

Physicians and Foundation Hospitals

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ABSTRACT – Foundation NHS Trusts will be constituted in the same way as Mutual Societies, and local people and patients will be invited to become subscribers. Subscribers will elect a board of governors who will appoint the non-executive directors of the Trusts. Foundation Trusts will be outside the performance management system, but will be subject to a regulator and to inspection. Contracts with commissioners will be legally enforceable. Issues discussed in the article include: financial borrowing; whether competition is being reintroduced; poaching staff; fears of a two-tier health service; fragmentation of the NHS; the impact on research and teaching; and the impact on the current ‘target culture’. Local communities and patient groups may welcome involvement with their local hospitals, but special interest groups could be a danger. Foundation Trusts may bring back some of the better features of NHS Trusts as originally conceived, and offer better opportunities for clinicians to influence local policies and priorities. Fears of yet another organisational change are an important issue. Only time will tell whether the outcome will justify the effort the changes will involve.

KEY WORDS: Foundation Hospitals, health sector reform, hospital management, NHS management

To most clinicians, the running of their own hospital, clinical directorate or specialist service is fundamentally important. Foundation Hospitals are a proposed new form of local management. For those who remember the debates of 1991 and 1992 about self-governing hospitals, much of the discussion around Foundation Hospitals (now Foundation NHS Trusts) will seem very familiar. The depth of feeling on both sides of the question appears to stem in part from the perception that these two sets of initiatives, separated by a decade, are much the same. So Frank Dobson MP regrets the return of competition.¹ Advocates deploy the rhetoric of ‘freedom from Whitehall control’,² which is remarkably like Ken Clarke’s promise that NHS Trusts would ‘manage their own affairs’. The process of application in a series of waves, culminating in every Trust becoming a Foundation Trust, mirrors the process established to create NHS Trusts in the 1990s.

If the legislation is passed, over the next few years clinicians in nearly every place may well be asked to support local Foundation Trust applications. This article aims to help clinicians form a view on these proposals and contribute constructively to local debate.

What are Foundation Hospitals?

Constitution

Foundation NHS Trusts will be constituted quite differently from NHS Trusts. NHS Trusts can be characterised as government-owned companies. They have a shareholder, the government, to which they pay dividends. By contrast, Foundation Hospitals will be set up like a Mutual Society. This is owned by its subscribers – people who have a stake in its activities. It does not pay dividends, but reinvests any surplus in the activities for which it has been established – for example, lending people money to buy their homes. Local people and patients will be invited to subscribe to membership of Foundation NHS Trusts. Members will elect trustees to a board of governors which will also include staff and (in teaching hospitals) university representatives. Elected trustees are to be the majority. The board of governors will appoint the non-executive directors, including the chairman, of a management board much like current Trust boards.

This is in principle a far-reaching change which denationalises hospitals, reversing a main plank of the 1946 National Health Service Act. (Hospitals were not private before 1948; they were owned locally by municipalities and voluntary organisations.) It is very different from the arrangements for NHS Trusts. In 1991, the Conservative government used the appointment of chairmen of Trusts to forge an iron chain of political command from individual hospitals to ministers. While the regulator retains the power to intervene in a crisis, this Bill proposes to establish organisations with potentially significant independence.

The Bill³ removes the Secretary of State’s power of direction and passes the power of intervention in the affairs of a Foundation Trust to the regulator. Of course the regulator is subject to appointment by the Secretary of State, which leaves the honourable gentleman with a degree of influence. The Bill also places

Foundation NHS Trusts outside the performance management role of strategic health authorities (SHAs). In practical terms that is likely to be very important. No doubt there will be some jockeying for influence between SHAs and the regulator, but given a reasonably robust assertion of independence by the new Foundation Trusts, the current performance management line will be broken.

The regulator

The main statutory roles of the regulator are intervention where a Foundation NHS Trust is failing and setting the Trust's borrowing limit. In effect, the regulator takes up the core roles performed in the past by Regions. But the regulator is independent of the Department of Health and will be able to operate within what is now a well established set of conventions for relationships between regulators and operators within an industry. It will therefore be a more detached role than that exercised by the Regions.

Inspection

Foundation NHS Trusts, like all NHS Trusts, will be subject to inspection by the Commission for Health Audit and Inspection.

Legally enforceable contracts

The performance management line of accountability will be replaced by reassertion of contracting arrangements. This will strengthen the role of PCTs and other commissioners and will constrain the Department of Health to pursue national plans and targets through the contracting system. Contracts within the NHS will be legally enforceable. This was very deliberately ruled out by Ken Clarke in the 1990s. As a consequence, it has been too easy for either party to simply disregard contracts when things become difficult. Armies of contracting staff in both Trusts and commissioning bodies have laboured to assemble volumes of paper which, when it really matters, serve no practical purpose. Making contracts legally enforceable will require everyone to treat the process seriously. Trusts will need to deliver what the contracts require, and so be more careful about what they sign up to. Commissioners will need to meet the costs of what they ask for in contracts, and be more careful about what developments are agreed. The Department of Health will need to be more precise about the funding attached to new initiatives or targets. The mantra that 'it's all in the national growth percentage' will not be good enough to fund a contract-based NHS. The reintroduction of these basic financial disciplines may or may not come in time to avoid an NHS funding crisis.

So what about ... ?

The passage through Parliament of the Bill introducing Foundation NHS Trusts is not proving easy and the Commons Select Committee on Health has published a less than enthusi-

astic report.⁴ The following sections outline some of the main concerns raised, and some other issues that are important to clinicians.

What about borrowing?

For opponents, the freedom to borrow that has been promised to Foundation Trusts fuels fears of unfair advantage over the rest of the NHS. For the Tories, the constraints on borrowing are one of the main ways in which the proposals have been emasculated.⁵ For local managers and clinicians, the promise of access to capital funds is likely to be a major attraction to seeking Foundation status.

Borrowing in the marketplace, as in 1991, has proved anathema to the Treasury. Borrowing by Foundation Trusts is part of public borrowing, and will be set against the Health Department capital funds allocation. There will be a ring-fenced allocation set aside for Foundation Trusts. Individual Foundation Trusts will be given a borrowing limit by the regulator, probably a proportion of turnover. The level indicated will fund acquisition of equipment and middling capital schemes. It will not replace the private finance initiative (PFI) for large schemes. But Trusts will need to be able to finance this borrowing without going into deficit, so they will need to be generating a financial surplus. Potentially this could create both a virtuous and a vicious circle. If a Trust is financially successful it will be able to support additional borrowing to improve its equipment and buildings and make investments to improve efficiency. So it will be better placed to be successful in future. Trusts which are less successful financially will be less able to invest, and so their position will tend to worsen over time. The reality is that the early waves will almost certainly enjoy a significant advantage in access to capital.

What about competition?

One of Frank Dobson's main objections to the Bill is that, 'Foundation Hospitals represent part of the reintroduction of competition into the NHS'.⁶ Neither Foundation NHS Trusts nor NHS Trusts as introduced in 1991 of themselves constitute introduction of competition. But NHS Trusts in 1991 were very much a part of the 'internal market' reforms. In much the same way, Foundation NHS Trusts sit alongside the financial flows regime, the patient choice reforms and encouragement of diversity of public, private and voluntary sector provision.

The Government argues that the system is not moving towards competition, and to support the argument cites the fact that standard tariffs for services are to be introduced. From 2005/6 there will be a national charge for a number of common conditions which will apply to all providers. In the USA, insurers and Medicare have had standard tariffs since at least the 1970s. It is not often suggested that there is no competition in healthcare in the USA. Standard tariffs, when they are comprehensive, will avoid price competition. Where there is excess capacity then diagnosis and treatment centres, Trusts and private hospitals are likely to compete for patients by trying to offer

Key Points

Foundation NHS Trusts will be constituted as mutual societies

Foundation NHS Trusts will be outside the performance management system

Local communities and patient groups may welcome involvement with their local hospitals

Fears of yet another organisational change are an important issue

shorter waiting times, cultivating GPs, improving parking and a hundred other ways which may make a patient choose one provider over another. This could be a good thing; perhaps this kind of rivalry is needed to create a more patient-centred NHS.

People do respond to those who have the power to give them success. In any command hierarchy, whether it is the Byzantine Empire, the Soviet Union or the NHS, people give priority to pleasing those above them. Contracting and patient choice will change the hierarchy and therefore the motivators of managers: success will be earned by meeting the needs of commissioners and of patients.

But severe competition is only likely where there is too much capacity. So long as the NHS continues to pursue ambitious access targets and capital continues to be rationed, patient choice is more likely to function as a useful capacity-balancing mechanism than as anything more threatening.

What about poaching staff?

Although *A guide to NHS Foundation Trusts*² promised freedom to offer new rewards and incentives to staff, what new freedoms are being offered is hard to pinpoint. Foundation Trusts are expected to participate in national pay arrangements, as NHS Trusts invariably chose to do in the 1990s. NHS Trusts always had discretion in application of agreements, where to place individuals on scales, whether to introduce local agreements for special groups or to make arrangements outside of national agreements for individuals.

This discretion has been used mainly to attract individuals to innovative positions, or jobs which are difficult to fill. Often discretion on pay has been used to attract people to hospitals in disadvantaged communities where it is hard to recruit. Prestigious teaching hospitals, or hospitals in pleasant areas with opportunities for private practice, do not usually need to offer additional incentives.

What about the 'two-tier' health service?

The real advantages of Foundation Trusts are not very dramatic, but they do exist. It is logically impossible to offer incentives and at the same time to treat everyone equally. The Government argues that in any case all hospitals will be Foundation Trusts within five years, and in the interim there will be special support for Trusts that are having difficulties.⁶

What about fragmentation?

Another of Frank Dobson's concerns is that Foundation Hospitals will 'set back the integration of hospitals with local primary care and community health services'.⁷ This will strike a chord with many members of the College, particularly those who work with the elderly and chronically ill. In many places, the NHS reforms of the early 1990s were very destructive of integrated services developed since the unification of the NHS in 1974. The Health Maintenance Organisation model adopted for PCTs perpetuates a more distant relationship between primary care led community services and hospitals. Some see a better future in Foundation NHS Trusts that again bring together hospital and community services under one management. Others would like to see PCTs managing local hospitals. But it is difficult to see how current proposals will affect the problem one way or the other. People in Foundation NHS Trusts and in PCTs will need to continue to work very hard together to ensure seamless services, within a structure that, as now, is not all that helpful.

What about research and teaching?

Clinicians are properly concerned that any new arrangements should not be detrimental to research and teaching, as the internal market was initially. Modern arrangements for post-graduate medical education (PGME) and for R&D were developed to address these problems. The arrangements are based on the contracting system, and so will apply to Foundation Trusts. The significant funding attached to PGME and to R&D makes it very unlikely any Foundation Trust would choose to neglect these important activities.

What about the target culture?

Many clinicians are concerned that targets and star ratings can override sensible clinical priorities. Few can object that hospitals are required to meet minimum standards for things like waiting times, and that progressively these standards are raised. People object to a small selection of administrative indicators being given absolute priority over any other consideration, including clinical ones. They object to lack of freedom to respond to local circumstances when the blinkered pursuit of a particular target defies common sense. These problems are largely a product of the performance management system. So a Foundation NHS Trust, which will be outside that system, may well be a more satisfactory setting in which to practise medicine. But until Foundation status is achieved, the rivalry inherent in the process of application may intensify pressures on managers to meet targets at all costs.

Risks and opportunities of the Foundation Trust proposals

The innovative feature of Foundation Hospitals is the way they are to be constituted, like Mutual Societies with subscribers. If you are looking for a form of ownership that offers much

autonomy but is not privatisation and is not local government, this is an ingenious scheme. However, the experience of the traditional Mutual Societies and cooperatives is not particularly good. In the last century they tended to be run by self-perpetuating oligarchies and members showed little interest in their management. In recent years they have consequently been vulnerable to some very dramatic attempted takeovers.

The hope is that local communities and patient groups will welcome the chance to become involved with their hospital. Community identity and support will be enhanced, non-executive directors will gain new legitimacy for their role and the Trust will have a significant constituency to bolster its independence.

The risk is that there will not be wide community interest and that the Board of Governors will be dominated by semi-professional politicians and special interest groups. Managers may come to look back with regret to the passing of community health councils. At worst a Trust may be targeted by special interest groups. The reaction of the Department of Health to the first Trust captured by the 'Right to Life' movement would be interesting.

The autonomy of Foundation Trusts offers the opportunity to bring back some of the better features of NHS Trusts as originally conceived. Staff respond well to a strong sense of institutional identity. Managers and clinicians can focus on their main job, providing services for patients, and spend less time in meetings at the SHA. Decision making will return to local hospitals. It should be easier for clinicians to obtain decisions and to influence decisions. Moving out from under the performance management system should enable clinicians to reassert the influence of the clinical community on local policies and priorities.

Both Frank Dobson and David Hinchcliffe, Chairman of the Health Select Committee, have emphasised fears about yet another round of NHS reorganisation.⁷ This is a very real issue for clinicians. People spend years patiently building up services within very severe constraints. It is hugely frustrating that every few years all the people in management with whom you have built relationships, and all the management systems you have learnt to master, can be swept aside, and everyone has to start again at the beginning.

In 1991, Trust status could be a way of protecting a hospital from the endless round of organisational change which afflicts the NHS, and of keeping good management teams together. Today a Foundation NHS Trust is less likely to be merged and its managers are more likely to stay.

The quasi-Mutual Society structure is interesting and offers real opportunities as well as some risks. Many people, for very good reasons, object strongly to the notion of markets in healthcare. But it is markets that have demonstrated the ability to transform productive systems. Can anyone imagine the transformation of the airline industry by Ryanair and Easyjet, without a free market? These proposals do not reintroduce a market in healthcare, but they do inch very cautiously in that direction. Whether such an approach will produce the transformation the Government is seeking, only time will tell.

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