A Guide to NHS Foundation Trusts

December 2002

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Foreword

The greatest post-War reform was the establishment of the National Health Service. It liberated millions of families from the fear of becoming ill but being unable to afford the cost of treatment. The NHS civilised our country. The values on which it is based – services that are free at the point of use according to clinical need not ability to pay – are as important today as when Nye Bevan created the NHS. In a world where healthcare can do more but costs more than ever before an NHS based on these values is a huge source of strength for people all over the country.

However for all its great strengths – its ethos, its staff and the huge advances it has brought in public health – the NHS has profound weaknesses too. Despite having the most equitable health care system in the world health inequalities have widened not narrowed. Uniformity in provision has not guaranteed equality in health outcomes. Local staff and local communities have too often felt disempowered by top-down control in the NHS. Lack of local accountability has prevented local services being properly attuned to the differing needs of local communities.

It is in pursuit of high standards, greater local accountability, genuine public ownership, greater emphasis on local service provision to tackle health inequalities that we are bringing forward proposals for NHS Foundation Trusts.

NHS Foundation Trusts will be part of the NHS, and subject to NHS systems of inspection. They will treat NHS patients according to NHS principles and NHS standards, but they will be controlled and run locally, not nationally.

We will shortly be bringing forward legislation to establish NHS Foundation Trusts as independent public interest organisations, modelled on co-operative societies and mutual organisations. Their ownership will be lodged in the local communities they serve. This form of social ownership will replace central state ownership with local ownership. They will be true to our traditions – of solidarity, community and fairness – but right for our times with power in the hands of local people and frontline NHS staff.

Local people will elect their representatives to serve on the NHS Foundation Trust's Board of Governors. They will have an absolute majority. Staff from the NHS Foundation Trust – alongside local stakeholders and Primary Care Trusts – will be represented. The Board of Governors will hold the Management Board to account, electing the Chair and non-Executive members of the Board, and approving the appointment of the Chief Executive. Local democracy will play an important part in local health service provision.

There will be a legal lock on their assets to protect NHS Foundation Trusts from the sort of 'de-mutualisation' we have seen in the Building Society sector or any future threat of privatisation. NHS Foundation Trusts will be there to treat NHS patients not to make profits or to distribute dividends.

NHS Foundation Trusts will be at the cutting edge of the Government's wider reform programme for the public services, with the freedom to improve services for NHS patients without interference from Whitehall. The first generation of NHS Foundation Trusts will be led by the best performers – existing 3-star Trusts. This is not about elitism. It is about starting with the hospitals currently most able to

benefit from NHS Foundation Trust status. Forty percent of these 3-star Trusts serve some of the poorest communities in the country. As more hospitals improve, more will become NHS Foundation Trusts. There will be no arbitrary cap on numbers. The freedoms that NHS Foundation Trusts will enjoy will provide an incentive for others to improve. There will, of course, be more help, support and where necessary intervention to raise standards across NHS Trusts where performance is poor.

Within the national framework of standards NHS Foundation Trusts will be able to gear their services more closely to the communities they serve.

For the first time since 1948 the NHS will begin to move away from a monolithic centralised system towards greater local accountability and greater local control. Reform cannot be achieved by holding on to the monolithic centralised structures of the 1940s. We cannot reform by looking backwards. We need to look forwards. Reform means investing not just extra resources in frontline services, but power and trust in those frontline services.

I believe the reform programme outlined here is every bit as radical and progressive as that which created the NHS over fifty years ago. It draws on the traditions of social and community ownership that inspired the founders of the NHS. It sticks firmly to the principles on which the NHS was founded. And it places a premium on local accountability for local services.

We are moving to an NHS where standards are national but control is local. NHS Foundation Trusts are a means to that end.

The Rt Hon. Alan Milburn MP
Secretary of State for Health

1. Introduction

Why change?

1.1 The National Health Service is one of the greatest achievements of post-war Britain. Based on clinical need rather than ability to pay, the NHS provides health care to millions of our citizens. NHS staff – doctors, nurses, therapists, scientists, managers, ancillary staff, cooks, cleaners, porters and many others – are dedicated professionals committed to the ethos of public service. It would be wrong in principle and in practice to change the values on which the NHS is founded.

1.2 It is not NHS values that need to change. But the NHS – in its organisation, the way it treats its staff, its responsiveness to patients, its accountability to local people – feels too much like a 1940s system trying to deliver 21st century care.

1.3 Whitehall has too much power. Communities have too little power. Staff too often feel change is something which is done to them rather than done by them. A national health service employing over one million people cannot be run from Whitehall. Standards should be national but control needs to be local. The Government's job is to set standards and to allocate resources in order to ensure equity. But since different local communities have different needs, central government cannot run local services. It is time to re-order accountabilities in the health service so the system is more accountable to local communities and so that staff are more engaged in improving services for themselves. This is why change is necessary now.

1.4 The NHS Plan set out a ten-year programme of investment and reform to deliver a better deal for patients and staff: faster treatment, higher clinical standards and a better patient experience. Steady progress is being made. Waiting times are falling. Death rates from cancer and heart disease are improving. Additional doctors and nurses are being trained and recruited. New equipment and new facilities are coming on stream. Quality is improving in both the clinical services and the environment in which they are provided.

1.5 The 2002 Budget provided an unprecedented increase in resources over the next 5 years – an annual average increase of 7.4 per cent in real terms raising the expected level of health spending to 9.4 per cent of GDP. As a result the NHS is now the fastest growing health system of any major country in Europe.

1.6 Investment alone, however, is not sufficient to transform the NHS into the 21st century healthcare system our nation needs. Investment has to be matched by reform. Modern public services cannot be delivered by monolithic organisations commanded and controlled from Whitehall. Because reform has to happen on the ground it has to be inspired by local innovation and initiative. Reform requires local leadership not central control.

1.7 The relationship in health care is particularly local: often it is the most local of all between health care professional and patient. To get the best for patients and to tailor services so they are better able to tackle local health inequalities, staff and local communities need to have greater ownership of the process of change in the NHS. Improvements happen with the right combination of national standards and local

control. Both are needed. We are now in the process of moving from an NHS controlled nationally towards an NHS where standards and inspection are national but delivery and accountability is local; with more diversity of provision offering more choice to patients.

1.8 We do not propose a free market culture where NHS organisations are left to sink or swim as though the provision of health services to local communities can be left to chance. National standards are now in place. The means to inspect and assure them is secured. Where services are performing badly central Government can and does step in to uphold standards. Where services are performing well Government needs to step back so that responsibility and accountability for individual hospitals can be returned from a remote Whitehall to local people. The more local services improve across the whole of the NHS the greater autonomy will be earned. This is an important incentive to encourage improvements in local services.

1.9 Reforming the NHS follows the four principles which the Government has established for public services:

- establishment of explicit national standards and clear accountability for NHS care – *so that patients know that the care they get will meet national standards wherever they get treatment, and clinicians and managers know what standards they will be judged against;*
- greater devolution of power and responsibility from the Department of Health to the clinicians and managers who are responsible for care at the front line – *so that the people who know best what needs to be done can take action without going through a complex bureaucratic process;*
- more flexibility for NHS staff – *so that care is provided in the way that best fits the needs of patients and the skills of individual members of staff rather than being designed around old-fashioned demarcation between the professions;*
- greater diversity of provision and choice for patients – *so that care can properly be designed around individual needs.*

1.10 NHS Foundation Trusts sit firmly within this framework. Fully part of the NHS, NHS Foundation Trusts will see central control from Whitehall replaced by proper accountability to the local community so that both public and staff have a direct say in how their local services are provided. They will offer a new form of social ownership by the public not by the State – not for private profit but in the public interest.

Freedoms for NHS Foundation Trusts…

1.11 NHS Foundation Trust status will open the way to significant new freedoms. NHS Foundation Trusts will be guaranteed, in law, freedom from Secretary of State powers of direction, removing control from Whitehall and replacing it with greater local public ownership and accountability.

1.12 Freedom from Whitehall control means freedom for the people who deliver care to develop services in a way that best suits patient needs. For high performing organisations, as NHS Foundation Trusts will be, the Government can step back from detailed performance management. NHS Foundation Trusts will be able to concentrate on results that matter for local people rather than being managed from the centre. The focus will be on outputs – for example national standards – rather than inputs.

1.13 NHS Foundation Trusts will have freedom to develop new ways of working that reflect local needs and priorities, within the NHS framework of standards and inspection to guard against two-tier health care. They will be able to recruit and employ their own staff, with flexibility to offer new rewards and incentives.

1.14 NHS Foundation Trusts will be free to innovate in asset use, retaining surpluses to invest in developing new services. They will have a wider range of options for capital funding so that new ideas can be brought to fruition.

1.15 The governance arrangements for NHS Foundation Trusts are rooted in the freedom from central control which goes with foundation status. And they are designed to allow flexibility to meet local circumstances – whether a general hospital serving a well-defined community, a large multi-site Trust or a teaching hospital. NHS Foundation Trusts will have freedom within the framework of legislation to decide on the governance arrangements best suited to their own needs.

Benefits for patients and the public

- Social ownership of local hospitals with rights to elect Governors
- Local decisions more responsive to community and individual patient needs
- Greater diversity and choice of healthcare within the NHS

Benefits for staff

- Freedom to deliver healthcare without direction from Whitehall
- Opportunity to develop locally based services with rights to elect staff governors
- Access to additional rewards linked to the success of the organisation

Benefits for the organisation

- Focus on delivering results which matter for local people, rather than being managed from the centre
- Freedom to innovate in service delivery, asset use and human resources
- More options for capital funding

Benefits for NHS commissioners

- Primary Care Trusts represented on the Board of Governors
- More transparent, delivery focused relationship with providers
- Clarity on where money is going and what for

…with safeguards

1.16 The freedoms given to NHS Foundation Trusts will be underpinned by safeguards that whilst giving organisational independence will protect the public interest. NHS Foundation Trusts will be part of the NHS and operate as part of the total mix of health services that make up the local health economy. The new framework will ensure that an NHS Foundation Trust operates within a system that:

- upholds the values and principles of the NHS
- protects high national standards for NHS services
- ensures that its prime purpose of providing NHS services to NHS patients free at the point of use and with treatment according to need, not ability to pay, is met
- prevents NHS assets from being sold off, mortgaged, or used for purposes that would be against the public interest.

1.17 This guide sets out how these aims can be achieved. The framework will need new legislation and the necessary powers will be included in primary legislation as announced in the Queen's Speech in November 2002.

1.18 The following section describes the overall model for NHS Foundation Trusts and gives a summary of how it will work in practice. Later chapters provide a detailed explanation of what is involved.

Outline of the model for NHS Foundation Trusts

1.19 NHS Foundation Trusts will exemplify a new form of social ownership, with central-state ownership replaced by local ownership by the public. As in co-operative societies and mutual organisations, local people, employees and other key stakeholders in the local community will be able to become members, and therefore the owners, of an NHS Foundation Trust. Legal protections will be in place to ensure against 'de-mutualisation' or privatisation.

1.20 NHS Foundation Trusts will have an organisational structure defined, in law, which will make them work for the public benefit. Each NHS Foundation Trust will have defined objectives – its Statement of Purpose – making clear that it is established:

- to provide health and health related services for the benefit of NHS patients and the community
- to uphold the values of the NHS.

NHS Core Principles[1]

- the NHS will provide a universal service for all based on clinical need, not ability to pay;
- the NHS will provide a comprehensive range of services;
- the NHS will shape its services around the needs and preferences of individual patients, their families and their carers;
- the NHS will respond to different needs of different populations;
- the NHS will work continuously to improve quality services and to minimise errors;
- the NHS will support and value its staff;
- public funds for healthcare will be devoted solely to NHS patients;
- the NHS will work together with others to ensure a seamless service for patients;
- the NHS will help keep people healthy and work to reduce health inequalities;
- the NHS will respect the confidentiality of individual patients and provide open access to information about services, treatment and performance.

Accountability

1.21 An NHS Foundation Trust will be subject to a legal regime that replaces accountability to Whitehall with accountability mechanisms to local people, most notably:

- its governance arrangements will define its accountability to its local community through a Board of Governors and Management Board;
- its licence, issued and monitored by an Independent Regulator, will require it to uphold NHS standards and guarantee that it operates according to NHS values;
- agreements with the organisations that commission its services will specify the range and volume of services to be provided, focusing on the delivery of outputs and introducing greater transparency;
- inspection by the Commission for Health Audit and Inspection[2], as well as annual performance assessment, will ensure that services meet health care standards, with reports fed back to the Independent Regulator.

1.22 The Independent Regulator will have powers to intervene where necessary to bring an NHS Foundation Trust back into line with its licence conditions and, in case of failure, to safeguard the provision of essential services. In the event of serious problems the NHS Foundation Trust will be legally dissolved but local services will continue to be provided.

1 Preface, *NHS Plan* published July 2000 (Cm 4818-I)

2 Subject to legislation, the Commission for Healthcare Audit and Inspection will be established no later than April 2004

Governance

1.23 There will be a new governance structure to reflect the freedom from Whitehall central control and give greater accountability to the local community. Within this NHS Foundation Trusts will have considerable freedom to develop governance arrangements to suit their local circumstances.

1.24 The new governance arrangements for NHS Foundation Trusts have been modelled on co-operative societies and mutual organisations. These combine community ownership with accountability. People with an interest in the development and wellbeing of their local NHS Foundation Trust will be able to register as members of the NHS Foundation Trust. Those eligible for membership will be:

- people living in the local area and patients of the NHS Foundation Trust;
- employees of the NHS Foundation Trust.

1.25 Each NHS Foundation Trust will have a Board of Governors and a Management Board. The members of an NHS Foundation Trust will elect representatives from amongst the members to the Board of Governors. The Board of Governors will be responsible for ensuring that the Trust operates in a way that fits with its statement of purpose and complies with licence conditions. It will not be responsible for the day to day management of the organisation; that will be a matter for the Management Board.

1.26 At the time of application, the size and composition of the Board of Governors will be set out and must ensure that the full range of members' interests are represented, with a proper balance between different interest groups within the membership, and that arrangements are workable in practice.

Board of Governors – duties and responsibilities

- establishing mechanisms for consulting the members or partner organisations they represent;
- holding at least one meeting each year that is open to all the members to approve:
  - the annual report and accounts of the NHS Foundation Trust;
  - appointment of the Auditor;
- meeting on no less than two other occasions a year – when the main business will be to advise the Management Board on the Trust's forward plans;
- from time to time[3], at an open meeting or another general meeting to:
  - elect or re-elect the Chair and non-executive directors to the Management Board;
  - approve appointment of the Chief Executive by the Chair and non-executive directors of the Management Board;
  - ratify appointment by the Chief Executive of executive directors to the Management Board.

3 i.e. on establishment and thereafter on resignation or at the end of the term of office of the relevant officer

1.27 An NHS Foundation Trust Management Board will have a constitution similar to that widely accepted in other organisations (with non-executives appointed to ensure prudence and good management). The Board will be responsible for the management of the NHS Foundation Trust, including its day to day operation and its forward business plan. Applicants for NHS Foundation Trust status will have the freedom to define the details of the constitution to fit local needs within a basic framework laid down in legislation.

Licensing and regulation

1.28 An NHS Foundation Trust will be granted a licence to operate by a new Independent Regulator who must be satisfied that the application fulfils the necessary criteria. The Independent Regulator will be accountable to Parliament through the Secretary of State.

1.29 The Independent Regulator will be responsible for ensuring that the terms of the licence are upheld. The licence will set out the requirement for the NHS Foundation Trust to operate in the public interest and to meet national clinical standards; requirements relating to continuity of NHS services; and a duty to work in partnership with NHS and other relevant organisations. It will also cover matters relating to finance and borrowing, provision of information and the safe operation of the NHS Foundation Trust.

1.30 The licence for an NHS Foundation Trust will detail:

- a requirement to focus on delivery of care to NHS patients with a strict cap on the provision of services to private patients;
- the clinical services which it must provide to the local community;
- the application of clinical and service quality standards against which the Commission for Healthcare Audit and Inspection inspects;
- its duty of partnership with other NHS and social care bodies;
- its duty to participate in the education and development of healthcare staff in the NHS;
- the circumstances in which it can make changes in the services it provides for NHS patients;
- the financial duties under which it will operate, including a prudential borrowing regime;
- restrictions on the disposal of assets used in the provision of NHS services;
- requirements to provide statistical and financial information and participation in the NHS strategy for Information Management and Technology.

1.31 An NHS Foundation Trust will be required to submit reports and information to the Independent Regulator, who will also get reports of inspections carried out by the Commission for Healthcare Audit and Inspection against value for money, clinical and quality standards. The Independent Regulator's duties and powers will be distinct from those of the Commission for Healthcare Audit and Inspection – and any other inspectors – and he or she will act independently in any dealings with an NHS Foundation Trust.

1.32 The Independent Regulator will agree a prudential borrowing limit for an NHS Foundation Trust's capital expenditure that will be linked to its ability to meet the cost of its borrowing. Within this prudential borrowing regime, an NHS Foundation Trust will be free to borrow from public or private lenders. Subject to an overall duty to achieve value for money in its activities and credit assessment by potential lenders, capital schemes will not be subject to individual project by project planning approval by the Independent Regulator provided any associated borrowing does not breach the prudential limit.

1.33 In normal circumstances the Independent Regulator will have no reason to intervene in an NHS Foundation Trust's affairs. But he or she will have clearly defined step-in powers if there is evidence that an NHS Foundation Trust is in breach of its licence conditions. These powers, to be set out in legislation, would be triggered according to the seriousness of the breach, and will include:

- imposition of additional reporting requirements or other special measures – in the event of an adverse report by the Commission for Healthcare Audit and Inspection or a low annual performance star rating which would indicate a cause for concern about compliance with the licence;
- formal warnings;
- removal of members of the Management Board or ordering new elections to the Board of Governors;
- powers to recommend that the assets of an NHS Foundation Trust to another NHS body, or merger with another NHS Foundation Trust.

Providing NHS services

1.34 NHS Foundation Trusts will have to deliver on the agreements they negotiate with Primary Care Trusts and other NHS commissioners. Under the current system NHS Trusts have service level agreements with Primary Care Trusts. The relationship between an NHS Foundation Trust and the Primary Care Trusts that commission NHS services from it will be governed by longer-term legally binding service agreements based on a national pricing structure[4] that will be applicable to NHS Foundation Trusts, NHS Trusts and private sector providers. This means that it will be clearer both to the NHS Foundation Trust and Primary Care Trusts what services have to be provided, to what standard and over what period of time, within a fixed price system where legally binding agreements are based on volume and quality not price. The national pricing structure will guarantee that NHS Foundation Trusts will be unable to undercut other NHS providers. Instead, these agreements will focus on delivery and on outputs and, where appropriate, attach specific conditions to ensure that the care given to NHS patients is appropriate.

Finance

1.35 An NHS Foundation Trust, as an organisation with a proven track record of success in delivery of care for NHS patients, and in management and financial prudence, will have increased financial freedoms in three key areas:

- to retain proceeds from asset disposals;
- to retain any operating surpluses;

4 *Reforming NHS Financial Flows* published October 2002 (29600)

- to access capital from public and/or private sector sources based on financial performance and not on the basis of national or local capital rationing by the Department of Health or Strategic Health Authorities.

1.36 An NHS Foundation Trust will, in addition, continue to have access to procurement of large capital projects through the Private Finance Initiative, subject to the same procedures and comfort levels that prevail under the existing NHS arrangements.

Employment, education and training

1.37 An NHS Foundation Trust will be free to recruit and employ its own staff building on the local flexibilities already available to NHS Trusts. It will have the flexibility to offer new rewards and incentives and explore innovative ways of working in partnership with staff to deliver local services, with increased freedom to reward excellence. In line with its statutory duty of partnership an NHS Foundation Trust will be expected to use these new freedoms in a way that fits with key NHS principles and does not undermine the ability of other providers in the local health economy to meet their NHS obligations. It will be able to benefit from participation in wider agreements negotiated by or on behalf of NHS employers collectively. Successful applicants for NHS Foundation Trust status will be amongst the first to implement the modernised pay system that has been negotiated for the NHS.

1.38 The change of legal status to NHS Foundation Trust will not disrupt continuity of service. Existing terms and conditions will be preserved and staff directly employed by an NHS Foundation Trust will have access to the NHS pension scheme and associated benefits on the same basis as other NHS employees.

1.39 An NHS Foundation Trust will be under a duty to participate in the education and development of healthcare staff in the NHS and will also be expected to take part in the development of the wider workforce. As a condition of its licence an NHS Foundation Trust will be required to co-operate with other public service providers, with universities and training institutions and with statutory regulators.

Application

1.40 NHS Foundation Trust status will only be available to health care providers that are considered likely to deliver the benefits to patients that come with the greater freedoms that the status offers. The application process will be transparent and fair although the entry criteria will be tough.

1.41 The first NHS Foundation Trusts will be drawn from existing 3-star acute and specialist NHS Trusts. But as more NHS Trusts improve more will be eligible to apply for NHS Foundation Trust status and in later waves eligibility will be opened up to other types of NHS Trust. A range of measures is already in place to improve performance across the whole NHS. These include extra resources, external help from the NHS Modernisation Agency and, *in extremis*, imposition of new management teams through the franchising process. Gaining 3-star status will continue to be a pre-condition for granting NHS Foundation Trust status. This is in order to reward good performance and to act as an incentive for others to improve their performance. No limit has been set on the number of NHS Foundation Trusts that could be established. In time NHS Foundation Trust status could also be opened up to organisations that are not currently part of the NHS.

1.42 The Independent Regulator will grant licences to NHS Foundation Trusts in accordance with provisions set out in legislation. Before an NHS Trust applicant can be granted a licence to operate as an NHS Foundation Trust, it will need to seek agreement from the Secretary of State for Health that the existing organisation should be disestablished and its assets transferred to a new organisation. The Secretary of State will consider proposals against published criteria together with, amongst other things:

- an assessment of how the new organisation plans to use the freedoms of NHS Foundation Trust status to improve services for NHS patients backed up by:
  - achievement of 3-star status in the NHS Performance ratings;
  - a documented and verifiable track record (subject to independent review);
  - evidence that key stakeholders – NHS commissioners, partner organisations, staff and local people – support the application.

1.43 The Department of Health will provide support for all short-listed applicants and ensure that applicants have full access to draft legal documentation in the final stage of the application process. Primary Care Trusts will also have to develop their capacity and new skills to work effectively with NHS Foundation Trusts. The Department of Health will therefore provide developmental and financial support for local Primary Care Trusts associated with an NHS Foundation Trust application. Chapter 7 sets out the timetable and provides a detailed explanation of what will be involved in applying for NHS Foundation Trust status.

2. Governance and Constitution

2.1 New legislation will set out the requirements that a prospective NHS Foundation Trust will have to comply with before it can be licensed to operate. This chapter sets out what that means in terms of governance – who will be the members of an NHS Foundation Trust, and how it will be governed through a two-part structure consisting of a Board of Governors and Management Board. Chapter 3 explains the accountability regime in which the new governance structures will operate and how additional safeguards will apply through licensing and regulation.

2.2 NHS Foundation Trusts will herald a new form of social ownership where health services are owned by and accountable to local people rather than to central Government. In this way, much stronger connections will be established between providers of NHS services and their stakeholder communities, extending involvement beyond current arrangements for consultation and building on the sense of ownership that many people feel for their local hospitals.

2.3 There will be new opportunities for individuals to be directly involved in the accountability arrangements for the NHS in their local area by registering as a member of an NHS Foundation Trust. In a similar way to becoming a member of a co-operative society or mutual organisation, the members of an NHS Foundation Trust will become its owners, taking on responsibility for their local hospitals from national Government. Eligibility for membership of an NHS Foundation Trust will be open to the people who have most interest in its development and well being because they:

- live locally, use, or may need to use, the health care services it provides, or
- are employed by the Trust.

2.4 Local people, patients and staff who become members will elect representatives onto a Board of Governors. The Board of Governors will have defined responsibilities for advising and overseeing the activities of the Management Board who will be responsible for the day to day operation of the NHS Foundation Trust.

2.5 Determining the details of what the constitution should look like will be an important part of the process of putting together and consulting on applications for NHS Foundation Trust status (see Chapter 7).

Who can be a member?

2.6 Eligibility for membership of an NHS Foundation Trust will be open to:

- members of the public – people who live in the local area (defined as its *membership community*), and people who live outside that area but have been patients[5] in the previous 3 years, and
- employees of the Trust[6];
- the representatives of partner organisations on the Board of Governors.

2.7 Because local circumstances differ from place to place, the boundaries of the *membership community* will be different in each case and applicants for NHS Foundation Trust status will be asked to put forward proposals for what the membership community should be. There will, however, be a requirement that the *membership community* must include people living in the area covered by the local authority in which any of the facilities run by the NHS Foundation Trust is located. An NHS Foundation Trust will be expected to extend the definition to cover neighbouring local authorities where a hospital is used by a significant number of patients in an adjacent local authority area. The intention is to ensure the involvement of local communities in the ownership and control of local health services. The policy is about inclusion rather than exclusion so the aim is to be as flexible as possible whilst retaining a strong and coherent emphasis on localism.

2.8 An NHS Trust will be expected to set out the boundaries of its proposed *membership community* in its application for NHS Foundation Trust status. On establishment, the *membership community* that applies to an NHS Foundation Trust will be defined under rules made in accordance with its constitution which should allow for review as necessary if patterns of use or demography change.

2.9 If an NHS Foundation Trust is to succeed in getting real stakeholder involvement – beyond the people who already engage for example through patient support groups or the League of Friends – access to membership needs to be opened up as widely as possible. One way of doing this will be through advertising eligibility for membership – for example in local newspapers, GP surgeries and through letters to local organisations and patient support groups. But applicants may want to take a more proactive approach particularly where there are communities where public participation is traditionally low. This might be necessary for example in some inner cities to engage minority groups who would not normally expect to be able to take part in the running of a public service. It might also be appropriate where rurality or geography makes community involvement more difficult. Applicants for NHS Foundation Trust status will be expected to demonstrate innovative approaches to ensuring genuine community membership.

2.10 Membership will be by registration and an NHS Foundation Trust will be expected to set up a register of members on first establishment and to keep it up to date. There will be no limit on the number of people who can register as members if they meet the eligibility criteria.

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5 including the parent or guardian of a patient under 18. In some circumstances a person who is eligible to register as a member may delegate the right to register to another person – for example a patient who was seriously ill might wish to delegate their right to register as a member to a relative or carer.

6 people who have a permanent contract, or a fixed term contract longer than 12 months.

What will membership of a NHS Foundation Trust mean in practice?

2.11 Membership of an NHS Foundation Trust will, in many ways, be similar to being a member of a co-operative society, mutual organisation or charity. The Management Board of an NHS Foundation Trust will be accountable to the members in two ways:

- first, for ensuring that it develops in a way that is consistent with the needs of its community of stakeholders in the local health economy and wider NHS, and
- second, for ensuring that the NHS Foundation Trust carries out its activities in a way that is compliant with its objects and the terms of its licence (see Chapter 3).

2.12 In this sense membership of an NHS Foundation Trust will be much like being a member of other non-commercial organisations. However, an NHS Foundation Trust will be established under a legal regime in which the membership:

- is bound to promote, and will not have the power to change, the public service purpose that the NHS Foundation Trust was established to achieve – provision of health services in the public benefit, consistent with NHS values, and
- does not have the power to determine that the NHS Foundation Trust should be wound up, merged with or taken over by another organisation.

This is an important lock both on the sort of 'de-mutualisation' that has occurred in the building society sector and on any future threat of privatisation (See discussion of the licence and regulatory regime in Chapter 3).

2.13 Registration as a member will bring with it, as a minimum, the right to:

- participate in the **election of representatives to the Board of Governors** of the NHS Foundation Trust;
- **receive information** about the NHS Foundation Trust, for example in quarterly newsletters, and the annual report and accounts;
- be **consulted**, for example, on matters relating to how provision of NHS clinical services by the NHS Foundation Trust could be improved.

2.14 An NHS Foundation Trust will be expected to explain in its annual report how it is meeting its commitment to members. It will be up to an NHS Foundation Trust to decide how to do this, building on what it is already doing as part of the NHS patient and public involvement agenda. But in its new role as an NHS Foundation Trust it may also want to look at experience of stakeholder involvement in co-operative societies, mutual organisations, charities and other not-for-profit organisations in the UK and Europe. The Department of Health will provide help and advice in this respect, as part of the continuing package of support to early applicants for NHS Foundation Trust status (see Chapter 7).

2.15 The members of an NHS Foundation Trust will, collectively, be its legal owners. This is a real and not a paper exercise in social ownership. As such the rights of membership will therefore confer some limited but real legal responsibilities. The registered members will be the "guarantors" of an NHS Foundation

Trust. This means that if the organisation became insolvent and had to be wound up its members would each be liable under the terms of the NHS Foundation Trust's constitution, to pay a nominal sum (£1) towards any outstanding liabilities (see Chapter 3).

Representation on the Board of Governors

2.16 Each NHS Foundation Trust will be required to establish a Board of Governors. The Board of Governors will represent the interests of the members and of partner organisations in the local health economy in the governance of the NHS Foundation Trust. The Board of Governors will be directly accountable to the members for ensuring the NHS Foundation Trust operates in a way that is compliant with its objects and with the terms of its licence (see Chapter 3). The Board of Governors will act both in a trustee role for the welfare of the organisation as it was originally established and as a vehicle for influencing change and development, replacing the public interest responsibilities exercised by the Secretary of State for Health for other NHS bodies.

2.17 The circumstances of each NHS Foundation Trust will be different. As part of the application process, it will be up to applicants to develop proposals on the size and composition of its Board of Governors to suit its local circumstances. The basic framework will be laid down in new legislation and will require:

- the **overall majority of the places** to be reserved for **representatives elected from the patient and public membership**, and
- the balance of places to include:
  - representatives **elected from the employee membership**;
  - people **nominated to represent partner organisations** including as a minimum:
    - the main **commissioning Primary Care Trusts**, or lead commissioners for specialist services,
    - **universities with responsibilities for undergraduate training and research** activity in the NHS Foundation Trust (unless represented on the Management Board).

2.18 As part of the assessment process for NHS Foundation Trust status, an applicant will be expected to demonstrate how its proposals would fulfil these minimum requirements. In particular, to demonstrate how effectively the new NHS Foundation Trust will genuinely shift accountability from central government to its local community.

Constitution of the Board of Governors

2.19 Many NHS Trusts serve a fairly well defined local community. Some NHS Trusts, however, provide specialist services to a large geographical area or on a national basis. In these cases applicants for NHS Foundation Trust status may have no obvious routes for engaging with the whole community. Part of the task of identifying a strong stakeholder voice will be to ensure that the people elected to the Board of Governors are able to get continuing feedback from the constituency they are chosen to represent. In some cases the NHS Foundation Trust may need to provide assistance to enable them to do so.

2.20 In deciding what approach to take applicants will need to consider as a starting point which are the main communities of interest amongst the membership. NHS Foundation Trusts may also find it helpful to consult the Commission for Patient and Public Involvement in Health on their proposals.

2.21 In some cases different groups of members will need to be recognised separately within the Board of Governors. This might be the case where, for example, an applicant for NHS Foundation Trust status runs several hospitals serving distinct geographical communities, or is responsible for facilities serving different groups of patients such as an acute hospital, community mental health facility and separate tertiary care unit for heart transplant patients. Elsewhere, rather than attempting to secure complete representation of a wide spectrum of interests on the Board of Governors itself, it may be better to establish divisions of the Board which relate directly to different geographical communities and/or different facilities. In this way a local community will have a direct involvement in the governance of a particular hospital even though the hospital is part of a larger NHS Foundation Trust serving a wider geographical area. If an applicant NHS Foundation Trust decides to adopt this model it will, however, be important to formalise the relationship to avoid the possibility of minority interests being marginalised. This might be achieved by including in the constitution provisions for an elected governor to chair the relevant division.

2.22 It will be up to applicants for NHS Foundation Trust status to propose, in consultation with stakeholders, what the total size of the Board of Governors should be, taking into account:

- the NHS Foundation Trust's primary purpose and the range of activities it will engage in;
- the interface both between governors serving on the Board of Governors and the members they represent and the interface with existing forums such as local Leagues of Friends, the PCT Patients Forums, the Overview and Scrutiny Committee, staff groups;
- the practicalities of bringing together people with a range of different interests in a way that will enable the Board of Governors to act effectively.

2.23 In considering the size of the Board of Governors, applicants may find it helpful to draw on experience of what works well in co-operative societies, mutual organisations and charities and other corporate bodies. There is a large body of research from the UK and Europe and the Department of Health will provide support for applicants who wish to follow this up.

2.24 The Independent Regulator for NHS Foundation Trusts will publish guidance on eligibility for members to sit as governors on the Board of Governors covering matters such as terms of office, conflict of interest and payment of expenses[7].

Election of governors from the membership

2.25 Before making an order to disestablish an NHS Trust so that a new NHS Foundation Trust can be formally established the Secretary of State for Health will need to be satisfied that the proposals for setting up new governance arrangements have been implemented. In particular he will need confirmation that the new organisation has established a properly representative public and patient membership base and set up a Board of Governors that is in fact representative of the members.

7 this will be made available as soon as possible following the enactment of new legislation.

2.26 Applicants for NHS Foundation Trust status will, therefore, be required to arrange for election of governors to represent both the patient and public and employee members on the Board of Governors before the new organisation is formally established[8].

2.27 It will be up to an applicant for NHS Foundation Trust status to arrange the election process in whatever way best fits its local circumstances; the only requirement being that elections are fair and transparent. Where an NHS Foundation Trust covers a wide range of different communities (see discussion in paragraph 2.21 above) the election process will need to ensure a proper balance on the Board of Governors. This may mean dividing the *membership community* into separate constituencies each with the right to elect (one or more) representatives to the Board of Governors.

2.28 People elected to the Board of Governors will be eligible to serve for a term of up to 3 years and to stand for re-election subject to serving for a maximum of 9 years in total[9]. On first establishment an NHS Foundation Trust will have flexibility to stagger the length of governor appointments so that only a proportion of places come up for re-election each year.

Nomination of Governors to represent partner organisations

2.29 It will be for NHS Trusts to decide in consultation with local stakeholders the best way of identifying governors to represent partner organisations on the Board of Governors. Depending on the overall size and makeup of the Council it may be appropriate for example for the relevant Primary Care Trusts to nominate one person to represent their interests as a group. Anyone who is nominated to represent a partner organisation on the Board of Governors of an NHS Foundation Trust will automatically be eligible, and will be required, to register as a member of the NHS Foundation Trust.

2.30 An NHS Foundation Trust may, if appropriate, decide to extend representation of partner organisations on the Board of Governors beyond the requirements in legislation (see paragraph 2.17 above). Examples might include:

- other NHS Trusts, social care and voluntary sector providers in the local health economy that will have significant links with the NHS Foundation Trust because they provide aspects of care for the same patient group (eg Ambulance Trusts and providers of continuing and palliative care), and

- organisations that have responsibility for education and training of non-medical staff.

Election of the Chair of Governors

2.31 The people who make up the Board of Governors will be responsible for electing a person to chair both the Board of Governors and the Management Board. The Chair of Governors will have an important role in securing effective communication between the Management Board and Board of Governors. Eligibility for appointment as Chair will not be limited to governors serving on the Board but open to anyone who meets the criteria for appointment as long as they are a member of the NHS Foundation Trust before appointment (see paragraph 2.34 below).

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8 i.e. in the period between approval of the application by the Secretary of State for Health and granting of a licence by the Regulator – see Chapter 7.

9 a person may be a member of more than one NHS Foundation Trust (e.g. for a Trust in their local area and also a specialist Trust where they have been a patient) but will not be eligible to sit on more than one Board of Governors.

Board of Governors powers and duties

2.32 The main function of the Board of Governors will be to work with the Management Board to ensure that the NHS Foundation Trust acts in a way that is consistent with its objects and with the conditions under which it is licensed to operate (see Chapter 3), and to help set the strategic direction. The Board of Governors will not to be involved in matters of day to day management – such as setting budgets, staff pay and other operational matters.

2.33 The governors will be under a general duty to inform the Independent Regulator of any action by the Management Board that appears to be inconsistent with the terms of the licence. Legislation will set out the minimum functions that the Board of Governors must be responsible for in all NHS Foundation Trusts. These will include:

- establishing mechanisms for consulting the members or partner organisations they represent
- holding at least one meeting each year that is open to all the members to approve:
  - the annual report and accounts of the NHS Foundation Trust;
  - appointment of the Auditor;
- meeting on no less than two other occasions a year – when the main business will be to advise the Management Board on the NHS Foundation Trust's forward plans;
- from time to time[10], at the open meeting or another general meeting to:
  - elect or re-elect the Chair and non-executive directors to the Management Board;
  - approve appointment of the Chief Executive by the Chair and non-executive directors of the Management Board;
  - ratify appointment by the Chief Executive of executive directors to the Management Board.

2.34 Election of the Chair and non-executive directors to the Management Board of an NHS Foundation Trust will normally follow open advertisement amongst the members of the NHS Trust. Eligibility will be based on assessment against specified criteria[11]. However, on first establishment applicants for NHS Foundation Trust status will be required to name the proposed Chief Executive and Chair designate[12]. The Board of Governors will be expected to confirm the election of the Chair without further advertisement and for a period of not less than 3 years. The Chair and non-executive directors would in turn be expected to confirm the appointment of the Chief Executive designate on the same basis.

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10 i.e. on establishment and thereafter on resignation or at the end of the term of office of a member of the Management Board.

11 the Independent Regulator will issue guidance on this and other matters relating to the role of non-executives as soon as possible following enactment of new legislation – this guidance is likely to follow the pattern of guidance issued by the Office of the Commissioner for Public Appointments.

12 to ensure continuity it will usually be appropriate for the existing Chair and Chief Executive of the applicant NHS Trust to be appointed to these posts.

2.35 An NHS Foundation Trust will be able to add to the functions of the Board of Governors to suit local needs. It might, for example, want to specify different mechanisms for consultation with the members including divisions with responsibility for liaison with different member groups (see earlier discussion in paragraph 2.21) and with the Patients Forums that relate to their main commissioning Primary Care Trusts.

Membership and functions of the Management Board

2.36 Applicants for NHS Foundation Trust status will be free to decide on the detailed constitution of the Management Board within the framework of basic requirements specified in new legislation. The relationship between an NHS Foundation Trust's Management Board and Board of Governors will be defined by its constitution.

2.37 The Department of Health will make available a draft generic model constitution for NHS Foundation Trusts setting out the elements that all applicants must include in their proposals. The intention is that applicants should build on the basic structure to meet their individual needs. An NHS Foundation Trust that is responsible for a teaching hospital may, as now, reserve a non-executive member position on the Management Board for a person drawn from the relevant university.

2.38 Setting out how the constitution will operate in practice will be an important part of the application. However all NHS Foundation Trust Management Boards will be required to comply with a general duty to consult the Board of Governors about:

- the development of forward plans for the NHS Foundation Trust;
- any significant changes to the existing business plan in year.

2.39 Legislative provision relating to membership of the Management Board will include requirements:

- for appointment of a ***Chief Executive, Finance Director*** and at least two other executive directors;
- for election of ***non-executive directors***, in addition to the Chair, to at least one third of the positions on the Management Board;
- for the Management Board to establish sub-committees with responsibility for ***audit and remuneration*** consisting solely of non-executive directors.

Additional accountability requirements under the Health and Social Care Act 2001

2.40 An NHS Foundation Trust will continue to be subject to the general duty to consult and involve patients. Although an NHS Foundation Trust, as an organisation directly accountable to local public and patients, will not be required to establish its own Patients Forum, it will be expected to liaise closely with the Patients Forums established by local Primary Care Trusts under the Act (under the terms of Section 15 of the NHS Reform and Health Care Professions Act 2002).

2.41 An NHS Foundation Trust, like other NHS bodies, will be expected to develop a co-operative working relationship with the local Overview and Scrutiny Committee and will be under a duty to respond to requests for information by the Committee. The Chief Executive of the NHS Foundation Trust may be required to attend Overview and Scrutiny Committee meetings to answer questions and explain decisions. It will also be subject to a duty to consult the Overview and Scrutiny Committee at an early stage on plans for substantial developments or variation of services that are designated as regulated services under the terms of its licence (see Chapter 3).

3. Licensing and Regulation

3.1 When an NHS Trust becomes an NHS Foundation Trust the Secretary of State for Health will make an order dissolving the NHS Trust and transferring its assets to the new community-owned organisation. The licence and regulatory regime for NHS Foundation Trusts will provide the accountability framework for management of those assets and in which the governance arrangements described in Chapter 2 will operate. Together with the new commissioning arrangements described in Chapter 4, these mechanisms will replace the existing controls exercised by the Secretary of State in respect of other NHS bodies. The new regime will be clearly defined in legislation, independent of the Secretary of State and designed to give NHS Foundation Trusts maximum freedom to operate while safeguarding the interests of NHS patients and the wider NHS.

3.2 The licence will include an explicit requirement on an NHS Foundation Trust to uphold NHS standards and to operate according to NHS values. It will ensure maintenance of clinical and service standards, service continuity and co-operation with other partners in the local and national health community. The licence will cover matters relating to financial management and borrowing, provision of information and the safe operation of the NHS Foundation Trust.

3.3 The licence to operate as an NHS Foundation Trust will be issued by an Independent Regulator accountable to Parliament through the Secretary of State for Health (the interface between the Independent Regulator and the Secretary of State for Health is discussed in paragraph 3.29 below). The Independent Regulator will be responsible for ensuring that the terms of the licence are upheld and will have powers to intervene if an NHS Foundation Trust has breached any of the licence conditions. The proposed arrangements for the Independent Regulator will be in line with best practice across the regulated industry sectors in the UK.

What the licence covers

3.4 For all NHS Foundation Trusts the licence will detail:

- a requirement to focus on delivery of care to NHS patients, with strict limits on the provision of services to private patients;
- the clinical services it must provide to the local community;
- the application of clinical and service quality standards against which the Commission for Healthcare Audit and Inspection inspects;
- its duty of partnership with other NHS and social care bodies;
- its duty to participate in the education and development of healthcare staff in the NHS;
- the circumstances in which it can make changes in the services it provides for NHS patients;

- the financial duties under which it will operate, including reference to the prudential borrowing regime;
- restrictions on the disposal of assets used in the provision of NHS clinical services;
- requirements to provide specified statistical and financial information and to participate in the NHS strategy for Information Management and Technology.

General purpose

3.5 New legislation will require any organisation operating as an NHS Foundation Trust to be established with objects that:

- include a primary purpose of providing health and related services for the benefit of NHS patients and the community
- require it to act in accordance with NHS values
- limit other activities to those that are conducive to and not detrimental to achievement of the primary purpose
- ensure that the assets, and any surpluses an NHS Foundation Trust makes, are applied solely to the primary purpose and are not used to provide dividends or bonuses for its members.

3.6 An NHS Foundation Trust will also be required to comply with additional conditions of the licence as set out in the following sections.

Provision of NHS clinical services

3.7 The licensing regime will ensure continuity of services for NHS patients. This is particularly important where alternative provision of a particular service is limited, or does not exist, in the local health economy. As an NHS Foundation Trust develops its activities over time, any substantial changes in provision of existing clinical services must be managed in a way that does not lead to Primary Care Trusts being unable to commission services to meet the needs of local people.

3.8 NHS Foundation Trusts will be subject to an obligation to offer certain NHS services for NHS patients (these will be known as *regulated services*[13]). The regulated services for a particular NHS Foundation Trust will be specified in a schedule to its licence and relate to service agreements with NHS commissioners. On establishment these will replicate the NHS clinical services provided to NHS patients at the time. Where clinical services are provided on more than one site the location as well as the nature of the service may be specified.

3.9 There will also be an obligation on an NHS Foundation Trust to meet reasonable demand for regulated services, taking into account its forward business plans as well as its contractual commitments. Primary Care Trusts will pay NHS Foundation Trusts to provide these services for their patients. Under the new system of payments by results being introduced throughout the NHS the cost of each service will be standardised (see Chapter 4).

13 The term *regulated services* refers to all clinical services provided to NHS patients as defined in the licence. All other services are non-regulated for the purposes of the protected failure regime defined elsewhere in this chapter and in chapter 5. Regulated assets are those assets required in the provision of regulated services.

Variation of regulated services

3.10 The licence will make provision for an NHS Foundation Trust to propose changes in the schedule of regulated services after it is established. Amendments might be needed because of changes in health technology, demographics or in demand for a particular service as alternative provision develops.

3.11 An NHS Foundation Trust will have a duty to involve and consult the public, and to consult the local Overview and Scrutiny Committee on any substantial variation in provision of a service that is designated in its licence as a regulated service[14]. It will also need to consult and where possible reach agreement with Primary Care Trusts and other interests. These consultations should normally take place before an NHS Foundation Trust submits proposed changes to the Independent Regulator. In most cases the role of the Independent Regulator will be limited to checking that due process has been followed (and that the proposal does not cut across the primary purpose).

3.12 If proposals amount to a substantial change in service and give rise to concerns that cannot be resolved, the Overview and Scrutiny Committee will have power to refer them to the Independent Regulator on grounds of inadequate consultation or on the merits of the proposal – (for other NHS bodies reference will be to the Secretary of State for Health). In these circumstances the Independent Regulator will have the power to determine whether the proposals should go ahead, to require further consultation or to reject the proposals. In reaching a decision, the Independent Regulator will be able to seek advice from the Independent Reconfiguration Panel, also used by the Secretary of State.

3.13 An NHS Foundation Trust will not be required to provide a new service (or to expand a service already provided) without its prior consent.

Provision of services to private patients

3.14 The primary purpose of an NHS Foundation Trust will, as with all other NHS Trusts, be to provide services to NHS patients that are free at the point of use and on the basis of their clinical need, not their ability to pay. But ever since its creation, NHS providers have engaged in a limited amount of non-NHS clinical work. Therefore, like NHS Trusts, NHS Foundation Trusts will be allowed to contract with patients or other organisations to provide a limited set of non-NHS clinical services. But to ensure that an NHS Foundation Trust does not use its freedoms in a way that cuts across the primary purpose of providing NHS services for NHS patients the licence will place strict limits on the extent that it can undertake private patient activity.

3.15 Contracted income from private patients will be strictly limited as a percentage of total income from clinical activities. The percentage will be fixed for each NHS Foundation Trust as the percentage that applied in the financial year ending April 2003.

3.16 It is important that maximum use is made of all NHS facilities for NHS patients. At the applications stage, therefore, the Government will be particularly keen to see NHS Foundation Trust applications that propose to convert existing NHS facilities currently wholly used for paying patients into facilities for the exclusive use of NHS patients.

14 Sections 7 to 10 of the Health and Social Care Act 2001 provide for specific scrutiny powers for Overview and Scrutiny Committees over matters relating to their local health service. The provisions will apply to NHS Foundation Trusts in the same way as to other NHS Trusts with respect to substantial changes in services that are designated as regulated services.

Financial duties and prudential borrowing

3.17 An NHS Foundation Trust will have significantly greater freedom to raise capital from the public and private sectors (see Chapter 5). It is important that this freedom to borrow is used in a way that does not undermine an NHS Foundation Trust's ability to meet its general duty to remain financially viable. Under the terms of the licence each NHS Foundation Trust will have a prudential borrowing limit that will be agreed with the Independent Regulator. This limit will be set in line with a code of practice (*The Prudential Code*) which is explained in more detail in Chapter 5. An NHS Foundation Trust will be able to borrow up to its prudential borrowing limit without additional regulatory approval. The level of the prudential limit will be subject to periodic review.

Disposal of assets

3.18 All the regulated assets of an NHS Foundation Trust – those required for the provision of regulated services – will be listed in a schedule to its licence. The licence will specify that the consent of the Independent Regulator will be required prior to any proposed disposal of these assets (over a de minimis amount). This consent should not be unreasonably withheld, conditioned or delayed. Nevertheless, the Independent Regulator will need to be satisfied that proceeds will be used to further the public interest objectives of the organisation and that disposal of the assets will not jeopardise an NHS Foundation Trust's ability to provide the regulated services.

3.19 There will be no restriction on disposal of non-regulated assets (ie those used for income generation eg franchises, car parks) as long as proceeds are used to further an NHS Foundation Trust's public interest objectives.

Clinical and quality standards

3.20 Like other NHS organisations, an NHS Foundation Trust will be required to comply with national clinical and quality standards and to ensure that buildings and equipment used in provision of NHS services are fit for purpose. This will include a general duty to put and keep in place arrangements for the purpose of monitoring and improving the quality of healthcare services. It will be subject to a national set of clinical and service standards applicable to all services for NHS patients against which the Commission for Healthcare Audit and Inspection will inspect.

Co-operation with other bodies

3.21 An NHS Foundation Trust will come within the remit of existing statutory bodies such as the National Audit Office, the Health Services Commissioner and Human Fertilisation and Embryology Authority. As a condition of legislation and the licence it will also be subject to a general requirement to co-operate with other public service providers and NHS bodies – in particular NHS and social care service providers and commissioners in the local health economy, education and training bodies, and the Department of Work and Pensions for social security purposes.

Provision of financial and statistical information

3.22 An NHS Foundation Trust will be required to provide financial and statistical information to enable the Independent Regulator to monitor compliance with the licence. The areas to be covered will be limited to what is specified in the licence. The Independent Regulator may however request, or in some circumstances require, additional information if he or she has reason to believe that the terms of the licence have been breached.

3.23 An NHS Foundation Trust will also need to contribute to standard national NHS data flows which are required to support policy development and funding decisions for the NHS as a whole as well as performance assessment by the Commission for Healthcare Audit and Inspection.

Information management and technology

3.24 The establishment of an NHS Foundation Trust will not disrupt current and planned NHS-wide initiatives for development of information management and technology. Details of the IT schemes that an NHS Foundation Trust will be required to participate in will be scheduled in the licence.

Grant, review and termination of licence

3.25 The Independent Regulator will grant licences to NHS Foundation Trusts in accordance with provisions set out in legislation. In the case of an NHS Trust applicant, the Independent Regulator will only be able formally to grant a licence following confirmation that the Secretary of State is content for the NHS Trust to be disestablished and the assets transferred to the new organisation that will become the NHS Foundation Trust. The precise terms of the licence, including the schedules of services and assets, will be determined following discussion between an NHS Foundation Trust applicant and the Independent Regulator in the establishment stage.

Periodic review

3.26 The Independent Regulator will be under a duty to review the schedules to the licence every 2 years – to take account of changes in health care provision in the local area and relevant developments in national policy. Such reviews may over time for example, result in changes to the designation of certain assets or services as regulated, and information obligations that an NHS Foundation Trust must fulfil. This review will be additional to the licensee's right to request a change to the schedules as and when the need arises.

Term and termination

3.27 Once a licence has been granted it will run for a period of 30 years or longer unless it is terminated by the Independent Regulator (see paragraph 3.37 below) or exceptionally at the request of an NHS Foundation Trust. Specified periods of notice will apply according to the circumstances of the decision.

The Independent Regulator

3.28 The office of Independent Regulator for NHS Foundation Trusts will be a new post, established in legislation as an independent body corporate. The Independent Regulator will be appointed by the Secretary of State for Health, and will be accountable to Parliament through him. The main functions of the Independent Regulator will be to:

- grant licences to applicants for NHS Foundation Trust status in compliance with the provisions set out in legislation;
- monitor compliance with the licence;
- undertake periodic review of the licence;
- take steps to mitigate any breach of the licence;
- publish an annual report on the activities of the licensed bodies.

3.29 In exercising these functions, the Independent Regulator will be subject to a general obligation to act in a way that is consistent with the public benefit.

3.30 The Independent Regulator will get information both directly from an NHS Foundation Trust and through the reports of inspections carried out by the Commission for Healthcare Audit and Inspection against value for money, and clinical and quality standards. The Independent Regulator's duties and powers will be distinct from those of the inspectors and he or she will act independently in any dealings with an NHS Foundation Trust.

3.31 The Commission for Healthcare Audit and Inspection will:

- inspect the management, provision and quality of services, in accordance with national standards and service priorities and tracking where, and how well, public resources are being used, as well as the arrangements for the quality assurance, quality improvement and safety at the local level;
- carry out investigations into serious service failures;
- publish annual performance ratings.

3.32 Reports of inspections or investigations that the Commission carries out in an NHS Foundation Trust will be made available to the Independent Regulator. He or she will be able to take into account any recommendations the Commission makes in deciding what if any action to take in the case of a breach of licence (see below).

3.33 An NHS Foundation Trust, like any other NHS organisation, will be subject to annual performance rating and the results will be made available to the Independent Regulator. Maintenance of 3-star performance is not a specific licence condition – the criteria for performance ratings and the licence are designed to serve different purposes. However, if an NHS Foundation Trust's rating dropped below 3 stars the Independent Regulator would be expected to exercise discretion, taking into account any other information available, as to whether the change in rating should be regarded as indicative of a breach of licence conditions. If the Independent Regulator considered that the NHS Foundation Trust had breached, or was likely to be in breach of, its licence conditions he or she would be able to use the powers of intervention (outlined in paragraph 3.37) to mitigate the breach. An NHS Foundation Trust rated at 0 or 1-star would almost certainly be in breach of one or more of its licence conditions and therefore subject to remedial action by the Independent Regulator to bring it back into compliance with the licence – and therefore to improve performance. *In extremis*, the Independent Regulator would be able to revoke the licence.

Breach of licence – provision for the Independent Regulator to intervene

3.34 In normal circumstances the Independent Regulator will have no reason to become directly involved in an NHS Foundation Trust's affairs and will have no power to direct what it does. However, if things go wrong there will be a robust mechanism in place with clearly defined intervention powers.

3.35 The intervention regime will be set out in legislation. The primary aim will be to enable the Independent Regulator to steer an NHS Foundation Trust back to viability when problems become apparent. It will also provide for managing failure where this cannot be prevented.

3.36 Intervention could be triggered by the Board of Governors of an NHS Foundation Trust. As explained in Chapter 2, the Board of Governors will have a general duty to inform the Independent Regulator of any action by the Management Board that appears inconsistent with its licence. People serving on the Board of Governors would however be expected to attempt to resolve concerns with the Management Board before approaching the Independent Regulator. Other triggers could be an adverse inspection report from the Commission for Healthcare Audit and Inspection, a low star rating in the annual performance ratings or concerns about financial viability arising from the information provided to the Independent Regulator by an NHS Foundation Trust.

3.37 The Independent Regulator will have a range of intervention powers that would be applied according to the seriousness of the breach, including:

- imposition of additional reporting requirements or other special measures in the event of an adverse report by the Commission for Healthcare Audit and Inspection;
- issue of formal or informal warning letters to an NHS Foundation Trust;
- removal of some or all of the Management Board or ordering new elections to the Board of Governors;
- *in extremis*, power to recommend that the assets of an NHS Foundation Trust are transferred to another NHS body, including if necessary the Secretary of State for Health, or merged with another NHS Foundation Trust.

3.38 In the event that an NHS Foundation Trust failed to meet its financial duties the key steps in the failure regime would be:

- dissolution of the Board of Governors and dismissal of the Management Board;
- appointment of a Special Administrator to ensure ongoing provision of regulated services including meeting any associated liabilities;
- the Special Administrator would arrange for the regulated assets and services, along with any liabilities, to transfer to another provider (another NHS Foundation Trust or NHS Trust);
- any part of the NHS Foundation Trust's operations that were not classified as regulated would be subject to normal insolvency rules;
- the NHS Foundation Trust as a legal entity would be wound up although, of course, the local NHS services it had provided would continue uninterrupted as they would transfer to another NHS Foundation Trust or NHS Trust (see paragraph 3.37 above).

4. Providing NHS Services

4.1 NHS Foundation Trusts will not be subject to performance management by the Department of Health or Strategic Health Authorities but will instead be held to account for delivering the outputs agreed with Primary Care Trusts, and other partners in the health economy, as part of the commissioning process.

4.2 These commissioning agreements will identify the range and volumes of services NHS Foundation Trusts will provide and develop in order to deliver their contribution to an integrated local health service that is responsive to patients' needs. This will ensure a focus on the delivery of outputs based on payment by results.

Commissioning from NHS Foundation Trusts

4.3 In their role as commissioners of services for NHS patients, Primary Care Trusts have an important responsibility to ensure that provider organisations can be held to account for the services provided to patients. In addition, because Primary Care Trusts control the majority of NHS resources, they need to ensure that the services commissioned represent best value for public money.

4.4 The new governance regime for NHS Foundation Trusts will mean introducing new and different arrangements for commissioning. Service Level Agreements negotiated between Primary Care Trusts and other NHS Trusts do not need to be legally binding because they are overseen by Strategic Health Authorities on behalf of the Department of Health. These arrangements work because Primary Care Trusts and NHS Trusts are directly accountable to the Secretary of State for Health through Strategic Health Authorities.

4.5 NHS Foundation Trusts will not be subject to Secretary of State for Health powers of Direction. Instead, an NHS Foundation Trust will take full responsibility for the outcomes it achieves in terms of volume, quality and responsiveness to patients. Outputs will need to be agreed with Primary Care Trusts and formalised under legally binding service agreements. This will introduce greater clarity and transparency in the relationship between Primary Care Trusts and NHS Foundation Trusts and ensure that these organisations are properly accountable for their respective commitments.

4.6 Primary Care Trusts will be able to use their 3-year budgets to determine which services they wish to commission from NHS Foundation Trusts. Initially, it is expected that their agreements with NHS Foundation Trusts will generally cover a period of 3 years so that a stable environment is created in which to build the new relationships with NHS Foundation Trusts.

Other Contractual Relationships

4.7 NHS Foundation Trusts, like other NHS Trusts, will not provide goods and services solely to Primary Care Trusts. An NHS Foundation Trust may, for example, provide community care services on behalf of Local Authorities, or may be active in the fields of research and development. It will be important for both public and private sector bodies to be able to hold NHS Foundation Trusts to account in the same way as Primary Care Trusts will. NHS Foundation Trusts will, therefore, need to negotiate legally binding agreements with these other bodies in order to safeguard both parties' interests.

Working in partnership to deliver an integrated system responsive to patient needs

4.8 An NHS Foundation Trust should participate fully in the commissioning process to ensure that its own plans for capacity expansion and service development reflect the direction of local strategic change.

4.9 The content of effective, output focused service agreements will need to reflect commissioners' plans for the development of services within the local health economy and make clear that standards of quality and safety must comply with the national minimum. In addition, these agreements should specify:

- the range of services that are to be provided by an NHS Foundation Trust;
- volumes of services to be provided;
- cost of services to be provided using Health Resource Groups adjusted for case mix where appropriate (see Chapter 5, paragraph 5.27 regarding transitional arrangements);
- where necessary, penalty clauses to enable commissioners to claw back funding where, for example, service targets or timescales for treatment are not being met;
- incentive clauses to encourage early delivery of key services;
- service development programmes;
- specialist packages of care relating to a minority of more complex cases;
- the information that both parties will need to make available.

4.10 It is vital that the expectations of both parties to the agreement remain clear. Commissioners and providers must develop robust arrangements for risk sharing and risk management. This means that agreements for NHS services should allow both parties a reasonable degree of flexibility and, crucially, must be responsive to patient choice. Effective agreements should be responsive to fluctuations caused by a range of potential variables including demand, medical advances and changing priorities, whilst at the same time providing sufficient financial stability for the bulk of the services to be delivered over the life of the agreement. This means that parameters must be agreed to allow reasonable variation in aggregate volumes of activity and to provide the necessary flexibility to move activity between particular services.

Managing Disputes

4.11 Even with a flexible, well-constructed service agreement there may still be occasional disputes and there must be arrangements for mediation and arbitration. The framework of commissioning will include a requirement for compulsory arbitration[15] in the event that disputes cannot otherwise be resolved.

15 Arbitration will be governed by provision of the Arbitration Act 1996. Ultimate recourse would be to the courts on points of law.

Support for the NHS in developing commissioning

4.12 Support will be provided for Primary Care Trusts and other purchasers as well as for NHS Foundation Trust applicants to develop competency in commissioning and in negotiating and framing legally binding agreements. This will include the production of a 'template' legally binding agreement for Primary Care Trusts and other bodies commissioning services from NHS Foundation Trusts to adopt. The model legally binding agreement will complement a broader package of support for Primary Care Trusts in moving to the new system of payment by results which is discussed further in Chapter 5. The whole support programme will be developed in consultation with Primary Care Trusts.

5. Financial regime

5.1 NHS Foundation Trusts, as organisations with a proven track record of success in delivery of care for NHS patients and in management and financial prudence, will be granted a wider range of financial freedoms. These freedoms will apply to decisions on managing the assets already vested in the organisation and allow access to a wider range of funding to improve and expand services and support innovation. These freedoms sit alongside the new arrangements for contracting with NHS purchasers and the licensing and governance arrangements described in chapters 2, 3 and 4.

5.2 The financial freedoms will cover three key areas:

- retention of proceeds from asset disposals;
- retention of operating surpluses;
- access to capital based on financial performance and ability to meet any liabilities incurred as a result of borrowing.

The new freedoms and discretion to borrow will be backed up by transparent and rules-based risk sharing mechanisms. There will be a credible failure regime that allocates risk, and holds to account those best able to manage that risk. This chapter explains how the financial regime for NHS Foundation Trusts will work.

Assets

5.3 When an NHS Foundation Trust is established the Secretary of State for Health will make an order dissolving the relevant NHS Trust and transferring its assets to the new organisation under the ownership and control of the local community. The transfer will cover land, plant and buildings. Intellectual property rights will, where relevant, be licensed to a NHS Foundation Trust on a negotiated basis. Intellectual property developed after the transfer will be owned by the NHS Foundation Trust unless otherwise negotiated. Assets will be transferred with associated debt.

5.4 NHS Foundation Trusts will not be able to borrow against the regulated NHS clinical assets that are essential to provide continuity of services to NHS patients. These assets will be listed in a schedule to the licence (see Chapter 3).

5.5 For borrowing purposes an NHS Foundation Trust will be able to offer security against any assets and revenue streams that are not listed as regulated in the licence. Such assets would include, for example, retail premises, general amenities (such as car parks and retail premises) and other non-clinical facilities (and revenue streams from associated activities).

Types and sources of revenue

5.6 An NHS Foundation Trust's principal source of revenue will be from legally binding agreements with Primary Care Trusts, other NHS commissioners or training bodies for clinical services and associated training or research activity. This will form the regulated services component of revenue.

5.7 Additional income may be generated from:

- legally binding agreements with Primary Care Trusts and other NHS commissioners and/or other public sector bodies for non-clinical activities;
- contracts for provision of other clinical services with individuals and bodies that are not part of the NHS;
- operating or investment income not directly associated with clinical service delivery.

This will form the unregulated component of revenue.

Revenues from regulated services

5.8 Revenue from the provision of regulated services will be derived exclusively from performing such services under legally binding agreements with Primary Care Trusts and other NHS commissioners. After a transitional period prices for clinical services will be driven primarily by a standard national tariff (see paragraph 5.25). The tariff will take into account regional variations in the cost of delivering services and allow efficient Trusts to recover costs, service debt and invest in long term capital investment projects. These regional variations (market forces factor[16]) will be assessed against published guidelines issued by the Department of Health from time to time.

5.9 An NHS Foundation Trust will be required, under the terms of its licence, to focus on delivery of services for NHS patients. Standard tariffs mean that commissioning will be on the basis of quality and volume, not price. Financial benefits for an NHS Foundation Trust will be generated not by reducing prices and competing with other NHS Trusts but by realising performance and efficiency gains and increases in the range and volume of services delivered to NHS patients.

5.10 Funding for education and training activity will be negotiated with Strategic Health Authorities and higher and further education institutions, with arrangements formalised in service agreements or contracts (see Chapter 6).

Revenues from unregulated services

5.11 Revenues from unregulated services will include all other income that an NHS Foundation Trust may generate through contracts for other activities either with or without input from third parties (see Chapter 3 for definition of regulated and unregulated services). Prices will be derived as a result of negotiation between the contracting parties and not subject to any tariff or other externally imposed price cap mechanisms.

16 The Departmental publication "*Resource Allocation: Weighted Capitation Formulas*" (Department of Health, July 1999) explains the "Market Forces Factor" that has been used up to and including 2002-03 allocations. From 2003-04 the Market Forces Factor is being revised. This will be explained in the Exposition Book and a revised version of the booklet "*Resource Allocation: Weighted Capitation Formulas*"

5.12 An NHS Foundation Trust may also pursue non-clinical activities – both of a service and/or investment nature. It will, however, be bound by the general requirement that such activities must not be to the detriment of its primary purpose – providing services for NHS patients in accordance with NHS values and in compliance with other licence restrictions relating to provision of private patient services (see Chapter 3).

Access to capital

5.13 An NHS Foundation Trust will be given the opportunity to access capital from the public and/or private sectors at appropriate rates of interest. This will enable it better to tailor capital planning to its individual circumstances, potentially increasing its access to capital subject only to its ability to service any resulting debt, hence offering the opportunity to finance a wider range of new healthcare delivery projects. Examples of such projects might include new elective capacity in the form of an extension to existing facilities or a new-build Diagnostic and Treatment Centre.

5.14 An NHS Foundation Trust will also be allowed to keep any year-end financial surpluses, subject to the requirement that they are reinvested in ways consistent with its primary purpose (health related activity carried out in the public interest as set out in their licence). Provided these requirements are met, an NHS Foundation Trust will be able to use surpluses either to pay down debt or to build up cash reserves to finance future capital schemes either directly or indirectly.

5.15 An NHS Foundation Trust will have freedom to access capital subject to three constraints:

- a discretionary borrowing limit agreed with the Independent Regulator
- prohibition on use of regulated assets as security for borrowing
- any additional degree of scrutiny imposed by financial institutions (public or private) which will also wish to make their own assessment on the serviceability of any debt based on the projected future revenue streams of the borrower.

5.16 Discretionary borrowing limits will be agreed on a case by case basis taking account of an NHS Foundation Trust's ability to generate operating revenue to service debt. The overriding objective is to enable an NHS Foundation Trust to access borrowing subject only to its ability to service the debt incurred.

The Prudential Code

5.17 A published code (*Prudential Code*[17]) will set out the basis for determining serviceability of the debt levels requested by NHS Foundation Trusts. The Prudential Code – which will be issued by the Secretary of State for Health – will provide a framework within which an NHS Foundation Trust will make its own decisions about funding future capital investment through borrowing, subject to the prudential guidelines which assess the sustainability of that proposed borrowing. Key objectives will be that all external borrowing and other long-term liabilities are within prudent and sustainable levels, capital expenditure plans are affordable and management decisions are taken in accordance with professional good practice. The Prudential Code will emphasise accountability and transparency to demonstrate that this is the case. It is also important that the framework provides a timely indication

17 The Prudential Code will be made available to applicants during the time period for submission of initial applications.

that there might be problems, so that remedial action can be taken by the NHS Foundation Trust and, *in extremis*, the Independent Regulator.

5.18 The new framework will place important responsibilities on the Finance Director of an NHS Foundation Trust in providing advice to his or her colleagues and establishing the necessary monitoring systems, and on an NHS Foundation Trust itself in taking the relevant decisions. The Code will require indicators, including key financial ratios, to be set using prescribed definitions that tie in, wherever possible, directly with generally accepted accounting practice.

5.19 The Prudential Code will require that external debt is kept within sensible and prudent limits by examining affordability in a transparent and structured manner based on best practice in credit analysis.

Setting discretionary borrowing limits

5.20 Applicants for NHS Foundation Trust status will be invited to submit proposals for a prudential borrowing limit under the terms of the Prudential Code as part of their final application (see Chapter 7). The Independent Regulator will assess proposals against the Prudential Code and agree a borrowing limit for each NHS Foundation Trust – the prudential limit. This limit will be reviewed annually. Prudential limits would apply to the total indebtedness of the NHS Foundation Trust as a group, i.e. all borrowing both public and private across the structure.

What this means for NHS Foundation Trusts

5.21 For most NHS Foundation Trusts the new borrowing freedoms are intended to facilitate eventual access to additional discretionary funds sufficient to finance working capital and new mid-sized capital projects. For larger projects procured under the Private Finance Initiative and/or requiring other support from Strategic Health Authorities or the Department of Health current approval mechanisms will continue to apply.

The Private Finance Initiative

5.22 The Private Finance Initiative is delivering a better quality of buildings and services to NHS patients. As a result the NHS is currently engaged in the biggest hospital building programme of its existence. It is essential, therefore, that the NHS reform agenda does not inhibit continued growth in the Private Finance Initiative market for NHS organisations that might benefit from it. An NHS Foundation Trust will continue to be able to procure capital schemes using the Private Finance Initiative process, subject to the same degree of oversight as applies under the current arrangements. Suitable comfort will be provided to sponsors of existing, pipeline and future Private Finance Initiative schemes in line with current best practice. This will prevent the new arrangements for NHS Foundation Trusts being regarded as an adverse change in law for existing deals or inhibiting an NHS Foundation Trust's ability to access procurement via the Private Finance Initiative in future.

Joint Ventures

5.23 Like NHS Trusts, an NHS Foundation Trust will be able to establish joint ventures and enter into Public Private Partnership arrangements with other organisations. Subject to compliance with the licence an NHS Foundation Trust will also be able to establish subsidiaries without the need for external approval.

Proceeds from asset disposals

5.24 An NHS Foundation Trust will be allowed to retain 100% of the proceeds from asset disposals subject to demonstrating, to the satisfaction of the Independent Regulator, that the proceeds from such disposals will be used to further its public interest mandate.

Transition to payment by results

5.25 From 2003/04 the NHS will begin to introduce a system of financial flows based on the principle of payment by results against a standard tariff. The details of these proposals are set out in the recently published consultation document *Reforming NHS Financial Flows: introducing payment by results* (Department of Health, October 2002). This new system is part of a reform programme that will increase patient choice and will provide strong incentives for providers to focus on quality and increasing patient satisfaction as well as efficiency. The standard tariff system across the NHS is designed to ensure that the NHS does not return to the internal market competition on price but is driven by incentives that raise standards, outputs and activity rates. The standard tariff will keep transaction costs down and remunerate trusts in a fair and transparent manner.

5.26 Tariffs will capture the cost of delivery including associated depreciation and capital charges against a national benchmark. NHS Foundation Trusts will no longer be subject to external financing limits set by the Department of Health or Strategic Health Authorities.

5.27 The intention is that the national tariff system should be fully operational no later than the end of 2007-8. Ultimately over 90% of NHS Trust and NHS Foundation Trust clinical activity will be paid for under the national tariff, using Healthcare Resource Groups and other standard service classification measures. The national tariff will apply to all providers of health care to NHS patients.

5.28 The transition to the new system of payment by results will start in 2003-04. For most of the NHS, the national tariff will only apply to a small percentage of elective activity in the first two years. From 2005-06, most activity in acute Trusts will be commissioned on a cost-and-volume basis, and a convergence period to national tariff prices will begin. This convergence period is likely to be 3 years for NHS Trusts.

5.29 All first wave NHS Foundation Trusts will be encouraged to commision on a cost-and-volume basis across as wide a range of services as possible from 2004-05. This will provide a clearer basis for legally binding agreements and it is likely that Primary Care Trusts will use their new 3-year budgets to make longer-term agreements with NHS Foundation Trusts. The Department of Health will explore with shadow NHS Foundation Trusts and their main commissioning Primary Care Trusts the possibility of beginning the convergence process to using national tariff prices for all their NHS services a year earlier than the NHS as a whole. Before making a decision on this, the Department will carry out simulation and modelling studies to analyse the impact of the transition to the national tariff on the financial position of both the NHS Foundation Trusts and Primary Care Trusts concerned[18]. The decision on whether to begin the transition to the tariff and the pace of transition for NHS Foundation Trusts in their first year will be taken in consultation with the relevant interests.

18 One issue that this modelling work will seek to take into account is the likely impact of the revision of HRGs and review of the training levies that will be undertaken in 2003-04. The final results of these reviews and their impact on the future national tariff will not be available until autumn 2004, in time for setting the national tariff for 2005-06. As a result, there is expected to be discontinuity in tariff prices between 2004-05 and 2005-06 and this will be taken into account in deciding the approach to be taken.

Failure regime

5.30 In addition to the positive incentives being introduced for management and staff to deliver excellence and to ensure patients and the public get the very best from their hospital, a robust mechanism for managing failure will be put in place to fully align risks with potential rewards.

5.31 This regime will ensure the Secretary of State for Health's overriding priority – that NHS patients continue to have access to the healthcare they need, free at the point of delivery in all circumstances – without underwriting the institutions that have failed to deliver under the terms of their service agreements and/or licence. The terms of the failure regime are discussed in Chapter 3.

6. Employment, education and training

6.1 An NHS Foundation Trust will be free to recruit and employ its own staff building on the local flexibilities already available to NHS Trusts. It will have the flexibility to offer new rewards and incentives and explore innovative ways of working in partnership with staff to deliver local services. In line with its statutory duty of partnership an NHS Foundation Trust will be expected to use these new freedoms in a way that fits with key NHS principles and does not undermine the ability of other providers in the local health economy to meet their NHS obligations. In particular, the arrangements for NHS Foundation Trusts will ensure that:

- high standards of employment practice are maintained;
- the benefits of pay modernisation are fully secured;
- there is a smooth transition for all staff;
- responsibilities for education and training of NHS staff are properly met.

6.2 Staff will be closely involved in the application process (see Chapter 7) and in the ongoing development and management of the organisation through the Board of Governors (see Chapter 2).

6.3 This chapter sets out how the framework for NHS Foundation Trusts will achieve these aims.

High standards of employment practice

6.4 As a high performing organisation, an NHS Foundation Trust will be well placed to maintain high standards of employment practice in line with best practice across the NHS. The governance arrangements will help to reinforce this through the involvement of employees in the Board of Governors. An NHS Foundation Trust will be able to take part in wider developments to improve employment practices across the NHS. And, under the terms of its licence, it will be required to work in partnership with other local NHS bodies – in particular in relation to the education and development of healthcare staff in the NHS. This will, for example, ensure that there are common approaches where there are common problems or opportunities and that local employment policy does not adversely impact on recruitment and retention elsewhere.

6.5 Employment practices will be an important part of the assessment process for applications. Applicant NHS Foundation Trusts will be required to set out their proposed approach (see Chapter 7).

Pay modernisation

6.6 Successful NHS Foundation Trust applicants will be leading pay modernisation and will be amongst the first to implement the new pay system that has been negotiated for the NHS. *Agenda for Change*, if agreed, will be introduced in a number of early implementer sites next year, ahead of full implementation beginning in 2004. The Department of Health will support successful applicants

for NHS Foundation Trust status to ensure that they are able to implement the new pay system ahead of establishment, by setting up a second wave of *Agenda for Change* early implementer sites from autumn 2003.

6.7 Once established, an NHS Foundation Trust will be able to continue to benefit from wider agreements negotiated by or on behalf of NHS employers collectively. But it will also have the additional freedom and flexibility to ensure it has the necessary mix of skills to provide the best standards of care to patients. As recognised in *Agenda for Change*, different labour markets face different recruitment and retention problems. NHS Foundation Trusts will have the local flexibility to deal with these in a way that is consistent with the needs of other local NHS organisations.

Transition arrangements for staff

6.8 The transition from NHS Trust to NHS Foundation Trust status will be in line with TUPE and existing staff will move across to an NHS Foundation Trust without detriment. Continuous service, which determines eligibility for various rights and benefits will be preserved. Staff will also retain all their pension rights. An applicant NHS Foundation Trust will be expected to discuss the process of transition with their staff and to consult formally on transfer arrangements. The Department of Health will support successful applicants and provide guidance and information on transition arrangements. Service in an NHS Foundation Trust will count as reckonable service with an employing authority in the NHS.

Pensions

6.9 Existing staff will continue to be able to move across the NHS without detriment to their NHS pensions and new staff employed directly by an NHS Foundation Trust will have access to the NHS final salary pension scheme, and to the associated injury benefit scheme and the compensation for early retirement benefits scheme[19]. As part of the arrangements to give NHS Foundation Trust employer access to the pension scheme they will be required to commit to paying employer contributions.

Education and training

Opportunities for staff

6.10 An NHS Foundation Trust will have freedom to develop practice in its own organisation and have access to NHS training resources. It will have full access to the new NHS University when it is established. The involvement of staff on the Board of Governors will help to ensure a greater degree of partnership with support for professional and clinical leadership at all levels of the organisation. Under the terms of its licence an NHS Foundation Trust will be responsible for development and training of its staff.

Contribution to development of the NHS workforce

6.11 As an organisation that is part of the NHS family, an NHS Foundation Trust will be expected to contribute to effective working of NHS arrangements for developing the NHS workforce and to work in partnership with Higher and Further Education Institutions.

19 As now staff will be able to opt out of the NHS pension scheme if they choose.

6.12 Under the terms of its licence (see chapter 3), an NHS Foundation Trust will be required to co-operate with other public bodies – in particular NHS Trusts, Primary Care Trusts, Strategic Health Authorities and postgraduate deaneries, the NHS University and university medical schools and other higher and further education institutions – and with statutory regulators. An NHS Foundation Trust will also have a general duty, under the terms of its licence, to support the education and training of healthcare staff in the NHS. Details of how this duty applies will be set out in legally binding agreements between an NHS Foundation Trust and the relevant Strategic Health Authority. An NHS Foundation Trust will, for example, be expected to provide clinical learning opportunities and placements for nursing, medical and dental students, cadets and staff undertaking National Vocational Qualifications, post-graduate training for junior medical and dental staff and placements for pre-registration students in the other health professions.

6.13 Training provided within an NHS Foundation Trust will need to meet standards set by the regulating bodies. Standards for the health professions education and training have been agreed across regulatory bodies, Strategic Health Authorities and higher education bodies. A streamlined and integrated framework of quality assurance is being developed for nursing, allied health professional and healthcare scientist education and training. Standard setting for undergraduate and pre-registration medical and dental training lies with the General Medical Council and General Dental Council. Like other training bodies, an NHS Foundation Trust will be expected to comply with these standards and quality assurance arrangements.

6.14 The standard for postgraduate medical training is currently the responsibility of the Specialist Training Authority and the Joint Committee on Postgraduate Training for General Practice, and will shortly become the responsibility of the new Postgraduate Medical Education Training Board. The new Board will offer a more streamlined approval to training in all NHS Trusts and NHS Foundation Trusts and will work closely with other 'visiting bodies' – such as Commission for Healthcare Audit and Inspection – to reduce duplication and disruption of service through repeat visiting.

Funding for education and training

6.15 NHS Foundation Trusts will continue to negotiate locally with Strategic Health Authorities and their Workforce Development Confederations and higher and further education institutions for the provision of NHS funded education and training. The resulting arrangements will be formalised in legally binding agreements. The Department of Health will support these arrangements by developing a model national contract that can be adapted to local circumstances. Following *Funding Learning and Development for the Healthcare Workforce*[20], the arrangements for local commissioning and funding of education and training are expected to change. However, in the interim an NHS Foundation Trust will continue to receive funding, on the basis of agreed long-term binding agreements for the provision of education and training in line with other NHS organisations, based on its responsibilities for the provision of diploma, undergraduate, postgraduate and continuing education.

20 *Funding Learning and Development for the Healthcare Workforce* – Department of Health, July 2002.

7. Application process and support

7.1 This Chapter sets out the process for applying for NHS Foundation Trust status.

7.2 NHS Foundation Trust status will only be available to health care providers that can demonstrate they will deliver the benefits to NHS patients that come with the greater freedoms that the status offers. The application process will be transparent and fair although the entry criteria will be tough. Suitability to become an NHS Foundation Trust will depend on an evaluation of financial performance as well as management vision and leadership potential.

7.3 For the first wave of NHS Foundation Trusts, applications will only be invited from acute and specialist NHS Trusts that achieved 3-star status in the NHS performance ratings published in July 2002. As more NHS Trusts improve more will be eligible to apply. There will be no arbitrary cap on numbers. In later waves eligibility will be opened up to other types of NHS Trust and eventually NHS Foundation Trust status may also be available to organisations that are not currently part of the NHS.

Key stages in the application process

7.4 The process of applying and then being established as an NHS Foundation Trust will fall into three distinct phases. The preliminary stage will be brief and will focus on the current status of 3-star NHS Trusts that apply. Those organisations short-listed following the preliminary stage will be given support to prepare detailed second stage applications that should articulate a vision for how the freedoms associated with foundation status will be used to deliver improvements for patients. In addition, they will need to demonstrate the support of key stakeholder groups and proposals for how local communities will be encouraged to exercise ownership and control within the new organisation. During the period between the application being approved in principle and formal establishment as an NHS Foundation Trust there will be a third phase to allow for setting up of the new governance arrangements and detailed discussion on the content of the licence and its legally binding agreements with NHS bodies.

7.5 The key stages for first wave applicants are set out in the table below:

Date	Milestone
	Preliminary applications
December 2002	Preliminary applications invited
February 2003	Closing date for preliminary applications
March 2003	Short-listed applicants announced
	Second stage applications invited
April 2003	Second stage applications
July 2003	NHS Performance Ratings announced
September 2003	Closing date for second stage applications
September/October 2003	Successful applicants announced
	Establishment phase
October 2003	Establishment phase started
April 2004	First wave NHS Foundation Trusts established, subject to legislation

Preliminary applications

7.6 The requirements for a preliminary application for NHS Foundation Trust status will be brief. The application must be supported by the applicant NHS Trust's Board, but will not require consultation with local stakeholders, staff or the public. The intention is simply to get sufficient information from NHS Trusts that are interested to enable the Department of Health to carry out a preliminary sifting exercise. This will help ensure that those NHS Trusts that are unlikely to be ready for NHS Foundation Trust status do not invest time in preparing and consulting on a full application. The Department of Health does not intend to provide individual applicants with any special financial support for preparation of preliminary applications.

7.7 At the preliminary stage, applicants will need to provide a report on the NHS Trust's current and recent past performance and working practices. This will be backed up with numerical information. Details of the preliminary application process will be sent to potential applicants separately, but the areas that must be addressed will cover:

- responsiveness to patients;
- high clinical standards and sound clinical governance arrangements;
- the existence of high quality leadership and management;
- a track record of commitment and support to clinical and other staff by the organisation;
- effective partnership working and stakeholder support;
- a sound underlying financial position.

7.8 Preliminary applications will be assessed against each of these six key areas.

Second stage applications

7.9 Applicants who are short-listed in the preliminary stage will be invited to prepare a second stage application. The second stage will be more detailed and require full consultation with stakeholders. Exact details of what will be required will be made available to short-listed applicants at the start of the second-stage process but as a minimum applicants will be asked to submit:

- a report that sets out how the new organisation plans to use the freedoms for the NHS Foundation Trust status to improve services for NHS patients. This will need to be endorsed by local NHS partners;
- an independent financial review undertaken for the Department of Health;
- outline plans for their new governance arrangements including proposals for engaging with the local community through membership and the constitution of the Board of Governors;
- amongst other things, a human resources policy statement agreed in outline with staff which should make clear the terms and conditions of employment for all staff and the transfer arrangements.

7.10 The report will need to set out the strategic vision for the applicant NHS Foundation Trust over the next 5 years underpinned by robust and meaningful financial and non-financial assumptions and sound forecasts of expected service demand. The assumptions will need to be backed up by the identification (through sensitivity analysis) of the key financial and non-financial risk areas and the proposed strategy for managing those risks. Applicants will need to provide evidence that key NHS stakeholders and others in the local community support both the short and medium term goals. They will also be expected to show how the new organisation plans to apply the principles of local accountability and ownership and the freedoms that NHS Foundation Trusts status brings to improve services for NHS patients.

7.11 Second-stage applicants will need to provide evidence that both the NHS Trust Board and key stakeholders – for example Primary Care Trusts, staff, partner organisations and local people – have been consulted and support the application and the strategic vision.

7.12 Second stage applications will be assessed by a panel of experts drawn from inside and outside the Department of Health. Experts from the co-operative movement, community development, mutual and charitable organisations will be involved to ensure that this new form of social ownership draws heavily from best practice in local accountability, community involvement and participation. The panel will look closely at:

- the vision and innovation with which the new freedoms are applied;
- robustness and adequacy of the proposed process for attracting community membership of the NHS Foundation Trust, constituting the Board of Governors and extending local accountability;
- the strength of the management skills contained within the proposed management team;
- the realism and robustness of financial and non-financial data assumptions and the adequacy of the financial and other management information systems supporting those assumption;
- the views and confidence of local health care commissioners;

- the financial competency of the organisation using Department of Health, Strategic Health Authority and external audit assessments.

7.13 Applicants will be given financial support during the second-stage application phase to free-up resources to undertake the work to develop a business plan for the first 5 years as a NHS Foundation Trust. These resources will also support the applicant Trust in consulting local stakeholders on the proposed governance arrangements and constitution of the Board of Governors.

Establishment phase

7.14 Success in the second stage will lead to shadow NHS Foundation Trust status. The Department of Health and the Independent Regulator will work with shadow NHS Foundation Trusts to prepare for formal establishment. They will provide financial and practical support to NHS Trusts during the establishment phase and this will continue until they are established in April 2004.

7.15 Shadow NHS Foundation Trusts will need to agree detailed arrangements in a number of areas, including

- how the new governance arrangements discussed in Chapter 2 will apply;
- a proposed prudential borrowing limit – following guidance in the *Prudential Code* (see Chapter 5);
- their proposed human resources policies;
- designation of *regulated* and *unregulated* services and assets in the licence, and more generally the list of assets to be transferred (see Chapters 3 and 5).

They will also need to develop longer-term legally binding agreements with Primary Care Trusts and other NHS providers (see Chapter 4).

7.16 Work to develop the new governance arrangements will include determination of the:

- boundaries of the proposed *membership community*;
- proposals for encouraging genuine community membership – including innovative approaches to engaging with communities where participation is traditionally low;
- proposals for the composition of the Management Board and Board of Governors within the framework described in Chapter 2, that are balanced and properly representative of socio-economic and geographical differences within the *membership community*;
- proposals for the election of governors to the Board of Governors *(which will need to be held before the NHS Foundation Trust is formally established*);
- a locally tailored constitution – adapted from the model made available by the Department of Health;
- proposals for communicating and consulting with the membership.

7.17 Successful applicants established as NHS Foundation Trusts in shadow form may also need support to develop the competencies to operate successfully in the new environment. The Department of Health will co-ordinate a development programme for shadow NHS Foundation Trusts and their partner organisations, including commissioning Primary Care Trusts, to develop the necessary legal and financial competencies for operating in the new environment. This whole system approach to development is intended to engender shared ownership of change at the local level and the important continued commitment to partnership working.

Annex A
Glossary of terms

Agenda for Change	*Agenda for Change* is the title of the white paper which first proposed a new pay system for NHS staff, and is used here to refer to the changes in pay and conditions of service which are proposed to be introduced for all directly employed NHS staff, except those covered by the Doctors and Dentists Pay Review Body and very senior managers. The Secretary of State announced on 28 November 2002 that the UK Health Departments', NHS management representatives' and staff organisations negotiators had successfully concluded negotiations on these proposals. A summary of the new system is available at www.doh.gov.uk/agendaforchange. Subject to the outcome of consultation the new system will begin to be introduced in some "early implementer" sites from Spring 2003, and across the NHS from October 2004.
Assets	In general assets include land, buildings, equipment, cash and other property.
Asset Disposal	The sale or other transfer of a fixed asset(s) by a particular NHS organisation.
Board of Governors	Each NHS Foundation Trust will be required to establish a Board of Governors. The Board of Governors will represent the interests of the members of the NHS Foundation Trust and partner organisations in the local health economy, thereby ensuring that the local community is directly involved in the governance of the NHS Foundation Trust. The Board of Governors will be directly accountable to the members for ensuring the NHS Foundation Trust operates in a way that is compliant with its objects and with the terms of its licence.
CHAI	Commission for Healthcare Audit and Inspection, a non-departmental public body that will be established under primary legislation. CHAI will be responsible for inspecting all providers of healthcare to NHS patients against national standards.
Commissioning	A continuous cycle of activities that underpins and delivers on the overall strategic plan for healthcare provision and health improvement of the population. These activities include stakeholders agreeing and specifying services to be delivered over the long term through partnership working, as well as contract negotiation, target setting, providing incentives and monitoring.
Constitution	An organisation's constitution describes what type of body it is and its primary purpose, as well as defining its membership and its address. Key offices/staff groups may also be defined under the constitution. The constitution may also set out the internal governance arrangements.

Executive Directors	The executive directors are senior employees of the NHS Foundation Trust who sit on the Management Board and will include the Chief Executive and Finance Director. Executive directors will have decision-making powers and a defined set of responsibilities thus playing a key role in the day to day running of the organisation.
Financial Flows	The flow of money between commissioners and providers associated with NHS activity. The Department of Health issued a consultation document in October 2002 *Reforming Financial Flows: Introducing Payment by Results.* The document proposes fundamental changes to the current financial flows in order that providers' income vary in proportion with the volume of activity undertaken.
Governance	Governance arrangements are the 'rules' that govern the internal conduct of an organisation by defining the roles and responsibilities of key offices/groups and the relationship between them, as well as the process for due decision making and the internal accountability arrangements. Governance arrangements are usually set out in the constitutional documents of particular organisations and will be enshrined under the licence of NHS Foundation Trusts.
HRG	Healthcare Resource Group – groupings of treatment episodes which are similar in resource use and in clinical response.
Independent Regulator	The office of Independent Regulator for NHS Foundation Trusts will be a new post, established in legislation as an independent body corporate. The Independent Regulator will be appointed by the Secretary of State for Health, and will be accountable to Parliament through him.
Joint Venture	An undertaking in which an NHS Foundation Trust is a corporate member. Joint ventures may be commercial or non-commercial and may involve an NHS Foundation Trust becoming a member of a company alongside one or more other public/private sector organisations.
Licence	Establishment as an NHS Foundation Trust will be subject to applicants being granted a licence by the Independent Regulator. Each licence will include a statement on the public interest purpose of the organisation, set out the conditions under which it will operate.
Local Health Economy	The NHS organisations including GP practices, and voluntary and independent sector bodies involved in the commissioning, development and provision of health services for particular population groups.
Management Board	The Management Board is the executive body responsible for the operational management and conduct of a particular NHS Foundation Trust.
Market Forces Factor	An index used in resource allocation to adjust for unavoidable variation in input costs. It consists of components to take account of staff costs, regional weighting, land, buildings and equipment.

Members

Individuals and organisations with an interest in the development and wellbeing of an NHS Foundation Trust will be able to register as members. In a similar way to becoming a member of a co-operative society or mutual organisation, the members of an NHS Foundation Trust will become its owners, taking on responsibility for their local hospitals from national Government. Composition of the membership will be different for individual NHS Foundation Trusts. Applicants will identify who will be the members of the NHS Foundation Trust as part of their final applications.

Membership Community

The constituency of individuals that are eligible to become members of the NHS Foundation Trust by virtue of the fact that they live in the area ('make up the community') that it serves. Because local circumstances differ from place to place, the membership community will be different in each case. However, there will be a requirement that the membership community must include as a minimum people living in the area covered by the local authority in which any of the facilities run by the NHS Foundation Trust is located.

Multi-Professional Education and Training Budget

The Existing Multi Professional Education and Training budget (MPET) was created in April 2001 by the merger of the Non Medical Education and Training Budget, the Medical and Dental Education Levy, and the Service Increment for Teaching – all of which continue as separate elements. The Universities UK and Department of Health consultation *Funding Learning and Development for the Healthcare Workforce* (Department of Health, July 2002) recommended the abolition of the present distinction between the SIFT, MADEL and NMET budgets, and their replacement with a single integrated budget.

Non-Executive Directors

Non-executive directors (NEDs) will be elected by the Board of Governors to sit on the Management Board of an NHS Foundation Trust. Legislation will require the election of non-executive directors to at least one third of places on the Management Board. NEDs are not employed by the organisation but will receive remuneration.

Patient Choice

The Government is committed to introducing reforms in the NHS that will make the system more responsive to patients (see Extending *Choice for Patients: A Discussion Document*; Department of Health, 2001).

Patients Forum

Patient forums will be created for every NHS Trust and Primary Care Trust in England. NHS Foundation Trusts will be expected to co-operate and liaise closely with the Patients Forums that work alongside their commissioning PCTs. Essentially, PCT Patient Forums:

- Monitor and review the range and operation of services provided by, or under arrangements made by, PCTs;
- Seek and report the views of patients and their carers about those services;

- Provide advice, and make recommendations, about those services; and,
- Provide independent advocacy services to persons in the PCT's area or persons to whom services have been provided by, or under arrangements with, the PCT.

Primary purpose

The primary objective/purpose of NHS Foundation Trusts will be to provide and develop services for NHS patients.

Prudential Code

A published Prudential Code will set out the basis for determining serviceability of the debt levels requested by NHS Foundation Trusts. The Prudential Code will provide a framework within which an NHS Foundation Trust will make its own decisions about funding future capital investment through borrowing, subject to the prudential guidelines which assess the sustainability of that proposed borrowing. It will be made available to applicants during the time period for submission of initial applications. The Independent Regulator will assess proposals against the Prudential Code and agree a borrowing limit for each NHS Foundation Trust – the prudential limit. This limit will be reviewed annually. This is the maximum An NHS Foundation Trust will be able to borrow at any given time.

Regulated Assets

Regulated assets are those assets required in the provision of regulated services.

Regulated Services

The term 'regulated services' refers to all clinical services that an NHS FT will be under an obligation to offer to NHS patients as defined in the licence. Special provisions will also apply where an NHS Foundation Trust wishes to withdraw or substantially modify the regulated services so that change can be managed in a way that does not lead to Primary Care Trusts being unable to commission services to meet the needs of local people.

Service Agreements

A Service Level Agreement (SLA) is the main mechanism for service provision between NHS Trusts and Primary Care Trusts for NHS services. An SLA is an agreement that sets out formally the relationship between service providers and customers for the supply of a service by one to another.

Special Administrator

In the event that an NHS Foundation Trust becomes insolvent a particular failure regime – special administration – will be applied. The Independent Regulator will apply to the High Court for appointment of a Special Administrator to ensure ongoing provision of regulated services including meeting any associated liabilities.

Stakeholders/ stakeholder groups

The Stakeholders for an NHS Foundation Trust are the constituencies of people, or organisations, who have an interest in the development and well being of the NHS Foundation Trust because they:

- use, or may need to use, the health care it provides
- are employed by the organisation

- are responsible for planning and purchasing services for NHS patients
- work in partner organisations in the local health economy

Step-in powers — In the event that an NHS Foundation Trust fails to comply with the conditions of its licence, the independent regulator will have a limited range of step-in powers that would be applied according to the seriousness of the breach.

Tariff — Proposals for reform of the financial flows system in the NHS involve the phased introduction of national tariffs at HRG level. The tariffs will effectively fix the prices that organisations can charge NHS commissioners in relation to services for NHS patients.

TUPE — Transfer of Undertakings (Protection of Employment) Regulations 1981 (TUPE). In broad terms, TUPE protects employees' terms and conditions (except occupational pension arrangements) when the business in which they work is transferred from one employer to another.

Unregulated Assets — All assets owned and managed by an NHS Foundation Trust other than the 'Regulated Assets'.

Unregulated Services — All services provided by an NHS Foundation Trust other than those defined as 'regulated services' under the terms of its licence.

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