**Ian Dalton:** The key elements for foundation status are fairly general and apply not only to South London Healthcare Trust but to trusts generally. Those

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elements include a credible financial position; a credible position on quality and performance; an established board that has the skills to govern the organisation and manage the extra level of autonomy that foundation status brings; and, importantly, a forward-looking clinical strategy that gives confidence to the regulator, as well as to local people, that services will be in place and will be financially and qualitatively sound for the next few years. So they are the normal set of things that you would expect. Those are the assessments that we expect boards to address and to form a view upon.

**Q101 Joseph Johnson:** I want to address two of those four metrics. On having a credible financial position, South London Healthcare Trust has the largest, and from my understanding it has consistently had the largest, operating deficit in the system. On the point about the board and governance, it presently has a good chief executive in Dr Chris Streather, but it doesn't have a chairman at the moment. The trust has an acting chairman. Over the past few years, the trust has suffered an incredible turnover in chief executives and chairmen, so I don't think we can really give it a tick in the governance box. I have no comment on quality—the clinical strategies seem to be adequate, but I am not an expert, so I cannot say. But on at least two of the four metrics, the trust is not up to scratch.

**Ian Dalton:** South London Healthcare Trust has to address some significant issues of the sort you are talking about. It is not yet in a position to reach a conclusion on its deliberations and discussions with NHS London. What we wanted to see—and what it put in the TFA—is that there will be a decision point, where it will take account of all those things in discussion with NHS London, and will determine whether there is a route to move through in its current form to foundation status. That is the nature of the process. The plans are not locked down, in the sense that you have written your plan, there is a timetable there, that's the end of it, go away and tell us when you have become a foundation trust. They are describing a journey that the organisations have to go on.

**Q102 Amyas Morse:** That last remark is helpful. I wanted to be clear. My understanding is that there might be this and one other trust where you could say that they are still deciding, that it is still very much in question whether they are going to be able to be foundation trusts, and you have given them more time to consider that question.

**Ian Dalton:** That particular one put in its document a point at which that decision is reached. There are other organisations that have other issues to deal with before they can determine whether they can become a foundation status organisation. There will be other organisations, as they go through this journey, that have to keep those things under consideration. That seems an appropriate way to describe it.

**Q103 Amyas Morse:** I was not trying to suggest that it wasn't. I was just trying to understand what proportion you would say would fall into the same category as that one at the moment.

**Ian Dalton:** The vast bulk of organisations in that category have already taken that decision by putting themselves on the list of 20. They have already considered the issues that we have heard about from the three chief executives, and therefore have put themselves in that place. But there are other organisations, including the one raised by Mr Johnson, that have to go through that process and reach a conclusion.

**Q104 Joseph Johnson:** I have two quick follow-up questions. On or before 31 December, you will come to a view collectively with SLHT as to whether it will get to foundation trust status. If you decide it is not going to get there under the current plan and it goes on this list, then what? Do you then sit in a room and devise a new strategy?

**Ian Dalton:** Fundamentally, I think the responsibility still stays with the trust board, clearly with the support of the system if it is struggling to find an answer. As we have heard in these three cases—and you will see in at least 17 of the 20 cases on the list already engaged in this—it is the board's responsibility to find a way forward, not just to achieve the badge of FT, but to provide a credible clinical strategy to give the sustainability the patients need. As we have heard from the three chief executives, this is fundamentally about the sustainability of clinical services; far less about the acquisition of a badge.

**Q105 Joseph Johnson:** Thank you. The last question is on PFI. Like many other trusts, the SLHT is particularly burdened by PFI on two of its hospitals. It is awaiting news on the status of the PFI debt. What is your thinking at the moment about what to do with the PFI debt, which is lumbering so many hospitals in our system with a very difficult cost base?

**Sir David Nicholson:** We are going through a process that we have not yet completed—using outside support and advice to enable us to do it, as we do not have the skills within the Department—to identify each of the organisations that identified PFIs as being a potential issue in relation to their foundation trust status. South London is one of them. We will get to a position relatively soon to identify the list of organisations that we think that by their own methods will not be able to deal with the scale of the issue. Then we will have to talk to the Treasury or whoever about what we do about that. We expect that to be a relatively small group.

**Q106 Joseph Johnson:** How are you analysing that? Are you saying that, if PFI interest costs are more than x% of income, we will shift it back to the Treasury? How are you looking at that?

**Sir David Nicholson:** No. It isn't as simple as looking at the amount or proportion of turnover going to PFI, because some organisations work well with relatively high numbers, higher even than South London Healthcare. We look at the potential for efficiency or productivity gains, so we look forward on how they can do that. We look at the clinical strategy: is it possible to bring more services into the building to utilise it? Finally, we look at whether there is a

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possibility of some other support to be given to them. We look at those things.

**Q107 Joseph Johnson:** Lastly, when will we have an announcement?

**Sir David Nicholson:** It is quite difficult to tell at the moment, but hopefully, as soon as possible. We want it by the end of the year, in the sense of it linking with decisions about the future of South London Healthcare. Some of it is out of our control.

**Q108 Chair:** I am conscious that Anne wants to come in on PFI, but I will bring her in later, because I think there are a whole lot of questions on that. I have James, Ian, Austin, and Anne, but one thing arises from what Jo said; you push it all to the trust, but at what point will the Department intervene, and what action will you take?

**Sir David Nicholson:** In a sense, that is the whole point. They have identified that, on their own, these organisations do not feel that they can support it.

**Q109 Chair:** When will you intervene? West Middlesex—when will you say, “You cannot reach foundation trust status”? Like South London.

**Ian Dalton:** It is not at a set point in time. What the SHAs will do—they are ultimately the first line of oversight here—is keep a monthly engagement with these organisations. At the stage that they, in discussion with us—if it were to happen—felt that things were going off-track, a local intervention would take place. We are not simply saying, “The plans are here. Go away and come up with the answer.”

**Q110 Chair:** The SHA, as the DH regional body, will decide whether a hospital can achieve foundation trust status, and if your judgment is, “No” you will intervene.

**Ian Dalton:** We and the SHAs will keep that under continual review and we will not let organisations pursue strategies that are not viable.

**Q111 Chair:** So, you will intervene.

**Ian Dalton:** Yes.

**Q112 Chair:** What will your intervention be?

**Ian Dalton:** It will be that which is required. It depends on the nature of the problem, does it not? The aim fundamentally is to help boards be successful and my intent would be that intervention is not needed because we support boards to make the right decisions. That, I think, is why you have 17 of the organisations—

**Q113 Chair:** That’s obviously where you want to be, but let’s assume that there are some. I might think of mine, which we will come back to later. It appears to have hit every criteria of non-sustainability. There must be a point at which you intervene and take action. I then want to know, in particular, what you will do to safeguard local services. Will you safeguard them? Who will be responsible? For all sorts of issues it does not work at the local level, so where does the buck stop?

**Sir David Nicholson:** The responsibility for safeguarding local service in those circumstances is the commissioner, and the buck stops here for commissioning.

**Q114 Chair:** Right. So, you will have to intervene, and you will have a menu of options—merger, takeover, or privatisation.

**Sir David Nicholson:** We will have a menu of options: we will have development support; we can put people in with expertise; we can bring in clinicians and clinical leaders from other organisations to support and help; we can replace the leadership of the organisation if we think that is necessary.

**Q115 Chair:** Can you?

**Sir David Nicholson:** Yes, of course.

**Q116 Mrs McGuire:** If they’re independent?

**Chair:** No, this is pre-foundation trust.

**Sir David Nicholson:** We can replace the leadership if we think that is necessary.

**Q117 James Wharton:** To satisfy my curiosity, following your answers to Mr Johnson’s questions, could you tell us which trust pays the highest percentage proportion of its income to PFI and what percentage that is?

**Ian Dalton:** From memory, I think it might be Dartford and Gravesham at over 18%.

**Q118 Mr Bacon:** The report says that 20.1% of turnover is the highest, in paragraph 2.14. Which one is that?

**Mark Davies:** It is Dartford and Gravesham.

**Q119 James Wharton:** We have this list of 20 which are not viable. What assessment have you made of how high that number would get before the pipeline process itself becomes unmanageable? Have you made any assessment, or any contingency planning on that? If you found it were 40, because something had gone very wrong, or 60, at which point would you need to seriously revisit the whole plan?

**Ian Dalton:** The aim is that the number remains relatively small, and the advantages of the process we are going through are that as trusts go into the sort of arrangements that 17 of the 20 are currently already talking about, that number should fall away as those arrangements, whether it is through acquisition merger or whatever, take hold. The aim is to get the number below that if at all possible.

**Q120 James Wharton:** I accept that, Mr Dalton, but if it increases, have you made any assessment of the level at which the whole process will not be manageable by the Department? I appreciate that the aim is to bring the number down, but what happens if it goes wrong?

**Ian Dalton:** It is not a question of oversight by the Department; it is a question of organisations doing the things that they need to do to become a foundation trust because they need to do them anyway to be viable clinically in the current arrangement. I do not think it is a question of the FT pipeline; the FT

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pipeline is a reflection of the activities that they have to undertake. They have to do those things because they are working in an environment that is characterised by less growth than they have previously had. I do not think that there is a number at which the pipeline gets drawn into question.

**Q121 James Wharton:** And your consultants have identified six for which the PFI scheme was a major obstacle, is that right?

**Ian Dalton:** That is correct.

**Q122 James Wharton:** Are those six in the list that we have got of the 20 trusts that are not viable?

**Ian Dalton:** Some of them are.

**Q123 James Wharton:** So they may be added later, but it may be that although it is a major obstacle it is not significant enough to put them into that 20?

**Ian Dalton:** There are some in the category that are going through to consider their future—I refer to the question raised by Mr Johnson, for instance.

**Q124 James Wharton:** Are you concerned—are they concerned—because when PFI schemes are signed off, both the Department and the trust would have said that they were affordable? Obviously, if we are in a position where six are being identified as being a major obstacle, the affordability of those schemes is clearly being brought into question. Are you concerned that something went wrong when they were signed off, and have you any idea why they were signed off if they are now a major obstacle to the transition that the trusts need to make?

**Sir David Nicholson:** That part of the process that we are going through at the moment is to identify what assumptions were made at the time they were signed off and what has changed about those assumptions. The most obvious assumption that was made at the time with many of them was that growth in health expenditure would continue into the future for a long time, and of course that is not the case.

**Q125 Mr Bacon:** You say “obviously”, but is that right—the basis of most of the PFI negotiations was that at financial close they had x, but they were expecting in the years ahead continued, steady growth in health expenditure?

**Sir David Nicholson:** No, what I am talking about is—there are a lot of PFIs that we have done, but we are talking about six.

**Q126 James Wharton:** Twenty two is a lot.

**Sir David Nicholson:** No, we believe it will be fewer than six—less than a handful, I think I have said—so we are looking at those six in particular. What it meant was they assumed larger increases in activity, and the income associated with that, than they will probably get in practice. That is probably the major reason, but we are examining each one individually to look at what the assumptions were, because it is important for us to do that before we make a judgment about whether any support or help might be needed by these organisations.

**Q127 James Wharton:** One of the things that the report indicates that the Department is looking at is loans to some of the trusts, or helping them to reorganise their loans, and it references discussions with the Treasury about that—I think the figure was £375 million.

**Sir David Nicholson:** This is for liquidity.

**Q128 James Wharton:** If you identify more problems, what contingency is there for that figure going up, and how flexible do you think the Treasury will be if you say that you want to extend that even further? Additionally, when you answer that—I am conscious to make this my final question—is there a danger that in sorting out such restructuring problems you actually cover up long-term organisational problems, which will just resurface when they have gone through the period of grace that you have bought them with Treasury money?

**Sir David Nicholson:** Yes, can I say that the purpose of the Treasury money is this whole issue—I am sure Ian will be able to explain it better than me—about liquidity. They have to have in their bank balances 15 days’ operating money, and of course NHS trusts do not necessarily need to have that because they have the whole of the NHS behind them. Each individual organisation needs that money; it will not count against our revenue expenditure, but it is cash that they will need. It will be counted against the totality of the Government’s cash position. We are hopeful that we can get a solution with the Treasury. I think the figure in here is £370 million—it might be slightly more than that when we do it, but we think it is worth doing. If you are saying that there is another issue about the costs of change, some organisations will need some resource to make the clinical change that they need. If we are going to invest in organisations to help them and support them to change we need to be pretty hard-nosed about what we get in return for that.

**Q129 Chair:** Is the Treasury going to help?

**Marius Gallaher:** We are going to listen to what the NHS and the Department of Health come up with and we won’t make decisions—

**Q130 Chair:** And what is your final bid? It is up from £376 million. You have put that in, but £376 million ain’t enough, I heard. What is it now?

**Sir David Nicholson:** I don’t think—

**Q131 Chair:** Well, you just said that it would be a bit more. So I thought that this was about that.

**Sir David Nicholson:** It might be. But at the end of the day it is implementing Government policy so I assume the Treasury will be helpful.

**Q132 Chair:** So it could be £500 million or £600 million?

**Ian Dalton:** It will also depend on the time of authorisation of each of the trusts. So this is what we have done on one occasion so far. Southampton, which is mentioned in the report, is a trust that is ready to be an FT. It is making a recurrent surplus. It is meeting all the objectives, but its balance sheet is

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at the time of application not strong enough to meet the monitor tests—the 15 days' liquidity and the 10 days' cash. A one-off injection of resource into the balance sheet to help them do that is payable at the day they become authorised, not in advance, for the purposes of strengthening a balance sheet. So it depends on the process as we go forward. We are at a stage of having to have those conversations with HMT.

**Q133 Mrs McGuire:** Sometimes in this Committee we talk figures but we do not paint pictures. So I would quite like to give you an opportunity to paint a picture and to tell me what Dartford NHS trust's facilities were like before the PFI project and what they are like now.

**Sir David Nicholson:** I couldn't tell you that.

**Q134 Mrs McGuire:** I assume that they are better.

**Ian Dalton:** I would imagine that they would be.

**Q135 Mrs McGuire:** I think for that amount of money—

**Ian Dalton:** The purpose of a PFI hospital is normally to replace out-dated buildings that are no longer suitable for modern health care. I do not know that particular scheme, but I am aware that through the PFI programme a large number of state-of-the-art new hospitals have been built and often they replaced facilities that dated back many, many decades. I just do not happen to know that particular scheme.

**Q136 Mrs McGuire:** So it is a fair assumption that what we had was part of the Victorian estate prior to PFI in Dartford and some of the other areas where PFI was used as a financial tool to renovate or rebuild the estate. Is that a fair comment? I do not ask you to be specific.

**Ian Dalton:** Whether it is Victorian or Edwardian, a lot of the buildings were extremely old. Some of them dated from before the NHS was created.

**Q137 Mrs McGuire:** Downton Abbey would probably have recognised most of our hospitals. Let us put it that way. Right, we have spent a great deal of time talking about PFI and the numbers. Sir David, I think it was lost at one point in your answer: how many trusts are in difficulties with PFI being part of the problem?

**Sir David Nicholson:** When we asked all NHS trusts, "Do you believe that PFI is contributing to your inability to become a foundation trust?"—is it 22?

**Ian Dalton:** It is 23 individual organisations, which are likely to become 22 trusts because two of them are coming together.

**Q138 Mrs McGuire:** And that figure came down to six and you suspect it may be even fewer.

**Sir David Nicholson:** And our analysis, based on looking at productivity benefits, service change and all the rest, is that we are down to about six. It may be smaller by the time we end.

**Q139 Mrs McGuire:** And the NAO report said that there were up to six. It may be fewer or it may be

slightly more. It said that PFI payments sat alongside a variety of other financial problems. That indicates to me that it was not just a PFI problem in some of those trusts but that there were other financial issues. Would that be fair?

**Ian Dalton:** That would be fair. It varies from organisation to organisation, but the purpose of the PFI work is to understand whether those trusts have excess costs specifically related to the PFI. They may have other financial problems as well, which would need to be fixed to allow them to become foundations trusts.

**Q140 Mrs McGuire:** So you can extract PFI, but again it would be fair to say that the PFI difficulties sit alongside other financial difficulties in those up to six trusts, give or take—

**Ian Dalton:** It varies from organisation to organisation. The purpose of the work we are going through now, looking at the opportunities for efficiency improvements in these organisations and the costs of the buildings and the way they pay for them, aims to split out the excess costs, if any, from the PFI exercise. If there are other financial problems that other hospitals without PFIs are having and these also have, they would necessarily need also to be fixed by the organisation as part of the journey towards foundation trust status.

**Q141 Mrs McGuire:** We have heard a wee bit this afternoon about being able to support financially some of the trusts that might be in difficulties, but I notice that paragraph 20 on page 9 of the NAO report states: "Interventions using public money to increase aspirants' apparent viability would also risk distorting competition and undermining the policy objective to increase hospitals' financial sustainability." Can you explain what the implications of that sentence might be for some of the trusts that might find themselves in financial difficulties?

**Ian Dalton:** I would have used slightly different language, but the issue is that we are looking at different things. There are three different categories of potential problems that we could be talking about, which need to be treated differently. Briefly, at one end, we could be talking about trusts that are currently not in an acceptable financial position, because they are not in recurrent balance at the moment. There are some there. Where that is a local performance issue, that needs to be dealt with locally.

There are other organisations that have liquidity problems but are fundamentally sound financially and performing well on a day-to-day basis, and then, as I have mentioned earlier, we would be looking at how we would need to help them become foundation trusts. Then there is a third category—a small number of organisations that have issues around the PFI costs. We need to dissect those different things, because they are different. The aim is to look relatively sympathetically at issues of liquidity and the trusts that genuinely have a PFI problem.

**Q142 Mrs McGuire:** Right. I want to park PFI. My question was about interventions that would distort competition. What would happen if you assessed that

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a public support intervention—a financial intervention—would distort competition? What would be the outcome for the NHS trust involved? Would it just be allowed to collapse? Would it disappear?

**Ian Dalton:** I don't recognise the language.

**Q143 Mrs McGuire:** Do you recognise the concept?

**Ian Dalton:** If there are a small number of trusts that have real problems in being financially sustainable because of PFI, that is the conversation that we want to have with them. It is about levelling the playing field.

**Q144 Mrs McGuire:** In that case, I will have to ask Mark Davies to explain his language, because I understand the language. It is at the foot of page 9, paragraph 20.

**Mark Davies:** What we are saying, in a nutshell, is that you cannot continue to inject finance into organisations in a way that makes them overly competitive in the marketplace. You have to inject sufficient money in ways that would not distort competition in the marketplace going forward.

**Amyas Morse:** Let me add a bit. The point we are making is that it is a stated intention that there will be competition to supply services. That's right, isn't it, David?

**Sir David Nicholson:** Yes.

**Amyas Morse:** If you are going to have various hospitals competing to provide services, and some of them have been given additional financial support to be viable, and they are winning competitions to provide services, it is at least something to be considered, because it might be seen as distortive of competition. We are not saying it is unavoidable or cannot be managed. We are simply saying that it is something to be borne in mind. For example, if you had one trust with a large PFI liability that was viable bearing the whole of that, and another had had some sort of assistance, you can see that there might be an argument about whether it was fair for the two to be fighting it out in competition terms as to who was delivering services. We are simply saying that it is something that needs to be considered. We think there is time to consider that, so we are not regarding it as a killer argument, but it is worth bearing in mind. That is why it is in the Report.

**Q145 Mrs McGuire:** Let me be clear. Even if there is a social and clinical need for a trust to exist in that area, and if there is an influx of public sector finance, it could be said that that is distorting competition. Is that a fair analysis?

**Sir David Nicholson:** All that could be said. It is absolutely true, but we are only talking about a relatively tiny number of organisations. This is not a big thing, but in the new, post-Bill world, subject to Parliament and all the rest of it, it is perfectly possible to give organisations subsidies. Commissioners and the economic regulator could agree that a subsidy was needed. It might be for a variety of reasons: because the particular services are geographically isolated and so cost more; it could be an arrangement that we did around the PFI to keep the service going because our responsibility is to make sure that the services are

continuous. You can do it, but you have to do it openly and transparently so that everyone can see what you are doing.

**Q146 Mr Bacon:** On this point, Sir David, can I just check one thing? Let us imagine a situation where a contractor was unable to meet its contractual obligations, and you said, "You can't meet your contractual obligations. We have looked at this hard and there is no way you are ever going to meet your contractual obligations. But if we give you enough of a subsidy, you may be able to develop a product that you could go out and sell in the market and compete with others who develop their products without that subsidy." Would you regard that as unfair, distorting competition?

**Mrs McGuire:** Do you have an EU competition lawyer with you somewhere?

**Q147 Mr Bacon:** It is not a hypothetical example.

**Sir David Nicholson:** I know that is not hypothetical.

**Q148 Mr Bacon:** You know what I am talking about. I am talking about CSC, aren't I?

**Sir David Nicholson:** I know exactly what you are talking about.

**Q149 Mr Bacon:** And that is exactly what you have just done, isn't it? That is exactly what you have just done.

**Sir David Nicholson:** I am saying that, in the NHS perspective, as long as the subsidy is there to protect services and to give us something that we need for future patients and communities and it is done transparently—

**Q150 Mr Bacon:** You could justify it—

**Sir David Nicholson:** It is possible to do it.

**Q151 Mr Bacon:** But if it were in a situation where it is not to protect services and not particularly transparent, and the only aim was to give the contractor which failed to meet its contractual obligations the possibility one day of producing a product that it could then use to compete with others who have managed to produce successful products without subsidy, it would be unfair, wouldn't it?

**Sir David Nicholson:** But—

**Q152 Mr Bacon:** Sorry, what is the answer? That would be unfair, wouldn't it?

**Sir David Nicholson:** The answer is that you pay when you get the product.

**Q153 Mr Bacon:** All evidence to the contrary in the past eight or nine years of the NPfIT.

**Sir David Nicholson:** That is subject to a whole different set of arguments.

**Q154 Ian Swales:** One of the features of the NHS at the moment is that we are playing against a moving target. In fact, it is worse than that. You can imagine all sorts of analogies. I would like to pick up one issue, which is the future of the PCT estate, particularly things like district hospitals and

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community health centres. My understanding is that the default position is that those assets will go to the local acute trust. Is that true?

**Sir David Nicholson:** The arrangements for the estate are that the first port of call is whoever is currently providing the majority of the service. If a community health service were providing the service, it goes to the community health service. If an acute hospital has taken over those services as part of an integrated organisation, it will go to the integrated organisation. It will go to who currently provides the service.

**Q155 Ian Swales:** I need to come back to that when I think about my local scene, but my question relates to the Report in the sense that we are looking at the ability to achieve foundation trust status at various hospitals, but the target is moving because around those hospitals there will be other services like district hospitals. To what extent do you see that complicating this in the post-PCT world?

**Sir David Nicholson:** What do you mean by “district hospital”?

**Q156 Ian Swales:** The difference between an acute hospital and a hospital that provides local, secondary-type services. It might have an A and E; it might have clinics and so on.

**Ian Dalton:** To be a successful applicant for foundation status, a hospital needs to be able to set out in some detail and subject to considerable challenge by the SHA, then by ourselves and ultimately by Monitor, how it will operate its clinical model, how that will deliver high-quality care and how it will be financially sound over the next few years.

As we heard from the chief execs, things are changing clinically in the NHS at a very fast rate. Ownership of the estate is a relatively minor part of those changes, but it is going on at the same time. It seems that, when a hospital is engaged in turning itself into an organisation that also provides community services, as a number of acutes are, its strategy must set that out. Within that strategy, it must be clear about things like the ownership of buildings and the assets necessary to deliver that service. So, yes, there are some changes, but that is the sort of thing that the management team and the board of that organisation must be able to explain and understand, otherwise the hospital will struggle to become a foundation trust.

**Q157 Ian Swales:** Are you saying that all the hospitals that we are talking about are making applications that cover the entire clinical delivery in their whole area?

**Ian Dalton:** When a hospital makes an application, it covers the delivery within its organisational boundaries. Increasing numbers of those have become providers of both hospital and community services. As David said, if they provide both in relation to the critical clinical infrastructure, as it is called, certainly the areas of the estate owned by PCTs that directly provide care to patients will have the first opportunity to acquire those assets.

**Q158 Ian Swales:** But what if they are not providers of both? If people are applying to become foundation trusts and there are community assets in their area that they currently do not control, what is the future of those community assets?

**Sir David Nicholson:** They would normally go to the organisation that is providing the community service.

**Q159 Ian Swales:** This is very important, because I have been told the opposite by a Minister—no pressure. Are you saying, therefore, that assets such as community hospitals and community health centres could be the subject of community trusts, of the new organisations? I am talking about after the PCT goes—community foundations.

**Ian Dalton:** We are not anticipating new community organisations coming forward. From memory, I think around 16 organisations are already progressing towards community foundation trust status.

**Q160 Ian Swales:** But what happens to the parts of the country in which there are community assets that are falling between the stools? What about those that are not an acute trust? They are not going to be picked up—I understand from your answers—by the process of becoming foundation trusts. What happens to them?

**Ian Dalton:** My understanding is that the first port of call for acquiring ownership of assets is with the organisation, as David says, that is providing the service from them<sup>1</sup>. If they do not decide to take them on to their balance sheets, I believe they will be managed as part of a national arrangement so that they can still be used by local health services.

**Q161 Ian Swales:** But with the assets I am talking about, the services are provided and commissioned through the PCTs. That is the point—the organisations that run them will not be there any more.

**Sir David Nicholson:** But their community services will be there and will be provided by someone.

**Ian Dalton:** Community services have not been provided by PCTs in most parts of the country for some months; they have transferred to new provider organisations.

**Q162 Ian Swales:** That comes to the nub of it, because I know that has happened since April.

Sir David, you said that one of the ways to get out of the PFI and financial binds was to bring more services into the building. How will you prevent the big acute trusts, essentially, closing down community operations in order to bring more services into the building to help deal with a financial crisis?

**Sir David Nicholson:** First, that must be dealt with locally. The people who are particularly responsible

<sup>1</sup> If the provider of community services is an NHS Trust (as a prelude to becoming a Community Foundation Trust), or NHS Foundation Trust then the assets would transfer to the provider. The current policy is that community assets would not transfer to non-NHS providers, i.e. private providers, charities, or social enterprises (including Right to Request social enterprises). Such non-NHS providers would be able to lease those community assets they need to deliver contracted community services from the relevant PCT and from whatever future national arrangements is agreed.

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for making sure that services are provided in the best way for patients are the commissioners. So it is the PCT's responsibility.

**Chair:** It's you.

**Q163 Ian Swales:** But we are not going to have a PCT—that's the point.

**Sir David Nicholson:** It is the commissioner's responsibility to ensure that services are provided and that there is a range in location of services. But of course there will be local discussions, because people will make trade-offs around all that.

**Ian Swales:** I have probably asked enough questions, but I am trying to flag something up. You made the point that only a handful of trusts are in this position and so on, but if you live in a particular area and it is one of your trusts, you don't care if it is a handful; it is your trust. I have a particular problem with a PFI new hospital in the town that I represent, which the acute trust, effectively, manages now. It does not want to put sufficient services in for the design of the new hospital. It is already happening—there is a real issue.

**Q164 Austin Mitchell:** I want to recap, because all the earlier talk about perfect competition left me a little lost. Are you going to help out the trusts—you have said that there are about half a dozen—that, because of the costs of PFI, cannot meet foundation status financially in any way?

**Sir David Nicholson:** If we are convinced that there is absolutely nothing they can do about it in terms of efficiency, moving services, service configuration and all of that, we will consider the possibility of providing a subsidy for them, but we will have to talk to the Treasury and everybody else about all that.

What we do not want to do is to set people up to fail. If we think that a particular organisation has so many problems because of the scale of the PFI that they have to deal with, and we know that is the case, the wrong thing for us to do is to pretend that that is okay and to watch them fail.

**Q165 Austin Mitchell:** So you are going to let them twist in the wind, but you will probably in the end give them the—our—money.

**Ian Dalton:** Potentially, we have to look at levelling the playing field, not so that they make a profit from it, but so that they have no disadvantage they cannot deal with, because if they carry that into an FT application, they will be financially unsound and they will not be successful.

**Q166 Chair:** In that case, why, in relation to the Barking, Havering and Redbridge University Hospitals NHS Trust—or whatever it now calls itself—did you refuse to give David Varney, when he was chair for a brief six months—the only time I thought something might sort itself out—the money he requested to provide him with a clean sheet of paper so that he could run a viable, sustainable service for my constituents and for six or so other MPs in the area?

**Sir David Nicholson:** We do not give out subsidies of this level because a chairman says that he wants them.

**Q167 Chair:** Obviously not. It was a perfectly rational plan to get rid of a long-term problem, which is what you have been talking about, that might have given the hospital a chance to be sustainable. You turned him down; he resigned as chairman. He is probably the only good chairman we have had.

**Sir David Nicholson:** I cannot comment on David Varney's plan, which I did not see, but if you think about what we are doing now, that is exactly what we are doing now.

**Q168 Chair:** Why didn't you do it then? What has changed that you are doing it now? That was two or three years ago—I cannot remember when he was there.

**Sir David Nicholson:** Because we are doing the analysis now, not then.

**Q169 Chair:** Why?

**Ian Dalton:** We are looking at this in the light of the changing financial circumstances of the NHS, the changing clinical practice and the need to have organisations that are sustainable in that environment for the next five years. We are looking right across the whole of the FT pipeline and we are trying to deal with the problems that we have to face—

**Q170 Chair:** You set him up to fail. He then walked away—I do not blame him—and he was our only hope of sorting out a decent bit of health infrastructure in north-east London.

**Sir David Nicholson:** Irrespective of that, we have the opportunity now to put it right.

**Q171 Austin Mitchell:** I take it that so far we have a definite maybe that you will help them financially?

**Sir David Nicholson:** A small number.

**Q172 Austin Mitchell:** Right. Just let me move on, because I do not want to get bogged down in London. Why is it that the proportion of hospitals that have already gone to foundation trust is so much higher in the north than it is in, say, London? Are there any peculiar difficulties in London or those areas, like the west Midlands and east Midlands, that have a low proportion of hospitals that already have foundation status—have been foundationised, or whatever you call it—which are going to make it more difficult to carry the programme through in those areas? Is the north just naturally more compliant, nicer and ready to fall in line with Government policy?

**Sir David Nicholson:** It is difficult. If I generalise, I know I will upset somebody. The point I would make about particularly the north of England is that it has had more growth than the south of England over the past few years, and it has also tackled many of the big reconfiguration issues that have not, for a whole variety of reasons, been tackled in the south, so in that sense it has a more sustainable, established hospital system. When you get down to London and the south-east, many of the kinds of reconfiguration decisions that have been taken in the rest of the country, for a whole variety of reasons have not been taken in London and the south-east. Hence you have got these

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issues, and the delay in moving people to foundation trust status.

**Ian Dalton:** I just want to give an illustration—and I declare an interest as a former north-east trust chief executive and as substantive chief executive of NHS North East. The north-east is the region that has probably got most of its trusts through—just the ambulance trust is currently with Monitor, but it has got all its mental health and acutes through. If you look back over the last 10 to 15-year period there have been significant organisational changes, organisations coming together, hospital trusts now providing services from more than one site, and clinical changes. Those things, combined with the factors that David is talking about, make it perhaps easier for those organisations to get through. That is one of the reasons we are having a look, on the list of 20, at whether some of the organisations need to come together. They then create a viable organisation—

**Q173 Chair:** What do you mean by viable? Viable in whose terms? Financially?

**Ian Dalton:** Ultimately, finance is invariably a product of clinical viability.

**Chair:** And what about patients? Anne said something earlier about how the whole argument is driven. I can see there are financial issues that you have got to confront, but at least be open about that; is it finance, is it clinicians, and where are patients?

**Ian Dalton:** I think patients want sustainable, high-quality services.

**Q174 Chair:** No, patients also want a service that is accessible. Particularly in the London context, where we have got the biggest problems—I am sorry I am the only one here; Jo is now gone—if you allow all the outer London hospitals to close or be forced into merger, you create inaccessible services. I am telling you there will be inequality in health, and more people will die in poor areas than elsewhere, because they just will not go to their hospital appointments, because they are too far and too expensive to get to on public transport. That is what you are creating.

**Sir David Nicholson:** Yes—

**Austin Mitchell:** I agree with the Chair, as usual; I was going to move on to another question now.

**Q175 Chair:** Can I just get an answer to that?

**Sir David Nicholson:** I do not really understand what the question was.

**Q176 Mr Bacon:** You said, “Yeah”. Were you agreeing with what the Chairman said?

**Sir David Nicholson:** No, I was just trying to work out how I was going to respond to it, because there were such a lot of things in all of that.

It is perfectly possible to change services and to change with the consent and support of patients. I was thinking as you were talking about Grimsby and Scunthorpe and the work that was done between those two hospitals. People said the population would not accept those things, but they did. In London I think we have got some really difficult decisions to take.

**Q177 Chair:** I will come back later, because I have stopped Austin, but I do not accept what you just said. It is not accepting. The whole point is if you are poor, you have not got a car and you are being forced into the centre of London for a hospital appointment, you will not go, and you will then die earlier, whereas if you have a decent service close to where you are you are far more likely to go to the early appointments.

**Sir David Nicholson:** Absolutely right; it very much depends on the services doesn't it? People were saying that about stroke services only four or five years ago in London. There are some services that you need to concentrate and centralise but there are lots and lots of services that you need to make absolutely accessible locally—out-patients, diagnostics, all those sorts of things. That is what people are trying to do in the different parts of London at the moment—to configure their services to provide exactly what you described. In none of the tripartite agreements, and the work that I have seen there, has anyone suggested the closure of any sites.

**Chair:** That is most interesting, because despite having asked my trust three times for a copy of the tripartite agreement, it has been refused to me.

**Q178 Mr Bacon:** Will you send it to the Chair?

**Sir David Nicholson:** I am very happy to.

**Ian Dalton:** It will be in the public domain, on their website.

**Chair:** It's not.

**Mr Bacon:** It will be after this hearing.

**Q179 Austin Mitchell:** To follow up the example of Grimsby and Scunthorpe, there has not been 100% acceptance of contraction of services, but let us move on.

We are now in a situation where it is no longer going to be the primary care trusts but the GP commissioners—this is the great constitutional innovation in this country: we introduce the situation before the legislation is actually passed. Are not the GP commissioners going to take a rather meaner attitude towards providing services and money for the hospital, and want to do more themselves, which is going to make it more difficult for hospitals to move on to foundation status?

**Sir David Nicholson:** I would not say it quite like that, but there is no doubt that we know that, with better long-term condition care and with better support in the community, quite a lot of people who are currently sitting in our hospital beds would not need to be admitted. That is true, and clinical commissioners will do quite a lot in relation to all of that.

In terms of this process here, the commissioners—in the terms we are talking about—who are signing up are the PCTs. What we are saying to them is that they must talk to their clinical commissioners to get their views on all that and, in time, get them signed up to the outcomes that we want here, because it is in all of their interests to get these organisations—

**Q180 Austin Mitchell:** You mean that they will tie it up in advance.

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**Sir David Nicholson:** I would not say tie it up. We want to ensure that, when commissioners sign this, there is consistency among the commissioning community about what the strategy is and what they want to happen. You could describe it as tying it up in advance, but I would not say it like that, because there is a consistency between what the PCTs and the clinical commissioners want in terms of these organisations.

**Q181 Austin Mitchell:** Okay. I have one final question. We have 20 trusts that have described themselves as unable to reach foundation status. Will that number not grow as we feel the effects of the present wave of cuts and economies, particularly on management? Is there not a danger that you will have far more who cannot reach foundation status?

**Sir David Nicholson:** These are 20 that have said that they are unviable and that they need support and help from outside. Undoubtedly, as we go through the process, all NHS organisations, including existing foundation trusts, will be under financial pressure to deliver the improvement in services that we want for the money that they have. That is absolutely true.

**Q182 Austin Mitchell:** It might make people less optimistic about the chances of delivering these services if they know that there will be cuts and if they have to endure management cuts at the same time.

**Sir David Nicholson:** From a national perspective, we are reducing the management costs of the commissioning system. We have said nothing about the provider system at all. It is entirely a matter for each individual hospital or trust to decide what it invests in its management. We do not identify that from the centre.

**Q183 Jackie Doyle-Price:** I am very concerned about accountability and governance generally across the board in the NHS. I think it contributes to the postcode lottery, because clearly in some areas of the country it is easier to recruit good-quality non-executive directors than in others.

What are you doing generally to improve standards of governance across the board? We see in this report that 39% of these aspirant trusts are reporting weaknesses in governance and in board composition, and that is still consistent with existing foundation trusts as well, where a number are reporting serious weaknesses. Frankly, less than a third of them have governance that could be judged as satisfactory.

**Ian Dalton:** There are two things to say. First, I think that reference talks about boards in the round—both executives and non-executives—and that has been a consistent theme from Monitor in those organisations that have failed at the point of assessment. The assessment was that their boards were not sufficiently well-developed to take the extra responsibility to the level of confidence that Monitor needed.

One thing that we are doing is that we are working up for deployment in the new calendar year a support package for trusts going through the foundation trust process, which will aim to identify the strengths and weaknesses of their boards and do that in a structured way. We have been working with Monitor and with

six of the leading foundation trusts that have already been through the process. We have put a lot of effort into governance to define what good looks like, and we are going to ask that, from January, all organisations go through that process before they apply for approval to go forward as foundation trusts. It is obviously worth ensuring that people are in a good position before they come through us at the Department of Health, rather than finding out that they are not in a good position at the time they go in front of Monitor, which has been an issue in some parts in the past. So there is a process of developing whole boards.

There is a separate issue, however, which you have discussed, about governor development, which is also important in this and which applies to existing foundation trusts as well as future ones. We are in discussion with the relevant agencies, including the Foundation Trust Network and the Foundation Trust Governors' Association, about what actions might be useful in that regard.

**Q184 Jackie Doyle-Price:** You need to look at the issue of governors and NEDs. In practice we will have to rely on NEDs to hold trusts to account.

**Ian Dalton:** The NEDs are really important to the whole concept of accountability that is necessary to form an effective foundation trust and take sometimes difficult decisions at a meeting round a table. That is why our process wants to look at the way the board functions.

**Q185 Jackie Doyle-Price:** On a scale between being a light-touch regulator and being very interventionist, how active do you expect Monitor to be to ensure that governance is of the right calibre?

**Sir David Nicholson:** It is obviously responsible and not at all light touch when identifying the success of a foundation trust and giving it a licence and so on. We expect Monitor to be heavily involved and engaged in looking at a trust's complete governance—the people and all the rest of it—before it becomes a foundation trust. That is at the heavy end. If a foundation trust gets into difficulty, we would expect Monitor to be interventionist, but we would expect it to be light touch for the vast majority of foundation trusts that continue to provide good services to the satisfaction of their patients and commissioners. In a sense we expect Monitor to be differential in the way it deals with foundation trusts.

**Q186 Jackie Doyle-Price:** Ultimately, Monitor relies on the NEDs as well, doesn't it? You mentioned in response to an earlier question that you can go in and replace an entire leadership team if that was felt necessary—

**Sir David Nicholson:** Not for FTs.

**Q187 Jackie Doyle-Price:** But Monitor reserves that right.

**Sir David Nicholson:** Monitor can replace the chair.

**Ian Dalton:** Monitor is keeping that power for all organisations until at least 2016, and for the first two years of operation for trusts that are late in the pipeline. It will keep a transitional oversight role with a view to ensuring, particularly for relatively new and

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inexperienced trusts, an oversight of governance during the first couple of critical years.

**Q188 Jackie Doyle-Price:** My concern is that if you look at Monitor's reports for existing foundation trusts, there are some serious causes for concern, but those trusts are obviously in a better state than those that are aspirant. I am looking for some satisfaction that perhaps Monitor might be more active. I say that in reference to my own foundation trust in Basildon, which was the subject of a parliamentary statement two years ago and is still judged as red in terms of governance. Monitor has worked actively with that trust, but from my perspective as a user of the service and the representative of my constituents, I am impatient. Those problems will only get worse when you look at this list of hospitals.

**Sir David Nicholson:** Monitor is an independent regulator and we expect it to intervene when things go wrong—I realise that they went wrong in your trust—and we expect it to be light-touch in relation to most other trusts.

**Q189 Chair:** But it is very scary that we have had an appointments commission, yet in nearly 40% of cases, you have concerns. Once you have moved to foundation trust status, the foundation trust appoints its own board. That is really scary—aren't you scared by that?

**Sir David Nicholson:** It is part of the Government's policy of autonomy and liberating the NHS. It is the implication of what you do—

**Q190 Chair:** And what happens if it goes wrong? We haven't had your accountability statement, Sir David.

**Sir David Nicholson:** There are two aspects to that. One is the safeguards that we are putting on Monitor by keeping its existing powers for longer and for the first two years for any foundation trust that is given a licence towards the end of that period. It gives us the opportunity to do exactly what you say and strengthen the foundation trust governor system and the people who do it. In this process, they are the people responsible for their organisation through the non-executives. In terms of service, that is a commissioning responsibility. The sustainability of services for patients is the responsibility of the local commissioners, the commissioning board and, ultimately, the Secretary of State. That continues.

**Jackie Doyle-Price:** There is a cultural issue. Generally—Monitor is not the only regulator that suffers from this—regulators tend to be risk averse in using their powers. It tends to be more of a collaborative relationship, which is helpful until you get serious failure. To make another point on behalf of my constituents, which supports the Chair's point, my constituents are served by Basildon and Thurrock. Because of the reputation of that trust, they elect to go to Havering and to Darent Valley, and they are both on this list as being potentially non-viable. So I come back to the point that unless we get the regulatory system right, we will exacerbate the postcode lottery.

**Chair:** It is interesting. Around the table, we are probably a representative group. We have so many

with problems in their own trust. It is a further issue. We have had four of us with problems. Ian was the other one. You are very confident about the majority, Sir David.

**Q191 Mrs McGuire:** I, of course, come at it objectively, representing a Scottish constituency. I want to ask a couple of questions about the financial plans. The NHS is in a state of change. One of the elements of the triple alliance—someone needs to come up with a better name for these TFAs—is due to disappear. That is the PCTs. The NAO Report commented on the robustness of the future financial planning if you are changing the commissioning agent, which means there is no security. What analysis have you done on the impact of those changes on the trusts?

**Ian Dalton:** I do not think it is a question of simply accepting, if this were the premise, that, because of the change in commissioning, trusts will not be able to have commitments from their commissioners that help them plan for their future. The issue is that the commissioning role is transitioning across the journey that some trusts have to make. Some trusts will be a foundation trust before those changes; others will have a journey that takes them longer.

The expectation we have is that PCTs, the aspirant foundation trusts and, increasingly, the clinical commissioners themselves will be having those conversations while the PCTs are still on the patch, so that the trust can have those conversations direct with the new commissioners while the old ones are still involved as well, so that there is a seamless transition. A key issue in putting forward a successful foundation bid is that there is a coming together of the plans of commissioners with that of the provider. It is no good making income assumptions that are not based on the clinical aspirations of commissioners. That role is changing. Those clinical commissioners need to be involved in that conversation from the relatively early stages of their development onwards, so that there is not a sudden change.

**Q192 Mrs McGuire:** Is that making an assumption that the aspirant commissioners as you call them will have the same objectives as the current commissioners?

**Ian Dalton:** My assumption is that commissioners will be interested in having accessible, high-quality hospital services and will therefore want to have that conversation.

**Q193 Mrs McGuire:** Are the aspirant commissioners going to be locked into decisions of commissioners who are no longer going to be there?

**Ian Dalton:** I do not think it is a question of locking people in. I do not think that PCTs are locked in. This is about a broad convergence of strategy. That is what we are looking for. Clearly a lot of this will be determined by individual patients making choices. We are not going to oblige patients to use individual hospitals. It is about people conversing and there being a coming together of strategy.

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**Q194 Mr Bacon:** A what of strategy?

**Ian Dalton:** A coming together of strategy. A detailed, line-by-line lock-in.

**Q195 Chair:** There are two final issues, one of which is a bit about London. You have a heck of a lot of hospitals—113—that you want to get to foundation trust status. Will Monitor be able to cope, particularly with the peaks?

**Sir David Nicholson:** When we originally did the work, Monitor was concerned that there was bunching up in particular parts of the period where there seemed to be lots coming together. It was concerned whether it had the capacity. We have done some more work on that and it is a much smoother transition now. Monitor is more comfortable with its ability to deliver that, if we deliver them in the order that we say.

**Ian Dalton:** That is an issue. The other issue that Monitor has been concerned about is that it has wanted to see a clear profile of when it can expect to have trusts in front of it. They will speak for themselves, but my assumption is now that we are starting to set out some forward dates, and it will be able to plan on that basis in scaling capacity.

**Q196 Chair:** Why, given the Government commitment, did we have only seven trusts agreed in 2011?

**Ian Dalton:** That is in the first six months.

**Q197 Chair:** Only in the first six months. Are you meeting your target of the number of applications in October?

**Ian Dalton:** I am trying to remember.

**Q198 Chair:** It was one of your peaks in the graph.

**Ian Dalton:** Yes, we have had some trusts that have not been able to submit, for a range of reasons, and we are following those up.

**Chair:** So you are behind.

**Mr Bacon:** Too busy looking after patients probably.

**Q199 Chair:** Can I ask about London? London is where you have the biggest problems. You have made heroic assumptions about half the trusts in London making it to foundation trust status. The reason I say heroic is that you assume that they achieve productivity savings in the top quartile of their peers or better. Am I right in saying that is your assumption? How realistic are your projections?

**Ian Dalton:** Those are the assumptions that the organisations themselves are making.

**Q200 Chair:** You in the end have said that you will intervene, so presumably you are monitoring it. That is just shoving it off on somebody else. Are you confident that half of the 38 or whatever it is in London—

**Mark Davies:** This is the modelling that is being done at the moment, which does require productivity savings. We are referring to paragraph 3.10 of the Report. Productivity savings in the top quartile of their peers are required to achieve, in respect of the 18 non-specialist acute—

**Q201 Chair:** Thank you. Are you confident about that, if we have you back in a year's time, which we will?

**Ian Dalton:** I think the evidence will be if they can deliver it. That is what the analysis suggests they need to do. There is a need to create efficiency.

**Q202 Chair:** Are you confident that they will perform?

**Ian Dalton:** I think it's too early to say. We will have to see as it happens. If not, we will have to keep close and intervene where necessary. That is the challenge that those organisations face.

**Q203 Chair:** I take that as you are not confident.

**Sir David Nicholson:** I think it is clear that the biggest challenge is around London, for all the sorts of reasons that have been well-rehearsed before: the difficulty of getting change in London; getting agreement among people about what needs to be done; and about the kind of decisions that need to be made in the order. All of those things still apply. Underpinning that is some service change.

**Q204 Chair:** Based on the fact that half of the trusts that still do not have foundation trust status have to be super-efficient at finding their savings, you are not confident. You are either confident or not.

**Sir David Nicholson:** I am moderately confident. I am in the middle of that. Changing health care in London is a very difficult thing to do. Two of the chief executives you heard earlier have been wrestling with the issue. You know as well as I do that anything you try to do with the health service in London suddenly becomes a massive issue. We have some really difficult decisions to make about the future of London's health care. We know, because we did the analysis, that in London we have a relatively unproductive secondary care system; we have an underdeveloped community system, with far more people going to hospital than parts of the country. Slowly but surely the London health system is trying to get itself together, hence the improvements in stroke, cancer and trauma. Change in London is like change nowhere else in the NHS. That is why I am moderately hopeful. I can see how they can do it but I can also see the obstacles that will be in place. To give the sort of people you described earlier who live in inner London the best health care we possibly can, we must make those decisions.

**Q205 Chair:** But you might make the decisions not by concentrating on health care in the centre of London.

**Sir David Nicholson:** I agree. I—

**Q206 Chair:** Or you might think about relocating one of the teaching hospitals. I would offer you the Queen's hospital site to relocate the Royal Free. That would give you a jolly lucrative site in Hampstead which you could flog.

May I say something else? It seems that your strategy of viability depends on merging—that is what you're

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doing—across London in particular. I'm looking again at my area of London. There is a massive and completely unsustainable PFI at Barts—I accept that it was agreed by the previous Government—for £1.2 billion. It seems that the only reason you're merging two failing hospitals—Newham and Whipps Cross—is to sustain the PFI at Barts. Rather than the stronger supporting the weak, the weak is being sacrificed to the PFI.

**Sir David Nicholson:** These organisations themselves have come to that conclusion.

**Q207 Chair:** Sir David, you can't get away with that. I know the role that the regional structure has played in forcing that against everyone's desires. It seems to me that, again, what is being sacrificed is accessibility to NHS services in poor areas of the capital.

**Sir David Nicholson:** On the contrary. They will publish their business case, which will set out what the benefits are for patients. I can say absolutely that it's not being driven by the PFI. What it's being driven by is making sure that everyone in that part of London gets the best quality health care possible.

**Q208 Chair:** Every MP across the spectrum believes that. What foundation trust that is viable at the moment and in its right mind will take on a hospital that is in financial difficulties? What on earth would impel them to do that?

**Sir David Nicholson:** Sorry?

**Q209 Chair:** What foundation trust in its right mind in London would take on one of the failing hospitals in financial difficulties? Where on earth is there any incentive in the system of competition and financial sustainability to make that happen?

**Sir David Nicholson:** First, most of the mergers are not driven in that way. Across the country as a whole, they're not driven by failing organisations being taken over by others. They're organisations coming together across the whole country. You were talking about mergers. There are many examples of successful mergers across the NHS, but in London we undoubtedly have some issues to tackle. Why would a successful NHS trust in London take on an organisation? They might do so because clinical interests are involved. They might see benefits for patients by bringing those two services together, which might improve the quality for both sets of organisations and patients. They might see a financial advantage, or a mechanism by which to rationalise services to deliver better across the piece. Some organisations want to do that because they want to do the best for their local community, and they have an interest in being engaged in that across the system as a whole.

**Q210 Chair:** You have a very sceptical view on that—I just don't believe that, and I cannot see in some of the worst ones how on earth you'll resolve it to get foundation trust status, except by closing.

**Sir David Nicholson:** None of the plans that we have around here involve closing hospitals.

**Q211 Chair:** Well they do in the medium term—

**Sir David Nicholson:** They don't. The TFAs don't involve closing hospitals.

**Chair:** I'd bet many bottles of champagne that in five years—

**Mr Bacon:** And you're a champagne drinker.

**Chair:** Absolutely. A champagne socialist.

**Q212 Mr Bacon:** I'm someone who drinks Adnams ale from Suffolk, or occasionally ale from one of the more local microbreweries in south Norfolk.

May I ask you a more 100,000-foot question about the nature of health care provision, and the number of mergers going on? If you look at a range of different commercial sectors over the past 50 years—whether metal processing, trades unions, international organisations and so on—there have been many mergers of all kinds for perfectly good reasons, but perhaps some of them for less good reasons. It is something that you often see in different settings. Has the Department done any work to determine the optimum number of acute hospitals? If you had a blank piece of paper, as we know you don't, what numbers might you come up with if you could ask, "What would be the optimum number of acute hospitals, and what would be the optimum number of other kinds of provision in this country?" Would those numbers be quite different from what we have now? That is not impossible.

I hear the scepticism, not to say cynicism, in the Chair's voice, and we have all seen things that appear to be happening for the worst possible reasons, but I take at face value what you say about local hospitals wanting to offer the best they can for their communities. It is perfectly possible to imagine a world in which the configuration of provision is quite different, yet significantly better in many ways, on a variety of metrics, than what we have now.

Have you done any work on that at a—I hate to say it—blue-sky level? If you look at it from a long way off and think about how things could be improved so that the available resources are optimised, absent what I know can be hideous political considerations, what conclusions do you come to?

**Sir David Nicholson:** No, we haven't done such blue-sky thinking.

**Q213 Mr Bacon:** Just too dangerous, is it?

**Sir David Nicholson:** No, for good reason. Health is not like the examples that you gave. The patient's—the community's—relationship with their local hospital is not like their relationship with other organisations. The NHS is not a group of autonomous organisations all operating together in a market. It is owned by the population as a whole and—you know this better than me—the population strongly feels part of it. Whatever arrangements you put in place, local accountability, and how you exercise that accountability through foundation trust status, is critical.

Great big plans from the sky that identify a blueprint simply will not work in our environment, but, as we look at specialty service by service, we can say that there are better ways of delivering. We know that in

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London there were 30-odd different organisations delivering acute stroke services, and now there are seven or eight. You can see in terms of both clinical and financial viability that that is a more efficient way of delivering a better-quality service for patients. If

you start to look at that on a service-by-service basis, you are much more likely to get a result for patients than by simply looking at the number of buildings or organisations that we have.

**Chair:** Okay. Thank you very much indeed.

### Written evidence from the Chief Executive of the NHS

#### *Public Accounts Committee—Achievement of Foundation Trust (FT) status*

Further to the hearing on Wednesday 19 October, I agreed to send you a copy of the Tripartite Formal Agreement (TFA) for Barking, Havering and Redbrige University Hospitals NHS Trust (BHRT).

As you aware, the TFA process is a locally owned one and as such, I am unable to provide a copy of the document until it has been published by the Trust. Matthew Kershaw, Director of Provider Delivery has written to the Chief Executive of BHRT to ask that you are provided with a copy of the TFA as soon as it has been published.

I enclose a copy of the letter for your reference.

#### LETTER FROM DIRECTOR, PROVIDER DELIVERY

#### *Public Accounts Committee—Achievement of Foundation Trust (FT) status*

As you may be aware, Sir David Nicholson and Ian Dalton were witnesses at a Public Accounts Committee hearing on Wednesday 19 October. Three NHS Trust Chief Executives were also called upon as witnesses at the hearing. Part of the discussion focussed upon Tripartite Formal Agreements (TFAs). The Chair, Margaret Hodge MP, specifically asked about the TFA for your Trust, please find a copy of her request from the transcript:

*Chair: That is most interesting, because despite having asked my trust three times for a copy of the tripartite agreement, it has been refused to me.*

We understand that you will be discussing the TFA at your next Board meeting and that following this the TFA will be published. We would be grateful if you could send Margaret Hodge MP a copy as soon as possible after the Board meeting has taken place.

27 October 2011

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