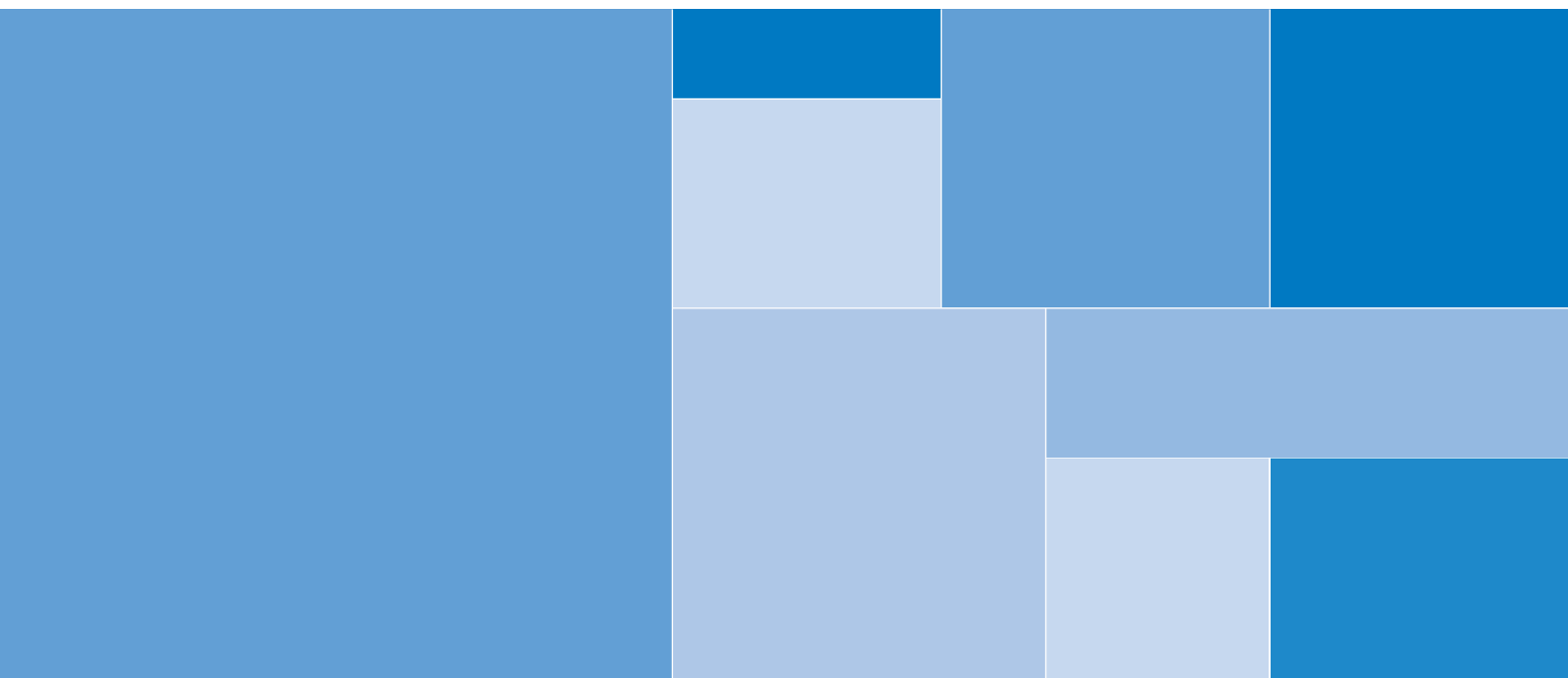


# Applying for NHS Foundation Trust Status

## Guide for Mental Health NHS Trusts





# Applying for NHS Foundation Trust Status

Guide for Mental Health NHS Trusts

April 2006

**DH INFORMATION READER BOX**

<b>Policy</b> HR/Workforce Management Planning Clinical	Estates Performance IM & T Finance Partnership Working
<b>Document Purpose</b>	Best Practice Guidance
<b>ROCR Ref:</b>	<b>Gateway Ref:</b> 6390
<b>Title</b>	Applying for NHS foundation trust status. Guide for mental health NHS Trusts
<b>Author</b>	DH – HSCD
<b>Publication Date</b>	28 April 2006
<b>Target Audience</b>	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Medical Directors, Directors of Nursing, NHS Trust Board Chairs, Directors of HR, Directors of Finance
<b>Circulation List</b>	
<b>Description</b>	Guide for mental health trusts interested in becoming NHSFTs. This document has been developed for potential mental health applicants, highlighting the opportunities and risks facing mental health applicants and provides guidance to address those risks.
<b>Cross Ref</b>	N/A
<b>Superseded Docs</b>	N/A
<b>Action Required</b>	N/A
<b>Timing</b>	N/A
<b>Contact Details</b>	NHSFT Unit Applications Team Department of Health Room 3N34D, Quarry House Leeds LS2 7UE 0113 254 5009
<b>For Recipient's Use</b>	

# Joint foreword from the Minister of State for Health and the Chairman of Monitor

NHS foundation trusts are at the cutting edge of shaping our national health service for the future. They have grown out of the wider public service reform programme, offering greater autonomy and freedoms for NHS organisations within a national framework of standards and inspections. NHS foundation trusts are firmly part of the NHS and subject to NHS standards, providing NHS care paid for by the NHS, to NHS patients according to NHS quality standards and principles – free care based on need, not ability to pay.

NHS mental health trusts are among the most innovative of our health and social care providers. This can be seen in their diverse models of care and treatment, sophisticated partnerships with local social, housing and education services, as well as the police and prisons services.

NHS foundation trust status will enable mental health trusts to take advantage of the Government's commitment to devolution and decentralisation across public services.

There will be significant challenges for mental health trusts moving to NHS foundation trust status, but we believe that they will deliver real benefits to patients and service users. This guide is a result of joint work between the first applicant mental health NHS foundation trusts, the Department of Health and Monitor to identify and meet these challenges.

With NHS foundation trust status, mental health services will continue to be at the forefront of innovative service delivery, both within the health and social care sector as well as within their wider communities.



**Norman Warner**  
Minister of State for Health



**William Moyes**  
Chairman, Monitor

# What this document provides

This document has been developed so that potential applicants, partnership organisations, commissioners, service user organisations and other stakeholders are aware of the opportunities and risks facing mental health trusts applying for NHS foundation trust status and provides guidance on how trusts can develop ways of addressing those risks.

## Part 1 – Introduction

This section:

- provides the background to the NHS foundation trust policy;
- sets out the accountabilities, benefits and issues for mental health trusts planning to become NHS foundation trusts; and
- provides an overview of the support available.

## Part 2 – Preparation for becoming an NHS foundation trust

This section looks at the main questions asked during the assessment process:

- is the trust legally constituted?
- is the trust financially viable and sustainable?
- is the trust well governed?

The key risks in each area are raised, and suggestions made to counteract the risks.

## Appendices

- Appendix 1 – The care group approach
- Appendix 2 – Model contract for mental health trusts
- Appendix 3 – Section 31 and other forms of agreements
- Appendix 4 – Useful website addresses

# Part 1 Introduction

## 1. Background to guidance

NHS foundation trusts were established under the Health and Social Care (Community Health and Standards) Act 2003. They have grown out of the wider public service reform programme, offering greater autonomy and freedoms for NHS organisations within a national framework of standards and inspections.

In 2004, the Government invited NHS mental health trusts rated 3\* by the Healthcare Commission to apply for NHS foundation trust status.

The Department of Health, Monitor, the first group of mental health NHS foundation trust applicants and their partner organisations have worked together to identify a number of common issues that need to be addressed through the application and authorisation process. There is also significant learning, relevant to mental health, from other trusts who have gone through the NHS foundation trust application process. This document is aimed to help mental health trusts prepare for NHS foundation trust status by sharing this learning.

To become an NHS foundation trust, a trust must first be invited to apply by the Secretary of State and seek Secretary of State support to continue with its application. This involves the applicant demonstrating its vision and how it can maximise the benefits conferred by NHS foundation trust status. It also must demonstrate the robustness of systems necessary to allow it to operate successfully as a public benefit corporation. Then, the trust has to demonstrate, via the Monitor application process, that it is compliant with the 2003 Act and, specifically, that it is legally constituted, financially viable and sustainable and effectively governed. If successful, the trust will then be authorised by Monitor as a NHS foundation trust. This process is described in *Applying for NHS Foundation Trust Status: Guide for Wave 3 Applicants* (November 2005) which should be read in conjunction with this document. A number of other support documents have been produced by DH, Monitor and the Foundation Trust Network. Please see a list of useful website addresses at Appendix 4.

## 2. Mental health trusts as NHS foundation trusts

### 2.1 Accountabilities

NHS foundation trusts are part of a wider programme of system reform, offering greater autonomy and freedoms for NHS organisations within a national framework of standards and inspections.

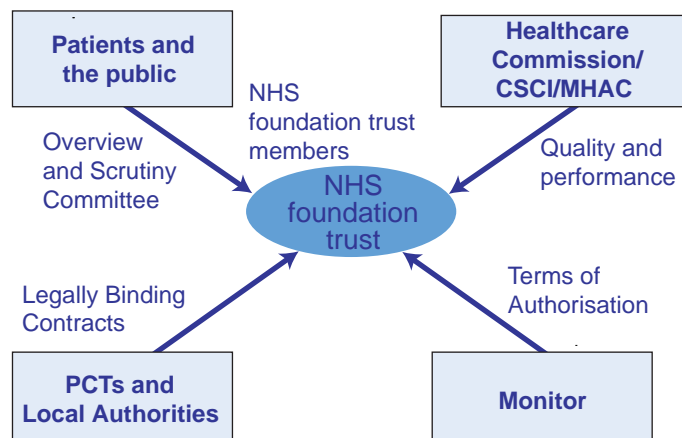
NHS foundation trusts are:

- a new type of NHS organisation, established as independent public benefit corporations modelled on co-operative and mutual traditions;
- free from central government control and from strategic health authority (SHA) performance management;
- providers of healthcare according to core NHS principles of free care based on need not the ability to pay;
- not required to achieve financial breakeven but must be financially viable;
- required to present their annual reports and accounts to Parliament;
- subject to the risk of insolvency (whilst service provision is protected).

Mental health NHS foundation trusts will continue to be inspected and reviewed by existing inspectorates (including the Healthcare Commission, the Commission for Social Care Inspection, and the Mental Health Act Commission).

What are new will be the accountabilities to Monitor (through the NHS foundation trust's terms of authorisation) and to local people, service users, and staff through the governance arrangements. These relationships are summarised in the diagram below.

#### NHS foundation trust accountability



Mental health NHS foundation trusts will be at the forefront of NHS provider organisations, delivering high quality health and social care services and must be seen in the context of a patient-led NHS and national mental health policy and legislation. They must also continue to work within mental health priorities as outlined in the National Director's report on progress – *The National Service Framework for Mental Health – Five Years On* and Public Service Agreement and Planning and Patient Framework (PSA/PPF) targets such as the PSA target of a 20% reduction in the suicide rate by 2010. In addition to the other relevant NSFs\*, this is also reiterated in *The NHS in England: the Operating Framework for 2006/2007*. Mental health NHS foundation trusts must also continue to work within mental health legislative framework.

## 2.2 Benefits

The creation of NHS foundation trusts remains a key element in the system reform of health services in England. This has been reinforced by *Health Reform in England: Update and Next Steps (2005)* and *The NHS in England: the Operating Framework for 2006/2007*.

The benefits of NHS foundation trust status to patients and service users are set out in the *Applying for NHS Foundation Trust Status: Guide for Wave 3 Applicants*. Our work with mental health trust applicants identified the following additional benefits:

- building on the good relationships which already exist with service users, carers and local people, as membership status and the board of governors gives them a direct link to organisational management;
- the freedom and ability to provide holistic patient-focused innovative services, responding to new initiatives and local needs;
- the application process for NHS foundation trust status is a rigorous process similar in scope to a due diligence review, providing the incentive for the trust to thoroughly review its internal systems, processes, and assurance arrangements;
- to build on relationships with all stakeholders to determine a long term local strategy across health and social care to ensure that local needs are met. Legally binding contracts will drive the need for good and transparent information so that the level and quality of service provision is clear to all; and
- the assessment process for NHS foundation trust status gives mental health trust applicants renewed impetus to clarify the risk and benefit sharing arrangements in their existing partnerships and joint venture arrangements. It will also give them the opportunity to develop further arrangements of this type using the freedoms offered by NHS foundation trust status.

---

\* Mental health NHS foundation trusts will also be expected to continue to work within other National Service Frameworks (NSF) such as the Children, Young People and Maternity Services, and the NSF for Older People plus documents which build on the service models presented in the NSFs.

### 3. What are the key issues for mental health trusts applying for NHS foundation trust status?

In addition to the challenges set out in *Applying for NHS Foundation Trust Status: Guide for Wave 3 Applicants*, our work identified some areas in mental health that require particular attention such as:

- financial stability and contracting in the absence of Payment by Results;
- partnership agreements;
- secondary commissioning;
- agreement on mandatory services; and
- information systems supporting activity recording and costing.

As NHS foundation trusts, mental health trusts will be required to have more robust contracting arrangements with PCTs, local authorities, and voluntary organisations. To achieve this, they will have developed their information systems, governance processes, management skills and financial management systems. Mental health trusts will need to increase their profile locally and maybe nationally to strengthen their relationships with stakeholders, service users and carers, and make new networks with public groups. A robust business strategy will be required. It will need to identify its financial and non-financial risks and develop systems to address those risks. The application process to become an NHS foundation trust requires demonstrable progress during the preparatory phase, culminating in rigorous assessment by Monitor.

These issues, and how boards of mental health NHS foundation trusts may wish to address them, are described in more detail in Part 2.

### 4. Support available

All NHS foundation trust applicants will receive a level of support through the application process provided by DH. Applicants should also expect to receive further details about support from the DH once they are part of the NHS foundation trust application process.

The DH, Monitor and SHAs are looking into developing a mental health diagnostic programme for mental health trusts. The programme will be based on the whole health diagnostic programme\* and will assist all organisations and stakeholders assess the trust's state of readiness to become an NHS foundation trust. Mental health trusts should expect to receive further information about this programme once it is finalised.

---

\* The whole health diagnostic programme consists of tools and methodologies to help an NHS trust identify the key areas it can and should address to have the opportunity to apply for NHS foundation trust status. The first part of this programme is being rolled out nationally, and will focus on NHS acute trusts and their development towards NHS foundation trust status. The second part of the whole health community programme, to follow in 2006, will focus on PCTs and their commissioning capability.

# Part 2 – Preparation for becoming an NHS foundation trust

The road to NHS foundation trust status starts with being invited to apply to the Secretary of State for support to become an NHS foundation trust. This can be achieved by developing a preparatory application guided by the support process provided by the DH. Once supported by the Secretary of State, a trust may make an application to Monitor for authorisation as an NHS foundation trust.

Although the focus of the two processes differ in scope, they are complimentary and the risks can be categorised according to the three broad questions that Monitor seeks to answer before granting authorisation.

1. Is the trust legally constituted?
2. Is the trust financially viable and sustainable?
3. Is the trust well governed?

This section of the document will define each of these questions in more detail and will outline the key risks facing mental health trusts seeking to become NHS foundation trusts, and the potential mitigating actions that our work has highlighted.

## 1. Is the trust legally constituted?

An NHS foundation trust should be accountable to and responsive to the needs of the local population. To achieve this in practice, an NHS foundation trust needs to have a body of membership which is representative of its service users and local population, and a board of governors of which more than half are elected from the service user and public constituencies.

A legally constituted NHS foundation trust must:

- ensure that its constitution complies with the 2003 Act and is otherwise appropriate;
- be able to demonstrate that it has undertaken the statutory consultation; and
- be able to demonstrate that the elections for governors were compliant with the 2003 Act.

In developing its constitution, there are a number of issues that mental health trusts need to consider:

- Particular care is needed in developing the inclusion and exclusion criteria for members and governors. The only exclusion specified in the 2003 Act is that a person who within the preceding five years has been convicted of any offence resulting in a sentence of imprisonment, whether suspended or not, for a period of not less than three months is excluded from becoming a governor.
- Some mental health applicants have developed codes of conduct for governors and trust principles for members but the assumption must be that membership is inclusive and restrictions are kept to an absolute minimum. Any exclusions must be the consequence of a clear and transparent process.
- The Electoral Reform Services (ERS) and Mencap have previously worked on joint ventures to help people with learning disabilities take part in election processes. Mencap recommends that mental health trusts have a longer lead in time as preparation for the election process and simplify all election literature. This additional timing allows for educating the membership in the election process, canvassing widely for candidates and also providing support to those members wishing to stand for election. The trust may also find that it has to provide support to enable some members to exercise their vote.

There are also specific aspects of the terms of authorisation (the document which outlines an NHS foundation trust's rights and responsibilities) that mental health trusts need to consider. These are covered in the following paragraphs.

### **1.1 Protected assets**

NHS foundation trusts' assets required for the provision of mandatory goods and services (defined below) need to be protected (i.e. cannot be sold or significantly altered without the agreement of the commissioners and notification being made to Monitor). NHS foundation trusts are required to make a list of their assets publicly available including whether or not they are protected. The asset status will be decided on by the applicant trust and then tested by Monitor.

Many mental health trusts operate from a number of small sites and these may be borrowed, rented, leased or owned. Protecting these assets should not place an unnecessary burden on trusts as many of these sites are not used to directly treat service users but are used as bases for community teams. Guidance is available from Monitor to assist applicants in deciding whether or not to protect their assets.

## 1.2 Mandatory health services

NHS foundation trusts are required to continue to provide healthcare services to NHS service users. To ensure the provision of mandatory services in acute NHS foundation trusts a schedule to the terms of authorisation sets out the volume of activity to be provided by the trust for each of the specialties which it undertakes to provide. This is expected to reflect the contracts between the trust and its commissioners.

At present, there is no standardised list of service descriptions and currencies for mental health trusts. Therefore, Monitor is currently using an interim approach based on a schedule to the terms of authorisation with services split as follows: (details are set out in Appendix 1 – see also ‘Variation in service definitions’ page 11 and ‘Contracted activity levels’ page 15.)

- by type of contract as defined in the model contract work undertaken by the DH i.e. Block Contracts and Cost and Volume Contracts for “high cost low volume activity” and for “short term episodic treatments” (see Appendix 2);
- by care group (e.g. adult, older people, etc.) and care sub-group (e.g., acute inpatient, CMHT, etc.), a standardised framework of services proposed by the first mental health trust applicants (see Appendix 1);
- by service specified by individual mental health trusts using, wherever possible, Reference Cost or Durham Service Definitions in the first instance; and
- the mental health trusts would also be expected to specify service currencies where appropriate and profile activity levels/capacity where contracted.

Over time this approach will be developed to reflect any developments in a tariff for mental health and/or movement to a nationally consistent list of service descriptions/currencies.

## 2. Is the trust financially viable and sustainable?

An applicant for NHS foundation trust status must provide a statement from its board that the trust has:

- sufficient working capital for its first 12 months of operation, and
- established robust financial reporting procedures which enable the directors to reach proper judgement on the trust’s financial position and prospects.

Both Board statements must be supported by an assurance statement from a firm of independent accountants.

From a longer term perspective, the trust must provide evidence that it is likely to generate a sustainable net income surplus and maintain a reasonable cash position on an ongoing basis under both a realistic base case and after the application of downside risk.

This presents a number of issues that mental health trusts aiming to become NHS foundation trusts need to consider. These are covered in the following paragraphs.

## 2.1 Stability of income flows

Currently, mental health services are predominantly commissioned under block contracts. In practice this means that mental health trusts' income is largely fixed. Payment by Results (PbR) does not yet apply to mental health services procedures. The DH is currently exploring ways of developing PbR for these mental health services. If this development is successful, then it is expected that any roll out would not begin until, at the very earliest, 2008.

There are a number of risks associated with the block contract model, potentially leading to instability of funding flows. These are:

- mental health trusts are unlikely to be able to demonstrate correlation between activity and costs and so PCTs/SHAs may require mental health trusts to repay earned surpluses;
- mental health trusts are generally not paid for over-performance, increases in activity volumes and/or complexity of casemix; and
- applicant mental health trusts have indicated a concern that PCTs may, at short notice, reduce the funding available for mental health trusts as a consequence of increases in acute care commissioning costs resulting from the implementation of PbR.

These issues could be mitigated through:

- improved relationships and better contracting with PCTs;
- contracts which define the nature of services as precisely as possible and, where possible, provide links between remuneration and activity/capacity;
- ensuring that financial systems and processes are robust, transparent and support analysis costs by service/care pathway; and
- improvements in IT systems to facilitate a better understanding of activity/capacity volumes, and the cost of service provision to assist contract negotiations and maximise appropriate remuneration and the retention of surpluses.

To further alleviate this risk, the DH has developed a model contract to cover the commissioning relationship between mental health NHS foundation trusts and their commissioners. The contract indicates that mental health trusts and their commissioners should sign multi-year contracts for activity/capacity to improve financial stability, coupled with extended minimum notice periods concerning divestment and centrally set inflationary uplift figures. Further information on contracting can be found in Appendix 2.

## 2.2 Better engagement with commissioners

Commissioners have varying degrees of involvement in and understanding of the mental health services they are commissioning. It is essential that mental health trusts increase both commissioners' awareness and understanding of mental health services in order to ensure effective commissioning.

## 2.3 Variation in service definitions

As indicated earlier, there is considerable variation in service definitions which will make it difficult to make valid comparisons between the outputs of different mental health trusts. This poses the following risks for stakeholders:

- for commissioners it may reduce the effectiveness of commissioning decisions;
- for mental health trusts it may increase the difficulty of making informed business decisions based on benchmarking with other trusts; and
- for Monitor it will make benchmarking between mental health trusts more difficult.

all of which will potentially compromise the improvements that NHS foundation trust status is intended to produce for service users.

As previously noted, Monitor is working with the DH to further the work on the standardisation of service definitions. However, in the absence of such standardisation, applicants need to be able to demonstrate how they currently benchmark their services and whether their systems are capable of supporting different service descriptions/currencies.

## 2.4 Choice

As part of the process to become an NHS foundation trust, all applicants are required to complete a market analysis and address the threats and opportunities their organisation faces under patient choice and competition.

Although there is currently no specific policy around choice for mental health services, mental health trusts should be aware of the benefits and risks of service user choice to their organisation, and should ensure they are able to respond to developments in the service user choice agenda as and when they occur, including choice of provider.

Independent providers play a significant role in mental health service provision and, although currently, they generally only provide certain specialist services for which there are no market alternatives, (i.e. as opposed to being in direct competition to mental health trusts), as part of the market analysis, mental health trusts should take into consideration both opportunities and threats from developments in this area.

The financial freedoms afforded by NHS foundation trust status are likely to create opportunities for mental health trusts to increase income and develop service provision by forming partnerships and/or joint ventures with the independent and voluntary sector.

## **2.5 Partnerships and joint ventures (including section 31 agreements)**

During the assessment process, Monitor will review all existing material arrangements with a focus on the level of risk faced by the mental health trust. The risks around these arrangements are that the contracts are poorly structured leading to:

- mental health trusts being exposed to increased costs/liabilities and/or having to withdraw services if one of the partners defaults on its obligations; and
- poor governance/ineffective contract management.

To mitigate against these risks mental health trusts should seek to ensure that partnership and joint venture contracts are robust, with clearly defined services, quality, and activity requirements. A checklist has been developed to help mental health trusts assess their current arrangements. This is at Appendix 3. In summary, mental health trusts should seek to ensure that the following terms are specified within the contract:

- payment terms;
- risk sharing arrangements;
- governance;
- dispute resolution arrangements; and
- penalties to minimise inherent levels of risk.

## **2.6 Secondary commissioning**

Secondary commissioning relates to arrangements where mental health trusts are contracted by commissioners to commission/contract for services externally (including any out of area treatments – OATs). OATs can be very costly and if they are part of a secondary commissioning arrangement in which the risk lies with the mental health trust, then they can pose a material risk to the trust's financial plans.

To mitigate against this risk, mental health trusts should seek to ensure that they have appropriate contractual and risk arrangements in place with commissioners to minimise the financial risks of any secondary commissioning agreements, especially with regard to high cost OATs.

## 2.7 Cost improvement plans (CIPs)

Whilst there is evidence that mental health trusts have a good track record of CIP achievement, there is also evidence that some of these plans are not sufficiently robust. The plans may be predominantly based on a 'balancing figure' approach rather than a more systematic plan of operating procedures to maximise the use of financial resources.

Mental health trusts should seek to devise formal, bottom-up CIPs to maximise their savings targets – an understanding of costs by service area/service is essential. The assessment of CIPs is a key part of the financial assessment during the NHS foundation trust application process and can be especially key for trusts which are heavily reliant on CIPs to achieve financial balance. The following broad questions will be asked during the assessment process:

- what is the trust's historic CIP achievement against CIP targets both recurrent and non-recurrent and can the achievement of these be clearly evidenced?
- how are CIPs measured and reported against?
- how robust are the CIP plans for the coming years?

## 2.8 Cash flows and headroom

Mental health trusts' cash balances and cashflows should generally be predictable, given the regular timings of block income receipts and payroll outflows (around 60-70% of the cost base). Mental health trusts must prepare rolling cash and working capital projections. This will allow them to deal with unforeseen shocks and model the sensitivities needed for forward-looking risk analysis. Mental health trusts should seek to mitigate against these within their legally binding contracts.

Mental health trusts should place greater emphasis on cashflow management and reporting. They should prepare rolling financial projections (including income statements, balance sheets and cashflow statements) on a monthly basis, looking forward for at least the following 12 months. These projections are a key tool for mitigating financial risks and are also an important part of the NHS foundation trust application process.

As a prelude to the authorisation process, mental health trusts should seek to acquire a committed overdraft or other suitable working capital bank facility. This will increase the available cash headroom in the event of unexpected calls on working capital.

## 2.9 Capital expenditure

Despite the financial freedoms that NHS foundation trust status would bring, it is likely, given the income risks and pressures noted above, that mental health trusts may have difficulty generating sufficient cash flows to repay capital and interest on any significant borrowings, and demonstrate affordability of new capital projects to support their services. All trusts will need to be able to demonstrate this.

With mental health trusts frequently operating from a large number of sites, there may be opportunities to rationalise these sites and release capital for future schemes. Many of these sites are not intrinsically needed for the provision of mental healthcare as many of the services are not predicated on the use of specialist facilities.

## 2.10 Financial reporting procedures

Management systems and business planning capabilities of mental health trusts need to be developed if they are going to operate as successful NHS foundation trusts. Although some mental health trusts have recently begun to produce in-year cashflows and balance sheets, most mental health trusts have little or no experience of producing long term financial forecasts as they have not generally been required to produce them. There is also evidence of mental health trusts reporting a large number of key performance indicators (KPIs) at board level but without an appropriate national context. Mental health trust boards need to assure themselves that they are receiving the appropriate information on which to oversee the activities and finances of the trust.

Financial projections are a key aspect of the NHS foundation trust application process and need to be capable of showing the sensitivities that can arise from different risk scenarios.

Mental health trusts should ensure they have effective management reporting processes in place that highlight any adverse in-year variances and that KPIs are reported in a timely manner.

## 2.11 Information systems

There is anecdotal evidence of insufficient investment in IT systems in mental health trusts, although the information systems of mental health trusts are improving as a result of the mental health Minimum Data Set. Mental health trusts may need to improve their information systems to understand the cost of providing particular services and to enable informed business decisions to be made. Robust information systems are an essential part of forward business and financial planning.

### 3. Is the trust well governed?

An applicant for NHS foundation trust status must be able to demonstrate that its governance proposals meet the statutory requirements laid out in the 2003 Act. An applicant must also show that:

- its governance strategy is both locally representative and comprehensive in scope; and
- the trust board considers that the trust has the organisational capacity necessary to deliver the business plan.

#### 3.1 Contracted activity levels

The mental health model contract takes a very flexible approach, allowing mental health trusts to contract in the way that is most appropriate for them (e.g. cost and volume contracts, block contracts, etc.). If this flexibility is used by mental health trusts to continue to contract with commissioners on a block only basis without any linkages to either activity or capacity, then there is a risk that the board may be unable to oversee the business effectively.

NHS foundation trust boards would be expected to be able to demonstrate, with reference to a wide range of measures, how as a trust board, they gain assurance that they are making informed business decisions at a service level rather than just addressing the 'bottom line'. Guidance on contracting can be found in the previous section and Appendix 2.

#### 3.2 Board skills

It is important that the board and senior managers of mental health trusts have an appropriate range of skills (including general management) in order to ensure effective leadership in an NHS foundation trust environment.

Mental health trusts should undertake a skills gap analysis of their board (both executive directors and non-executive directors (NEDs)) in terms of their prospective roles within an NHS foundation trust and put in place measures to address any gaps. This may include recruiting or replacing NEDs in advance of applying for NHS foundation trust status.

The role of NEDs in an NHS foundation trust is broadly as follows:

- to challenge constructively the executive directors;
- to help develop business strategy;
- to scrutinise the performance of management in meeting agreed objectives and goals; and
- to satisfy themselves that the financial, governance, and risk controls and reporting is robust and defensible.

This role differs in scope from the role of acting as community representatives that they may have historically undertaken in NHS trusts.

### **3.3 Reputation risk**

Mental health services are rarely considered by the general public, media and politicians until their attention is drawn to an incident involving one of the very small minority of mental health service users who may pose a risk to others. The combination of the stigma still attached to mental illness and the independence from central government control that NHS foundation trust status brings means that operational failure of a mental health NHS foundation trust service is less likely to be tolerated than many other health service failures.

Mental health NHS foundation trusts will need to continue to develop effective communication strategies and achieve good relationships with their local communities and media in order to try to reduce the levels of stigma. This will also keep the general public well informed and assist in the implementation of a response plan should an untoward incident occur.

### **3.4 Service specific risks**

Monitor will rely on concerns raised by existing third party inspectorates, such as the Mental Health Act Commission and the Commission for Social Care Inspection in respect of service specific risks. As with all NHS foundation trusts, responsibility remains with Monitor to consider what action maybe required, including, if necessary intervention by Monitor.

Where secondary commissioning occurs applicants need to demonstrate that they actively monitor third party reports on those services that they commission in addition to the services they provide directly.

### **3.5 Membership**

Service users and their carers can often have a long relationship (over a period of years) with mental health services. Service users and their carers also often have a major say in their treatment and care regimes; clinicians and trusts want to increase their involvement. Membership status of a NHS foundation trust will strengthen efforts to provide service users and carers with a meaningful voice and reduce the objectification of service users.

There is a risk with NHS foundation trust status that a single-issue group could exert control over the agenda of the board of governors. Trusts should seek to mitigate this by establishing a broad membership and use representative electoral methods to deliver a balanced board of governors.

The sheer variety and volume of partnerships that make up mental health services means that mental health trusts can be more advanced than acute trusts in attracting local community membership; although this can be counteracted by the stigma and lower profile of mental health. The first group of mental health trusts have demonstrated that they can develop very successful and innovative methods of attracting the wider local community to become members of the trust.

Mental health trusts will also need to continue to develop effective communication strategies and achieve good relationships with their local communities and media in order to try to reduce the levels of stigma and increase membership.

## Conclusion

This guide has been provided as a starting point for mental health trusts considering NHS foundation trust status. As more and more mental health trusts become NHS foundation trusts, then lessons learned and experience will be made available and will be an invaluable source of assistance.

Other documents available on websites of the Department of Health, Monitor and the Foundation Trust Network will also be essential reading.

For those mental health trusts who are well prepared, the challenges and opportunities of NHS foundation trust status provides an exciting future.

# Appendix 1 – The care group approach

The “care group” approach was proposed by the first group of mental health trust applicants. It is categorised into six “care groups” (i.e. adults, etc.) and then sub-categorised into a number of “care sub-groups” (i.e. acute inpatient, CMHT, etc.). This in essence provides a standardised framework within which mental health trusts profile the services they undertake. Additional care sub-groups can be added by mental health trusts as necessary although this should be considered the exception as opposed to the rule.

Although service definitions and currencies are down to individual mental health trusts to decide, they are requested to use definitions from the Reference Cost or Durham listings in the first instance where appropriate.

Care Group	Care Sub-groups	Service definition/currency
Adults	Acute Inpatient	
	CMHT	
	Assertive Outreach Team	
	Crisis Resolution Team	
	Early Intervention Team	
	PICU	
	Rehabilitation – inpatient	
	Rehabilitation – community	
	Low Secure	
	Medium Secure	
	High Secure	
	Mother & Baby	
	Eating Disorders – inpatient	
	Eating Disorders – community	
	Prison Inreach	
	Personality Disorder	
	Psychiatric Liaison	
	Daycare	
	Court Diversion	

Care Group	Care Sub-groups	Service definition/currency
CAMHS	Tier 1 Tier 2 Tier 3 Tier 4	
Older People	Inpatient – Functional Inpatient – Organic Inpatient – Mix CMHT Outpatient & Daycase	
Substance Misuse	Inpatient Community Outpatient	
Learning Disability	Inpatient (i.e., assess treat) CLDT Activities of Daily Living	
Other	Supporting People Clinical services other than MH & LD	

## Appendix 2 – The model contract for mental health trusts

DH has developed a model contract to cover the commissioning relationship between mental health NHS foundation trusts and PCTs. Its development was informed by the various principles set out below. Although use of the model contract is not mandatory, applicants are encouraged to use it as a starting point as it has been prepared with the active and detailed involvement of mental health trusts and their partner PCTs in the first group of applicants.

- For PCTs:
  - agreeing in principle to the applicant mental health NHS foundation trusts three year income;
  - agreeing a reasonable amount of notice (e.g. at least 12 months) to give to the NHS foundation trust, should the PCT want to negotiate a change in funding;
  - working under the assumption that mental health NHS foundation trusts will not be able to manage any reduction in income without a reduction in volume of service;
  - adhering to a mental health inflationary uplift figure set by the DH; and
  - working with the mental health NHS foundation trust to ensure that income can be managed in a more transparent way and therefore can make informed decisions on future planning.
- For mental health trusts:
  - ensuring that the systems to support the negotiations of commissioning services are transparent;
  - developing cost and volume systems on services where there are financial risks attached;
  - producing evidence to support the decision of how an identified surplus can be used for future planning; and
  - working with PCTs to ensure financial challenges can be foreseen upstream to assist informed decisions on future financial and service planning.

Although the bulk of specialist mainstream secondary mental health care may exhibit gradual trends of demand change (reflecting an ageing population or the change from inpatient to community provision) posing limited risk to the trust, there are two groups of

activity: high-cost low-volume care and short-term episodic treatment which will require a greater level of risk management by applicant mental health trusts.

One approach to manage the greater levels of risk is for applicants to develop systems which identify cost for these types of activity and apply a strict demand management practice (i.e. through Cost and Volume contracts). Detail of this is covered in the explanatory notes for the model contract for mental health available on the DH website. All mental health trust applicants will need to ensure that:

- the quality of local data is adequate to enable the service level to be monitored by commissioners and providers;
- the effect of changes to the model contract, and to future service levels, have been modelled and understood by both the Trust and its PCTs;
- local commissioners also have the capacity to undertake the necessary work;
- the overall percentage balance of block/non-block work undertaken by the trust is acceptable to all parties, including Monitor;
- for any cost and volume contracts, ensure there is complete clarity as to services covered by the contract (as opposed to the block) and as to demand management arrangements (see above); and
- with any cost and volume contracts, ensure that consideration is given to the potential for varying tolerance levels and marginal rates.

# Appendix 3 – Section 31 and other forms of agreement

## Introduction

This appendix outlines key principles to be addressed in local arrangements when assessing how they will work in an NHS foundation trust environment.

Applicants should ensure through their own legal advice where necessary that all agreements accord with legislative requirements such as the Health Act 1999. Guidance on the use of the Health Act in particular is also available from the Integrated Care Network:

<http://www.integratedcarenetwork.gov.uk/healthact.php>

Issues which are likely to require review within any contracts and agreements are as follows:

### 1 Form of agreement

- 1a Does the trust have agreements with its local authorities?
- 1b Are these agreements enabling frameworks, or detailed forms of contract?
- 1c Is the trust content to carry these forms of agreement forward as an NHS foundation trust?
- 1d If not, what changes might be needed?

### 2 Benefits

- 2a Is it clear from these agreements what the trust is hoping to achieve and how it shall perform its duties within the partnership ie delivery of the service, operating duties plus measurable milestones in terms of:
  - service change?
  - service improvement?
  - user experience?
  - financial efficiencies?
  - financial growth?
  - influence over future service direction locally?

- 2b Have any of these benefits been achieved to date?
- 2c How will these benefits be secured and safeguarded as an NHS foundation trust?
- 2d What new opportunities for benefits might be available as an NHS foundation trust?
- 2e What changes might be needed to secure these benefits?

### **3 Finance and risk**

- 3a Where the trust is operating within a ‘pooled’ arrangement under s.31 of the Health Act, is it satisfied that it has complied with the requirement for NHS commissioner consent to pool the resources which are the subject of the agreement/s?
- 3b Are the agreements satisfactory in terms of demonstrating financial viability against the agreed objectives, targets and measurable milestones?
- 3c How do existing arrangements between the trust and its local authorities deal with reporting arrangements for information on finance and activity performance?
- 3d How do the existing arrangements address process for managing financial risk and its distribution in terms of:
  - contracts and collaboration with third-party providers?
  - overspends?
  - underspends?
  - budgetary pressures?
  - virement?
  - annual inflation?
  - cost improvements?
  - new investment proposals?
- 3e How could agreements between trusts and local authorities be made sensitive to service volumes and service quality?
- 3f Are the arrangements for indemnity and liability adequate?
- 3g Is the trust content to carry forward this pattern of financial and service risks as a NHS foundation trust?
- 3h If not, what changes might be needed?

## 4 Staffing

- 4a Has the trust seconded staff in or out as part of an agreement?
- 4b Has the trust transferred staff under TUPE in or out as part of an agreement?
- 4c Are the agreements about management of ‘integrated staff’ which can undertake each other’s duties; or are the agreements about ‘integrated management’ of staff on behalf of a partner, without full integration of staff duties?
- 4d Is the trust clear on the differences within 4c and the impact upon stability and viability of trust business?
- 4e Is the trust content to carry forward this pattern of staffing as a NHS foundation trust?
- 4f If not, what changes might be needed?

## 5 Governance

- 5a Are there arrangements for governance, monitoring and review of any local agreements?
- 5b If so, have they proved effective? Is the trust content to carry forward this pattern of governance as a NHS foundation trust?
- 5c If not, what changes might be needed?

## 6 Disputes

- 6a Do the trust’s agreements contain procedures for dispute resolution?
- 6b If so, have these been tested? Did they prove effective?
- 6c If not, what changes might be required in preparation for NHS foundation trust status?

## 7 Changes

- 7a In summary, is the trust content with the current structure of its agreements with its local authorities?
- 7b What changes would be required to bring about a better structure?
- 7c What local work would be required to bring about those changes in order to ensure fit with the NHS foundation trust framework?

# Appendix 4 – List of useful website addresses

The Department of Health  
[www.dh.gov.uk](http://www.dh.gov.uk)

Monitor, the Independent Regulator of NHS Foundation Trusts.  
[www.monitor-nhsft.gov.uk](http://www.monitor-nhsft.gov.uk)

The Foundation Trust Network  
[www.foundationtrustnetwork.org](http://www.foundationtrustnetwork.org)







© Crown copyright 2006  
274413 1p 1k Apr 06 (CWP)  
Produced by COI for the Department of Health

If you require further copies of this title quote  
*274413/Applying for NHS Foundation Trust Status.*  
*Guide for Mental Health NHS Trusts* and contact:

DH Publications Orderline  
PO Box 777, London SE1 6XH  
**Email: [dh@prolog.uk.com](mailto:dh@prolog.uk.com)**

Tel: 08701 555 455  
Fax: 01623 724 524  
Textphone: 08700 102 870 (8am to 6pm Monday to Friday)

[www.dh.gov.uk/publications](http://www.dh.gov.uk/publications)



Monitor  
4 Matthew Parker Street  
London SW1H 9NL  
Tel: 020 7340 2400  
<http://www.monitor.nhsft.gov.uk>