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Psychiatrists' experiences of trust status hospitals

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It is over a year since the Government introduced its reforms of the NHS and, despite surveys of consultant attitudes to these changes (Whitfield *et al*, 1989; Delamothe, 1990) and numerous letters to journals from those working in Trusts, there has been no attempt to systematically investigate the experiences of consultant psychiatrists working in NHS trusts. This information would be of use to those contemplating whether to countenance trust status for their own hospitals and those yet to make up their mind about their attitudes to the reforms.

There have been arguments that different specialties will be affected in contrasting ways by reform, and so it might be the case that consultant psychiatrists may have experiences, peculiar to the specialty, of the NHS changes.

For these reasons it was decided to survey all consultant psychiatrists in trust hospitals for their attitudes and experiences of NHS reform.

The study

Three months after the establishment of NHS trusts each consultant psychiatrist identified as a trust-employee, using the Department of Health Records and telephone contact with Trusts, was sent a short questionnaire consisting of nine questions plus half an A4 page of space for open-ended comments. One hundred and fifty-four consultant psychiatrists were identified as employed on in-patient units by hospital trusts and of these 111 or 72% responded.

Findings

Particulars of the results to the nine scaled questions are reported elsewhere (Bullmore *et al*, 1992) and only the open-ended comments of consultants' experiences are presented here. At least one consultant psychiatrist from each of the 22 Trusts providing hospital-based mental health services responded. More than five responses were received from 11 of the trusts. The responding sample comprised 75% men and 25% women and their median date of qualification was 1969.

As there were 68 open-ended comments the responses reproduced below are only a small sample. They have been selected to be representative of the overall tone of the experiences of consultant psychiatrists in Trust hospitals. In some cases these have been edited for reasons of space. Comments were selected on the basis of appearing to result from an actual experience of Trust status rather than a pre-formed opinion.

Positive experiences

An analysis of changes in attitude to trust status showed that there had been a statistically significant shift among consultants towards the view that psychiatry is adaptable to trust status (Bullmore *et al*, 1992). The reasons for this are illustrated by some of the positive comments received about Trust status.

"Things are happening which would never have happened without opting out – mostly for the good so far. A great deal of the fears I had prior to opting out have proved unfounded as yet, and this is also true of the benefits – they were empty promises (especially getting capital), but I did not anticipate the revolutionary changes within medical directorates – which may have less to do with Trust status – I'm not sure. On the whole, so far, so good."

"I've been in mental handicap for over 25 years and we've always been all the employers' poor relations, and been impotent to alter that fact; we never had any political clout and so were last in every queue ... Trust status has at last given us freedom after so many years of bondage ... I have nothing to do with any financial aspects (mercifully) ... it is not difficult to set our standards by consensus. The Board and Chief Executive are very good at leaving the medics to decide what we can and will do, always with a view to enhancing our patients' care. We are encouraged to teach, do in-service research, attend further education of all sorts to improve our practice. Our contracts are Whitley or better, no redundancies are (yet!) anticipated."

"Freedom from direct district and regional management procedures that took too long has enabled us to appoint a second child psychiatrist in not much more than a month from the decision being taken that this post was needed. This could never have happened under the old system as we should still be arguing about the job description and funding etc."

"As a former unit general manager I learnt an awful lot about fundamental flaws of management in the health service ... What has been tried down the years mainly tinkers around the edges – preserving vested interests – radical change of the Trust variety may be the only way of changing things."

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Neutral experiences

Twenty-five or 36% remarked that it was too early to judge the full effects of the change in administration and this number noted good and bad features of the changes so far.

"So far the trust has had very little impact on services – squeeze on money was in evidence well before trust status was conceived. I am amazed at the *lack* of impact. But we are currently in the first year when many contracts and arrangements have remained the same. The real 'crunch' will come in the second year."

"Little change as yet but staff are all much more motivated and positive, which is a help."

"There has been restriction on prescribing; there has been much pressure to deal with patients hastily in order to maintain maximum turnover; there has been inadequate resourcing of community facilities; in-patient facilities, i.e. ward environment has improved."

"I am marginally in favour of our unit opting out because of the capital management improvement given the forced choice – but I am strongly opposed to the trust idea as a whole . . . Our trust is improving its management structure but it feels to be a desperate attempt to survive rather than a positive move!"

Negative experiences

The major statistical finding has been that there was a significant excess of negative feeling over positive towards trust status (Bullmore *et al*, 1992), and is reflected in the number of negative experiences reported in the open-ended comments. Some experiences illustrated that several effects of trust status may be unexpected, in particular the increased conflict with management noted by many respondents.

"At our hospital we have had to 'rate' other consultant firms (or groups of firms) on such questions as 'marketability', 'social responsibility', 'expendability', etc. This has had a divisive effect and resulted in consultants arguing among themselves about where cuts are to be made – rather than the consultant body presenting a concerted opposition to such change (or concerted support)."

"A plan to close our specialist ward to expand private surgery as income generation for the trust was only thwarted by sustained internal objection from physicians and ourselves, political pressure and press leaks."

". . . the managerial lack of interest in consultants' views and opinions remains a major concern."

"There will be no choice for the patient to select his own consultant or particularly his own hospital, where he wants to be treated. If he wants this he will be asked to pay for it. GPs will prefer cheap and nearby hospitals rather than high quality hospitals. Managers are all powerful and there will be no job protection. They can hire and fire, as there will be no NHS terms and conditions and protection will be under common industrial law. Morale of staff has gone down, and they work with fear. At this hospital 66.6% of consultants were against opting out. Opting out has been thrust upon them by the Government on the application made by the managers."

"There is a general sense of insecurity and instability which may be linked with becoming a Trust. The role of the division of psychiatry is diminished."

Twenty-eight or 41% complained of increased administrative responsibilities as the following comments illustrate:

"As a clinical director, the most overwhelming issue is the phenomenal amount of time that has to be spent on managerial/administrative issues. Bureaucracy may have been reduced in structural terms, but has escalated out of all proportion at the 'workface'! The problem of having to deal with various bits of legislation in social policy that seems to be in conflict with each other is nightmarish. The uncertainty about contracting etc creates great anxiety. These radical changes are under-resourced. The rules are being made up as we go along. The lack of forethought is infuriating."

"Administrators up; patient beds down; paperwork up; care of patients down; community care appalling; generally not in the best interests of patients."

"The strains of increased management function have significantly affected patient contact and teaching time, the nursing staff are already demoralised, the job evaluation programme has been started with no real consultation so the unions and others are paranoid. Mostly at present we're still in the dark. Budgets change mysteriously, contracting hasn't really started, the inertia and hostility in introducing management changes is enormous. Generally life is very little different except that the budget has been eroded by various not very overhand means. I approve in general of the aims of the reforms. NHS Trusts are irrelevant to achieving these aims. The reforms as implemented are hugely under-resourced and will either collapse or lead to burn-out."

Finance, of course, provided major complaints; 26 or 38% complained that under-funding had not been improved by the trust status.

"The promise of extra finance seems to be evaporating and the process of cutting services to provide better patient care continues as before."

"I fear the worst . . . Costing the care of chronic schizophrenic patients seems an impossible exercise and they are likely to end up losing out."

". . . there is no overall increase in investment in health for the people of this district . . ."

"It may be that psychiatry will bear the brunt of overspending in other areas."

"I am quite certain that the process of becoming a SGT hospital will make it much more difficult to develop a more community based general psychiatry service. Already our unit is £56,000 over-spent in the first four months of this financial year, resulting in frozen posts and service cuts. Ideologically, I am utterly opposed to SGTs as a result of which I have resigned my post, and am about to start a new job in a non-trust service."

Twenty-one or 30% felt that the introduction of purchaser/provider contracts was more significant than the establishment of NHS trusts in terms of impact on clinical practice.

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"The real impact of the White Paper on psychiatry will come from the contracting process and how purchasers/providers and users/patients handle this process; this process applies equally to Directly Managed Units as to Trusts."

"The changes inherent with the new regime with health authorities as purchasers are much bigger than were differences between trusts and directly managed units."

"One general practice felt they could employ their own consultant on a sessional basis and hence save money! My own unit will now not attract national referrals – they are costed as £12,000 a month."

"The move to autonomous multiple provider units is leading to fragmented services and militates against rational long-term planning. The lack of direct control over trusts and their increasing number is likely to lead to duplication of expensive resources as units vie with each other for the 'high tech' market and thus less efficient use of the overall resources available to the NHS. The introduction of contracting now means that the main forms of debate on service provision is financially driven and because of the nature of trusts these are likely to feel the financial pressures more keenly. This sort of competition always disadvantages the 'Cinderella' services. The changes as a whole are likely to divert resources from clinical care to management and administrators and the pressure to do this will be greater in trusts as they are not protected by being under the umbrella of district health authorities."

The management and not the staff took the decision to opt out. The point they were right about was that it did protect the money from land sales and keep it within the MHU. However consultant appointment committees are now 50% board members. The purchaser has strong political views, e.g. they don't want a DGH unit we have been planning. This year the service has not changed but next year things look less certain. We are being told we will be charging other districts who refer to us which is a shame as our teaching centre has been trying to be acceptable to non-teaching hospital consultants."

"Limits on clinical freedom include referral to outside specialist units, which are expensive. This is a consequence of the purchaser-provider separation, not strictly of Trust status."

"The system of extra-contractual funding is not working and about half of our patients are not getting the treatment they need. It is making it difficult for us to continue functioning and the patients are deprived of treatment."

Conclusion

From these verbatim comments it is apparent there has been a wide contrast in the experiences of consultant psychiatrists of trust status, ranging from the extremely positive to the deeply negative. It may be that the impact of trust status will differ depending on the particular hospital and circumstances of the unit involved. This would suggest that further research is needed into what determines the outcome of the introduction of trust status.

A problem with using these consultants' experiences is that while it has become apparent there will be local gainers and losers, they tell us little about the impact of trust status on the health service as a whole. Furthermore, this was a study of consultant psychiatrists' experience of NHS trust status and surveys of patients' experiences, although perhaps even more important, have yet to be done.

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