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The Impact of the NHS Reforms on Health Authorities and Trusts

Dr Chris Ham

The Impact of the NHS Reforms on Health Authorities and Trusts

1. The NHS reforms are intended to create a market in which the providers of health care compete for contracts from purchasers. The major elements in the reforms are:

   * the purchaser/provider split: health authorities have been charged with purchasing services for their residents and this has been separated from their responsibility to provide services. Complete separation will take a number of years to achieve and most health authorities continue to be responsible for directly managed units (DMUs)

   * NHS trusts: trust status is now seen as the model of choice for provider units. 57 trusts came into operation on 1st April 1991 and over 100 more are expected to be approved in the second wave which will begin in 1992. Eventually, all DMUs are expected to become trusts

   * GP fundholders: practices with more than 9,000 patients are eligible to apply to become fundholders. The funds they are allocated enable them to buy a limited range of hospital services for their patients. These funds are deducted from the allocation of the relevant DHA

   * Contracts: purchasers of care (DHAs and GP fundholders) are required to negotiate contracts with providers. These contracts apply to DMUs as well as NHS trusts. Contracts specify the cost, volume and quality of care to be provided.

2. Underpinning these changes is a new method of allocating resources to health authorities. In the past, DHAs were funded as providers of services. This meant that DHAs whose hospitals attracted patients from other districts were funded to treat them in their allocations. The flow of patients across health authority boundaries was allowed for in the Resource Allocation Working Party (RAWP) formula.

3. From 1st April, DHAs have been funded not as providers of services but as purchasers of services. Their budgets are now based on the money they need to buy services for their resident population. In 1991/92, the amount of the budget is calculated on the basis of the size of the resident population and the use this population has made of

services in the past. The flow of patients across health authority boundaries is allowed for in the contracts that health authorities negotiate with providers.

4. The new method of allocating resources to health authorities has made a big difference to the amount of money available to health authorities in some parts of the country. The effect is particularly dramatic in the Thames regions, although other regions are affected in a similar way. Inner London health authorities in general receive less money than in the past for two reasons. First, they have relatively small resident populations. Second, the money they previously received for treating patients from outside their boundaries is now allocated directly to the health authorities where these patients live. As a consequence, health authorities in the shire counties in general receive more resources and are expected, at least initially, to use these resources to purchase services from hospitals in London. The net effect of these changes is that health authorities should still be able to purchase the same volume of services as were used by their residents in the past, although this will not apply when resident-based funding gives way to weighted capitation funding.

5. Ministers have indicated that they intend to move to a weighted capitation formula over a period of years. The formula will be based on the size of the resident population, weighted for age, sex and other factors. A start has been made in moving to weighted capitation funding for RHAs, although in December the Secretary of State announced that this will proceed more slowly than had been planned. RHAs are currently developing their own methods of weighted capitation funding for DHAs. As with the previous RAWP formula, this is likely to mean major changes in the resources which some DHAs are allocated, and many authorities in inner city districts stand to lose significantly. These districts will find that they have much reduced purchasing power in real terms. This is likely to have a major effect on the provision of hospital services, going well beyond what has been experienced in recent years.

6. If health authorities were allowed complete freedom to use their new resident-based budgets in the way they wished, there would almost certainly be considerable instability and disruption. Hospitals in districts that receive less money would find that they had to reduce their services. Similarly, hospitals in districts that receive more money might not be able to respond quickly to additional demands for their services. These problems have been recognised by Ministers and the Management Executive. To allow purchasers and providers to adapt

to the new arrangements, health authorities have been advised that 1991/92 should be the year of "steady state" and "smooth take-off". This is code language which means that services should continue to be provided where they have been in the past. Thus, although the allocation of resources to DHAs has changed significantly, authorities are expected to use their resources to place contracts with those hospitals that have traditionally treated their residents. Entrepreneurial purchasing behaviour (seeking the best deal by switching contracts) has been actively discouraged. Peter Griffiths (now Chief Executive at Guy's and Lewisham Trust) was instrumental in the development of the smooth take-off policy as Deputy Chief Executive of the Management Executive.

7. To help ensure a smooth take-off, the Management Executive initiated a stock-take exercise in July 1990. The exercise involved health authorities and hospitals submitting reports on their plans for buying and selling services. The so called "first cut" was undertaken in September 1990 and the "second cut" in December 1990. DHAs reported on their plans for contracting to RHAs, and RHAs reported to the Management Executive. The results have never been published but it is believed that the stock-take exercise revealed that some hospitals might find themselves with less money than in the past, following the introduction of contract-based funding.

8. In this context, it is worth noting that the Management Executive has also been aware of the particular problems of the Thames regions. These problems include the possibility that health authorities in the shire counties might decide to treat patients locally instead of referring them to London's teaching hospitals. There is also the likelihood that GP fundholders might change their referral patterns in the same way. The effect could be to de-stabilize hospital provision in London, leading to piecemeal closures and cutbacks. The combination of declining purchasing power for many London health authorities and the higher costs of providing services in the capital means that major changes are likely to occur (see Virginia Beardshaw's note).

9. One particular source of instability is the GP fundholding scheme. While in theory it may be possible to control the purchasing decisions of health authorities through the general management line, it is much more difficult to do so in the case of GPs. As a matter of policy, GP fundholders in some regions were advised to use 80% of their funds as they had done in the past and to switch contracts for only 20%. Given the independence of GPs, it is almost impossible to make this stick

and fundholders have been widely characterised as the wild card in the reforms.

10. As this analysis suggests, NHS trusts are only one element (albeit an important one) in the reform package. All hospitals and services are faced with a similar challenge in responding to the new pressures of the market. The decision to reduce jobs and services at the Charing Cross and Westminster Hospitals illustrates that directly managed units are following the example set by the Guy's and Lewisham and Bradford trusts. The action taken at all these hospitals (and others are likely to follow suit) is best seen as an immediate response to the first year of contract-based funding. In other words, hospitals are having to adjust their services to bring them into line with the contracts negotiated in 1991/92 and this includes eliminating underlying deficits (the source of many of the problems at Guy's and Lewisham). Despite the aspiration to achieve smooth takeoff, some gaps in funding also appear to be emerging. One of the reasons for this is the provision purchasers are having to make for extra contractual referrals. At the same time, some providers are taking action to make their services more efficient in anticipation of the more competitive environment which is likely to develop in subsequent years.

11. The public perception that "opted out" NHS trusts are to blame for what has happened at Guy's and Lewisham and Bradford is therefore wrong. Far more significant is the introduction of the market and the requirement that hospitals compete for resources from DHAs and GP fundholders. Essentially, what is happening is a rerun of previous NHS "crises" in which services have to be reduced in line with the resources available. The difference on this occasion is that the cutbacks and service reductions that occur will probably be more widespread and uncertain in their impact because the NHS reforms have introduced a number of new and unpredictable factors. Although there will undoubtedly be some winners from the reforms, there will also be losers, especially in London and the major conurbations where there is greatest scope for competition.

12. Against this background, what is the position in relation to NHS trusts? Sixty-six candidates were considered for trust status in the first wave and, in the event, fifty-seven were given the go-ahead. This was despite a critical assessment of the financial and managerial strengths of trusts commissioned by the Management Executive from Coopers and Lybrand Deloitte. There was, apparently, an active debate within the Management Executive about how many trusts should be supported in the first wave. Those who urged caution failed to carry

the day and hence the vast majority of first wave candidates were approved.

13. In announcing his decision on trusts, the Secretary of State said that he applied four criteria:

* that the establishment of a trust would give clear benefits and improved quality of service to patients

* that the management had the skills and capacity to run the unit effectively

* that senior professional staff, especially consultants, were involved in the management of the unit

* that the trust would be financially viable.

In view of the underlying deficit at Guy's and Lewisham, it is not clear how rigorously the criterion of financial viability was applied.

14. The Coopers and Lybrand Deloitte study has never been published and so it is not possible to summarise the reservations noted in the study. However, two other assessments have highlighted a number of potential problems in the published trust applications(1). These include:

* application documents rarely contained the depth of information needed to make a considered judgement on their financial viability

* many applicants were optimistic about the likely resources available for capital developments

* favourable (and unrealistic) assumptions were made about the split between interest bearing debt and public dividend capital

* favourable assumptions were made about the long term rate of interest to be paid on interest bearing debt

* favourable assumptions were made about the likely inflation rate

* the fact that some hospitals had a history of financial difficulties raised questions about their longer term financial viability.

It should be noted that each applicant was required to produce detailed financial projections and analyses for the Management Executive but these were not published.

15. The Management Executive's guidance to trusts (TELl) required them to submit business plans by March 1991. This guidance asked trusts to submit plans which covered, among other things, the following:

* overview of existing activity and planned changes

* a description of the trust business environment, and the competitive position of the trust within that environment

* a list of assumptions made by the trust about its economic environment and an indication of how sensitive the trust performance is to changes in those assumptions

* an assessment of the effect of planned changes in capital stock and of changes in the expectations of purchasers on the volume of activity, service provided, sources of patients and quality of service.

These plans should have given Ministers and the Management Executive advance warning of the decisions announced by the Guy's and Lewisham and Bradford trusts. If they did not, serious questions would need to be raised about the quality of trust business plans. The Management Executive intends to monitor performance against plans on a quarterly basis, although apparently trusts over which there is some concern will be monitored monthly.

Implications for the Committee's Enquiry.

Arising out of this briefing note, the following lines of enquiry might be pursued:

a. the Committee might like to ask Ministers and the Chief Executive about the results of the stocktake of contracting intentions (paragraph 7). Did the exercise give advance warning of likely disruption in service provision?

b. the Committee might like to ask Ministers and the Chief Executive about London's health services. Given the risks that exist in the London, are they prepared to allow the market to operate in the capital?

c. the Committee might like to ask to see the report prepared by Coopers and Lybrand Deloitte on trust applications. Given that financial viability was one of the four criteria used by the Secretary of State to assess applications, how does he now explain what has happened at Guy's and Lewisham and Bradford?

d. the Committee might like to ask to see the unpublished financial analyses submitted by trust applicants to the Management Executive. What assumptions were made in these analyses and how realistic were they?

e. the Committee might like to investigate the assumptions made in trust business plans. Did the business plans submitted in March identify the need for the changes that have since been announced? If not, why not? If so, what was the response from the Management Executive?

f. in the longer term, the most significant factor is likely to be the shift towards weighted capitation funding of DHAs. The Committee might like to explore with Ministers and the Chief Executive the likely impact of this on health services in London and the other major conurbations.

Dr Chris Ham
15 May 1991

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(1) The Newchurch Guide to NHS Trust Applications

London Health Emergency: Opting Out in London and Acute Agony.

The Impact of the NHS Reforms on London

Virginia Beardshaw

The Impact of the NHS Reforms on London

Introduction

1. Implementation of the National Health Service and Community Care Act 1990 from April this year has important implications for health services in London. Critically - as Chris Ham's paper for the Select Committee on Health makes clear - hospitals and other acute service providers across the UK will be competing for contracts from health authorities and general practice fund holders for the first time. In addition, as the reforms are implemented the intention is that health authority purchasing revenues will begin to correspond more closely to the health needs of district populations through the move to weighted capitation funding.

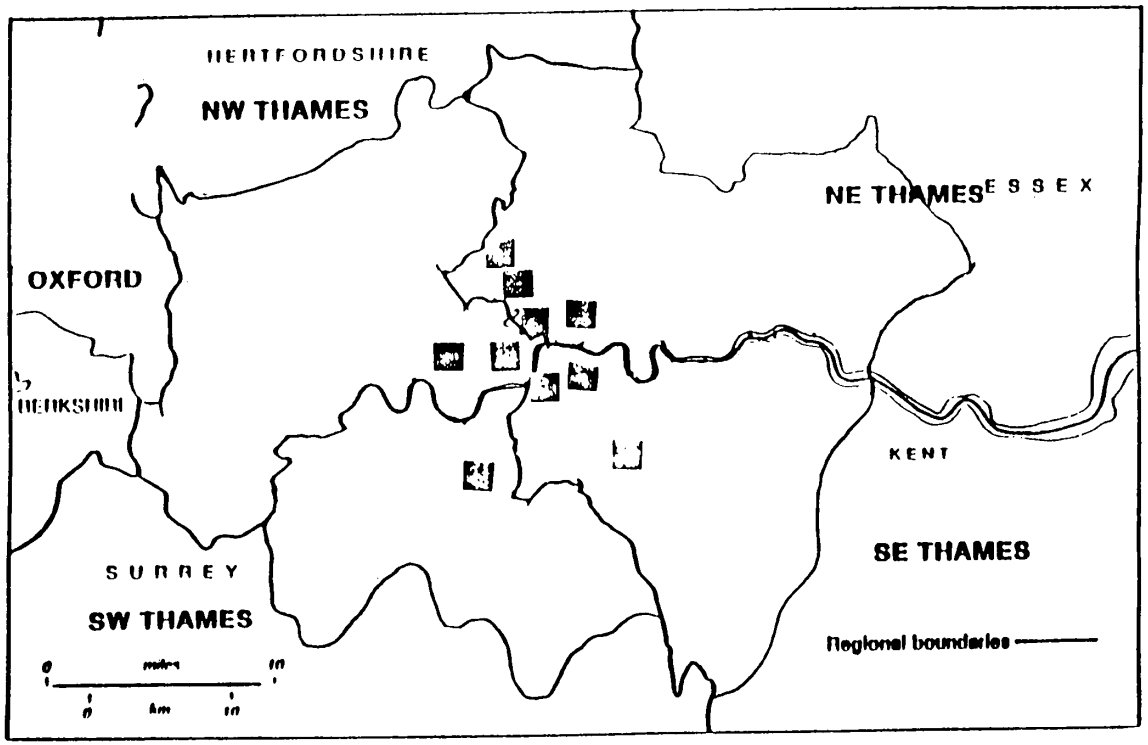
The reforms and London

2. These changes will have a particular impact on London, which has maintained a very significant number of acute hospitals in the centre of the capital despite a substantial decline in the population of the inner-city (see Map 1 and Tables 1 and 2). The concentration of hospitals in inner London reflects the capital's traditional role as the country's major centre for medical and nursing education and research. Traditionally, too, London's teaching and specialist hospitals have acted as regional and national referral centres for complex or unusual cases.

TABLE 1: ***London Population (in millions)***

				(projected)
	1931	*1971*	*1991*	*2001*
Inner London	*4.9*	*3.0*	*2.3*	*2.4*
Outer London	*3.2*	*4.4*	*4.4*	*4.5*
Greater London	*8.1*	*7.5*	*6.7*	*6.8*

Source: King's Fund Institute, 1991



MAP 1: LOCATION OF UNDERGRADUATE TEACHING HOSPITALS IN LONDON ■

TABLE 2: ***Area characteristics of acute hospitals (as a percentage of the English average)***

	Hospitalisation rate	*Average daily beds per thousand population*	
	1988/1989	***1983***	***1988/1989***
Inner London	*104.1*	*284.2*	*169.6*
Outer London	*96.9*	*90.4*	*80.8*
London	*99.5*	*137.0*	*123.8*
England	*100.0*	*100.0*	*100.0*
England value	*113.2*	*3.0*	*2.6*

Source: Benzeval *et al*, 1991

3. In essence, the move to contracting and the introduction of weighted capitation funding will present a new set of challenges to acute services providers in the capital, who will have to attract contracts for their services as the funds available to inner London purchasers adjust to reflect the numbers of people living locally.

4. At the same time, the introduction of charges for capital assets such as land and equipment will mean that London hospitals' costs - which have historically been higher than elsewhere in the UK because of factors such as higher labour charges and longer than average lengths of stay - will rise still further (see Table 3). Clearly, this will create strong incentives for purchasers to place contracts elsewhere, when possible. Accordingly, the potential for reversing traditional patterns of patient flow from relatively low cost locations in outer London and the home counties to relatively high cost locations in the centre is very real.

TABLE 3: ***Average absolute impact of capital charges on cost per episode in three Thames areas****

Inner London	*£332*
Outer London	*£219*
Rest of Thames	*£209*

*Assuming a standard throughput of 40 patients/bed/year in all areas

The impact on cost per case within Inner London is very variable. For the District most affected, cost per case will be raised by 33% while for that least affected the uplift will only be 8%.

Source: Akehurst *et al*, 1991

Underlying problems

5. These new challenges will be added to a range of unresolved issues which have persisted since well before the establishment of the National Health Service (NHS). They include:

* **Heavy investment in acute hospital services**

  London health services display a heavy emphasis on acute hospital facilities when compared to other parts of England. In particular, inner London has 70 per cent more beds than the English average, despite a sharp decline in overall numbers since 1983 (see Table 2). Thus, despite attempts at national level to shift resources away from historically well-endowed areas like London and the south-east to the north and north-west through the use of the Resource Allocation Working Party (RAWP) funding formula from the early 1970s, London retains relatively more acute hospital services than other parts of England. Despite this, it is worth noting that hospitalisation rates for London's

residents are marginally lower than for England as a whole (Benzeval et al 1991, and see Table 2).

Medical manpower is also in relatively abundant supply in London. London's non-teaching districts have 27.5 per cent more junior doctors and its teaching districts 83.3 per cent more relative to England as a whole. Consultants are 67.9 per cent more numerous in London teaching districts when compared to the rest of England. Both average length of stay and cost-per-case are higher in London than elsewhere in England (Benzeval et al, 1991).

* **Patchy primary care services**

The provision of primary health services in London has long been recognised to be of uneven quality. A major review of primary health care services in inner London chaired by Sir Donald Acheson in 1981 identified a number of problems with the delivery of primary care which - although not unique to London - are particularly acute in the capital. They include a high level of single-handed general practitioners (GPs); large numbers of GPs with small list sizes; unsuitable practice premises; lack of support staff and poor coordination with hospital services. Acheson argued that these and related problems made it difficult to develop primary health care teams and services appropriate to the health needs of Londoners.

As a result, 'In areas with major social problems the primary care services are less well organised to cope with the extra burdens involved in caring for patients in the community and many more people end up being treated in hospital (Acheson, 1981).' A recent re-examination of general practice in the capital suggests that its structure and organisation remains undeveloped when compared to the rest of England: for example, London has 70 per cent more single-handed GPs and 40 per cent fewer support staff than the rest of the country (Benzeval et al, 1991).

* **Inadequate continuing and community care**

London lacks adequate provision for people with long-term mental or physical disabilities. Historically, it has relied on a ring of large Victorian and Edwardian institutions on the

outskirts of the capital. These are unsuited by their location and design to meet contemporary concepts of appropriate care, and their ageing plant is increasingly expensive to run. Many are in the process of being closed as part of the development of care in the community. Services in London are not well equipped to meet this challenge, or the related one created by the increasing numbers of elderly and very elderly people in its population overall. As a result, Londoners with long-term health and social care needs have few options apart from inappropriate care in expensive acute settings or inadequate support at home (Maxwell, 1990).

* **Confusion of roles**

London retains its traditional role as the national centre for health care training and research. A third of all UK medical students train in London, which also holds the principle national responsibility for postgraduate medical training. The capital plays an important part in the basic and further education of nurses and other health professionals. It also contains a number of regional and national specialist medical centres - for example the National Children's Hospitals - with national research responsibilities.

However, the importance of London as a national referral centre has decreased as expertise and technology has been developed elsewhere in the health service: a Department of Health survey conducted in 1985 showed that less than 10 per cent of London's patients came either from outer Thames districts or from East Anglia and Oxford regions (DHSS, 1988). While this study did not examine flows to the Special Health Authorities, there is evidence that their role as national referral centres has also declined markedly (Hogg, 1991).

While Londoners can benefit from proximity to national centres of excellence, the fact is that national and local priorities for - and spending on - health care are hopelessly confused. In practice, the true cost of London's national training and research responsibilities is unknown, and local and national spending are consequently inextricably intertwined within many of London's undergraduate and postgraduate teaching and research establishments.

* **Multiple management**

  There is no one body with the authority to take a London-wide view of health services. Overall, responsibility for planning London's acute services is split between the four Thames regions. London's acute teaching hospitals are managed by ten health districts. The capital's eight special health authorities and their associated post-graduate teaching hospitals and research institutes remain directly accountable to the Department of Health. This fragmentation has consistently worked against the development of a coherent plan for the future of acute health services in London.

* **Ageing plant**

  A high proportion of London's acute hospital services are housed in buildings which date from the great 19th and early 20th century hospital building era of 1850-1920. This plant is in urgent need of renewal.

Conclusion

6. The 'London problem' in its various manifestations has been a major issue for British health policy throughout the lifetime of the National Health Service. A number of attempts have been made to deal with it centrally - most recently, the work of the London Health Planning Consortium in the late 1970s and early 1980s and the Flowers report on medical education in London in 1980. Although some changes followed these initiatives - notably the amalgamation of four of the capital's medical schools into two new institutions - many of the political and other issues involved have proved to be stubbornly entrenched.

7. The introduction of purchaser and provider relationships into the reformed health service throws the question of the development of health services in London - and the future of its major institutions - into sharp relief. For the first time, the capital's hospitals will have to compete between themselves and with units outside London for the work they need to remain financially viable. The high cost of London's services coupled with the introduction of weighted capitation funding mean that this is likely to prove difficult for many of the hospitals involved. Accordingly, a major restructuring of health services in the capital over the next five to ten years appears inevitable.

Questions for the Select Committee

Members of the House of Commons Select Committee on Health may like to ask representatives from the NHS Management Executive and the Department of Health the following questions:

a. What is the Department of Health and Management Executive's approach to restructuring health services in London? Will it take place solely through the application of market mechanisms?

b. How is the Department of Health and Management Executive working with the Thames regions to ensure that services to patients experience minimal disruption as the effects of the NHS reforms begin to be felt in London?

c. Does the Department of Health and/or Management Executive think there are too many major hospitals and medical schools in London? If so, how many too many might that be? What is the best way to deal with any surplus - for example, is it feasible to move any out of London?

Virginia Beardshaw
15 May 1991

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Appendix 1: KING'S FUND LONDON INITIATIVE

Introduction

The King's Fund is a leading independent charity dedicated to improving standards of health care in London. Its London Acute Services Initiative was established in September 1990 in response to concerns within and outside the Fund about the future of health services in the capital. In December of the same year the Fund set up a Commission to examine the future of acute health services in London, with Baroness Cumberlege of Newick, Mr Brendan Devlin, Professor Richard Himsworth, Baroness Hollis of Heigham, Mr Marmaduke Hussey, Mr Robert J. Maxwell and Mr Peter Westland as its members.

The Commission's terms of reference charge it with developing 'a broad vision of the pattern of acute services that would make sense for London in the coming decade and the early years of the next century'. In doing so, the Commission's main focus will be on service requirements, although it will also take account of undergraduate and post-graduate education and research. The London Initiative will assist the Commission with gathering and analysing information, and with the implementation of its recommendations.

Aim of the Programme

Through the London Initiative and the work of the Commission, the Fund is seeking to stimulate and inform debate on the future of health services in London and to influence their development. The first signs of the impact of the National Health Service reforms on London - most notably the recent furore over job losses at Guy's hospital - suggest that the establishment of the London Initiative was timely, and that its work may prove useful in helping to clarify the way services in the capital should develop.

Way of Working

The London Initiative will bring the full resources of the King's Fund to bear on the complex issues surrounding the future of London's health services. Where necessary, outside researchers and others will be asked to contribute to the research and information gathering which is informing the Commission's work. The Commission will also consider evidence and views submitted to it by outside bodies and individuals.

The London Initiative's Research Programme

Papers on the following topics are currently being prepared for the King's Fund's London Initiative. Most of them will be published as in a working paper series in the autumn of 1991 prior to the publication of the Commission's report and strategy in early 1992.

1. The Health Status of Londoners

   Working from the best available primary data sets, and making a thorough search of the available literature, this paper will summarise existing knowledge on the health status of Londoners, and discuss their 'health need' relative to people in other parts of the UK.

2. Overview of Health and Social Care Services in London

   This work will bring together the best available descriptive statistics on the health and social care provided by Health Authorities, Family Health Services Authorities and Social Services Departments in London. Where appropriate, this information will be compared to that available for other parts of the UK in order for the relative position of services in the capital to be assessed and analysed.

3. Hospital Services in London

   This paper will provide detailed descriptive statistics on London's hospitals, their work, costs, and staffing, drawing on the best available sources.

4. Primary Health Care in London and the Future of Acute Services

   This paper examines the relationship between primary and secondary care, with particular attention to likely shifts and possible changes of practice, and their implications for the future of health services in London.

5. Resource Allocation in London

   The King's Fund Institute is presently undertaking a programme of work on resource allocation in the 'new NHS'. As part of this work, they have agreed to produce a paper on the implications of the new arrangements for London.

6. Stakeholder Position Paper

   This paper will be a candid summary of the positions expressed on the 'London problem' - and solutions to it - by a representative of key stakeholder groups.

7. London's Acute Services: A user perspective

This study aims to look at the current health needs of Londoners, by drawing on the experience of London's CHCs and voluntary groups. It will use a variety of methods to tap these, including interviewing, questionnaire surveys and a series of symposia on selected topics. The eventual report will provide an overview of key issues for London's acute services from a user perspective, and two detailed case studies of services available to elderly people and to people that are homeless.

8. Acute Specialities in London

This work will cover the distribution of acute regional and supra-regional specialities in London, with special attention to how this distribution compares with the national picture. The paper will discuss the impact of these specialities on the organisation of health care in London, and possible developments and trends following the implementation of the NHS and Community Care Act 1990.

9. Future of Acute Services

This paper will review trends and developments in the future of acute services, and discuss their implications.

10. Future of Medical Education

This paper will draw on a 'Delphi study' on the future of medical education which is currently being completed by the King's Fund Centre. It will summarise the findings of this work and discuss its implications for medical education in London.

11. The Condition of the NHS Estate in London

This work will provide a summary picture of the condition of the estate of London's acute hospitals. It will centre on an assessment of the functional suitability of London's hospitals. In addition, an assessment of the backlog of maintenance expenditure will be provided. The research will cover the ten inner-London Districts.

12. The London Labour Market and its Relation to Healthcare

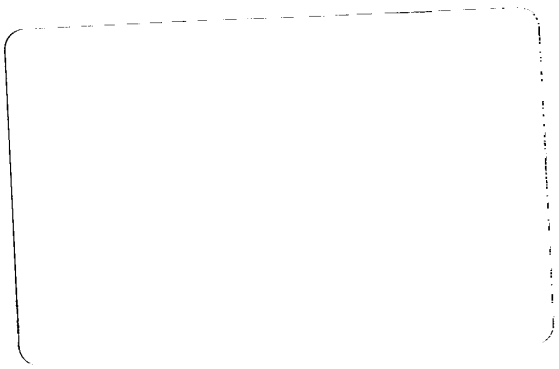
This study will give an overview of the London labour market as a whole, with an assessment of likely future trends over the next thirty years. It will go on to relate this general picture to the particular labour market for healthcare workers, with special emphasis on nurses.

13. The Structure of London's Healthcare

This study will trace the evolution of the present structure for the administration of London's healthcare system. It will consider a number of other matters including the likely effects of the government's white papers on the organisation of care in London; the question of 'coterminosity' with local authority boundaries; the organisational interface between Special Health Authorities and the other hospital services in London; and the financial environment within which London authorities operate. For this work, it will draw on the expertise of IHSM members with experience of managing health services in London.

14. London Health 2010

This is a programme of work rather than a study, which will result in a discussion paper for the Commission. It will involve working with clinicians, managers and other experts to develop models for future acute health services development, and test out their applicability to London. This work will feed directly into the Commission's work on a future strategy for London.

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