



The Foundation Trust Trap

The Carrot, the catch and the crucial imperative

Perhaps trap is too strong a word but it does imply something you fall into because you didn't notice it and at that level the word carries the meaning suitably well. Furthermore, the trap itself, whether by design or inadvertently, is particularly well crafted. So, what are we speaking of? You could call it a funding trap but we'd prefer to describe it as the trap of self-determination and it gives rise to some vital imperatives if organisations wish to avoid being impaled on the spikes at the bottom.

Self-determination – the meaning

Self-determination is defined as free choice of one's own acts without external compulsion; and especially as the freedom of the people of a given territory to determine their own political status or independence from their current state. In our context, it can be defined as Foundation Trusts effectively cutting ties with the NHS 'mother ship', albeit constrained by a regulatory, Monitor, and with strict contracting requirements, in favour of going it alone or managing their own lot with much greater levels of freedom. However, with freedom comes responsibility and although 90% of Foundation Trusts are declaring a 'green' governance rating to Monitor, we'd like to explore some of the less obvious issues arising out of self management.

The carrot

Foundation Trusts are described by Monitor as not-for-profit, public benefit corporations. Although they remain part of the NHS and provide over half of all NHS hospital and mental health services, they are free to decide their own strategy and the way services are run. They remain constrained by the NHS core principles - free care, based on need and not ability to pay – but are

not directed by Government, instead being accountable more to their local populations.

With Foundation Trusts status comes the ability to be master of your own destiny, for instance they can retain their surpluses and borrow to invest in new and improved services for patients and service users. This is not an insignificant benefit and ask almost any coal face clinician whether they would prefer to be lead by Government or more self-determining and you'll find a strong vote in favour of the latter.

For instance, should a Foundation Trusts wish to focus on oncology, it can extend its cancer services by perhaps opening a new treatment centre, for which it must seek, raise or identify funding in much the same way that a business would seek funds to expand into a new market or for a major capital investment. Organisations must assess the likely ROI (return on investment) to ensure that they are utilising their financial resources wisely and in much the same way so must Foundation Trusts. Perhaps the clue is in how Monitor describes them "not-for-profit, public benefit corporations" and, other than having to reinvest surpluses for the greater benefit of patients, they do operate in essentially the same manner. The ability to determine a strategy, bring it to reality, generate surplus revenue as a result of it and then see that reinvested to improve the health of the population and the success of the Trust is enormously gratifying and arguably an intelligent way to organise the delivery of secondary and tertiary health services. But what if there isn't a surplus...

The catch

122 Trusts now hold Foundation status (as of August 2009) and the above carrots will have grown and sprouted in many of the minds involved both prior to the decision to acquire FT status and subsequently. Furthermore, when most applied, 105 of these 122 gained their status a year or more ago with well over half more than 2 years ago, the NHS remained firmly in the midst of mandated funding increases, which meant that if you could get your financial house in order to gain FT status then the future looked rosy indeed. The harsher reality is that we are entering a more famine-like period and this will have implications for the all Trusts, let alone those with FT status. However, that isn't really the trap.

If the exciting world of how to spend your surplus is the carrot then the catch is undoubtedly that you also have the same responsibility for managing your shortfalls. A Foundation Trust with tight fiscal control, which arguably they all needed to gain FT status in the first place, can operate relatively easily whilst balancing its books. In times of increasing funding, successful Trusts generate healthy surpluses and can develop proactively to address need, demand, new technology and more. When funding is effectively flat, the status quo remains still and although you probably can't invest in all the things you'd like, balancing is still possible. However, when the cost of delivery outstrips any funding increase, the Trust must make efficiency savings or constrain activity in order to maintain balance. But that's not the trap either.

The trap actually stems from the wider strategy for health. Concurrently with the promotion of Foundation Trust status, the

Our NHS, Our Future, Darzi-led movement has gained momentum. As part of that quality-cost-demand driven agenda, a differential funding system has been implemented, whereby hospital-based episodes are remunerated on a tariff-based system and community care is directly funded. Consequently, activity conducted in the community setting is almost always 'cheaper' than the same activity under the tariff-based system. Consequently, with increased financial pressure and growing demand there is not only an appetite to make greater use of the community setting but growing recognition that if you strip services of more simple procedures, diagnostics and care in general, then there is too much provision at the secondary care level. Now that is a problem...

To be clear, across England, elements of services will move to the community, a movement that is already under way through PCT commissioning, practice-based commissioning and even the Any Willing Provider route too. For the ill-prepared or even 'sluggish' Foundation Trust, that could represent the undermining of financial stability at a service level and the need to ask some very difficult questions about post (redundancies) or even whole service viability going forward. Hang on, nobody mentioned that when we signed up...

The crucial imperative

The community movement is not one that a Foundation Trust can readily influence and therefore, rather than futile resistance,

developing alternative strategies becomes an imperative. To effect this, we also need to drop the traditional focus on tight geographical boundaries and think of the NHS as an open market. For instance, if I lose injections for rheumatoid arthritis to a GP with a special interest, could I attract more referrals for diagnosis? Typically, a hospital service serves the majority of its local population and so those extra cases may have to come from outside its traditional catchment area and maybe run through an outlying treatment centre – a competitive strategy designed to 'take business' from potentially a neighbouring Foundation Trust. See what we mean?

Now, if you are a Senior Manager in a Foundation Trust, you are probably thinking "yes, we know this..." and far be it for us to suggest otherwise. However, we strongly suspect that the challenge to be resolved arises not from knowing it but from aligning and coordinating the behaviour of your clinical services, who may well have seen their role traditionally as including 'protecting the patients from the evil, money-saving managers', resulting in often competitive relationships, not collaborative ones. If an FT is to survive and thrive, there are some conditions which need to be in place in relation to the services themselves:

- They must act collaboratively with managers and senior managers – there is no room for internally competitive behaviour

- They must understand the market in which they operate – the majority have been so tied up with the day-to-day job of delivering medicine that it has been difficult to keep up
- They must understand and address the fuller picture of what constitutes service success in the modern environment – the 6 core components of service success (ask!)
- They must apply as much attention to service excellence in that wider form as they naturally do to clinical excellence

The hard truth is that let alone understanding the environment, most clinical teams have had little training in the sort of strategic service leadership that is necessary to drive services forward under the current constraints, trends and wider health strategy. Furthermore, this runs much deeper than the Clinical Director. To truly excel in a truly demanding environment requires a coordinated, consistent and effective approach by the whole service i.e. everyone in it. The crucial imperative is that this needs creating within a timescale sufficiently short to allow the Foundation Trust to adapt and proactively manage its business, rather than fall on the spikes of the trap and be slave to reactionary cuts to balance books, resulting from this community-led funding erosion. Exciting times ahead.

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