Freeman hospital: countdown to self government

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We are three weeks away from the beginning of what will be the most profound change in the NHS since its birth over 40 years ago—and the whole world is watching. Many countries are struggling to find more cost effective ways of delivering health care, and they will be as interested as the British to see whether the NHS experiment will enhance or destroy the service. As one of our contributions to monitoring the changes we have identified an NHS trust, a predominantly urban and a predominantly rural health district, and a fund holding practice. The experiences of each will be described in a series running over the next four weeks, and we will then plan to return to them several times over the next few years. We are grateful to the doctors, managers, and others who have been generous with their hard pressed time and spoken to us frankly. We begin today with an account of the Freeman group of hospitals in Newcastle upon Tyne, which has become an NHS trust.

The Freeman hospital in Newcastle upon Tyne has always been surplus to requirements. In one sense this makes it an ideal candidate to become self governing (as it will be from 1 April). But in another it makes it uniquely vulnerable.

Twenty years ago, when the hospital was being planned, local consultants got up a petition to oppose it. What did a city of only 280 000 people want with a third teaching hospital, which was likely to suck resources away from the two existing ones—the Royal Victoria Infirmary and the Newcastle General? They lost the argument, and the Freeman hospital opened in 1977. But to justify its existence it had to offer new or better services than were available elsewhere. It quickly became a centre of excellence for the Northern region, developed an international reputation in heart and lung medicine, and now draws two thirds of its patients from outside Newcastle District Health Authority (table).

The hospital already draws patients from all 16 districts within the Northern region, so its task is to expand its existing markets rather than—and this is more difficult—creating new ones. On the other hand, outlying district health authorities will want to develop local services—to reduce costs and improve accessibility for their local populations—which may draw patients away from the Freeman.

"We could be in conflict with neighbouring health authorities," admitted Len Fenwick, general manager of the hospital. But it is the scent of opportunity, not anxiety, that is in the air. He is already distributing glossy leaflets advertising lithotripsy and other specialist services to libraries and general practitioner's surgeries. He is planning to open departments at evenings and weekends "if the demand is there." But though managers remain determinedly optimistic about the future and medical staff cautiously so, there is a powerful sense from all sides of people feeling their way in the dark.

Lack of information

The information on which contracts for services are to be based is simply not available. A matter of weeks before "D Day" (1 April) the hospital has still not produced a price list. Specialist managers—nurses

Statistics for Freeman Group of Hospitals (including Walker Gate Hospital and disablement services centre)

Budget: £50m
No of beds: 980
Medical staff: 250 (100 of whom are consultants)
Nursing and midwifery staff: 1200
Inpatients (1989-90): 32 000 (elective admissions: 70%)
Day cases (1989-90): 10 000
Outpatients: 123 000
Waiting lists: generally good (Newcastle is well provided with hospitals) but worst in ophthalmology, orthopaedics, and urology

Where the Freeman's patients come from

Region	% Of patients
Newcastle	33.6
Northumberland	16.9
North Tyneside	16.4
Gateshead	8.7
South Tyneside	4.6
Sunderland	4.3
Durham	3.4
Northwest Durham	2.4
East Cumbria	1.8
Southwest Durham	1.7
South Tees	1.6
North Tees	1.2
West Cumbria	1.1
Darlington	1.0
Outside region	0.7
Hartlepool	0.4
South Cumbria	0.2

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responsible for handling the budget for each of the main specialties—complain that they are overwhelmed with requests for information from potential purchasers. "If a health authority asks can we do an extra 100 ear, nose, and throat cases it is not just a matter of checking on bed availability and theatre lists," said one. "We have to take account of anaesthetists' time, nurses, porters, lab facilities and so on. We can't cope."

The Freeman is one of six hospitals selected to pioneer computerised information systems under the resource management initiative over the past six years. Its experience makes you fear for those not so blessed. Even basic information—such as which district patients come from, how long they have been waiting, and which general practitioner has referred them—has to be retrieved manually, which consumes precious time. The postcode and general practitioner of all the 30 000 inpatients and 10 000 day patients has to be checked manually so that the appropriate health authority can be billed. Yet it is still unclear whether it is the address of the patient or of the referring general practitioner that will count. In many cases postcode boundaries do not follow district health authority boundaries, complicating matters further.

"The idea of starting contracts from 1 April is a joke," a senior surgeon said. "They will be notional contracts only. We understand how to do it but the infrastructure to provide the information isn't there. It is going to cost a fortune." Mr Len Fenwick said that the difficulties were "frustrating." Tony Jameson, director of corporate planning and contracts at Newcastle Health Authority, said: "The information system is certainly not as robust as we would wish it to be." Progress to more sophisticated pricing was bound to be patchy. "That issue is going to be a main constraint on the progress of the reforms."

The most disturbing observation came from Newcastle's only general practitioner fundholder, the practice of Dr Robert Chalmers and partners in Gosforth. "We have had a superb response from the Freeman," said practice manager Maureen Rillens. "Their information is much better than that from other hospitals." It is a stark comment on the unpreparedness of most of the NHS as it faces the biggest upheaval in its history.

Freeman hospital

Pricing the contracts

Because most hospitals have information systems that are even less sophisticated than the Freeman's, the Northern region has ruled that services will initially be priced on the basis of average costs in each specialty—so purchasers will be charged the same for grommet insertion as for rhinoplasty. Even this limited exercise has already thrown up "quite wild anomalies," according to Mr Jameson, with price variations of up to 50% among units. "It may be the expensive ones perform more complex procedures or it may be they spend far too much on lab investigations," he said.

In the first year, health authorities are pledged to retain historical patterns of referral in order to create "minimum turbulence." But beyond that Mr Jameson knows what he is aiming at. "Newcastle patients get a general hospital service in expensive tertiary facilities. What we need is a sufficiently sophisticated pricing mechanism so that we aren't paying tertiary level prices for secondary level care." He is also anxious that his block contracts—which specify six quality measures for each specialty, such as waiting times and communication with general practitioners—should not be used to subsidise purchasers at the margin, particularly general practitioner fundholders. But hospitals, as he acknowledges, will be under pressure to offer special deals to attract extra business at the margin. That is what markets are about.

Another of his aims is that the Freeman should succeed. "The more successful it is the more business it will get, the better the rates it will charge next year, and the greater the benefit to the local community." The health authority has had great difficulty looking after three large units in the past, it has been overspent and has had to cut beds. "The future of the three depends on their being well positioned, regionally and nationally."

In pricing its services, the Freeman faces similar difficulties. Last September the hospital installed its first lithotripter (cost £850 000). How much should it charge for its use? A charge of £400 a patient would pay the running costs but £500-£600 is necessary to recover the capital investment. Similar machines in Leeds, Manchester, and Edinburgh, have been bought with charitable donations, however, and these hospitals can therefore afford to charge running costs only. "It is a classic example of competition," said Peter Ramsden, consultant urologist. It also illustrates how hospitals with large charitable incomes will enjoy a double advantage in the post reform NHS: once from the

money donated and twice because it will enable the hospital to set lower prices and attract extra business.

Profits, pay, and incentives

The Freeman will never make a profit. It may, however, make a "surplus," if things go according to plan. How will it be spent? According to Mr Fenwick, "understandings have emerged" over what proportion of any surplus will be kept by the department that makes it and what proportion will go into central funds. He would not reveal details, but it was clear that there had got to be "some motivation" for staff to improve productivity.

First in the queue for extra resources will be Dr Lakkur Murthy, clinical head of radiological services. The workload of his department has gone up by leaps and bounds over the past decade so that it is now very understaffed. "By Royal College of Radiologists guidelines we are four and a half posts short based on the workload and expectations of a teaching hospital," he said. But the mechanism for increasing manpower in the past has been cumbersome. "We are waiting for the first trust meeting to give us the green signal to advertise for at least one consultant radiologist," he said. "We can't run this department on goodwill indefinitely."

Radiology, like many departments, is under such pressure there will be no question of its seeking new work. But pathology, which has had cuts imposed on it by the health authority in recent years, is already targeting private hospitals, drug companies, occupational health schemes, and food manufacturers, offering to take over their laboratory work. "We want to work in an efficient, nice lab with up to date equipment and offer a good service, and over the last few years we have seen that eroded," said Dr Kate Gould, chair of the pathology executive. If the department was successful benefits for staff might be improved too, she said.

Staffing and pay anomalies are crying out for resolution. The hospital's activity rate has increased by 28% since 1988, but only eight extra nurses have been employed. Members of the heart transplant team receive four different rates of call out pay. Nurses on stand by are paid the extraordinary sum of £2.60 for an eight hour stint spent beside a phone. If called out at the weekend they are paid time and a third, whereas the perfusionists get double time. "I could see some benefit in changing all that," said Andrew Beeston, patient services director and the Freeman's chief nurse, with commendable understatement.

Changes in provision

An unanswered question is how the services being offered by the Freeman may change in response to market pressures. Besides being a specialist centre the hospital has always also provided a general hospital service to east Newcastle. Mr Fenwick echoed the prevailing view among medical staff: "The hospital cannot be all things to all people. It will strive to do the things it's best at. It is primarily a tertiary care centre. But it needs to secure an adequate amount of routine work for education and research. We are trying to strike the right balance."

How realistic that will prove to be remains to be seen. Managers in outlying districts are sceptical. "It has always been our plan to pull work away from Newcastle and provide more services locally," said John O'Brien, district general manager of Northumberland health authority. "The Freeman may change their profile not because they want to but because they are forced to," said Gareth Jones, district general manager in North Tyneside. The Community Health Council is

also anxious that the provision of routine services to local people will be undermined.

Peter Wright, clinical head of general surgery, said: "We may have to decide we don't want to do some of the mundane surgery like amputations. They may be better done in the local district." But some consultants are worried that changes like this could lead to lower standards. "If provision is switched to allow the Freeman to concentrate on something more technically complex, we have got to ensure the service to the patients is not affected," said Dr Ian Griffiths, consultant rheumatologist, the hospital's elected medical director, and member of the trust's board. "The only way you can check that quality does not suffer is with medical audit, but the worry I have is whether it is sufficiently robust to take on a policing role."

But most consultants look forward to greater flexibility in the way that they organise their work. "There are rigid divisions between the specialties at the moment," said Mr Wright. "We could change the configuration of wards. We could envisage the whole first floor as a day care unit. We could have five day wards, overnight wards, an open endoscopy service. The organisation will have the freedom to decide its own priorities."

Attitudes of staff

Like doctors elsewhere, consultants at the Freeman initially opposed the NHS reforms. But later in a ballot on whether the hospital should apply for self governing status, 85% of full time and "a small majority" of part-time consultants voted in favour. "In the end it came down to what's the best deal for the Freeman," said one. Many remain sceptical, however, that the promised benefits will be forthcoming.

Nurses have never been balloted but are "anxious about their jobs," according to the local branch of the Royal College of Nursing. Unlike many large cities, Newcastle has a surfeit of nurses and the Freeman has a waiting list for applicants. But senior nurses who are specialty managers believe that the introduction of the market will give them more power. "We have been very much dictated to by the clinicians in the past," said one. "In the future we will be able to plan more effectively for the workload so wards aren't left half empty. In a ballot of ancillary staff, 78% voted against the hospital's seeking self governing status on a turnout of 56%.

View from outside

Local general practitioners voted 85% against the plan for the city's hospitals to go self governing. "They were not convinced that the new arrangements were going to be better for their patients," said Dr Tim Van Zwanenborg, deputy chairman of Newcastle Local Medical Committee. Only one practice in the city (population 280 000) has opted to become a fundholder compared with eight in Northumberland (population 340 000). General practitioners in Northumberland want to secure their right to continue referring their patients to Newcastle. Newcastle general practitioners do not have to worry.

The real test of the reforms for general practitioners will be how far the health authority is prepared to challenge "set ways of doing things," said Dr Van

Zwanenborg. There could be conflicts of interest. Diabetic patients, for instance, are better cared for in the community. But efforts to improve general practitioner care of diabetics could reduce an important source of income for hospitals. Which approach will the health authority back? "That is the acid test," said Dr Van Zwanenborg.

Tony Jameson, for the health authority, accepts the challenge. Plans are already being laid to give general practitioners direct access to physiotherapy, under agreed referral protocols, to free up the long orthopaedic waiting lists. But he is realistic enough to recognise that shifting services into the community is "only possible with growth money." None the less, the potential for change over the next five years is "very exciting," he said.

The city's only fundholding practice is equally optimistic. "We are in on the ground floor," said Dr Chalmers, senior partner. "We are confident we will get maximum help because this is an inaugural thing." Already the practice has secured direct access to physiotherapy and laboratory services and has been promised it to radiology at the Freeman. "They told us they would treat us like their own consultants," said Maureen Rillens, the brains behind the computerised budgeting system. The delicate question is whether their patients will get priority treatment, or even jump the queue. Nothing is said, but it would be easy to make the assumption. "It's a brave new world, a door is opening that we never saw before," said Ms Rillens. "Now other hospitals are having to follow along. The Freeman is acting as a catalyst for change."

District general managers in outlying districts insist that it is the general practitioners who will dictate the pace of change. "We have gone to enormous lengths to find out where GPs want contracts placed," said Mr O'Brien, manager in Northumberland. Competition for patients will nevertheless intensify over the next few years. New hospital developments are underway in Ashington and Hexham, Northumberland, and north Tyneside. "Access for our GPs to local services could improve," said Mr Jones, manager in north Tyneside, "and the Freeman could come to seem expensive. It could face some degree of vulnerability there."

But only the Community Health Council seems nervous. It has two principal fears, according to chairman Keven Bellis: that the health authority will lose control of the Freeman, allowing it to expand at the expense of other local services and that this will lead to more resources being swallowed up by acute care. "The Freeman is the best prepared of Newcastle's hospitals to go self governing," said Mr Bellis. "But it is also the most predatory."

"If the reforms work as they should they will demonstrate the quality of the service available and the level of the unmet need," said Mr Fenwick. "It will force the NHS to plan and prioritise and put the service under closer scrutiny than ever before." But his fear is that the reforms will turn into a "bureaucratic paper-chase." The main problem is the "cosy parochial relationship" between district general hospitals and their conterminous health authorities. Mr Fenwick cannot wait to flex his considerable muscle in the market place. But he is careful to moderate his enthusiasm. "The NHS is caught in an efficiency trap with no incentive to improve," he said. "The market is the way forward to give it a gentle shake."