NHS trusts

Recent government policy and legislation

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The present paper reviews the restructuring of the NHS that has taken place since 1991, with particular reference to the introduction of self-governing NHS trusts. Established to strengthen the financial management of NHS assets and to contain costs, NHS trusts represent a political solution to the problem of health service funding. Despite the speed of the reforms, there is no evidence yet of any improvement in the cost-effectiveness of resource deployment, and it is too soon to say what effect trusts will have on mental health services. Concern remains that the present reforms will ultimately lead to fragmentation of the NHS.

A total of 289 health care units have become self-governing NHS trusts since April 1991, as part of the reforms set out in *The NHS and Community Care Act* (1990). Trusts now provide the majority of NHS services (Department of Health, 1992), accounting for two-thirds of total NHS expenditure and employing nearly 60% of NHS staff. It is anticipated that 95% of health care services will be delivered by trusts after April 1994 (Newchurch Guide to NHS Trusts, 1993). The speed of this restructuring has been unprecedented in the history of the NHS (Newchurch Health Briefing, 1993).

Trusts arose from the NHS review which Margaret Thatcher announced in January 1988 in response to accelerating bed closures and lengthening waiting lists. The central element of the ensuing reform has been the introduction of an 'internal market' into the NHS. These changes have attracted widespread and persistent criticism on both ideological and pragmatic grounds (Cook, 1989; Graham, 1989; Mott, 1993). Indeed, the 1993 annual representative meeting of the British Medical Association reiterated its opposition to NHS trusts.

The facts

Since April 1991 all district health authorities (DHAs) have received central funding on a weighted capitation basis with which to purchase health care for their resident population. DHAs were initially required to separate their traditional roles as purchasers and providers of health care. Provider units that have not sought or been granted trust status continue to be managed by the local DHA and are known as 'directly managed units' (DMUs). Trusts differ from DMUs in their freedom to borrow money, generate income, retain surpluses and employ staff as well as to acquire, own and dispose of assets. DHAs are now responsible for ascertaining the health care needs of their local population and purchasing services from providers, who compete with each other for contracts.

Provider units may apply to opt out of regional, district or special health authority control while remaining within the NHS (NHS and Community Care Act, 1990). The Secretary of State has extensive powers to grant ownership and management of any health care unit to a corporate body comprising a chairman and equal numbers of executive and non-executive directors. The chairman is directly appointed by the Secretary of State, and executive directors must include the chief officer of the trust, the finance director, the medical director and a senior nurse manager. NHS employees and representatives of trade unions whose members work in the NHS are excluded from becoming non-executive directors, all but two of whom are appointed by the Secretary of State. In assessing applications for trust status, the Secretary of State seeks evidence of strong leadership and participation of senior professional staff. Each prospectus must include a statement of overall aims, plans for service development, quality assurance, personnel and training.

Although trusts are more accountable than their predecessors, this obligation extends only to the NHS Management Executive, and not to local health authorities. The role of the NHS Management Executive is largely confined to monitoring contracts and regulating standards, with minimal direct responsibility for the delivery of health care. While services remain free at the point of use, the Secretary of State retains the right to determine the minimum range of 'core services' a trust must provide. To date there has been no attempt to define such services.

NHS trusts were established to strengthen the financial management of NHS assets, contain costs and ensure that resources are used in the

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most cost-effective way. To achieve these objectives, trusts have been set three performance targets. First, NHS trusts must break even in each financial year. Second, they must generate a 6% annual return in real terms on their total assets. Third, annual expenditure by trusts must be within pre-determined strict external financing limits (EFLs). The EFL represents the amount which can be either borrowed or repaid by a trust during a given financial year.

The establishment of a trust entails the formal transfer of property, rights and liabilities to the newly-constituted corporate body. The total of each trust's assets (as calculated by the Treasury) is referred to as the originating debt. To encourage the creation of NHS trusts, interest is payable on only a proportion of this debt (known as the interest bearing debt, IBD), and not on the remainder, referred to as public dividend capital (PDC). The relationship between IBD and PDC, interest rates and the size of dividends to be paid are determined by the Department of Health. Any surplus which remains once a trust has met all of these obligations can be used for the further development of the hospital. At present the only investments allowed are in government securities.

Although no trust has so far 'gone bust', it has been made clear that if a trust fails to meet its performance targets it may be wound up (Current Law Statutes, 1990). The obligation to return a profit marks the most radical departure in health service accounting, and is in keeping with legislation governing competitive tendering for local authority services. Although Return on Capital Employed (ROCE) is favoured by the Department of Health as an indicator of an organisation's performance relative to the size of its asset base, evidence suggests that it is sensitive to events beyond the control of trust directors (Third Newchurch Guide to NHS Trusts, 1993). Although only eight out of 57 first wave trusts failed to achieve a ROCE of at least 6% in their first year, this was largely due to windfall revenue as a result of overestimated capital charges. This idiosyncrasy has since been eliminated, and some of the surplus clawed back through increased dividends (Third Newchurch Guide to NHS Trusts, 1993).

Implications for individual psychiatric practice

Government statistics show that NHS trusts treated more patients during the first 12 months of operation, and increased acute activity by 1% more than the NHS average (Department of Health, 1993). It is not clear from such figures, however, whether these increases are statistically significant, or if health outcomes for patients were improved. It is far too early to evaluate the full impact of NHS trusts on the provision of psychiatric services. Many mental health units that became NHS trusts in the second or third waves did so either in their own right or as part of community unit trusts. While this may allow greater flexibility in service delivery and closer links with primary care (Griffiths, 1992), it further reverses the trend towards greater integration of psychiatry in general hospital settings.

Although certain (as yet unspecified) 'core services' will be preserved, the clinical activity of trusts is driven by the need for financial survival rather than the needs of the local population. Strategic planning has become the sole preserve of purchasing authorities, while trusts must concern themselves with the achievement of relatively short-term performance targets. It has been suggested that increasing specialisation will lead to a more restricted range of services within individual trusts, and thus fewer opportunities for training (Crown, 1990; Crombie, 1991). The most vulnerable service would appear to be in- and out-patient psychodynamic psychotherapy, where treatment may be costly and outcomes are difficult to quantify. While critics of the internal market bemoan its 'short-termism', advocates welcome the impetus given to cost-effectiveness, evaluation and innovation in the development of new and briefer therapies.

As NHS trust employees, mental health staff will be subject to changes in pay and conditions of service. In 1991, staffing accounted for 76% of the total revenue cost of the NHS, following a decade in which the balance of staff had shifted in favour of senior managers. Between 1981 and 1991 the total number of NHS staff fell by 3% while the number of senior managers increased by over 4000% (Department of Health, 1993), a figure which is partially explained by the transfer of nurse managers onto senior manager pay scales. By 1992 staffing had fallen to 74% of revenue costs in DMUs and 71% in NHS trusts. It is clear that this will remain a major target for savings, with emphasis on the introduction of performance-related pay. The then Director of Personnel with the NHS Management Executive predicted in 1991 that ". . . within two years, I can't see that anybody will think that either Whitley or the review bodies will have any sort of function left" (Lucas, 1991). Though indicative of government thinking at the time, this prediction was clearly wrong.

In the interests of training, doctors below consultant grade retain national terms and conditions of service. Registrars and senior registrars receive contracts from the local RHA, although house officers and SHOs are directly employed by trusts. Both the numbers of doctors on these grades, and their conditions of

employment, are carefully controlled by local postgraduate deans. Trusts are likely to seek stricter management control over consultants, drafting contracts to ensure fulfilment of the business plan (Matthews, 1989). Trusts may stipulate restrictions on extra-contractual activities such as private practice and Category 2 work, and concerns have been expressed about tenure of appointment, distinction awards, disciplinary/grievance procedures and freedom of speech. Senior registrars taking up their first consultant appointments are particularly vulnerable, and are advised to consult the BMA before signing a contract (British Medical Association, 1991). Although the Secretary of State ensures that trusts abide by national agreements such as that restricting junior doctors' hours of work, their future ability to participate in these broad initiatives must remain in doubt.

Implications for users of mental health services

In order to achieve financial viability NHS trusts must develop those specialties which provide the greatest return on investment (Matthews, 1989). Although this has led to asset disposal in the form of land sales and savings on staff costs, the predicted income from private patients has failed to materialise. Nevertheless, despite efforts to portray recent NHS reforms as patient-centred, it is now purchasing authorities who dictate when and where patients receive treatment. It is the intention of many health authorities and fundholders to transfer some parts of the mental health service from secondary care to primary care. Where there is dissatisfaction with a mental health trust, there may be transfers of work to non-statutory or private sector providers in the locality. There are also disincentives for those who exceed contract specifications and treat too many patients, an occurrence ominously referred to as 'overperformance' (Kingman, 1993).

Implications for working arrangements with purchasers and providers

Staff working in NHS trusts have had to adjust quickly to the harsh realities of the internal market. Purchasers must be actively courted if existing services are to survive, and securing contracts in a buyers' market has meant doing more work for less money (Kingman, 1993). Greater attention is being paid to the needs of local GPs. While this is widely welcomed, the priorities of primary care staff may not be wholly appropriate for determining secondary mental health services (Thomas, 1992). Concern has also been expressed that patients of fundholding GPs will be given priority, undermining the principle of equality of access and creating a two-tier NHS. This risk may be further exacerbated if NHS trusts take advantage of their greater freedom to attract contracts from the private sector.

International perspectives

The introduction of the internal market and the creation of NHS trusts must be viewed in the context of the problems that currently beset health care delivery systems throughout the western world. The problems of increasing demand, rising costs and finite resources have been exacerbated by rapid advances in medical technology and demographic shifts toward older populations. The recent reforms in the UK were introduced primarily as a means of containing costs and rationing (or 'prioritising') access to health care in as equitable a fashion as possible. The choice of a market-led strategy, however well-regulated, leads to inevitable parallels with the USA, where the problems described above are more acute than in this country. The problems of health care financing in the USA are such that President Clinton's administration may stand or fall by the success of its health care reform package.

The lesson from the USA, where delivery of health care has long been determined by market forces, must be that de-regulation of providers result in uncontrollable costs, fragmentation of services and over-bureaucratisation (Mott, 1993). It has recently been shown that the number of health care administrators in the USA rose from 1.4 per patient in 1960 to 3.2 per patient in 1990 (Roberts, 1993). Despite total annual per capita health costs nearly three times those in Britain, comprehensive health care is currently beyond the means of millions of Americans.

Although the NHS is now dominated by the internal market, significant differences remain between the British and American systems. Trusts compete for contracts placed by purchasers, but under strict regulations governing their financial activities. The NHS is still intact (at least for the time being), services are still free at the point of use, and, above all, the service continues to be based on universal primary care. Nevertheless, and despite vehement government denials, the recent reforms have made it more likely that the NHS will eventually fragment, with the most profitable parts passing into private ownership. A two-tier NHS could become a reality should present controls over the activity of providers be relaxed.

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Concluding remarks

The structural changes in the NHS that have occurred over the past three years have been dramatic in their extent and pace. The first phase of this process, namely the assumption of self-governing trust status by all providers is nearly complete, and the 'fourth wave' of trusts is likely to be the last. It has been predicted that the next phase will be characterised by acquisitions and mergers (Newchurch Health Briefing, 1993). It is now unlikely that the 'old' NHS could ever be reconstituted, even under a Labour government.

The creation of NHS trusts within an internal market has been credited with introducing new discipline in the financial management of health service resources. Nevertheless, where those in favour see unprecedented scope for innovation, critics of trusts express alarm at the incipient, and some would say intended, fragmentation of the NHS (Cook, 1989; Resolution 14 passed by the BMA annual representative meeting, 1993). The freedom of NHS trusts to raise capital comes at a price, namely the obligation to maximise return on investment. The most likely effect will be increasing specialisation of services and attempts to secure private sector contracts. Staffing costs will continue to be closely scrutinised, and departure from national pay structures appears to be a financial necessity. There will be stricter management controls on consultants in an effort to incorporate senior staff into the business plan of the organisation. The concentration on short-term financial objectives may have serious adverse repercussions for clinical practice, research, training and medical education.

Self-governing trusts are an integral part of the market-oriented reform of the NHS. Faced with a political crisis in the late 1980s, the government introduced competition and managerial freedom as a means of controlling health service expenditure. 'Self-government' amounts to the devolution of responsibility for services away from central government onto the corporate bodies of NHS trusts. The government has attempted to absolve itself of responsibility for the survival of providers. Where once underfunding was decried, providers under threat of closure can now be accused of either inefficiency or 'overperformance'. Only when it became clear that this approach would prove catastrophic in London was a government-led management plan introduced in the shape of the Tomlinson Enquiry. This timely intervention represents an attempt to ensure the most efficient deployment of health services resources in London, in stark contrast to the 'hands off' strategy of the NHS Management Executive responsible for regulating NHS trust activity.

The political philosophy underpinning the internal market combines an emphasis on competition with a populist anti-bureaucratic zeal. It is paradoxical, therefore, that the very reforms which were intended to improve efficiency and rationalise the health service have resulted in a significant diversion of resources into non-clinical areas, particularly management, accountancy and information technology. While there may indeed be scope for local innovation, the radical nature of these reforms has raised serious questions about the future of the NHS itself.

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