NHS Foundation trusts
ippr briefing note

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The ippr view

• Whilst the establishment of foundation trusts is broadly welcomed, government needs to refine the policy and give greater priority to other complementary areas of health policy.

• The position of Primary Care Trusts needs to be strengthened. It makes sense for PCTs to also have community ownership, as they are responsible for purchasing care on behalf of the local community. Without this, it will be even more difficult to challenge the current dominance of the acute sector in healthcare.

• Government should pay attention to ensure that the new treatment tariffs and associated funding flows in the NHS create the right incentives to reward productivity and efficiency. Although less politically prominent and salient than new ownership structures, these funding issues are critical in ensuring an improved NHS.

• Borrowing from the private sector is likely to bring little, if any, advantage to foundation trusts. Government should put in place a prudential borrowing regime within the public sector for foundation trusts, similar to that being developed for local government.

• Whilst it is right that government intends to control borrowing powers and the ability to treat increasing numbers of private patients, it needs to ensure that foundation trust managers experience some real freedoms. It is currently unclear whether the reality will match Ministerial rhetoric.

• Government should insist that foundation trusts take a proactive approach to community and patient membership. Leaflets in GP waiting rooms will not be enough. Effort should be made to ensure public members reflect the diversity of local areas.

• Government should encourage all staff, not just hospital consultants, to be effectively represented on foundation trust governance boards.

• Government should be cautious over granting foundation trusts the freedom to set local pay and conditions. In a capacity constrained system this could lead to wage inflation and poorer quality trusts being unable to attract the best staff.

• Government should continue to fund the NHS adequately, and concentrate on other key areas of public policy reform, such as working practices in the NHS. The NHS in the past has suffered most from inadequate funding, not a lack of structural change.
1. Background

NHS foundation trusts will be legally independent organisations (called ‘Public Benefit Corporations’ in the legislation), owned by local communities, not by shareholders. As such they are a type of ‘not-for-profit’ organisation or ‘Public Interest Company’ (PIC), described in the forthcoming ippr report *In the Public Interest? Assessing the potential of Public Interest Companies* (published 24 April 2003)

Foundation trusts will deliver care purchased by locally based Primary Care Trusts (PCTs). The public will still experience health care free at the point of use, based on clinical need and not the ability to pay. The best 68 NHS trusts out of 304 have been invited by the Government to tender to become foundation trusts. Thirty-two trusts had applied by March 2003.

2. Why are foundation trusts being introduced?

There are four key issues behind the foundation trust policy:

2.1 Accountability. The Secretary of State has made much of foundation hospitals following on from a centre-left co-operative tradition. The democratic deficit within the NHS is to be addressed by the having local ‘members’ of foundation trusts, and a board of governors featuring patients, the public and staff members. This could help make services more responsive to patients, and reduce inefficiency disguised through bureaucratic secrecy.

Staff will also be included on the board of governors of foundation trusts. This could help improve communication and working between hospital managers and clinicians – vital if the changes are to be successful and if standards are to be improved.

2.2 Diversity. Foundation trusts are part of a move to create more diversity and ‘contestability’ (ie where service providers can be replaced if they are not providing an adequate service) in the NHS. This is seen by the government as crucial to providing incentives to NHS managers to improve the quality of their services.

Government has signalled that it is willing to involve the private sector more elsewhere in the NHS, for example in new Diagnostic and Treatment Centres. However, it is reluctant to use shareholder-owned private sector hospitals because it would have to rely on a contract to ensure the public interest is guaranteed. Whilst contracts are useful for relatively simple services (such as PFI buildings, and arguably routine hip operations), it is extremely difficult to draw up an adequate contract for complex clinical care.

2.3 Freedoms. Ministers have announced their intention to use foundation trusts to reduce the levels of bureaucracy and political intervention faced by NHS trust managers from central
government. Foundation trusts will be legally independent of Whitehall, and it has been suggested that they will face fewer targets and other central diktats. They will deliver fixed price contracts for care to Primary Care Trusts and will be free to decide their priorities to attract more PCT commissioned services in order to maximise their income. However, the real degree of freedom that foundation trusts will be allowed in practice is not yet clear.

2.4 Finance. The prospect of allowing foundation hospitals to borrow from the private sector and for this investment to be 'off balance sheet' has been a prime concern for supporters of the policy. Opposition from the Treasury has led to a compromise whereby foundation trusts can borrow from the private sector, but this will be restricted by an independent regulator and count against Departmental spending limits.

3. Key questions

3.1 Are foundation hospitals the first step towards privatisation?

- Unlike privatisation, no assets will be sold to shareholder owned companies when creating foundation trusts. Instead, patients, staff and the public will own hospitals, and they cannot benefit financially or demutualise in years to come.

- Foundation hospitals are not free to determine the level of service they provide. The public sector will retain control over what activity is undertaken through contracts from Primary Care Trusts. Foundation trusts’ activity will also be curtailed by the independent regulator which will limit their borrowing and the Commission for Healthcare Audit and Inspection which will monitor their performance.

- Whilst the numbers of private patients will be restricted for the first time under the new legislation to current levels, it is possible that a future government less favourable to the principles of the NHS could reverse this policy.

3.2 Should Foundation hospitals have the freedom to borrow from the private sector?

- ‘Off-balance sheet financing’ is a dubious reason to pursue any public private partnership that is supported by taxation. It doesn’t result in ‘extra’ investment and is little more than an accounting trick. In any case, foundation trust’s borrowing is highly unlikely to be judged as off-balance sheet.

- In regular PPPs private finance (ie shareholders) provides scrutiny over deals, and bears risk in the project. However, foundation trusts will only be backed by debt finance, not a mixture of debt and equity (shares). As a result private finance will not bear risk, or provide any serious contribution to corporate governance. Private finance will only result in higher costs of borrowing.
3. Will it result in a two-tier health service?

- Two-tierism could come about through, firstly, only allowing the few best NHS trusts to become foundation trusts, and secondly, by allowing foundation trusts to set local pay and conditions.
- Neither of these policies is dependent on the foundation trust principle – they are separate policy decisions taken by government.
- Creating foundation trusts in waves will lead to greater diversity in the hospital system, but it is unlikely to make existing variations of standards in the NHS significantly worse.
- However, there is a danger that allowing hospitals to set local pay and conditions in a capacity constrained system might lead to higher wage costs, with poorer performing hospitals unable to attract higher quality staff.

3.4 Will it mean more choice for patients?

- Government has been keen to link greater patient choice with the issue of foundation hospitals. However, this is a little misleading.
- Allowing Primary Care Trusts to commission care from a number of hospitals under fixed-price contracts could lead to increased capacity in the system and a greater range of hospitals serving each local population. However, this policy applies whether hospitals are either foundations or typical NHS trusts. In any case it provides more choice for providers at an institutional level (PCTs) rather than at the level of individual patients, although patients might experience limited increased choice.
- The public scrutiny of foundation trusts might help encourage more patient-centred healthcare, and more choice by patients over the type of care they receive. However, this is by no means guaranteed.

3.5 Will it lead to a fragmented NHS?

- There has always been a wide variation in standards in the NHS, and whilst there has been some degree of national strategic direction, national standards and the National Institute for Clinical Excellence (NICE, which is designed to end the so-called ‘post-code lottery’), were only established in the last few years.
- However, allowing foundation trusts to decide their own priorities for investment will necessarily reduce the scope for national strategic decisions. Government calculates that
allowing managers to pursue income opportunities will offset this strategic direction through more dynamic and innovative services.

- Whilst foundation trusts could lead to greater integration between clinicians and managers within each hospital, it could also lead to less co-operation between hospitals. This may be problematic, for example, in jeopardising the recent improvements such as the development of clinical networks.

3.6 Where will accountability lie?

- There are complex lines of accountability in the new foundation trust system. There is a danger of a 'democratic tug' between Primary Care Trusts (who commission care on behalf of local people), foundation hospitals (owned by staff, patients and the local community), and Ministers (elected by voters).

- If political responsibility is not devolved alongside operational power, Ministers will still find themselves blamed if things go wrong in a particular hospital. Although foundation trusts will be legally independent, ample opportunities will remain for Ministers to exercise their influence.

3.7 Will hospitals be allowed to go bust?

- Foundation Trusts will be allowed to go bust, but ensuring continued service and acceptable standards will remain at the heart of the new policy.

- The regulator will have the powers to direct Trusts, or remove their management if performance falls below pre-determined standards, and the Commission for Health Audit and Inspection will publish annual reports on the performance of foundation trusts.

- It is also unclear how the governance structures of foundation hospitals will relate to other bodies responsible for the accountability and scrutiny of local service provision, particularly local government.

4. More information

For more information on NHS foundation trusts and other types of Public Interest Company see ippr’s forthcoming report *In the Public Interest? Assessing the potential of Public Interest Companies* due to be published 24th April 2003.

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