



Foundation Trust
Network

Seizing the opportunity

FTN lecture by Rt Hon Alan Milburn

Ten new perspectives from healthcare leaders

Contents

Acknowledgements	2
Foreword Gill Morgan chair, Foundation Trust Network	3
Ten years of foundation trusts: an overview Chris Hopson chief executive, Foundation Trust Network	5
Seizing the opportunity: the next decade for NHS reform Rt Hon Alan Milburn former secretary of state for health	9
Stuart Bell chief executive, Oxford Health NHS Foundation Trust	17
Dr David Bennett chief executive, Monitor	19
Nigel Edwards chief executive, Nuffield Trust	21
Sir Leonard Fenwick chief executive, Newcastle Upon Tyne Hospitals NHS Foundation Trust	24
Alastair McLellan editor, Health Service Journal	26
Sir Robert Naylor chief executive, University College London Hospitals NHS Foundation Trust	28
Angela Pedder chief executive, Royal Devon and Exeter NHS Foundation Trust	30
Tracy Taylor chief executive, Birmingham Community Healthcare NHS Trust	33
Tony Thorne chair, South East Coast Ambulance Service NHS Foundation Trust	35

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Sir Robert Naylor, chief executive, University College London Hospitals NHS Foundation Trust

Angela Pedder, chief executive, Royal Devon and Exeter NHS Foundation Trust

Tracy Taylor, chief executive, Birmingham Community Healthcare NHS Trust

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Foreword



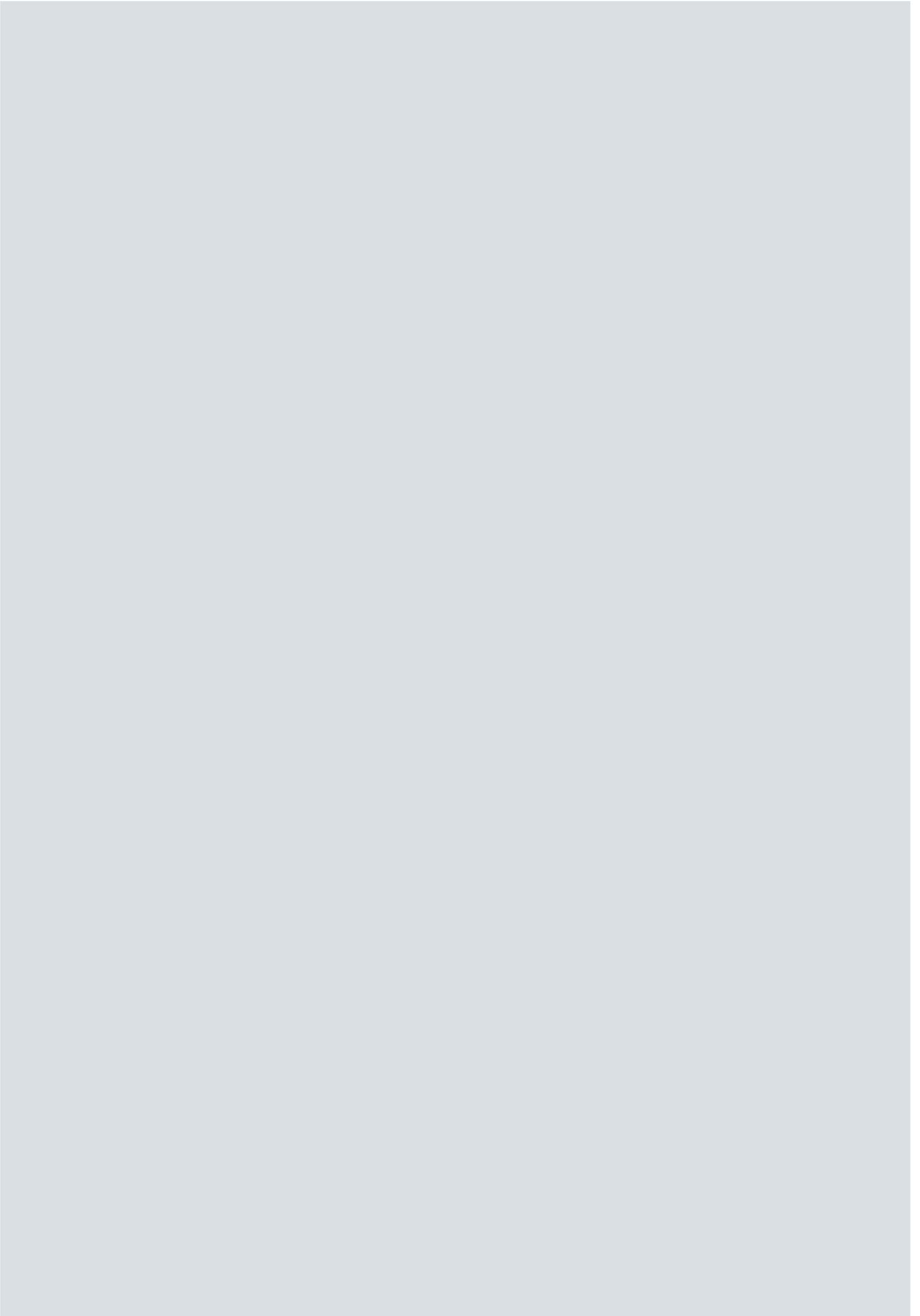
Gill Morgan
chair,
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Network

We were delighted to have Alan Milburn give the FTN's inaugural annual lecture on 1 April this year. The day-to-day delivery of high quality care, improving services and balancing the books can consume all our time. We do not take sufficient time to step back, evaluate what we have achieved, learn lessons and apply these to future challenges. Alan Milburn's lecture did exactly that. It reminded us of how much transformation has been achieved since the first foundation trusts were created. The response of providers to changing patient needs, improving the quality of and access to care whilst enhancing their governance and accountability has been significant. Acquiring and exercising foundation trust status has been a key factor in making these changes.

Alan Milburn also identified that the work is not yet complete. For all the achievement there remains substantial potential to fulfil. His lecture kicked off that debate and this publication now takes it further.

We have asked leaders from the NHS, media and health policy to talk about how the NHS provider sector will change, what it can achieve and how it can further transform patient care and outcomes? The interviews are stimulating, the views diverse and the passion for patient-centred care evident. We are grateful for the time our contributors gave and the thoughts they shared. We hope you are stimulated by them and please join the debate @FTNtweets #10yearsofFT.

Gill Morgan



Ten years of foundation trusts

an overview



Chris Hopson
chief executive,
Foundation Trust
Network

Background

On 1 April 2014, the tenth anniversary of the creation of the first foundation trusts (FTs), Alan Milburn, progenitor of the foundation trust concept, delivered the FTN's inaugural annual lecture, in which he reflected on ten years of FTs. His lecture is reproduced here in full.

The FTN has also commissioned nine contributions (conducted via interviews, reviewed by each participant) from others involved in the FT movement over the last decade. We hope that, together, this provides a wide-ranging and stimulating set of reflections on what the FT movement has achieved, and where it should go next. The contributors span a range of perspectives. There are a number of voices from the FT movement itself, spanning all four sectors – acute, ambulance, community and mental health – as well as from Monitor, the health sector regulator, and two experienced independent NHS commentators. Reviewing all the contributions, nine key themes emerge, with considerable alignment across the contributors despite their widely differing perspectives.

Looking back

1. Provider autonomy sits at the heart of the FT concept

Alan Milburn was clear in his lecture that a key driver of the FT concept was freedom from central control: in his words, “the recognition... that the NHS could simply not be run from the top down... power had to be moved out of the hands of ministers”. The concept was “to put those in charge of delivering local healthcare in charge of controlling local healthcare so that local services could be improved for the benefit of local communities”.

Many contributions recognise the importance of this driver: “allowing us to set our own agenda... devolution and empowerment¹”; “autonomy was music to our ears²”; and “moving away from a culture of seeking permission for everything³”.

Many talk about the rights conferred by this freedom. Crucially, both Tony Thorne and Alan Milburn focus too on the responsibilities conferred. Moving out of state control requires FTs to fashion their own success; stand on their own two feet; and move away from a relationship of financial dependency. What Tony Thorne describes as the “sense of responsibility for delivering the right performance, financially and clinically... and spending less time explaining to head office!”

2. Local accountability also sits at the heart of the FT model

Removing FTs from direct ministerial control required a new governance and accountability model. This new model, with its strong emphasis on local accountability, is the second of the twin pillars of the FT concept. The FT board has a range of accountabilities – to commissioners, to national regulators – but also a very strong accountability to local stakeholders through the FT governors' council and the wider local membership who elect it.

Many contributors from the NHS provider sector, notably Sir Leonard Fenwick, Angela Pedder and Tracy Taylor, from an aspirant trust perspective, persuasively outline the benefits from this enhanced local accountability. For example, "Having a 16,000 membership base, and an elected council of governors representing them, means we will have additional formal avenues through which to connect with and hear what our public think and want from our services. This enhances our ability to work on a macro and micro level dependent on the issue"⁴.

3. The FT model has enabled a range of innovations benefitting patients

How have FTs used this new found autonomy, underpinned by a significantly enhanced local accountability? Contributors describe a welcome and understandable variety of innovations and advances too numerous to list in full here.

Innovation and advances because, in Tony Thorne's words, "we appreciate being able to establish the right approach with our

commissioners and invest, without having this checked out by others". A welcome and understandable variety because, as Stuart Bell observes: "healthcare is more complex and fundamentally rooted in local geography than some may expect, even for highly specialist tertiary care".

Many stress the benefits that have resulted for patients. For example, changed priorities moving from "finance and hitting government targets [to] patient safety, outcomes and their experience as a customer"⁵; development of new clinical models – "a specialist cadre of paramedic professionals"⁶ and "the development of clinical leadership"⁷.

Both Sir Robert Naylor and Sir Leonard Fenwick also talk powerfully of the way that FT status has allowed their trusts to grow in scope and size. For example, using FT freedoms to create a capital programme that has built a set of new world class medical, research and biomedical facilities⁸; and to expand into primary and integrated care "that was not possible as an NHS trust"⁹.

4. Success has been accompanied by a sense of, as yet, unfulfilled promise

Alongside these successes many of the contributions, including some of those from inside the FT movement, do contain a sense of an as yet unfulfilled promise. Alastair McLellan talks, for example, of how the local accountability mechanisms remain "unfulfilled in any meaningful way". This is echoed, albeit less definitively, by Stuart Bell's "we need to make the most of the opportunities of our membership – perhaps an area where we have maybe not done as much as we could". Dr David

Bennett argues that "We have many examples of good and innovative practices across foundation trusts, but performance is not uniform". There is also a strong sense that excessive regulation has restricted FT freedoms and that the FT model needs to develop to take account of the changing circumstances of the NHS.

Supporters of the FT model will argue that the model is only ten years old and that once FT status went beyond the initial elite high performers, a greater degree of performance variability was inevitable. The fact that many FTs need to do more to embed the FT model, that the model itself needs to develop over time and that the strategic environment is getting more difficult, should not obscure the significant advantages that FT status has brought.

So any sense of as yet unfulfilled promise should be set against the facts that "on the whole FTs have lived up to their promise in the first decade"¹⁰ and that "the FT model has stayed the course for ten years – and in a change-prone system such as the NHS, that is an achievement in itself"¹¹.

5. Excessive regulation has eroded the FT model

One concern that is reflected in almost all the contributions is the sense that, as the FT model has developed, a growing degree of regulatory intervention has restricted FT freedoms, with a particular focus on what is perceived as a change in behaviour by Monitor. Alastair McLellan, for example, talks of how "an increased use of regulation has degraded [the] sense of autonomy". This is echoed by Angela Pedder, Nigel Edwards and

Sir Leonard Fenwick, for example, “Monitor was not originally conceived as an eleventh SHA, but it has steadily become much more interested in the detailed operation of FTs”¹².

Key drivers of this higher degree of regulatory intervention are seen to be the more stretching financial environment; the fact that “FT status has become the norm”¹³; and recent FT failures driving greater risk-aversion: “after Mid-Staffs, everything changed to a very risk-averse environment and a focus on avoiding getting a kicking. Disappointingly we are returning day by day towards an overcrowded bureaucracy, with a new initiative a day”¹⁴.

Looking forward

6. FTs need to become more effective system leaders

So how might the FT model develop in future? For some, the FT model encourages a strong, potentially excessive, single institutional, focus on the FT itself, rather than the broader environment in which it sits. It is therefore striking that nearly all the contributions point to the concept of FTs taking more of an explicit wider system leadership role within their health and social care economies; a role which transcends the individual FT’s institutional boundaries. This is usually paired with moves towards greater integration of care.

Although each contributor has their own different way of expressing this – “a foundation community, embracing health and social care with FTs as lead provider”¹⁵; “accountable care organisations”¹⁶; “strategically thought-through health systems”¹⁷;

“health services integration across the populations we serve”¹⁸ – the underlying concepts are the same. Sir Leonard Fenwick, Sir Robert Naylor and Stuart Bell all, for example, explicitly point to the need to integrate primary care with secondary care FTs whilst Angela Pedder talks of the need to “think through how we work with local authorities”.

7. Enabling greater provider collaboration and consolidation

There is also much talk in the contributions of the need for the FT model to develop to enable greater collaboration and consolidation across the secondary care provider sector itself. A number of people see this as essential in an environment where provider clinical and financial sustainability is increasingly under pressure. Sir Robert Naylor and Sir Leonard Fenwick both argue the case for scale and the need for the FT model to adapt to allow this: “of course there are some very successful small FTs, but they are coming under growing pressure as financial constraints bite”¹⁹.

Some of the comment typically focuses on the concept of management chains. Alastair McLellan, for example, argues that “management chains could work with the grain of the FT model if the best provider organisations earn the right to lead chains”. But Nigel Edwards sounds a cautionary note here: “If FTs go down the standardisation route, then inevitably some of their localism goes”.

Greater collaboration and consolidation do not necessarily, though, mean management chains. And the Dalton Review, referenced by several contributors, hopes to identify a range of ways

to develop the FT model to enable providers to come closer together to ensure sustainability.

8. Reversing the tide of increasing regulatory involvement

The third way in which contributors want to see the FT model develop is for the tendency towards greater regulatory intervention to be reversed.

Dr David Bennett does explicitly acknowledge that Monitor is “committed to supporting foundation trusts in their efforts to change and improve, and recognise that this means allowing them the freedom to get on and do what they need to do – including taking measured risks”. Yet this is qualified by his view that “we also have to minimise the impact of failure... monitoring everyone carefully and stepping in quickly when foundation trusts are struggling... to nip potential issues in the bud and prevent them from spiralling into serious problems”.

A substantial part of Nigel Edwards’ contribution is devoted to exploring the FT-Monitor relationship, and the vast majority of contributors would probably agree with his desire to explore “how far might we float away from Monitor’s oversight/regulation role over FTs?”

9. Clarity is needed on the future of the FT pipeline

The final theme identified by the contributors is the need for greater clarity on the future of the FT pipeline. Many of the references are in reaction to Alan Milburn’s suggestion in his lecture that all trusts should become FTs within three years.

No-one challenges Alan Milburn’s argument that “the pace of

conversion [from trust to FT] is glacial [and] this organisational impasse needs to be broken... not just because the current parallel-provider system is overrun with complexity and bureaucracy but because it [also] leaves the NHS with too much ambiguity and too little clarity”.

But there is less agreement that making all trusts FTs to a deadline is the right answer. Sir Robert Naylor disagrees, arguing that “having set a high barrier to exercise these freedoms, surely the last thing you would want is to lower the bar to make it less meaningful”. His answer is to “rationalise non-FTs into organisational groups or chains”. Both Stuart Bell and Nigel Edwards recognise the validity of the Milburn solution “given the logic of the situation. It can be seen as a sort of tipping point that pragmatically recognises where we have got to”²⁰. But both recognise the danger of lowering the bar and, in Edwards’ words, the need to deal with “the not always happy consequences” of doing so, as he argues they have discovered in Poland and the Czech Republic.

Summary

So where does this leave us, looking back and forward? The provider sector is the bedrock of the NHS as it has to provide the most complex patient care 24 hours a day, 365 days a year to a consistently high quality and within an increasingly tight budget.

Whilst there may be some who yearn to reimpose central control, there is little doubt that provider autonomy is essential in today’s NHS. It is impossible to deliver effective patient care and drive change in such a large and complex system from the centre. Accepting this, local accountability should lie at the heart of the new model of governance that has to accompany provider autonomy from the state. It is notable that none of the contributions seek to challenge the validity of these twin pillars of the FT concept – provider autonomy and local accountability.

“We need FTs to help lead the integration of care, we need to facilitate greater collaboration and consolidation between providers themselves and we need to reverse the increasing tide of regulatory intervention.”

All in the FT movement would argue that there is much to do to fully embed the model, to reduce variability between FTs, and to develop the model to meet changing circumstances. We need

FTs to help lead the integration of care, we need to facilitate greater collaboration and consolidation between providers themselves and we need to reverse the increasing tide of regulatory intervention. We also, as Alan Milburn argued, need to develop the model to enable FTs to lead the fundamental change in the distribution of power in healthcare so that the patient is in control. But these are not convincing arguments to abandon the FT model, rather they argue for building on its undoubted successes.

Those who seem most worried about the future of the FT model are those who regard it as a fixed, final, destination, unable to develop to meet changing circumstances. Yet if we regard it as a flexible model based on the twin pillars of provider autonomy and local accountability, NHS foundation trusts are, in Alan Milburn’s words “more relevant now than they were a decade ago”.

1 Sir Robert Naylor
2 Sir Leonard Fenwick
3 Angela Pedder
4 Tracy Taylor
5 Sir Robert Naylor

6 Tony Thorne
7 Stuart Bell
8 Sir Robert Naylor
9 Sir Leonard Fenwick
10 Stuart Bell

11 Tracy Taylor
12 Nigel Edwards
13 Stuart Bell
14 Sir Leonard Fenwick
15 Angela Pedder

16 Alastair McLellan
17 Stuart Bell
18 Sir Leonard Fenwick
19 Sir Robert Naylor
20 Stuart Bell

Seizing the opportunity

the next decade for NHS reform



Alan Milburn
former secretary
of state for health

I would like to try to assess where we have got to on the ten-year journey that started with the creation of foundation trust status on 1 April 2004, and where we should be heading next. I will argue that what feels now like an insurmountable challenge – how we make the NHS sustainable – is, in fact, a really big opportunity. I will set out an agenda for change in which NHS foundation trusts can once again play a leading role in turning those very real challenges into big opportunities for the future.

The genesis of foundation trusts

In assessing where we have got to, it is worth recalling where we came from. In no small part, the foundation idea came from the NHS; especially the then three-star rated trusts. I went to visit all 13 zero-star trusts in our first year in office, and it was not a terribly comfortable experience. Interestingly, however, everyone had an excuse: their population was more diverse; their health need was far greater.

In truth, the data we were then using was pretty rosey, but the important thing was to publish the data, because, once you published it, it became valid and significant. For me, the real lesson was that, a year later, none of the 13 trusts were in the zero-star category; in fact, some had gone from being zero to three-star. The three-star trusts were the genesis of the foundation idea.

As health secretary, by and large you get sent to visit the good places, not the bad. I got sick to death of hearing from the best-performing NHS organisations, how resources were being diverted to bail out the bad, rather than being used to incentivise the good. So I decided to do a simple thing: to ask high-performing NHS trusts what they really wanted. Their reply was simple: they did not want more money, but more freedom to get on with the job of improving services for patients.

That request matched my own recognition, borne from experience, that, however hard you tried, the NHS simply could not be run from the top down. Sitting in the health secretary's hot seat was often uncomfortable because the public, the press and parliament were all united in one belief: that the secretary of state had to be held responsible for everything that happened in the NHS.

One of my key learning moments was when I was dragged to parliament to explain why a mortuary in Bedford had failed. Of course, since I had the power to intervene, I had to promise intervention. If you have power, it is pretty hard not to use it.

The consequence was to reinforce the notion that, when it came to the performance of local health services, the buck stopped in Whitehall rather than where it belonged: in Bradford, Bournemouth, or Bedford. The conclusion I came to was that, if accountability was ever to be



lodged in the right place, power had to be moved out of the hands of ministers.

If bedpans that dropped in Tredegar were ever to be heard there, the ties that bound Whitehall to local health services simply had to be severed. The inspiration for this thought, oddly enough, was none other than the creator of the NHS, Nye Bevan, who argued that the ultimate purpose of Labour being in power was to give it away. He might not have always practiced what he preached, but the lesson that I learned was that an irreversible shift in power in the NHS was both necessary and long overdue.

Empowering local healthcare

The idea was simple: to put those in charge of delivering local healthcare in charge of controlling local healthcare, so that local services could be improved for the benefit of local communities. That

could be done only by addressing the democratic deficit that lay at the heart of the NHS: the fact that, while services were delivered locally, in practice they were controlled nationally.

Contrary to those who argued – many of them on my own side and, indeed, some in my own cabinet – that foundations would mean the privatisation of the NHS, I always saw them as a means to strengthen public ownership since they would be owned and controlled by the public locally.

A decade on, and notwithstanding the appalling failures at Mid-Staffs and amongst some other foundation trusts, service innovation and improvement have become watchwords for the foundation movement. They have used their freedoms to create new services, commercial ventures and entities like Academic Health Science Centres. Together, foundation trusts generate £30 billion annually through employment, partnerships and

procurement. In fact, their direct economic contribution to our country is now higher than that of all of England's universities put together or the whole of the pharmaceutical industry.

When it comes to scale, NHS foundation trusts should rightly be proud of one other thing: having managed to recruit a total membership of 1.5 million people – more than all main political parties put together. That may say more about the political parties than about foundation trusts.

Although foundations have not yet proactively turned public participation into improvements in public health – a theme I will return to in a moment – their engagement with local communities provides a sure platform for the future.

I say that because, in this next period, there will have to be far-reaching changes to the relationship between the citizen and the service, if the NHS is to be sustainable. A decade ago, the most pressing health problem was to rescue the NHS and, in particular, to cut what were then appallingly long waits that patients had for treatment.

A decade on and that old bugbear of the NHS – long waiting times – has, more or less, been beaten through a mix of many more resources and top-down reforms. It was difficult but, in retrospect, it was relatively easy.

The issues facing the NHS today are different and altogether more complex. The NHS now not only needs to cope with the pressures of an ageing society and advancing technology; it now has to focus on how to improve health, with a growing number of patients

with chronic conditions – how to manage their diabetes or their arthritis, and how to beat obesity and tackle alcohol abuse. It now has to find ways not just of providing collective care, but of shifting individual behaviour, and it has to achieve that without the benefit of generous resourcing.

The problem today is different, as the solution must be. It fundamentally lies in patients being treated less as passive recipients of care in a system that tends to deny them both power and responsibility, and instead being more in charge and becoming more responsible for their own health.

That entails big changes in NHS culture. NHS foundation trusts are uniquely well-placed to lead it. You lead on service innovation; you lead on community involvement. Your leadership is needed now more than it has ever been. NHS foundation trusts are more relevant now than they were even a decade ago.

A time of profound uncertainty

I say that because we have reached a real inflection point. In the last year in particular, the NHS has taken a real battering. First, there was the car-crash of the coalition's health reforms – an extensive and expensive upheaval that foolishly focused on changing structures, not improving services; next, the impact of squeezing £20 billion of savings out of a system under escalating demand pressure. Then, the hammer-blow of the Mid-Staffs Hospital scandal and the spotlight politicians and regulators have subsequently shone on failings in quality elsewhere. Meanwhile, as

both The King's Fund and Nuffield Trust have recently highlighted, cost pressures are building and waiting lists are growing once again, A&Es are stumbling and social services are creaking.

“Together, foundation trusts generate £30 billion annually through employment, partnerships and procurement.”

In two decades in health policy, I have never known a time of such profound uncertainty. The NHS supertanker is drifting, with little clarity about its direction in the present and even less certainty where it could be heading in the future. It is being pulled this way and that.

All the political parties argue for more nurses on hospital wards but none are prepared to write the cheques to pay for them. They all want to prevent lapses in care, but the army of regulators being unleashed on the NHS forces care providers to look upwards to those who regulate them; rather than outwards to the citizens who use them and, ultimately, the taxpayers who fund them.

The balance has swung far too far towards top-down regulation as the primary instrument for improving standards. It needs to swing back to reforms that empower patients, engage staff and embrace competition. The policy agenda fundamentally needs to change.

Something else needs to change too: the way we think and talk about the NHS. Browse any health policy document, listen to any political speech, read any expert commentary and you will find it suffused with the language of challenge: the challenge the NHS faces of coping with an ageing population; the challenge of a rising burden of chronic disease; of soaring public expectations; of constrained resources. The more the debate about healthcare is couched in terms of insurmountable challenge, the more unsustainable the NHS feels and, critically, the more disempowered NHS staff feel.

Opportunities for healthcare today

There is another way of looking at things and talking about them: less the language of challenge and more about opportunity. That may sound odd, given the context that you all face and that the NHS, as a whole, confronts, but I believe healthcare has a big opportunity today.

Five big factors are producing a sure platform for change: each provides a challenge, but also contains an opportunity. First, we all know we live in an ageing society and that there will be more very old people living with more health problems – co-morbidities – than ever before. That will require significant investment in elderly care, and more seamless care from a system that currently is more fragmented than it is cohesive. The challenge is that the new generation of the old will not tolerate a system of care that tells us what to do; we will want to tell it what to do. The opportunity is to

refashion care so that it is aligned with the mindset of this century rather than the last.

Second, if the healthcare battle of the last century was to beat infectious disease, the battle for this century is all about chronic disease. What differentiates diabetes or arthritis from other forms of illness is that they become a permanent fixture of people's lives: it is with them 24/7. What patients do to manage their own condition – their lifestyle, diet and exercise – becomes as important as what clinicians do. The challenge is to find ways of empowering patients to take greater responsibility for their own health. The opportunity is to bring patients inside the decision-making tent, so that they share the day-to-day dilemmas that every clinician and manager faces, rather than keeping them outside.

Third, changes brought by technology also make possible the advent of more citizen-controlled services. In the long term, if the benefits of pharmacogenetics can be harnessed, the next few decades could see our whole model of healthcare, which has been about detecting and then treating illness, instead becoming one that predicts and prevents ill-health. In the short term, more chronic disease will drive the focus away from episodic treatment, largely in hospital, towards earlier preventative action and treatment, first in the community and then, as telecare and telemedicine technology evolves, in people's home. The challenge is to address the mismatch between the services that are provided today, with an over-concentration on hospital-based care, and those that are needed, for more care in the

community and at home. The opportunity is to harness technology, from big data to patient-controlled health records and mobile health applications, to help us make that transition.

Fourth, we live in a world where people are more informed and inquiring. Figures from Pew Research show that 50% of Americans consult the internet before visiting their primary-care physician, rising to 80% after visiting the surgery. Why is this happening? We live in a world where deference is down and expectations are up. The challenge is to find new ways of treating each patient as an individual rather than as just another number. The opportunity is to harness the modern citizen's appetite for knowledge and control in order to finally make a reality of the notion of self-care.

“The world is on the verge – not that you would know it from the public discourse – of a huge leap forward in how healthcare is delivered.”

Fifth, and most potently of all, in the last three decades across the OECD, health budgets have been growing more quickly than the economy. We have been spending more than we have been earning. The global financial crisis and a squeeze on public spending have brought those good times to an end. The next decade will see, at best, a far lower rate of spending

growth than we have seen in the last decade. The problem is that resources might slow down but pressures will not, so the accent will be on finding new ways of getting more out of healthcare for what is put in. That is a challenge but also an opportunity.

Doing more with less

Faced with a rising tide of demand for care, doing more with less may look like mission impossible, yet consider this: healthcare is surely unique among modern industries (and that is what we are, an industry) in that improvements in quality have not been matched by reductions in cost. Think of the price and quality of your car, mobile phone or computer. Doing more with less and doing it better, more quickly and more cheaply has become the new normal.

This is the time for healthcare to catch up.

None of these challenges are unique to any one country; they affect every healthcare system in every country. Their combined effect is to break the old assumption that improvements in performance could only be created by large, continual increases in investment. That proposition is no longer sustainable. A new holy grail in global health policy is emerging: how we get better outcomes, not for higher costs but for lower ones.

Some are already stepping up to the plate. Across the country, the absence of a national lead is producing a flowering of local innovation, but that will get the NHS only so far. What is needed is a plan to harness the benefits we



are going to see in the next decade from new science and new approaches.

The world is on the verge – not that you would know it from the public discourse – of a huge leap forward in how healthcare is delivered. Whether it is nanotechnology or cloud computing, technology is going to change what healthcare is able to do and how it does it: mobile phones will routinely be used to monitor the health of patients with chronic disease; people will have virtual consultations with their doctors and nurses. This is not some sort of fantasy future. It is happening now in some parts of our NHS but it needs to become universal.

Many of these changes have the potential to improve outcomes while containing costs. In 2001, it cost hundreds of millions of dollars to read an entire human genome. This year, it is being done for approaching \$1,000.

Before long, inexpensive gene sequencing will let doctors routinely diagnose and treat patients based on information about their individual genomes.

Vaccines for a wide range of chronic illnesses are already in clinical development. The big question those in charge of the NHS should be focused on is how to capture and realise those benefits, which will require some far-reaching reforms.

Organisational reform

Let us start where former health secretary Andrew Lansley left off, with organisational reform. There is a job of clearing up the mess. The controversy that surrounded the creation of foundation trusts has given way to the idea that the NHS has to be accountable locally, where services are delivered, not just nationally, from where they are funded.

Government should continue to be a key player in health, setting strategic direction, creating capacity for improvement and raising and distributing resources; but the thrust of reforms across at least three decades and across governments of all political persuasions has been for Whitehall to run less, not more.

In truth, however, today the NHS sits in an uncomfortable no-man's land. Jeremy Hunt, the current health secretary, feels the need to intervene with local services, even though his government's legislation, just like the 2003 Act, aimed to prevent him from doing so. I understand the day-to-day temptations, but Jeremy should recognise the self-defeating consequences that, with every intervention, accountability and responsibility in the NHS never moves to those running local services but remains with those overseeing national politics.

In part, the current ambiguity about where organisational power really lies in the NHS is the product of a bifurcated system. Today, while there are 147 NHS foundation trusts, there are a further 99 providers operating under the national control of the NHS Trust Development Authority (TDA).

The long-term objective remains for all trusts to become foundations, but the pace of conversion is glacial at best. Only three have made it through the rigours of the Monitor foundation trust authorisation regime in the last year. If we are not careful, we will be in the 22nd century before we have a 21st century system of healthcare.

This organisational impasse needs to be broken once and for all, not just because the current parallel-provider system is overrun with complexity and bureaucracy, but because it leaves the NHS with too much ambiguity and too little clarity.

I would like to see the current approval foundation process being scrapped and, within the next three years, every NHS trust being made a foundation. The TDA, as it has always wished, should be abolished and its resources made available to Monitor to help turn around those organisations that are in trouble. Some would need to be placed in a special-measures category, but, as a general rule (and as I and my special adviser at the time Paul Corrigan always intended), all other foundation trusts should be given greater independence and more financial freedom to run their own affairs. Ten years on, it is time for the decades-long journey to be completed towards an NHS where provider organisations are autonomous but operate to common standards and incentives.

Paying providers

That brings me to reforms to how providers are paid. Having over the last decade changed from paying providers for who they are to what they do, we now need to move to paying them for what they achieve.

In future, providers should be paid less on the basis of the quantity of what they do and more on the basis of the quality of what they achieve. The focus should not be on inputs or outputs but on outcomes. Critically, the key financial incentive across the whole care system needs to be targeted on keeping patients healthy and out of hospital.

Having obsessed in this last year on toughening regulation, ministers need to focus as much energy in the next year on refining how money flows around the system, so that local services are better incentivised to see patients in the right part of it.

That means taking a population-based approach, so, next, there will need to be new reforms to make primary and community care the

bedrock of any new system. In recent years, absurdly, spending has been rising on hospital-based care just as it has been falling in primary-based care. That nonsense must change.

The policy objective for the NHS should be to reduce the number of patients being admitted to hospital, and to secure a switch in spending from within healthcare budgets so that less goes on hospitals and more goes on new forms of care in community.

The new investment priority for health and social services should be to build a new care infrastructure – polyclinics, intermediate care, telecare and telemedicine – aimed at promoting health, preventing illness and empowering patients. Critically, NHS foundation trusts should be working to vertically integrate their hospital services with those provided in primary and community care; in other words, they should be reinventing what hospitals do and where they work.

New structural models

Next we need reforms that create new structural models capable of better integrating care around the needs of individual patients. The current system is riddled with wasteful and expensive silos. Ultimately, the price is paid by patients: those who have mental-health problems as much as those with chronic physical illnesses. All too often, their experience is one of duplication and fragmentation.

Thankfully, it is now widely recognised that, in future, sustained management of patients with multiple chronic conditions



will require a more integrated approach. Much of the current debate on integration focuses on how to unite health and social services into a single care system. That is a noble objective, but one fraught with complexity and (potentially) at very large cost.

Elsewhere in the world, integration has taken a rather different form. People often speak of Kaiser in the USA as an example of what a vertical integration of services can achieve, but the model I want to focus on tonight is not from America, but from Europe. The model I find most interesting is the Alzira model from Spain, where a whole community of patients is looked after under a single capitation-based contract. Providers are paid according to the outcomes they achieve, with strong incentives to keep people healthy and out of hospital. Profits for the private providers are capped. Importantly, if patients choose to seek treatment elsewhere – as they can do, if, for example, the quality or timeliness of local services is poor – providers face stiff financial penalties. By making friends of competition and collaboration, rather than assuming them (as we so often do in public discourse) to be enemies, outcomes have improved and costs have been capped.

There is growing interest in how such a model might work in the UK or, more particularly, in England. NHS foundation trusts, not just commissioners, should be acting as a catalyst for such change in local health economies, and government should help local pioneers remove the barriers – whether regulatory, financial or organisational – that stand in the way of making it happen.

Supplier reform

That brings me to supplier reform. Our system of healthcare is unique in at least one respect: the dominance enjoyed by one public-sector provider – the NHS. Monopolies in any walk of life, whether public or private, rarely deliver either operational efficiency or customer responsiveness. That is why, as health secretary, I created what I called a managed market in the NHS with the introduction of private and voluntary providers.

“We need reforms that create new structural models capable of better integrating care around the need of individual patients.”

There should be no preferred providers, whether public, private or voluntary. The only yardsticks for deciding who provides health services should be quality, which is what counts for patients, and efficiency, which is what counts for taxpayers.

The next wave of reform should create a legal level playing field, where public, private and voluntary sectors are able to compete to be providers and are subject to the same exacting standards and incentives:

- Regulation should be simplified to make it easier for the best NHS foundation trusts to form chains of local services they run across the country.

- New entrants should be systematically encouraged onto the provider pitch to bring much needed know-how and innovation.
- Pharmaceutical companies, for example, should be encouraged to forge new partnerships with local commissioners, surgeries and pharmacies to deliver compliance and support services for patients with a chronic condition.
- Retailers should be encouraged to provide in-store, instant-access services for local communities.
- Telcos should be encouraged to develop new homecare services for elderly and infirm patients.

For the NHS to meet the challenges of the next decade, it is not less competition that will be needed; it is more.

Shifting the power paradigm

There is one final area of reform that, above all others, holds the key to making the NHS sustainable: how we move patients from being passive bystanders to active participants in healthcare. If we can achieve it, this shift in the power paradigm will be the most significant long-term change of all, because the explosion in chronic conditions we are now witnessing across the developed world calls into question how we have traditionally delivered healthcare. Clinicians have diagnosed and prescribed, and patients have received. If you have diabetes, however, the choices you make in your life (lifestyle, diet and exercise regime) have a huge bearing on

your health. That is why we have to find new ways of making patients co-producers of their healthcare.

We can glimpse what that new future could look like. During my time as health secretary, I championed Liam Donaldson's Expert Patients' Programme to give people – mostly those with a chronic condition – the tools to better manage their own care. By putting the individual patient in charge of managing their conditions, the programme succeeded in reducing physiotherapy visits by 9%; hospital-outpatient visits by 10%; and accident-and-emergency visits by 16%.

Much lip service is paid a decade on to the notion of empowering patients, but, in truth, patient power is marginal in today's NHS. It is time to make it mainstream, and NHS foundation trusts should take the lead in doing so:

You should work together to make patient-reported outcome and experience measures central to how local services are assessed and rewarded.

You should spearhead a transparency revolution across the whole care system so that patients, carers and clinicians alike are able to see which services work best and which do not, from care homes to hospitals.

You should lead a national drive to give people, through pharmacies, GP services and community care, the practical help they need –

blood-pressure monitors, testing kits and mobile health – to improve their own health.

Hundreds of thousands of patients – and especially those with a chronic condition – should get their own individual healthcare budgets so they have direct control over resources to buy the healthcare that is right for them and personalised for their needs.

NHS foundation trusts, owned as they are by local communities and run as they are by those accountable to local people, can play a leading role in making these changes. In the last decade, a new NHS architecture has been built: national standards, local commissioning, diverse provision, community ownership.

These reforms, which were once highly controversial, are now a matter of broad consensus. The issue now is whether, on this platform, we can build an even more fundamental purpose: to fundamentally change the distribution of power in healthcare so that the patient is in control.

Change will have to happen not just because the cash is running out, but because time is running out for a system that was designed to deal with yesterday's challenges, not tomorrow's opportunities. Meeting these changes will be daunting, but it opens up an enormous opportunity to reshape how care is delivered, so that we improve outcomes, optimise resources and, above all else, empower patients.

Conclusion

It is long overdue to move the debate on from how to deal with grinding challenges, to a conversation about seizing new opportunities. Amid the gloom, there are reasons for optimism.

Today, there is a particular reason we should all feel a bit more optimistic. A new chief executive for NHS England has taken up office. 14 years ago, Simon Stevens worked with me on The NHS Plan. Quite simply, he is the best person I have ever worked with in healthcare. Due credit to Prime Minister Cameron and to Secretary of State Hunt for recognising Simon as the right man for the job, but, having appointed him, they now need to empower him.

If they do so, he will bring in strategy to replace tactic as the governing motif of how the NHS is run, he will give the NHS clarity instead of uncertainty, and he will bring something even more significant: hope.

Hope is what the NHS needs. If there is one thing above all else that Simon can do, it is to give the NHS that precious gift.

Text of the questions and answers session that followed the speech is available on the FTN website
www.foundationtrustnetwork.org/blogs/alan-milburn

Stuart Bell

chief executive, Oxford Health NHS Foundation Trust



“An important positive contribution is the way the FT movement has helped support the development of clinical leadership – that has improved over the last decade.”

Being an FT gives us the opportunity and the responsibility to fundamentally reshape the way in which we respond to the community’s needs for healthcare in the 21st century. As a provider of community and mental health services, it is really important to us that we view healthcare as a joint endeavour, co-produced with patients and carers. That is going to be one of the key changes in the constructs and paradigms of health systems over the coming century.

Only a few years ago, when the concept of FTs was invented, hospitals were still very much seen as the centre of the healthcare systems. Today, we see much more clearly that the patient and their family are the centre, and the advantages to be gained through co-production of health based wherever possible around people’s homes and in their communities. Aspects of the FT model still go well with the grain of this, so we need to make the most of the opportunities of our membership – perhaps an area where we have maybe not done as much as we could.

However, many aspects of the current funding regime disproportionately incentivise the consumption of healthcare interventions once people are sick over keeping people well. And we still see unhelpful tweaks, like the differential tariff deflator for community and mental health services, which are manifestly at odds with the overall strategic

direction that almost everyone now professes. That needs to change if we are to achieve the strategic change in healthcare that we know to be essential.

On the whole, FTs have lived up to their promise in their first decade, because in general the provider sector has significantly raised its game in the delivery of healthcare. Similarly, some of the fears that people had when FTs came in have not been realised. Ironically, the idea that FTs would develop chains across the country has not proceeded at pace, if at all so far. This is probably because healthcare is more complex and fundamentally rooted in local networks and geography than was anticipated, even for highly specialist tertiary care.

An important positive contribution is the way the FT movement has helped support the development of clinical leadership – that has improved over the last decade.

As FT status has become the norm and we have more FTs than non-FTs, it has altered the way that Monitor has to act. In many ways, it was easier to be the regulator of a small, tightly-contained elite drawn from the best performers, rather than of the majority and in time the totality.

Now, Alan Milburn suggests we should quickly make all providers FTs and have done with it. You can see his point, given the logic of the situation. It can be seen as a sort of tipping point, which pragmatically recognises where we have got to.

But the down-side of the idea is that it removes some of the edge and the raising of the bar and sharpening-up of the act associated with becoming an FT. That said, times are harder than they were ten, or even five years ago, and so even if the FT authorisation bar had not been raised (which it has), reaching the bar is a tougher ask now for many organisations than it would have been ten years ago.

The system still needs further change to provide truly 21st century care – most importantly, the integration of provision of general practice and primary care. If the NHS compares itself with the most effective, best developed healthcare systems internationally, we still see primary care provision as being in a separate box based on the 1948 compromise, on the periphery or somehow separate, rather than as central to the whole. There have been a few tentative examples of FTs entering the world of primary care, but we need more to develop strategically thought-through health systems. System is the paradigm which should drive our attitude to competition, which as it currently stands is conceived in a way which is fundamentally out of kilter with the true nature of most healthcare, and is more often than not manifesting itself as a really powerful dysfunctional disincentive to progress.

We still struggle to tackle what are often deep and unresolved strategic problems of organisations currently configured in outdated

patterns of provision. Competition policy makes dealing with this harder than it used to be. The most challenged providers find themselves going round in circles; not necessarily because they are poorly-run, but you just ‘wouldn’t start from there’ if you were trying to achieve FT status. It is a cruel and wasteful form of procrastination, and it does not serve the public well.

“We often pay too little attention to the pace at which science and technology moves, and that should guide us more than inherited institutional structures.”

It will take a vision of a profoundly different model of healthcare to change this, but our ability to articulate and to achieve this has not really been resolved. Do we have a small number of specialist hubs, supported by networked care systems covering a broader range of specialties, sustained on a locality-based, community-focused model with the superordinate aim of keeping people well, or as well as possible, at home? That is the Alzira or Kaiser Permanente integrated network provision

model, providing systemic care to a population within some degree of geographical footprint. It is probably sensible to start there, rather than to try and force the current hotchpotch of institutions to randomly reshape and to deliver that model of care.

Providers, as currently configured, owe most of their configuration to accidents of history. 21st century healthcare needs something more sophisticated and networked. Many established FTs have been thinking radically about their future composition, so they can do better for less and keep up with the practice of 21st century medicine. We often pay too little attention to the pace at which science and technology moves, and that should guide us more than inherited institutional structures. FTs, especially those which are good at understanding how to capitalise on progress in biomedical sciences, have a responsibility to take the lead in reshaping our healthcare over the next ten years.

Dr David Bennett

chief executive, Monitor



“Now is the time for foundation trusts to show, individually and collectively, that the foundation trust policy is the right way to support change and improvement in the NHS.”

We all agree that the NHS in England has got to change a lot. This should not be seen as a threat to the foundation trust sector but a real opportunity. The changing nature of our population, with increasing numbers of elderly people requiring care, and higher expectations all round, means there is a great opportunity to provide a service that meets their needs better and helps NHS money go further. Foundation trusts can, indeed must, play a major role in this.

There is a lot of agreement about the broad direction of change, for example the need to treat more patients outside hospital, closer to home. Inevitably this will mean some restructuring of the way provider organisations deliver care. Making these changes will be very challenging, not least because it has to be done at a time when funding is tight and there is renewed pressure to improve quality. Because of this, change has to happen much more quickly than it has in the recent past – we have to ‘turbo-charge’ change.

Nevertheless, if we get this right, we will have an NHS that is truly fit for the 21st century, delivering better care, providing more of it and providing a better experience for patients. And what is true for the NHS as a whole is particularly true for foundation trusts, which now comprise about two-thirds of the provider sector. We have many examples of good and innovative practices across foundation trusts, but performance is not uniform. Not all foundation trusts are at the

leading edge of reshaping how they provide healthcare, and even the best will need to do more.

So now is the time for the leaders of all foundation trusts to lift their heads from the daily grind – difficult as that might be – and use the freedoms that come with being a foundation trust to reinvent themselves, to break with the past. Now is the time for foundation trusts to show, individually and collectively, that the foundation trust policy is the right way to support change and improvement in the NHS.

And we at Monitor have to change too. We have a new duty to focus on the interests of patients, and this now drives everything we do. We are committed to supporting foundation trusts in their efforts to change and improve, and recognise that this means allowing them the freedom to get on and do what they need to do – including taking measured risks. We are not setting out a central plan that everyone has to implement, although we will push people to get on and work out what is right for them locally, for their commissioners and, above all, for their patients. And, if people already know what they want to do, we want them to get on with it.

As the regulator, we know that we are not going to get change happening if we are rigid in the way we look at a provider’s business model. We do not want to get ourselves into a situation where trusts have the impression that only one model is acceptable

in order for them to achieve foundation status. An NHS trust chief executive recently said that he wanted to change his hospital into an integrated care organisation but could not because the organisation's priority was becoming a foundation trust. That is the wrong way to think. At Monitor, we should always be flexible about business models, and never more so than in these challenging times when innovation is at a premium.

Similarly, we have got to be able to assess the readiness of NHS trusts to be given independence without asking for a long track record in their current form, or a detailed financial projection out into the distant future. The environment of an applicant NHS trust is changing so quickly it is at least as important for us to understand how an organisation is set up to deal with change as it is to predict what their cash flow might be in four years' time. The real test of both applicant and existing foundation trusts is their capability to deal with the major change that is necessary; to make their own versions of change happen in their own organisations. And although leadership is crucial, this is not just about the capabilities of the leadership team but the institution's capability as a whole to learn and change.

The question we face is how to measure an organisation's capacity to change. We are already looking at quality governance and will start now to look at the governance of planning, performance

improvement and organisational development. This means asking if trusts have good processes, including whether they are asking themselves the right questions. For example, is a board asking hard questions about their ability to handle uncertainty? What analysis have they done about how their world is likely to change? Do they know what their commissioners are doing to address the challenges they face? And what other providers are doing locally? Is theirs an organisation that is thinking systematically and thoughtfully about dealing with its challenges? How are they driving operational performance improvement? Do they benchmark against peer groups? How do they set targets for improvement? What tools and techniques do they use for driving improvement?

We are talking to the NHS Trust Development Authority (TDA) and will engage with the sector in due course about the details of what exactly we will aim to do. As we made clear in our corporate strategy for 2014-17, we will seek to bring about any necessary changes in a measured way so we do not raise the bar for achieving foundation trust status.

With money tight and an increasing focus on safety and quality, we also have to minimise the impact of failure. So we have simultaneously to allow good performers to innovate and improve while monitoring everyone carefully, and stepping in quickly when and where

foundation trusts are struggling. Our objective in doing so is not to punish but to support, to nip potential issues in the bud and prevent them from spiralling into serious problems.

However, if problems do become serious our aim in fixing them is to take a whole health economy approach, even when we need to put a trust into special administration – although this should only be a last resort. Taking this approach is in recognition of the fact that changes at one provider may well impact neighbouring providers, and may even need their support. And, of course, it is not possible to develop a plan for the future of a struggling trust without having a clear understanding of their commissioners' intentions. As long as there is effective co-operation between us, the NHS TDA and NHS England, we should have the powers we need to do this effectively.

Finally, in accordance with our new responsibilities, we will be working to make sure all the rules of the system work to support the delivery of more and better care for patients, in particular on payment, and on procurement, patient choice and competition. Everything we do is intended to enable others to provide better care, and more of it. Where we have regulatory decisions to make, with all the different levers at our disposal, we always ask ourselves: what will produce the best outcomes for patients?

Nigel Edwards

chief executive, Nuffield Trust



“The current theory about the creation of FT status, that it could enable devolved strategy-setting, is a retrospective justification.”

After the first decade, have FTs fulfilled their potential as system leaders? I do not think so, really, but there are good reasons why this is the case. We have seen examples of FT leadership such as UCL Partners and the Academic Health Science Centres; trusts working across Manchester to change the system; Southend stepping away from Agenda For Change; and decisions on the consolidation of cancer services.

But should FTs have been responsible for system leadership? Admittedly, in retrospect providers do look like the stable bit of the NHS system over the last decade.

The policy context matters. ‘Commissioning A Patient-Led NHS’ said that commissioners were meant to be leading the system for some of this period, during which there were three major commissioner reorganisations: first in 2006 from 302 PCTs to 150; then in 2010 the clustering of the PCTs to 50; then the move to 211 CCGs in 2013. Later, SHAs believed that they led bits of the system: they too were much-reorganised.

Those very mixed messages reflected the system’s lack of clarity about system leadership. It is hard to make this a criticism of FTs, since they were not really expected to lead the system.

But we have not seen great strategic steps from providers. In general, we have not seen them realigning their portfolios of work or fundamentally rethinking their strategies. There has certainly not

been a huge amount of big-scale strategic change in the provider sector, in the way that policy may have expected. Again, we might wonder if that was a reasonable expectation given the continued grip from above and the enthusiasm for transformation at the centre often being more theoretical than real.

So one reading is that there was a system leadership vacuum, which FTs could have filled. But there were mixed messages, and it would have needed FTs to bring their always-being-disrupted commissioners with them, which would have been hard.

The current theory about the creation of FT status, that it could enable devolved strategy-setting, is a retrospective justification. Some providers may think that as an FT, they can just get on and do things; but for the system’s checks and balances to work, they need commissioners who know what they are doing. Bankruptcy courts are full of those for whose inventions the market was not yet ready.

The under-developed nature of commissioning is the other half of this. For FT providers to have been more strategic, they would have needed someone to listen to and support (or oppose) their proposed strategy. Paradoxically, the weakness of commissioning may have held back FTs from developing this.

Internationally, independent, standalone hospitals tend not to be great at strategy. They are very tactical and operationally-focused, which is appropriate, given the safety-critical nature of what they do! But they tend not to be strategic. It is almost as if the culture of acute medicine to some extent infects the way hospitals operate. In healthcare, all too often 'next week' is strategic and 'the week after' is the unimaginable future.

By contrast, mental health trusts have tended to be a bit more strategic: they have a different culture and tend to think longer-term and treat people with what is often a long-term condition. So the culture of the services you are providing probably has an impact on how you think about strategy.

Add to this the fact that for a long time, strategy was handed down from on high in the DH, whereas now it is more DIY. Providers are looking to satisfy commissioners, health and wellbeing boards, NHS England's specialist commissioning – and of course to meet all the waiting and quality targets.

The obvious feature distinguishing self-managing and self-governing hospital in England from other countries is the presence of Monitor. So in Netherlands, their independent providers have a board of governors "who basically are accountable to history, posterity and God" as one told me, describing the arrangement as "a burden and a rather attenuated

form of accountability". This person is a professor of political science and the chair of big teaching hospital, and he liked the idea of a body like Monitor.

"The original concept was that FTs should be embedded in their community: it was about localism and meeting local health needs."

When FTs were first set up, the policy insider's view was that once all providers became authorised, Monitor might still be required in its non-authorising oversight functions. Monitor would be much less like a regulator, and more like a private equity fund owning a large block of shares in an enterprise. But that was not the model publicly described to sell the idea of FTs, which was a model of local ownership by staff, patients and the community; not oversight by ex-KPMG and ex-McKinsey staff in London SE1.

Then we had the 2010 reforms' take on this. Monitor's oversight role was due to move from oversight in detail to one of FTs becoming self-managing and self-governing, with Monitor providing a backstop. Andrew Lansley was keen to stop detailed oversight by Monitor, and

the governors were to take on that responsibility (although they were not really trained for it nor were they recruited on this basis).

How far might we float away from Monitor's oversight/regulation role over FTs? Policy makers seem to have little appetite for it currently. Could a time come when the model of a board of governors made up of members and supported by non-executives supported by regulation could be enough to guarantee to the public that a local provider is delivering care well, safely and cost-effectively? There is interest in mutual models in policy circles and this was one of the original inspirations for the FT model, however there are concerns about the application to large healthcare providers.

Monitor was not originally conceived as an eleventh SHA, but it has steadily become much more interested in the detailed operation of FTs. One possible evolution could be that some of Monitor's activist oversight / intervention role falls away. But the question is why do this, and if that role is necessary, who would do it instead? Is the evolution of FTs held back by Monitor oversight? I do not have the feeling that it is, particularly.

Another current option under review by Sir David Dalton is the idea of chains of providers. The original concept was that FTs should be embedded in their community: it was about localism

and meeting local health needs. That met another idea that public providers can improve their governance when they are freed from central control to develop devolved decision-making. Those are two distinct ideas. Now they have been joined by a third idea about chains: that standardisation of processes and quality may give economies of scope and scale. But if FTs go down the standardisation route, then inevitably some of their localism goes.

The chains model might work in various ways. Some chain models in the US are networks, so some hospitals have their own board drawn from their local community, with some delegated decision-making. In Germany, some networks mainly share resources, such as back office and IT. In other systems, hospitals are run to a strict formula; strategy is set nationally at head office and local managers are there to keep the doctors happy and exploit local commercial opportunities.

Looking at that range of options, it is about what we are trying to achieve in what context. Inevitably, if providers go into a chain, some decision rights will be sacrificed – that is the whole point. That might be how many orthopaedic implants they offer, or what service lines they operate. Potentially, this makes the membership model a bit problematic: if a chain decides that vascular surgery goes from a local hospital to their main hub, and the local hospital's members

disapprove, then who trumps whom? A membership model is not obviously as good for a chain as for a standalone institution.

While many countries have changed to having more autonomous hospitals, in Norway and Hungary, they are currently pulling some strategic decision-making back nationally: while they can still run organisations operationally semi-autonomously (though having to deliver various must-dos), the strategy has been pulled back centrally. The 'new public management' concept of devolving decision rights to quasi-commercial autonomous organisations is not a one-way gate. It is not impossible for this to be pulled back. In Norway, they have done that across the whole country.

Then there are those aspirant FTs who for various reasons do not look set to make it to FT status. In Poland and the Czech Republic, they basically said 'there you go: you're all autonomous' and dealt with the (not always happy) consequences.

The Alzira model, in Valencia in Spain is interesting. That was a PFI hospital run by the private sector, which ran into difficulties. Rather than make the provider bankrupt the Valencia regional government increased the size of the contract and added in more risk, to create a whole-population health management system.

The Polish 'instant liberation for all' system exposed a number of financially utterly unsustainable hospitals. Poland's approach to improving providers' governance and financial management in that way does rather assume that the people in charge will know what to do, and that it is do-able. It is not clear that this is necessarily the case.

In Germany, we have seen some straightforward takeovers, with struggling hospitals sold to a number of the chain operators. That is one approach; Poland's 'make them all independent and hope for the best' is another; as is the Alzira concept of the hospital as head of the local health system.

Sir Leonard Fenwick

chief executive, Newcastle Upon Tyne Hospitals NHS Foundation Trust



“Some providers who looked unlikely to succeed have come through with flying colours and should be commended.”

The FT provider sector has in good part been a success. However, as Alan Milburn, Bill Moyes and others recognised, I have always thought there could be up to a 10% failure rate of public benefit corporations (which is what FTs are). That is something which could be accepted, or at least tolerated, through acquisitions mergers and support.

In assessing FTs’ success, we must remember that the idea was received with as much hostility as NHS trusts in the 1990s, brought in by another very dynamic health secretary Kenneth Clarke. Some NHS trusts failed in their first few years, and that created opportunities for acquisitions and re-evaluations. But yes, the FT sector from 1 April 2004 to now has seen some tremendous success stories.

One change is from the former view that perhaps felt small could be beautiful. For providers today, small does not tolerate the ebbs and flows of change, investment and risk. There is a required size, and for DGHs, narrow service portfolios will be an issue. Our trust has what we believe is the widest scope of service portfolios in England: supra-regional, regional, local and primary care. And I think you need that kind of breadth and scope to cope with change.

In retrospect, I am a little surprised by how few failures we have seen: I thought there would be more, and some providers who looked unlikely to succeed have come

through with flying colours and should be commended. For some, FT status has been an opportunity to excel and develop.

“For providers today, small does not tolerate the ebbs and flows of change, investment and risk.”

Another key factor for us was the support of the strategic health authority. Ours was pragmatic, and just got on with their tasks without too much ceremony. The mood music for autonomy was right at the time: the FT policy was made and our SHA acknowledged it and had the confidence to let us go and to focus on actually being strategic – not interfering with us in a line management way (which they could not really do any more), but focusing on the health of our population, changing service models, public health dynamics and investing in unmet need. Steve Singleton, the SHA regional medical officer, was very switched-on to health improvement.

For a progressive FT like us, autonomy was music to our ears. We did not have to deal with anxiety about waiting list checking or cross-boundary flows: our focus was on quality improvement and how we could better meet public

expectations, investing in service benefits, translational medicine and innovation.

FTs rose to the challenges, but after Mid-Staffs, everything changed to a very risk-averse environment and a focus on avoiding getting a kicking. Disappointingly we are returning day by day towards an overcrowded bureaucracy, with a new initiative.

“We have made the most of our membership and council of governors. The council of governors published our manifesto ‘Better Together’ in 2010. That has been the bedrock for our strategy in the last five years and our current agenda of doing more outside the acute setting.”

Being an FT made a measurable difference to our local population. I believe we were much more responsive. This is shown in the breadth of our service portfolio and many new services; improved quality outcomes; minimised waiting times. And we moved beyond tertiary and secondary care into community and primary care settings: something not possible under the old model. We have Freeman Clinics Ltd, a primary care spin-off.

We also have a greatly enhanced relationship with the local authority and their proactive health and wellbeing board, who are embracing the opportunities of the Better Care Fund, with its upsides and downsides.

We have also made the most of our membership and council of governors. The council of governors published our manifesto ‘Better Together’ in 2010. That has been the bedrock for our strategy in the last five years and our current agenda of doing more outside acute settings. People living an extra decade changes the dynamics of care and we have to work with other agencies. The local authority is a real catalyst and the driving force emerged from our directly-elected governors in the community.

They challenged us to do more in our city, and in a way FT status brought us back down to earth. It reminded me of the 1960s when the DGH was very much out working in the terraced streets

with loan equipment and rapid access – so FT status has brought about a regeneration of that freedom to think outside the hospital box and to change and challenge without the fear of someone coming along to clip your ear. Freedom does breed enhanced accountability, even if some providers seem to fear their own shadow. Or Monitor’s.

Being an FT allowed us to pursue health services integration across the populations we serve especially our local city population. That was not possible as an NHS trust. FT status offers a distinct self-determination in the context of the NHS system constraints, while being held to account by the respective regulators.

Alastair McLellan

editor, Health Service Journal



“Meeting the needs of the public and delivering efficiency of service means a move to accountable care organisations, judged on population-based outcomes and paid on that basis.”

How do you think FTs have performed over the past decade, relative to their original promise?

AM: Assessing FTs’ performance relative to their original promise begs the question of what that promise was. The original idea for FTs was effectively sold in two ways: the first promise was to the public, of democratisation of the provider sector, and that local people would have greater influence over their provider organisations. There is limited evidence at best that governors and members have had any significant impact on major choices made by FTs (there will of course always be exceptions).

I am always guided by what health sector leaders and chiefs talk to me about: and none talk to me about what their governors think, or are doing, or about getting more governors. While the FT governors model was established and exists (and broadly has not blown up with governors declaring war on chairs, or vice versa), bluntly, it feels a bit ‘so what?’ It is neither bad nor good. That first promise remained unfulfilled in any meaningful way.

The second promise made was to the people running provider organisations: that they could have greater freedom from central control and earned autonomy. Here, we have seen significant changes, and very few FTs would give up the freedoms they have won.

It depends to what use these freedoms were put: already-strong organisations who became FTs have used them more fully than less-strong organisations. Those with sustainable financial and clinical performance have proved much better able to use FT freedoms. You could say they have made the strong stronger without making the weak stronger (though nor have they made the weak weaker), so it probably increased in-sector inequalities among providers. It is interesting that the Shelford Group has emerged so strongly as the FT sector has matured.

The freedoms themselves are a good thing and we have seen definite improvements in the use to which the freedoms have been put. Some organisations – those with their heads above water – have used them robustly to keep regulators and government at arms’ length for a long time (though less so recently), and have been more the masters of their own future than in the past. As an aside, we have seen that an increased use of regulation has degraded that sense of autonomy. Though in many cases FTs were effectively involved in a Faustian pact of surrendering some autonomy via Monitor for extra cash.

What evolution of the format of FTs would create the most sensible future for the provider sector?

AM: There are many ways it could go, but to me, logically, meeting the needs of the public and delivering efficiency of service means a move to accountable care organisations (ACOs), judged on population-based outcomes and paid on that basis. To build these organisational models, less defined by bricks and mortar and more by service pathways, we can turn to the FT model aspects about freedom and democracy. If taking a more population-based approach, involving that population would seem to be a good thing if we want to measure new systems on outcomes as opposed to inputs. So we would focus less on standards (also known as targets) and delivery process measures and more on outcomes.

That intellectual and philosophical approach behind FTs is right and aligned with the direction of travel. For all the talk of moving to ACOs, the system is still trying to manage through standards (the new name for targets). The FT model needs significant re-engineering to make it right for an ACO-type system, but so does the healthcare sector as a whole. Re-engineering the FT model does not feel like an urgent need: that is about restructuring the provider sector so it is aligned with the way we want the NHS to

operate. If we start reviewing that, then questions of local autonomy and accountability are an important part of package rather than the main driver.

Do management chains of hospitals, as being investigated in the Dalton review, conflict with the notion of FT freedoms for autonomous organisations?

AM: Management chains could work with the grain of the FT model if the best provider organisations earn the right to lead chains.

It could certainly help with the leadership challenge. It is currently really hard to find acute trust chief executives – partly because nobody wants to do the job. There are 243 NHS provider organisations, but it seems unlikely that there are 243 people able to have that entire skill mix for successful leadership, including experience, knowledge and robustness. There are probably about 50 people with that skill-set and the experience – so they can lead chains and grow new talent under their protection and tutelage. So that works beautifully with the earned autonomy elements of the FT model.

How many provider organisations – FT and non-FT – do you think there will be by 2020?

AM: The provider landscape will not look exactly same. We would probably see more larger organisations, more smaller organisations and less medium-size ones.

How many might be joint ventures – public and private? Priory Group is in aggregate the biggest mental health supplier in the country: far bigger than any mental health trust. By 2020, we could see BMI or Ramsay running big elective care factories, as NHS organisations consolidate around specialist care.

There will probably be more providers than there are now, but some will be organisations in networks or chains, of which there will be a small number. We could see 50 chains, some geographical and some by service line, within which organisations/chains/networks the leaders would be the larger-profile organisational providers. These smaller new organisations that would be part of those chains would also include spin-offs from acute care or extended GP and community services to make standalone services.

That version of the future works both with the broadly right-of-centre view (let as many providers as appropriate become available to deliver the right-quality service) and with Labour's preferred provider schema to identify a lead contractor, who decides what it should do and what others would do. I think economics of delivering healthcare to meet proper quality and safety and experience standards make doing it all, as in the past NHS monopoly situations, impossible.

Sir Robert Naylor

chief executive, University College London Hospitals NHS Foundation Trust



"A decade ago our top ten priorities related to finance and hitting government targets – today they are all about patient safety, outcomes and experience."

The most valuable freedom of FT status is to allow us to set our own agenda. It is an opportunity to focus on what matters to our patients, and at UCLH our priorities are all about the quality of patient centred care that we provide.

Speaking recently at a conference, I said that since becoming an FT, our priorities changed to being much more focused on patient quality. We were challenged on the evidence, I replied that a decade ago our top ten priorities related to finance and hitting government targets – today they are all about patient safety, outcomes and their experience as a customer.

So that shows how our whole philosophy changed away from looking up for instructions to how we can achieve the best patient experience in those three dimensions of patient safety, outcomes and experience.

Of course finance is important, and good control allows you to focus on those aspects that are more important to patients. Here at UCLH we have managed a £1 billion capital programme largely from our own resources, at first with PFI, but in the last five years we have been resourcing our capital from our internal revenues, and making better use of our assets. We inherited the Middlesex hospital, which was valued at £32 million, and through acting as a property developer sold it for £175 million at the top of the market. We re-invested this into expanding the university/hospital campus and providing the kind of care we

wanted to deliver. We and UCL are now one of the most impressive in the world, delivering the greatest biomedical research output in the UK.

And our strategy for the next decade is to do the same again – our forward capital programme is equally impressive. It is all focused on developing world-class research, and top-quality care for our local population. The combination of these freedoms enables us to be regarded as one of the flagship FTs. So now we compare ourselves with the top-performing acute providers in the NHS and beyond.

As a specialist provider of regional and national services, there is no question that bigger is better. For example, you simply cannot provide complex cancer services in a fragmented way any more. Clear evidence shows that you need critical mass in specialised services for the best outcomes – exemplified by the stroke strategy for London, and we are about to do the same with a complex cancer care rationalisation the most specialist services onto much fewer sites across UCL Partners' six million population footprint.

The survival rates for complex care are substantially better with critical mass coming from doing some procedures day in day out rather than distributed across many sites. That is why our standardised mortality ratio (SMR) is 30% below average, and why smaller DGHs' tend to be above average. There is a profoundly obvious argument for

centralising specialised services – local care where possible and centralised care where necessary, as Ara Darzi said.

Can smaller provider organisations justify the overhead costs of being separate organisations? Look at those smaller providers, FTs and non-FTs. Of course there are some very successful small FTs, but they are coming under growing pressure as financial constraints bite. Of the 99 non-FTs, I think many will fail to meet the standards to achieve FT status and will need to seek partnerships with others.

And for that reason, I disagree with Alan Milburn's suggestion that all non-FTs should become FTs. Frankly, I was surprised. Having set a high barrier to exercise these freedoms, surely the last thing you would want is to lower the bar to make it less meaningful? Many people in my position will argue that we need to rationalise non-FTs either into organisational groups or chains of hospitals, but we certainly cannot allow ourselves to continue to subsidise failing organisations – that is just creating a dependency on the centre.

The major challenge is adapting to the changed financial NHS reality. We have long argued that the financial cliff-edge in 2015–16 could make the NHS unsustainable without additional funding. And when it comes to the debate about the Better Care Fund, I think we need more evidence that care in the community is likely to be more cost-effective in the way that is proposed. We can already see

more trusts going into special measures because of deficits, and it will reach the tipping point of political unsustainability at about the time of the next election.

So we need to solve the 2015–16 issue, and part of that depends on how realistic the main political parties' debate will be about future funding.

Having said that, I accept the urgency to develop the integration of services, but the difficulty is that the 'i' word can be interpreted in many ways by many people. By integration, I mean closer collaboration between primary, community and secondary care in organisations with a common purpose and integrated systems.

We can no longer sustain single handed contractors in general practice, particularly in urban areas. So we need reform in primary care alongside the acute sector. It might be in unified organisations, or in groupings with clear contractual relationships. Only that can offer us potential integrated care organisations for geographically-based communities.

FTs have to be part of the leadership process of making these changes happen, but it will be controversial and take a long time to implement. As currently configured, the NHS is not sustainable and we need to test out the development of accountable care health organisations. Politicians will need to grasp the nettle. Primary care has been the 'jewel in the crown' of

the NHS, but its current configuration is no longer fit for purpose in the 21st century.

Alan Milburn was seen by many of us as the most successful health secretary of our generation. Many of us found his focus on devolution and empowerment in the FT model inspirational. Devolution to organisations allows us to devolve the critical decisions about patient care much closer to clinicians at the front line.

His emphasis that this is not a problem unique to the NHS, but a challenge to healthcare systems internationally facing exactly the same problem, is correct. This is not just an NHS problem: it is one of how we can meet legitimate public aspiration for better care and choice. We would all emphasise the use of new technology, both medical and IT, as major levers towards changing the way we provide healthcare systems in future. Alan's emphasis on the balance travelling too far towards top-down regulation and the need to swing back to empowering patients is one with which those of us in the FT world absolutely agree.

Angela Pedder

chief executive, Royal Devon and Exeter NHS Foundation Trust



“Despite the challenges we currently face, the FT model is the best provider model I have worked in during the 38 years I have been in the NHS.”

Becoming an FT was absolutely liberating. Providers moved away from a culture of being constrained and seeking permission for everything they did, going from an attitude of saying (in our former chair’s phrase) “if only they would do x, we can do y” to just “we can do y”.

And in place of external double-, triple- and quadruple-checking, suddenly an FT board became accountable for the decisions they made. We recognised the freedom also bought with it the freedom to make errors and wrong decisions, and this made our approach to decision-making more rigorous and robust. And having much more freedom was not just about how we worked, but how we were embedded into our wider community.

I was involved in the development group that worked on the FT policy, but although we intellectually understood the scope of the freedoms we were being given, they only became meaningfully real when we were licenced.

In our early days, we were sceptical about the need for a membership base and governors and were concerned about how this would work and whether it would encroach on the role of the board. As things progressed, and engagement with shadow members and prospective governors developed, we recognised this was a valuable mechanism to work more directly

with the populations we served and was a necessary part of local accountability.

So when the 2003 Act creating FTs was on a knife-edge, we decided that even if the Bill failed we would try to create something akin to a membership base, seeking direct feedback from patients on how to set priorities for the way we deliver care.

As an FT, our first strategy was developed with staff and public members, asking them to ‘tell us their top five priorities’, and what staff and patients told us correlated strongly. Public perception at that time was that if you walked through the front door of an acute trust, you would probably pick up a nasty infection, so eliminating avoidable hospital-acquired infections was priority for us. It was a real chance to get close to the people we serve, and we have largely achieved this objective.

It was very noticeable in the early days, when there were 10-20 FTs, that the philosophy in Alan Milburn’s lecture to remove the secretary of state from the operational running of FT organisations was absolutely achieved.

However, as the number of FTs grew, the centre regrouped and demanded standardisation and a single interface with the sector. And over time, Monitor has become something much more akin to an eleventh strategic health authority. The indicators of FT operational freedom’s death-knell

started to clang for me when Monitor was required to put in consolidated accounts for the whole of the FT sector, and year on year NHS England imposed national contract terms and reinstated control mechanisms that had been removed in the 2003 Act. In the guise of making reporting and accounting easier for NHS England and DH, the direction of policy was incrementally rolled back and the direction of travel changed.

Those of us in early waves who had had the privilege of shaping the policy were steeped in the liberation ethos. For later phases, as the number of FTs grew, some of the 'hearts and minds' understanding of the intention underpinning policy was lost and achieving FT status became more exactly procedural, and perhaps less cerebral.

The original approach was permissive and developmental. From the outside, it seemed the later cohorts to come through were more likely to ask for permission rather than to decide for themselves. The development of the authorisation process and SHA involvement almost required that, and I recognise getting authorised today is clearly much harder now than ten years ago.

Things began to shift, and to feel more like the centrally-directed system (away from which we were supposed to be moving). We have not lost all the gains, and there are still opportunities, and as FTs we

need to have the courage to use them for the benefit of the populations we serve.

"We recognised the freedom also bought with it the freedom to make errors and wrong decisions, and this made our approach to decision-making more rigorous and robust."

The FT form probably does need more flexibility and freedom now: the difficulty is that in economically-constrained times, it becomes a very courageous step to say 'here, take more freedom'.

The healthcare delivery systems we need today may not be something traditional FTs can do alone. The concept of a foundation community, embracing health and social care with FTs as lead provider for a system perhaps with a capitation funding arrangement in place, would be an attractive option.

We have to think through how we work with local authorities in that scenario: we can learn a lot about how they engage with their

population and align services with their demographic and democratic responsibilities.

To make such changes work would need permissive mechanisms, which recognise and accept plural solutions to meet the differing needs in different locations.

Vast resource is currently tied up in non-value-adding transactions within the health system, which can and should be released for value-adding activities.

Should we become mutuals? I do not know, but there could be much to learn. Equally, the Co-operative Bank's current troubles show that mutualisation is not a perfect model. Perhaps the truth is that there is no perfect model; but we need a model that is capable of being developed over time. Permissive flexibility is the key.

Changing to a more local foundation health system approach would require changes to the funding/commissioning system. Similarly, to the approach to tariff setting; the 4% annual efficiency savings and 30% emergency tariff would also need to be changed. There is a risk currently (particularly among acute FTs) of having to focus so much on money in the narrow silo of acute care that it constrains creative solutions and limits the changes we need to make.

Despite the challenges we currently face, the FT model is the best provider model I have worked in during the 38 years I have been

in the NHS. It can be developed further, and there are many aspects we should celebrate.

We have found engaging with our governors and members really useful for testing and sounding out the board's approach, particularly when difficult decisions need to be made which might bump up against the system's regulatory regime. Traditional regulatory performance management is very black and white: you are compliant or you are not.

The board has statutory safety and fiduciary responsibilities for the services we provide, and has to do the right thing in the interests for patients. On occasion, this can mean that some mandatory targets might not be achieved. Consequently, making the right decision for patients may put the organisation at risk of regulatory intervention.

The legitimacy of our board decisions in these circumstances is reinforced by our dialogue with our governors and public members. An example is that although we have had two reasonably good winters, three years ago winter was chaotic. As a result we had a high waiting list backlog, and missed the 18-week RTT target. Once you are in that position, there are workarounds that could be put in place, but they mean that you get a pool of breached patients who may become very long waiters, whilst pre-18 week patients are treated to smooth performance.

Our board made the right decisions to prioritise emergencies, and after that to admit on clinical priority and then on chronology. That meant we missed the 18-week RTT target for three quarters. Our discussions with governors and members ahead of any risk of regulatory failure said that the board has decided that we must do right thing for patients, but there is a risk of regulatory failure: do you understand why this is our plan and do you endorse the decision we have made?

“The concept of a foundation community, embracing health and social care with FTs as lead provider for a system perhaps with a capitation funding arrangement in place, would be an attractive option.”

This, to me, is an example of being a responsible organisation. It is too easy to say ‘the public don't understand and it's too complex’ we are in charge; you have to get out there and engage them and

present your proposals coherently. We are doing the same thing now with the financial challenge and the impact of the 4% efficiency target: we have a current open dialogue with staff and the public, so that they understand the challenges we face in the £80 million savings requirement over the next five years. In the past, and certainly pre-FT status, I doubt whether any NHS board would voluntarily have bought such a challenge into the spotlight.

Tracy Taylor

chief executive, Birmingham Community Healthcare NHS Trust



“The FT governance model, combined with empowered patient users, leads to better engagement and real influence in how we deliver our care.”

A decade of FTs is a good milestone for those in the NHS to look backwards as well as forwards. Looking back, we can see various highs and lows.

Perhaps the biggest of the highs is the fact that not only do we have a number of FTs established but that the FT model has stayed the course for 10 years – and in a change-prone system such as the NHS, that is an achievement in itself.

However there have been lows – particularly some of the emerging governance and quality issues and financial challenges currently being identified in FTs (as in non-FTs). It is a shame therefore that FT status – something that is really hard to achieve and previously held in high esteem as marking out the really good organisations – has not always turned out that way. Consequently, high-quality and high-performance are not automatically synonymous with FTs any more.

As a community service provider organisation, one of the benefits that FT status has for us is focused on the governance model. We see the governance model as being a very real, tangible part of our accountability to and relationship with the public and the patients we serve.

We have strived for many years in the NHS to engage purposely with our patients and service users but in reality this has been relatively fragmented and possibly tokenistic. What the FT

governance model does is formalise this as a priority for our organisations, as well as demonstrating our accountability to the public.

“The money is important and ever diminishing but unless we focus on service user and clinically led transformation first and foremost we have no hope of managing the financial challenge.”

As a community provider organisation, we can be closer to the public than many NHS providers because much of the care we provide is undertaken in the public’s own home – we are on their ‘turf’ – and that geographical dynamic often makes the people we serve feel more empowered. The FT governance model, combined with empowered patient users, leads to better engagement and real influence in how we deliver our care.

Organisations and forms do not stay fixed in stone and unchanged, of course and it may be that some evolutions to the FT model would help providers deliver better care.

One such evolution might be to put even greater emphasis on the role of members and governors than in the past. Locally, that is certainly an intention of ours, but if the system developed a focus more on governance and the original rationale behind the FT model as community-based local organisations, rather than the historic business-commercial focus, it may enhance how FTs achieve change and provide better care in the NHS of today.

The money is important and ever diminishing but unless we focus on service user and clinically led transformation first and foremost we have no hope of managing the financial challenge. We need to do things radically differently utilising all elements of the system working better together and driving through efficiencies, the people who know how that can be achieved better than anybody else are those on the frontline, service users and staff.

Birmingham is a big, diverse city with some significant pockets of deprivation and inequalities. A core part of our strategy is to make the most of the fact that we work in local communities. Our commitment to being really rooted in our communities across the city means that we are planning and doing our work in a

more integrated and meaningful way than perhaps community providers in the NHS have generally tended to historically.

“Having a 16,000 membership base and an elected council of governors representing them means we have additional formal avenues through which to connect with and hear what our public think and want from our services.”

We describe our focus on local areas and smaller communities as being about ‘health synergies’. In the localities across the city, we have to recognise difference and diversity. Too often in the past, health and care providers have tended towards a one-size-fits-all blanket blueprint. Locally, we try to work with our communities to jointly agree and co-produce care. This is transforming how we deliver our care with greater effect for smaller communities, breaking down the city into localities and looking at the local socio-economic factors influencing

health and wellness and outcomes. This kind of work has to be done at a smaller level than the city’s 1.1 million population.

Through our FT application process we have developed a clear membership strategy and have recruited a large number of members. Having a 16,000 membership base and an elected council of governors representing them means we have additional formal avenues through which to connect with and hear what our public think and want from our services. This enhances our ability to work on a macro and micro level dependent upon the issue.

Tony Thorne

chair, South East Coast Ambulance Service NHS Foundation Trust



“Across different sectors I have seen well-led FTs with excellent, highly committed teams and I believe that these will arrive at better local decisions than if these decisions were driven centrally.”

My time-frame of reference for the NHS and the FT sector is the past three years. My impression is that the performance of FTs is variable. However in assessing performance and progress, it is difficult to disentangle good efforts and clever positioning by a local leadership team from the environment in which they are working. You can have a good, well-led board and executive whose good work is undermined by an unforgiving environment, and of course the reverse.

So it is quite difficult to generalise about FTs’ performance: local circumstances vary, although nationally, the picture’s getting much tougher due to tighter funding.

I do not have the information to judge whether FTs are performing better than non-FTs in similar environments. Nevertheless across different sectors I have seen well-led FTs with excellent, highly committed teams and I believe that these will arrive at better local decisions than if these decisions were driven centrally. I say that less from my experience in the NHS, which is relatively short, but having had responsibility for some quite large companies with many operating units. I learned that a central team contributed best if it was setting the overall goals and strategy, checking that local plans were being successfully implemented and ensuring that the local leadership was up to the task. Attempts to manage issues from the centre inevitably showed

that it is hard enough to correctly identify a local operation’s problem let alone find the right answer.

Change in the FT format is needed. I believe that the FT idea largely came out of government realising that in a tougher environment where hard decisions will have to be made, it is best these decisions are worked up and determined locally.

Many of these tough decisions revolve around service delivery and the current approval system is not ideal. Providers have to be able to restructure, which will mean that some will get bigger while others get smaller. Some mergers and acquisitions fail, however, growing, merging and even swapping assets does often lead to better services at lower cost.

At the moment, the process by which FTs get permission for significant investment or merging/acquisition is unclear. It is also not clear whether those with responsibility for approving mergers, acquisitions and service changes have the experience to judge the benefit-to-risk ratio.

There will be errors but without providers being able to grow in areas where they have advantage, through investment or consolidation, we will remain with a cohort of providers trying to improve but only with the assets they currently have; this limits the opportunity for significant innovation.

I feel that the FT concept has got ahead of the permission structure.

Much will rest with the CCGs. They will have to be prepared to back those they consider as likely to provide the winning solutions and accept that there will be losers. Currently, the system shows a tendency to try to keep all the shows on the road.

The FT format is well-suited to an ambulance trust such as ours. Our executive team is innovative particularly as regards the changing role the ambulance service can play in unscheduled urgent care, rather than trauma where our role is already well defined. The SECAMB team recognised that for many patients, for example the frail elderly with multiple conditions, being taken to hospital is often not the best option for them. Therefore the trust is developing a specialist cadre of paramedic practitioners. These have the education, skills, equipment and drugs, to enable them to diagnose and treat many of our patients in their homes or refer them to specialist clinics. This approach is safely reducing the numbers conveyed to hospital and has been cited as an example of emerging good practice in the A&E Care Review (and we are not yet the finished article).

This concept, with the preparedness to invest in people, training and equipment, was very much done under the auspices of our being a FT. We got good support from our commissioners

who were prepared to recognise the benefit to the overall health system in our getting patients treated in the right place, not necessarily hospital. It is unlikely that we would be as advanced if we had not been an FT and felt able to back our approach. As a board, we appreciate being able to establish the right approach with our commissioners and invest, without having this checked out by others.

“I feel that an FT’s local accountability makes it more likely for it to succeed; so long as the leadership is given the space to get on with the job and the rules covering future development are clear.”

In common with other sectors it has been a tough time for ambulance trusts lately; facing a big increase in demand but not a commensurate increase in resources. At SECAMB there has been a great concentration on delivering performance, clinically and financially but also to drive in

the innovation. Under the FT structure the board has found it effective and efficient to be accountable through a locally based council of governors, rather than explaining itself to a distant head office!

I look to the future with optimism. FT status is not of itself the answer: decentralisation and local accountability are hard – you have to back your judgement, sell your approach to commissioners who have many calls on the money and then deliver. Nevertheless I feel that an FT’s local accountability makes it more likely for it to succeed; so long as the leadership is given the space to get on with the job and the rules covering future development are clear. The first may be difficult in an environment where politicians have to demonstrate to the public that they have a grip on what is going on. I have sympathy for politicians, who, if they are not seen as solving the immediate issues, are not around for long. However they will not solve the NHS’s problems by centrally running it; but they probably know that.

The Foundation Trust Network (FTN) is the membership organisation and trade association for the NHS acute hospitals and community, mental health and ambulance services that treat patients and service users in the NHS. The FTN helps those NHS trusts deliver high quality, patient focussed, care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

The FTN has over 225 members – more than 90% of all NHS foundation trusts and aspirant trusts – who collectively account for £65 billion of annual expenditure and employ more than 630,000 staff.



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