The Government Reponse to the Health Committee Report into Foundation Trusts and Monitor

Presented to Parliament by
the Secretary of State for Health
by Command of Her Majesty
January 2009

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Introduction

This Command Paper responds to the Conclusions and Recommendations of the Health Committee's report into *Foundation Trusts and Monitor*, published on 17 October 2008.

NHS foundation trusts (FTs) are a key part of the Government's reform programme in the NHS. They are autonomous organisations, free from central government control. They establish strong connections with their local communities through local people becoming members and governors. This enables FTs to design their healthcare services around local needs and priorities. FTs are firmly part of the NHS, providing healthcare according to core NHS principles; free care, based on need and not ability to pay.

There are now 113 FTs, just over half of the 225 acute and mental health trusts eligible to apply for FT status. The strategic health authorities are working closely with the remaining NHS trusts, to get them ready to meet the exacting standards required to obtain Monitor's authorisation to become an FT.

The Government agrees that FTs have proven strengths and are performing well. As the recent Healthcare Commission ratings have shown, FTs continue to perform at a high level.

Responses to the Conclusions and Recommendations

The numbering of these responses corresponds to the Conclusions and Recommendations (pages 39 to 43) of the Committee's report.

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

So far, some of the improvements delivered by FTs have been through better financial management and accountability. While we need to recognise that the strongest and best-performing NHS organisations were the first to become FTs, the results so far point towards an improvement from FT status.

One of the features of PbR is the clear link between activity and income for all organisations. Following a phased period of introduction of PbR, from 2008/09, all providers of services covered by the national tariff are able to retain 100% of surpluses generated.

2. We were told that FTs are holding back both from investing their surpluses and from making full use of their borrowing powers because of a lack of direction from commissioners. (Paragraph 23)

There is no clear evidence to suggest that this is the main explanation for FT behaviour. Nevertheless, as part of World Class Commissioning, PCTs are now required to produce robust and high quality strategic plans for their organisations reflecting their priorities over a five year timescale. Strategic plans will be underpinned by a long term (five year) financial plan, an organisational development plan and an annual operating plan. The strategic plan provides a means for the PCT to communicate to a range of stakeholders and partners including clinicians, providers and local government.

In addition, PCTs will need to display eleven commissioning competencies that ensure that they are setting direction for and working in partnership with providers. Specifically, PCTs are required to promote continuous improvements in quality and outcomes through clinical and provider innovation (competency eight) and effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes and value for money (competency ten). From this year, PCTs will be held to account for their commissioning activity through the commissioning assurance system which will include a robust assessment against these competencies.

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

The Government established the private patient cap for FTs primarily to safeguard the interests of NHS service users. Income derived from private patient activity can increase but only if a trust's NHS income is increasing at the same or higher rate. The Government recognises that FTs providing mental health services may be faced with a zero cap if they were not carrying out any private activity in 2002-03. While there are no current plans to revisit the legislation, we continue to keep the policy under review, including the potential for mental health foundation trusts to develop services for private patients.

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

The Annual Health Check ratings produced in October 2008 by the Healthcare Commission show a very positive picture – of the 42 trusts rated 'excellent' for both quality of services and use of resources, 38 were FTs. However, there can be no complacency about quality of services; the regulatory regime for FTs is intended to ensure robust organisations that are able to deliver high quality services. Monitor intervened at five trusts, during 2007-08, prompted by those trusts not reducing their rates of MRSA in line with their original intentions.

Lord Darzi's review of the NHS, *High Quality Care for All*, published on 30 June 2008, noted that from April 2010 all providers of NHS healthcare will be required to publish annual Quality Accounts. We expect that the need to prepare these Accounts will mean that providers – including FTs – are encouraged to focus on quality improvement as a core function, and publication of this material will enable patients and the public to hold providers to account for the quality of NHS healthcare services they provide.

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

We welcome the Committee's support for the Commissioning for Quality and Innovation (CQUIN) payment framework, which will enable providers to earn additional income conditional on locally agreed quality improvement and innovation goals. The framework is part of the wider drive to put quality at the heart of all we do, as outlined in the *High Quality Care for All* report and the locally-developed visions. The aim of the CQUIN framework is to embed quality improvement and innovation in commissioner and provider discussions everywhere, and help to shift these discussions beyond a focus on minimum quality standards.

6. Freedom for the NHS to develop innovative models of care unencumbered by bureaucracy was widely seen to be one of the chief attractions of FT status; however while we have seen some examples of innovative practice, there seems to be little robust evidence to suggest FTs are using their new status to innovate in a significant way. Some witnesses thought it was too soon for FTs to be expected to be generating major innovations when they were still concentrating on achieving and maintaining financial stability; others considered that FTs' ability to innovate was being constrained by commissioners. (Paragraph 44)

Innovation, investment decisions and entrepreneurialism are matters for service providers. The role of Government is in setting national priorities and standards for health and healthcare through the Operating Framework, and in designing a system that enables providers to receive rewards from improving services for patients. Ways to achieve this include designing reimbursement systems that enable money to follow patient choices, and in the launch of a new national procurement portal 'Supply2Health' for commissioners to advertise opportunities in a single place.

There is also an essential role for commissioners in engaging with their local communities, identifying local priorities and creating opportunities for providers to respond. The new duty on PCTs and Local Authorities to carry out a Joint Strategic Needs Assessment of the health and wellbeing needs of the local area will improve this community engagement, as well as encouraging local innovation. All PCTs prepared strategic plans this autumn, which send providers a clear signal on local priorities for improvement and areas for investment. Competitive tendering is then a tool for commissioners to use in encouraging providers to respond to this agenda and utilise competition in driving up quality and efficiency for the benefit of patients and taxpayers.

The NHS Next Stage Review identified a range of cultural, professional and organisational barriers to innovation, and innovative service delivery. In response, *High Quality Care for All* promised a series of actions to improve innovation in the NHS. It promised to strengthen leadership in innovation by introducing a new legal duty for SHAs to promote innovation. It promised significant new funds for the NHS to support innovation. It promised new IT to help staff access clinical and non clinical evidence and best practice more easily – all three to be in place by April 2009. It promised greater personal and organisational reward and recognition for innovators through a new prize programme, to be operating from 2010. It promised a new single pathway to get medical technologies and medicines accredited and adopted across the NHS, and in Academic Health Science Centres (AHSCs) and Health Innovation & Education Clusters (HIECs) it promised new local and national support and infrastructure to speed the time it takes ideas to get from bench to bedside – AHSCs and HIECs will become the powerhouses that drive and diffuse innovation in the NHS.

7. We were surprised and concerned that no organisation seems to have a clear remit to assess objectively whether or not FTs are becoming more innovative, which makes it difficult to evaluate whether or not there are sufficient incentives for FTs to innovate. Given that innovation is meant to be an important part of the 'value added' by FT status, and given the potential benefits to the rest of the NHS from sharing best practice, the Government should commission objective evaluation in this area. (Paragraph 44)

The Department of Health is currently exploring options around research into FT innovation and the value added by FTs. Further details will be made available once work has been commissioned.

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

The governance of FTs – i.e. a membership body comprising local staff and service users, who elect governors – is fundamental to the FT model. A review undertaken by Mutuo concluded that the model worked well and offered significant benefits, but as FTs matured, there was scope for further benefits to be obtained. In the light of the Committee's report, we will consider the need for further action to achieve this.

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

This is a matter for the independent regulator, Monitor.

10. In considering the impact of FT status on FTs themselves, a recurring theme has been a lack of firm evidence that FT status is yet conferring the benefits hoped for. While it is clear that the majority of FTs are high performers in terms of finance and quality as measured by Healthcare Commission ratings, these were high-performing organisations prior to becoming FTs, and so it is difficult to ascribe this high performance to FT status per se. Two other major aims were to give trusts the freedom to invest in innovation and to promote better local engagement with the public and other health providers through new governance systems. Evidence of benefit on both of these scores is also thin. Systematic and independent evaluation is needed. The Department of Health should make it a priority to commission research to measure FTs' progress objectively, and to disseminate their successes more widely. (Paragraph 62)

The Department of Health is currently exploring options around research into FT innovation and the value added by FTs. Further details will be made available once work has been commissioned.

11. Before their establishment a number of fears were voiced about the impact FTs might have on wider health communities. There is little evidence that FTs have poached staff from other trusts. Evidence from Dr Mark Exworthy and the Healthcare Commission suggests that in

local health communities where collaborative working has historically been good this has continued to be the case; Dr Exworthy did suggest that in other areas the presence of FTs may be generating tensions and resentment. However, others felt that tensions exist between high-performing and less well performing trusts regardless of their status because of the system of Payment by Results. (Paragraph 69)

The report suggests that Payment by Results (PbR) is a cause of tension between high performing and less well performing trusts. In response, we would draw attention to the role of PbR as an 'enabler' of policies, such as patient choice. The introduction of a clear link between activity and income means that there is an added incentive for all trusts to attract patients by demonstrably delivering high quality care.

Following a phased period of introduction, from 2008/09 all trusts are able to retain 100% of any surplus generated through PbR activity (i.e. where the cost to the trust of delivering services is lower than the tariff price), regardless of whether or not they have FT status.

We are not aware that FT status creates tensions within the health economy.

12. The ability to retain surpluses was a key element of the FT reform, and FTs are now building up surpluses. FTs report that they are looking to PCT commissioners to collaborate on how these surpluses should be reinvested to improve patient care, but that PCTs are not in a position to give this guidance. We did not see any evidence that PCTs are thinking strategically about how FT surpluses might best be reinvested in their local health communities, a situation which we find extremely worrying. We recommend that the Department of Health takes steps to ensure that PCTs are able to play the strategic planning role urgently required of them; without this, public money risks sitting idle or being invested without proper strategic planning. (Paragraph 79)

The national priorities are clear. The NHS has set out a 10-year vision for addressing priorities for improvement in each of the regions. In addition, the incentives we have designed into the system will increasingly ensure that money follows patient choices, providers compete on quality and those that respond to patient preferences will reap the rewards.

- The Operating Framework for 2009/10 has set out the national priority areas for where all PCTs are expected to take action and requires PCTs to set local targets for improvement to address those issues that are most important locally.

- Local priorities are at the heart *High Quality Care for All* and each of the Strategic Health Authorities has published a 10-year 'vision' for improving clinical standards in line with local priorities.

- A new duty to carry out a Joint Strategic Needs Assessment (JSNA) requires Local Authorities and PCTs to jointly assess the health and

wellbeing needs of their local community. Doing so enables them to identify areas for priority action through Local Area Agreements (LAAs) and PCT plans, as well as serving to inform strategic planning over the longer term future (five to ten years). Community engagement is an essential element of the JSNA process and ensures that PCTs address the concerns of local citizens when commissioning services.

- Every PCT in the country is preparing a strategic plan for transforming local health services. These strategic plans will offer a clear signal to providers as to where to invest.

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

The Committee's concerns about the proposed expansion to the scope of PbR to cover mental health and community services are misplaced. The 'currencies' that would support future tariffs in these areas are being designed around the patient's care pathway, rather than the setting in which the care is provided. There will be, therefore, no inherent bias against mental health FTs that provide care in a community setting.

The Department is working towards the expansion of the scope of PbR in line with the feedback received from the 2007 *Options for the Future of Payment by Results* consultation exercise. Consideration will be given to expanding the scope of services covered by PbR as and when we are satisfied that cost data which would underpin any new tariffs is sufficiently robust. It is not necessarily our intention to set a national tariff for all services. This is because some services are not sufficiently uniform to be funded in the same way across the country.

Strong support was expressed by respondents to the consultation exercise for further work on the development of potential tariffs for mental health and community services. This direction of travel was further supported by the commitment in Lord Darzi's *High Quality Care for All* report to develop national currencies for other services, including mental health, to be available for use from 2010/11, which the report notes "will allow the comparison and benchmarking of mental health services, supporting good commissioning."[1]

[1] The High Quality Care for All report is available at the DH website at the following location:

The development of new currencies, which will be the 'building blocks' of further expansion of PbR, is being driven from the ground up by NHS staff, with several projects now underway on payment for non-acute sector healthcare, using the local NHS as "development sites" to test out new ideas.

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

The 2006/07 fitness for purpose programme recognised weaknesses in PCT commissioning capability. The Department has responded with the world class commissioning programme which promotes a strong vision for commissioning outcomes, 11 organisational competencies and the commissioning assurance system. PCTs will be assessed against the competencies as part of the commissioning assurance system. One of the competencies: *Promote improvement and innovation*, encourages PCTs to promote improvements in quality and outcomes through clinician and provider innovation. A second focuses on strong contract management which will require PCTs to robustly hold providers to account for contract performance. The competencies have been in place since the beginning of 2008. PCTs have just undergone the first cycle of an annual commissioning assurance system to assess their performance and development. Any areas for development will be addressed by the PCTs working with their SHAs.

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

From 1 April 2006, in order to better share the financial risk between providers and commissioners of the costs of unanticipated growth in emergency admissions, a reduced rate tariff of 50% was applied to emergency spells above a specified threshold. If the threshold level of activity was not met, 50% of tariff was withdrawn for the difference between actual and threshold. As the commissioning function has strengthened over the last few years the differential tariff adjustment will be withdrawn with effect from 1 April 2009. From that date commissioners will be responsible for meeting the costs of all emergency admissions at the full, appropriate tariff rate. This will increase the incentive for commissioners to ensure that patients receive the right treatment, at the right time and in the right place.

http://www.ournhs.nhs.uk/

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

The Department of Health is currently exploring options around research into FTs' progress, innovation and the value added by FTs. Further details will be made available once work has been commissioned.

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

The existing Memorandum of Understanding between the Department and Monitor is currently under review. We expect that the Department and Monitor will continue to engage with one another constructively, using effective channels of communication to ensure FTs remain at the forefront of the NHS delivering high quality services and care.

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

There is no duplication of roles and responsibilities here. The Cooperation and Competition Panel (CCP) has no powers of its own. The CCP will advise Strategic Health Authorities regarding services in their areas and Monitor will be mindful of the potential impact on FTs and the FT regime. Similarly, there is no overlap in jurisdiction with the Office of Fair Trading, which would be the responsible authority in the limited number of cases where the provisions of the Competition Act or Enterprise Act apply.

We do not foresee any overlap or duplication of effort between Monitor and CQC (the successor body to the HCC). Their respective roles are clear and the 2008 Act places a responsibility on them to work together productively. CQC is responsible for registrations (e.g. clinical governance); Monitor is responsible for authorisations (e.g. ensuring FTs are well governed and financially viable.)

Conclusions

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

The Department of Health is currently exploring options around research into FTs' progress, innovation and the value added by FTs. Further details will be made available once work has been commissioned.

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

The Department of Health is currently exploring options around research into FTs' progress, innovation and the value added by FTs. Further details will be made available once work has been commissioned.

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

We are working on the potential expansion of PbR to a number of priority areas such as mental health, community services, critical care, urgent and emergency care (including ambulances), and long term conditions. We have several projects underway on payment for non-acute sector healthcare, using the local NHS as 'development sites' to test out new ideas.

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

The world class commissioning programme has developed a set of 11 organisational competencies which PCTs will be assessed against as part of the commissioning assurance system. One of the competencies: *Promote improvement and innovation*, encourages PCTs to promote improvements in quality and outcomes through innovation. The competencies have been in place since the beginning of 2008 and PCTs have been assessed for the first time against these competencies.

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

The NHS is a system of organisations responsible for organising and providing a universal and comprehensive health service to the people of England. The Government is responsible for setting the direction and priorities of the NHS, and ensuring that appropriate standards are met. In filling this remit, the Government can communicate with all providers of NHS care, including FTs, on significant matters that affect the interests of patients. The Government's role is to highlight any particular issues of concern, leaving decisions on any necessary action to the FTs, which are accountable to their local community through the Board of Governors and the commissioning process.

The existing memorandum of Understanding between the Department and Monitor is currently under review. We expect that the Department and Monitor will continue to engage with one another constructively, using effective channels of communication to ensure FTs remain at the forefront of the NHS delivering high quality services and care.

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

The Department of Health is currently exploring options around research into FTs' progress, innovation and the value added by FTs. Further details will be made available once work has been commissioned.

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

We do not foresee any overlap or duplication of effort between Monitor and CQC (the successor body to the HCC). Their respective roles are clear and the 2008 Act places a responsibility on them to work together productively. CQC is responsible for registrations (e.g. clinical governance); Monitor is responsible for authorisations (e.g. ensuring FTs are well governed and financially viable.) In addition *High Quality Care for All* recommended the establishment of a new National Quality Board (NQB) to provide strategic oversight and leadership in quality across the NHS.

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