The New NHS: six months on

The Freeman Hospital

Jeremy Laurance

Earlier this year we visited four parts of the NHS—two districts, a trust hospital, and a GP fundholder—as they made their preparations for the introduction of the internal market on 1 April. This summer we revisited them to see how the first few months had gone. We start this week with Jeremy Laurance's account of how the Freeman Hospital in Newcastle is faring as a self governing trust.

The quality of a hospital is measured by the size of its car park to judge by early responses to the NHS reforms in Newcastle.

You can take this as a demonstration of the reforms' effectiveness or their bankruptcy, according to taste. But to Dr Robert Chalmers and partners, the city's only GP fundholders, in Gosforth, it was a surprise. The practice has block contracts with Newcastle's three teaching hospitals but has been allowing its patients to choose where they are referred—and an unexpectedly large number have been opting for the district general hospital in North Tyneside. "There is plenty of parking there while the teaching hospitals clamp you," said Maureen Rillens, practice manager. "We will probably have a contract with North Tyneside next year."

Patients may have difficulty telling encephalitis from endocarditis but they know how long a bus ride it takes to find someone who can. "We forget that a lot of people who come into hospital are ill," said Tony Jameson, acting district general manager at North Tyneside Health Authority (formerly contracts manager at Newcastle). "Convenience, access, and a genuine sensitivity to patients' needs matter. These were always values we held but now they are in the forefront of our minds. We were systems and services focused rather than patient focused. There has been a complete reorientation."

Len Fenwick, general manager of the Freeman Hospital, which became a self governing trust on 1 April, confirms the change. "In the last few months we have become much more sensitive to how we receive patients," he said. "We are upgrading the entrance hall and outpatients and we have looked at the quality of reception, staff attitudes, and the timing of appointments."

The changes at the Freeman are not only cosmetic, however. The ones behind the scenes that will ultimately matter most have already thrown up some difficult dilemmas. The most serious is that acute medical admissions are running 35% above the contracted level. "It means we are not meeting our contracts in other areas," said Dr Ian Griffiths, consultant rheumatologist and elected medical director of the hospital, "and it raises one of the spectres of the reforms: do we get paid for the extra work?"

The excess admissions are the result of bed closures elsewhere in Newcastle. Some surgical subspecialties

at the Freeman are falling behind with their work as a result, but overall activity is up by 4.4% according to Mr Fenwick. "The question now is does the trust increase its capacity [in medical beds] for the winter and can the increase be afforded by the purchasers," he said. For the first time the gap between demand and supply would be clearly articulated and could be openly debated. "It's the reforms in action."

But Bernard Canning, director of management at Newcastle Health Authority, denied that the 35% excess would cost the Freeman more. "If they are 35% up in medical, it follows that they must be down elsewhere. Surgery generally costs more... it could be they end up owing us money. The problem is that we have been underresourced for years. We haven't got any more money, we can only move it around. At the end of the day we still face the same old problems."

GP fundholders are experiencing financial problems too. They have complained to the Northern Regional Health Authority that the prices charged by the teaching hospitals are higher than expected when their budgets were set. Several, including the Gosforth practice, have asked for an increase. "The region has been very understanding," said Ms Rillens.

If the increase is not forthcoming or prices are not adjusted downwards it will concentrate their minds powerfully when it comes to negotiating next year's contracts. Ms Rillens has been heavily canvassed for the practice's business by other hospitals. "I am keeping a list of all the phone calls, brochures, and comments I receive," she said. "Next year it's a whole new ball game."

The Freeman had said it would treat the practice as if they were consultants and had "lived up to that promise superbly," said Ms Rillens. The general practitioners had direct access to radiography and, in urgent cases, could refer patients to be seen the same day by the consultant on the ward. Relations with consultants had grown closer, she said. "They have realised they have got to chat to GPs."

These benefits are apparently equally available to non-fundholders. "There is no evidence that fundholders are being treated differently from any other practice," said general practitioner Dr Chris Drinkwater, a member of Newcastle's local medical committee, "But there is concern that competition might drive some services to the wall."

However, most of those involved with the Freeman, on both sides of the purchaser-provider divide, are cautiously optimistic about the future. While admitting to teething problems, everyone tries hard to sound upbeat and enthusiastic. "I don't think there is anyone saying 'Oh my God, what a mistake,'" said Dr Griffiths, the medical director.

The hospital has had the advantage of six years'

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experience pioneering computerised information systems under the resource management initiative. This shows in its price list, which is more detailed than those of some of its competitors, giving individual prices per procedure in many cases in place of the cruder average specialty costings. Its prices appear lower than average in general surgery; ear, nose, and throat surgery; and ophthalmology but higher than average in urology and orthopaedics.

"A lot of hospitals are not costing properly," said Mr Fenwick. "They still regard capital as a free good. We are working to real costs but some are still working to Mickey Mouse costs. We must ensure we are comparing like with like." He denies that any of the Freeman's prices are badly out of line. But Ms Rillens of the Gosforth practice claims that some are unrealistic, such as £1300 for a sebaceous cyst, which can be done in the surgery for a fraction of the price, and—what appears to be a mistake—£12 000 for removing a pin in a bone.

On billing, the toughest area has been outpatients because of the difficulty of classifying cases. "You have got to have a diagnosis to hang your hat on," said Mr Fenwick. Extracontractual referrals have also proved difficult to identify in time to bill the referrer, and obtain approval, before administering treatment. In

general, however, the administration was coping well, he said.

There have been some tangible benefits. The hospital has bought a £350 000 computed tomographic scanner, made possible by the freeing up of capital under the reforms, and appointed a locum radiologist to run it. Agreement has been reached to appoint an extra consultant cardiothoracic anaesthetist and an extra staff grade anaesthetist. The pathology department has picked up "a couple of small private contracts from local industry," according to Dr Kate Gould, chair of the pathology executive. But Dr Lakkur Murthy, clinical head of radiology, is still awaiting trust board approval to appoint the extra consultant radiologist he urgently needs.

Mr Fenwick is tentatively exploring ideas for a new "reward strategy" to recognise high productivity. "There has got to be recognition for achievement," he said. He is also considering evening and weekend working in "a couple of surgical subspecialties."

But he has faced difficulties negotiating contracts for next year. Health authorities are taking their time to think about what they want. "I find it frustrating. Our three year business plan is quite vulnerable. When I say let's talk about the next three years they are very hesitant."

The Health of the Nation: responses

Alcohol as a key area

Peter Anderson

Alcohol satisfies the government's criteria for inclusion as a key area and should form part of a health strategy for England.¹ Alcohol consumption is a major cause of premature death and avoidable ill health in the whole population; effective interventions are possible for reducing alcohol consumption which offer significant scope for improvement in health. Objectives and targets related to alcohol consumption can be set, and progress towards them can be monitored.

and excise, routine national data are available for trade and production of alcohol from which alcohol consumption per person can be calculated.⁹ Regular national surveys of drinking habits are provided by the general household survey¹⁰ and ad hoc but frequent inquiries of drinking are undertaken by the Social Survey Division of the Office of Population Censuses and Surveys.¹¹ Other targets should relate to reducing risk, state of health, and provision of services.

Burden of ill health

The harms related to alcohol consumption are many and act at both population and individual levels.^{2,5} They include physical ill health; psychological ill health; public disorder, violence, and crime; family disputes; child neglect and abuse; road traffic accidents; accidents at work and in the home; fire; drowning; and employment problems. The total costs of harm to society are difficult to estimate. Economic costs for the United Kingdom related to alcohol consumption are more than £2 billion annually,⁶ and estimates of the deaths attributable to alcohol consumption in England and Wales vary from 5000 to 40 000.⁷

At population and individual levels as alcohol consumption increases harm increases and as consumption decreases so does harm. This is illustrated by what happened in the United Kingdom in 1981-2, when consumption of alcohol fell from 10.4 litres of pure alcohol per adult to 9.2 litres. The fall was associated with an 11% reduction in convictions for drunkenness, an 8% fall in drinking and driving convictions, and a 4% fall in deaths from liver cirrhosis.⁸

Setting and monitoring targets

Many different types of targets can be set. One target should relate to alcohol consumption. Because of tax

Risk reduction

Changes in consumption affect drinkers at all levels of consumption. The mean alcohol consumption of a community and the prevalence of heavy drinking are highly correlated ($r=0.97$), such that a mean reduction of alcohol consumption of 10% would correspond with a fall of about 10% in the numbers of heavy drinkers.¹² A Scottish study showed that after a substantial rise in the price of alcoholic beverages in the 1981 budget heavy and problem drinkers reduced their consumption in parallel with more modest consumers.¹³

Although heavy drinkers have a higher proportion of problems than other drinkers the contribution of heavy drinkers to the total number of alcohol related problems in the country is small. Most alcohol related problems occur in large numbers of light and moderate drinkers, although only a small proportion of such drinkers have alcohol related problems.¹⁴ Thus two possible strategies exist to reduce risk: to target preventive activity at those identified as being heavy drinkers (the high risk approach) or to attempt to reduce consumption across the whole population.

The high risk approach is concerned with identifying and helping minorities with special problems by treating their risk factors or seeking changes in their behaviour. The aim is to truncate the risk distribution related to alcohol consumption, eliminating the high tail but not interfering with the rest of the population.¹⁵

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