DEPARTMENT OF HEALTH

GOVERNMENT RESPONSE TO THE FIRST REPORT FROM THE HEALTH COMMITTEE, SESSION 1992-93

NHS Trusts: Interim Conclusions and Proposals for Future Inquiries

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NHS TRUSTS: INTERIM CONCLUSIONS AND PROPOSALS FOR FUTURE INQUIRIES

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Introduction

I. This Command Paper sets out the Government's response to the Select Committee on Health's Report, "NHS Trusts: Interim Conclusions and Proposals for Future Inquiries". The Government's response to the Report's interim conclusions is in Part 1. Some of the general points raised by the Committee are addressed in Part 2.

II. The Government welcomes this opportunity to place on record a great deal of evidence of the success of the NHS reforms which was not available when the former Committee began its inquiry. Like the Report itself, this response deals not only with Trusts but with other components of the NHS, particularly purchasing authorities. This is because NHS Trusts remain an integral part of the National Health Service and their role only becomes clear when set in the context of the roles of Trusts' NHS partners.

III. The Government congratulates the new members of the Committee on their appointment and looks forward to co-operating with its investigations in the future.

PART 1—INTERIM CONCLUSION AND PROPOSALS FOR FUTURE INQUIRIES

1.1 The Government welcomes the Committee's recognition that the NHS reforms are now securely in place and that the real question to be addressed is how well they are working. Since the former Committee began its inquiry evidence has been mounting of the beneficial effects of the new health service:

- an average 600,000 more patients treated per year;
- the successful elimination in all Regions of people waiting over two years for hospital treatment and a reduction of over half in the number of one to two year waiters;
- greater patient choice;
- delegation of responsibility to where the services are provided;
- better value for money.

1.2 The Government welcomes the Committee's recognition that Trusts are the management model of service provision for the future. Hospitals and other providers are choosing to become trusts in ever greater numbers, 156 Trusts are

now fully operational. A further 137 Trusts will be operational from 1 April 1993, making a total of 293. A further 137 units have been given approval to prepare a full application for NHS Trust status in the fourth wave becoming operational from April 1994. If these are successful, some 95 per cent of Hospital and Community Health Service expenditure will be delivered through NHS Trusts from April 1994. We agree therefore with the Committee that there is little point in continuing to compare Trusts with directly-managed units.

1.3 Any remaining directly-managed units are likely to be small and may not be viable on their own as NHS Trusts. The Secretary of State for Health recently approved an application for Trust status by Teddington Memorial Hospital, a smaller than usual applicant. The approval is subject to a two-year period as a shadow Trust (normally a few months). This will give time for the impact of becoming a Trust to be assessed, both in terms of patient flows and financial stability. This is a pilot project and, if it is shown to work, will be a possible model for future Trusts of similar size.

1.4 We note the Committee's intention to focus its inquiries on a number of aspects of the functions of District Health Authorities (DHAs). A great deal of work has been done by the National Health Service Management Executive (NHSME), with Regional Health Authorities (RHAs) and DHAs, to clarify the purchasing role of local authorities and to develop their purchasing capabilities. A range of work is in hand to promote effective purchasing, including the development of needs assessment, ensuring purchasers are sensitive to local people, developing joint working and integrated purchasing between NHS authorities and other local agencies, developing the contracting process, strengthening the organisational and managerial capacity of purchasing organisations, clarifying purchasing levers and ensuring purchasing innovations. We have started and will continue, to disseminate the results of this work to the NHS through the publication of reports, workshops and conferences.

1.5. The increased effectiveness of NHS Trusts in delivering services has become more and more apparent. Individual Trusts are taking advantage of their freedoms to innovate and improve services, as the following examples illustrate:

(a) the Kingston Hospital NHS Trust in South West Thames has introduced a patient hotel to accommodate patients who no longer require medical care but who cannot go home immediately for social or domestic reasons. This has enabled patients who might otherwise have been treated as in-patients to be treated as day cases. This has contributed to the Trust's ability to reduce waiting times and has helped reduce the average length of stay across all specialities;

(b) Premier Health NHS Trust in West Midlands Region has established a pilot scheme for community nursing which involves working with fund-holding GP practices to pave the way for the future management of community nurses within integrated primary care teams;

(c) the Staffordshire Ambulance Service NHS Trust has taken part in a number of training exercises with the County Emergency Services and the Ministry of Defence to improve its capacity to respond to a major incident. The Trust has developed the nucleus of a team which, in combination with clinicians and nurses from elsewhere in the county, is able to assist at major incidents not only in the West Midlands but throughout the United Kingdom and overseas. Members of this team were deployed in Yugoslavia in July, sponsored by the Overseas Development administration and attached to the World Health Organisation;

(d) the Lancaster Priority Services NHS Trust is working with the Police, Probation and Social Services on a scheme to divert mentally ill offenders from police custody;

(e) a pacesetter scheme has been implemented at the Royal Liverpool University Hospital NHS Trust to provide a third evening shift in theatres in the hospital. This will not only enable an additional 230 patients to be treated but will also reduce the maximum waiting time for general surgery, helping the hospital achieve its six-month target;

(f) the Walton centre for Neurology and Neurosurgery NHS Trust has reinvested the surplus produced by its good performance last year to purchase a CT scanner a year earlier than would otherwise have been possible;

(g) Southend Community Care Services Trust has developed an "internal rotation" scheme on its psychiatric in-patient wards. Staff now work a combination of night and day shifts, which means that the Trust no longer has to employ separate night and day staff. Patients benefit from continuity of care while the ward manager is now able to exercise twenty-four hour control of the ward;

(h) New Possibilities NHS Trust in North East Thames is working with local housing association to provide community homes in Colchester, enabling people with learning difficulties to move out of long-stay institutions into the community. The services are founded on six key principles of privacy, dignity, independence, choice, human rights and fulfilment. The services are run on a much smaller scale than institutional care and respond more appropriately to the needs of individuals;

(i) the freedom to retain funds acquired through income generation has enabled Northumbria Ambulance Service Trust to purchase thirty-two ambulances in its first year, compared with an annual replacement rate of ten in previous years;

(j) the United Leeds Teaching Hospitals NHS Trust are introducing a multi-skilled ward-based housekeeping system so that nurses no longer have to perform non-nursing duties. The Trust is also collaborating with a local wholesaler to provide a comprehensive warehousing and supplies services which enables staff to obtain medical and surgical equipment at twenty-four or forty-eight hours' notice, making significant saving and increasing efficiency.

1.6 Waiting times figures for the six months to March 1992 show that Trusts reduced their numbers of over one year waiters by nearly 60 per cent compared with just under 50 per cent in directly-managed units. Last but very far from least, an opinion survey of patients at eight Trust hospitals showed that 48 per cent said that the units has improved since they became Trust, 96 per cent were very satisfied or quite satisfied with the service they received, 42 per cent thought that medical treatment was better and 45 per cent said that the staff were more courteous.

1.7 We agree that the remit which the Committee has identified for itself is appropriate to the new-style NHS. The Government remains firmly committed to the principle of a comprehensive health service available to all, largely free at the point of delivery and financed mainly from general taxation. The aim is to deliver the best possible health services for the resources available both to improve the health of individuals and as a basis for improving the wider health of the nation. The Government believes the success of the NHS Reforms will become more and more evident as time goes on and looks forward to co-operating with the Committee in assessing improvements in the coming years.

PART 2—GENERAL POINTS RAISED

Financial Issues

2.1 *The strategic planning of capital investment.*

2.1.1 Proposals concerning the future distribution of capital investment are still under consideration. However the Government envisages that strategic oversight of capital investment will be the responsibility of the intermediate tier see paragraph 4.1, below. Individual Trusts will remain responsible for developing their own capital plans, and will have freedom to select and pursue their own priorities. The financial disciplines of Trust status are designed to encourage Trusts to match their capital assets more closely to what their revenue income will support; so their plans need to reflect the future resources, purchasing intentions and requirements of the purchasers which provide Trusts' income. Consequently, business cases for capital investment, as much as any other aspect of Trusts' business planning, will be founded on local dialogue and negotiation between Trusts and their purchasers. Like other parts of the NHS, Trusts will wish to take the opportunity, following the Chancellor's Autumn Statement, of exploring means of introducing private sector capital investment into projects.

2.1.2 The Government also recognises the need for close consultation at regional or intermediate tier level between those responsible for the strategic direction of purchasers on the one hand and, on the other, those responsible for monitoring Trusts' business planning. It is intended that the distribution of capital investment in each health region will rest on this consultation; so that the schemes which go ahead are for services which purchasers want and can afford, and reflect an agreed view of priorities within the region which takes account of strategic considerations as well as local issues. It is also intended that the apportionment of capital spending within regions should strike a balance between giving Trusts discretion to select and pursue investment opportunities, and giving purchasers influence over prioritising investments with strategic implications.

2.1.3 Although detailed proposals about the arrangements for the intermediate tier and capital in the future are still under consideration, the Government expects to issue proposals during 1993.

2.1.4 The Government agrees that one of the important aims of the reforms is to ensure that money for capital investment is used efficiently. The introduction of capital charging has had a major effect here, ensuring that capital is no longer seen as a free good. Capital charging forces providers, both Trusts and directly managed units, to recognise the revenue cost of their investment decisions. The NHSME is confident that this, and the revised arrangements for allocating capital referred to above, will result in the NHS getting best value for money from its capital investment. We note that the committee will be monitoring the efficiency of capital investment.

Pay, Terms and Conditions of Service

2.2 *Confidentiality clauses in staff contracts.*

2.2.1 The NHSME has produced draft guidance, "Freedom of Speech for NHS Staff", which is currently being finalised, following the public consultation exercise (which was extended beyond 13 November at the request of a number of organisations to allow further time to respond). Secretary of State has said that policies adopted by Trusts should be in line with the principles contained in the guidance. Some Trusts have withdrawn their confidentiality clauses for further consideration and consultation. The Government recognises that the Health

Committee will wish to consider the final version of the guidance, which it is aimed to publish in the spring of 1993.

2.3 *The move away from nationally agreed pay rates and terms and conditions.*

2.3.1 We agreee with the Committee that relatively few Trusts have moved away from centrally-determined pay and terms and conditions. We note that the Committee will return to this topic when more evidence is available. However, there is no evidence that decentralised decision making has led or will lead to the adverse effects such as the fragmentation of professions. Indeed there are clear advantages from local flexibility in pay determination though the Government accepts that it will be difficult to make progress on this in the coming year where a 1·5 per cent public sector pay constraint will apply.

2.3.2 We note the Committee's concern about the need to clarify the legal position of staff transferred to Trusts. Priority is being given within the NHSME to resolving the many complex issues both statutory and contractual relating to the transfer of staff between health service employers. The NHSME is well aware of the importance of maintaining staff morale and intends to issue clear guidance to the service once the issues have been clarified and resolved.

Consultation

2.4 *Accountability and public scrutiny*

2.4.1 The Government does not accept that Trusts are less open to scrutiny by the public than provider units have been in the past. In fact Trusts are more open to public scrutiny than hospitals and other units ever were under the old-style NHS. They are required to publish their strategic direction, business plans and annual report and accounts; they are obliged by law to hold at least one public meeting each year; the local CHC retains rights of access and service agreements between health authorities and Trusts are open to public scrutiny.

2.4.2 Many Trusts go beyond the minimum requirements on public access. For example:

(a) the Freeman Group, Newcastle on Tyne, hold quarterly board meetings in public. The papers discussed at the meetings, which give a clear insight into the performance of the Trust on matters such as contracted activity, waiting list management and financial management, are circulated to local Members of Parliament. A member of the local CHC participates at the meetings and is involved in setting the agenda;

(b) The United Leeds Teaching Hospitals Trust has followed up its public board meeting with meetings with the local CHC, Leeds Hospital Alert, Leeds City Council's Health Committee and other interested bodies. The Trust is reviewing the provision of patient information to develop a Trust-wide method of providing patients with comprehensive information about services. The Trust is developing a public relations function with the specific remit of improving public communications about the work of the Trust;

(c) Northumbria Ambulance Service NHS Trust hold quarterly public board meetings. The meetings are publicised widely and attended by the press. A public meeting was also held to publish the Trust's first annual report in September 1992. In addition, a joint CHC/Ambulance Committee meets every two months, when CHC members are briefed on new developments within the Trust;

(d) New Possibilities NHS Trust in North East Thames Region hold monthly open board meetings.The Trust circulates a newsletter to patients' relatives and other agencies and allows the local CHC open access to its facilities;

(e) The Staffordshire Ambulance Service opened all thirteen ambulance stations to the public during a weekend in September 1992. The Trust received almost five hundred visitors and took the opportunity to display ambulance vehicles and to explain the role and relationship of the Ambulance Service locally. Representatives of the three Staffordshire CHCs attend the Trust's monthly board meetings and are given full information on the Trust's accounts, strategies, business plans, activity and performance;

(f) South Yorkshire Metropolitan Ambulance and Paramedic Service (NHS Trust) have standing arrangements for the Chairman and Chief Executive to meet local Members of Parliament informally twice a year. The Chief Executive also regularly meets the Chairman or representatives of the four local CHCs and a direct link exists between the local Ambulance Service Managers and each of the four CHCs.

2.3.4. A particular feature of successful relationships between the NHS and the public is the involvement of CHCs. The Committee recommended that the Department of Health undertake a thorough review of the statutory basis of CHCs in relation to the reformed NHS. The Department's current guidance on consultation and the role of CHCs, attached to EL(90)185, reflects the changes the NHS reforms have made to the position of CHCs within their existing statutory basis. Ministerial and Executive letters last year also emphasised the important link between CHCs and purchasers.

2.4.5 The Government has consistently made it clear that health authorities need to involve CHCs and the wider public in the purchasing process. the NHSME's publication, "Local Voices", identified a number of ways to make such involvement effective. Health authorities have been encouraged to adopt a "no surprises" policy based on continuous dialogue with CHCs. In particular, health authorities are expected to consult CHCs on the proposals in their purchasing plan. The latter sets the context for detailed changes and provides CHCs with the opportunity to register any views at an early stage in the purchasing cycle. There is also scope for consultation outside the yearly purchasing cycle. The NHSME's Priorities and Planning Guidance for 1993/94 requires purchasers to develop at least a five-year strategic forward look and to consider the use of contracts covering more than one year. As purchasers develop this strategic approach CHCs should be able to make a contribution at an even earlier stage to possible changes in service provision.

2.4.6 There is an impressive body of evidence that many purchasing authorities are developing effective and original ways of involving NHS users and the wider public in their decision-making process. For Example:

(a) North Derbyshire Health Authority recruited a random sample of the community passers-by and invited groups of eight to ten individuals to attend a one and a half hour discussion group. Areas of investigation included: health problems within the locality; knowledge of the DHA structure and work; experience of services; attitudes towards health promotion; trade-offs between different types of services, and willingness to travel. The intention is to incorporate the results into the DHA's strategic reviews;

(b) Southampton and South West Hampshire Health Authority have set up a community relations working group within the purchasing team. Its aim is to build up a strategy for listening and informing local people in discussion with DHA non-executive members, the Family Health Services Authority (FHSA) and the CHC. Progress includes: a direct access telephone "healthline" to help people find their way around local health services and to register views; an "A to Z" of local health services, "Your Guide to Good Health"; the appointment of a community relations manager to take forward the DHA's links with the community;

(c) Wandsworth Health Authority set up workshops on palliative care services involving representatives from local providers, the CHC, voluntary groups (eg

bereavement organisations), carers, the local authority, the FHSA and the DHA. The purpose was to develop a shared understanding of the needs of patients, their families and carers and how best to meet those needs. The workshops identified areas for action which are being addressed in the DHA's purchasing plan;

(d) Wandsworth has also helped Wandsworth CHC establish a Community Care alliance of local voluntary groups. Alliance members are represented in the DHA's five community care planning teams (for the elderly, those with mental illness, learning difficulties, physical disability and who need home care). At least three voluntary bodies are represented in each planning team to ensure effective local input;

(e) West Dorset Health Authority has set up an initiative called Planned Approach to Community Health (PATCH). The DHA has been divided into eleven localities or PATCH areas based on natural communities or local towns. The aim is to develop direct links with local people, build up a local profile of issues such as health needs, user views and service preferences and to develop an action plan to improve local health. Community facilitators are being appointed to each PATCH area. Local views are being sought through local steering groups (involving representatives of statutory agencies, voluntary organisations, the CHC, churches, schools and local residences) and through ont-to-one interviews. The facilitator ensures that local views are conveyed to the DHA and that the community is informed of subsequent action.

2.4.7 Trusts, too, are using the results of public consultation to make innovative and imaginative improvements to services. For example:

(a) Premier Health NHS Trust have established a service users council and a number of mental health development groups, which assist in planning the development of mental health services and make services more responsive to users. As a result, St. Matthew's Hospital and the National Schizophrenia Fellowship have established "Premier Produce" to provide work and training opportunities for those with mental health problems;

(b) as a direct result of consulting patients, Staffordshire Ambulance Service have designed a fleet of thirteen new non-emergency vehicles which will provide greater safety and comfort for patients and staff. The fleet will be introduced in March 1993;

(c) In Oldham NHS Trust a Saturday speech therapy clinic has been organised in response to patients' wishes. Under another initiative, parents and children are given the opportunity to visit the hospital Saturday Club before admission to the paediatric ward, and are shown around the clinical areas. "Patient Teams" are organised, in which managers meet parents waiting for appointments to discuss improvements to services. This has resulted in improvements to car parking, extra disabled parking, improved appointment systems for certain clinics and a great variety in menu choice;

(d) Southend Community Care Service Trust has improved both patient and staff morale by involving them in decisions about the refurbishment of their wards;

(e) Harrogate Health Care are involving patients and staff in an initiative to improve facilities for disabled visitors, especially in relation to parking and signposting.

2.4.8 As part of the Government's commitment to a National Health Service which is responsive to people's views and needs, the NHSME will be issuing new guidance later this year on how the relationships between purchasers and providers and CHCs can help to enable public involvement and encourage high quality services.

2.5 *Development of purchasing consortia and locality purchasing*

2.5.1. The Committee refers to the emergence of consortia covering a number of health authorities and the concern that this takes purchasing decisions further away from the local community. The current configuration of many health authorities still largely reflects the different role they had prior to the introduction of a purchaser-provider system in the NHS. Some re-configuration of health authorities is proving necessary in order to achieve greater economies of scale, to facilitate joint working with other local agencies, particularly FHSAs, Local Authorities and the voluntary sector, to enable greater choice of services from more local providers, and to ensure that sound epidemiological projections (which often require a large population base) can be made. The NHSME's Priorities and Planning Guidance for 1993/94 makes clear, however, that Ministers will only be receptive to proposals for mergers between DHAs where the weight of opinion demonstrates that these are clearly in the interests of patients. Locality purchasing arrangements provide a way of reconciling the benefits of a larger purchasing organisation with the need to ensure sensitivity to local communities. In 1992 the NHSME commissioned the University of Birmingham Health Services Management Centre (HSMC) to examine different approaches to locality purchasing in a number of health authorities and to distil lessons which might be of help to other health authorities. The results of this work were published by the HSMC in November 1992 and have been disseminated to all health authorities by the NHSME.

2.6 *Information on costs, prices and outcomes*

2.6.1 The Committee refers to the need for information concerning costs, prices and outcomes of NHS services to become more sophisticated in order to enable purchasers to allocate their resources more effectively. All providers, including Trusts, are required to price their services in accordance with the principle that price must equal full (net) cost with no planned cross-subsidisation between contracts. In addition, all purchasers should expect to see efficiency gains demonstrated in a provider's costings. The NHSME actively encourages openness in the contracting process to facilitate this. Access to published provider tariffs also helps purchasers to make informed comparisons.

2.6.2 The need to improve costing and contracting has been highlighted in the NHSME's recent review of contracting and is being addressed by a National Steering Group on Costing. The review also revealed increasing efforts by purchasers to focus contracting on identified needs and intended health outcomes. Some purchasers have commenced pilot work in this area. In particular, Healthcare Related Groups (HRGs) are being studied to determine their clinical acceptability and relevance in this area. If the pilot projects prove successful, this will represent a major development in costing and will enable informed comparisons to be made between providers across a range of well defined areas of health care.

2.6.3 In addition, guidance is to be issued on minimum standards to ensure there is a common classification and treatment of the elements of providers' costs according to whether the cost is directly attributable, indirectly attributable or an overhead to the "contract category" being costed. The guidance will set out the acceptable standard method of apportioning indirect and overhead cost to contract categories. So as to understand the consequences of differing levels of activity, providers will separate out the elements of cost into their fixed, semi-fixed and variable components. Work is under way at six reference sites to test these standards in depth and to test the practicality of lower level contract categories based on HRGs. This work will lead to further guidance for the 1994-95 contracting round which will make the costing standards prescriptive and will set out the new recommended contract categories. It is intended that a prescriptive list of contract categories will be in operation in time for the 1995/96 contracting round.

2.6.4 Guidance is also to be issued covering the level of disclosure on detailed costing information that purchasers are entitled to expect from providers. This, combined with a more detailed and relevant breakdown of services being provided, will assist purchasers to judge more reliably the cost-effectiveness of providers.

2.6.5 The NHSME is also publishing a series of bulletins on effective health care and epidemiologically-based needs studies to ensure that information about the effectiveness and cost-effectiveness of different interventions is more accessible to health authorities.

Purchaser or Provider led?

2.7 The Government notes the Committee's intention of examining the respective roles of NHSME Outposts and RHAs. The Government is currently undertaking a review of the RHAs and NHSME Outposts. We will publish proposals in due course.

2.8 The Government has consistently stated that the new NHS is intended to be purchaser led. Purchasing is the means by which genuine health gain can be achieved. The Government wishes to see the purchaser role clarified vigorously and effectively so that the true potential of the health reforms can be realised. That is why the NHSME is working with purchasers to develop and strengthen their purchasing capabilities.

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