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The New NHS: The Second Year

East Birmingham: all change

Tony Delamothe

This is the second article in our re-examination of the NHS reforms at the end of their second year

On my fourth visit to East Birmingham to track the course of the NHS reforms, I expected to find them "bedding down," with little new to report over my visit of a year ago.¹⁻³ But I could hardly have been more mistaken. My three contacts within the East Birmingham Health Authority (chief executive, director of corporate management, and director of public health) expected to be out of a job from next April, when East Birmingham was meant to merge with North and West Birmingham Health Authorities. (The region has since put these plans on hold.)

East Birmingham's Yardley Green unit had failed at the eleventh hour in its trust application. Its services for elderly people are moving across the road to the trust hospital; its mental health services are throwing in their lot with providers of similar services in North and West Birmingham Health Authorities and applying for trust status. The community unit is doing the same.

Previously East Birmingham had no fundholders within its boundaries (although outside practices referred patients to its providers). Now, fearful that a newly merged health authority might be out of touch with general practitioners and unhappy about the development of a two tier system of care, nearly 80 general practices from West, North, and East Birmingham had expressed an interest in becoming fundholders as part of a "multifund."⁴ And a new regional chairman had been appointed whose enthusiasm for the reforms was already having effects.

Heartlands

Even East Birmingham Hospital had changed its name—to Birmingham Heartlands Hospital, after a development area some miles down the road. In 1992-3, its first year as a trust, it was expecting to end in balance, having met all its financial targets. According to Robert Naylor, chief executive, the hospital had overperformed its contracts by about 4% (equivalent to an extra 1500 inpatients). That had brought down most waiting times to less than 12 months compared with many of more than 24 months a year ago.

Last month's closure of the Birmingham General Hospital to general patients was expected to benefit them: the Audit Commission had estimated that about a third of them would come to Heartlands. On the basis of this three new wards (providing 75 beds) will be added to the trust's complement. Naylor had been instrumental in organising a Birmingham-wide deal that money from emergency admissions would be shared out pro rata by local hospitals. "This year we've overperformed all our emergency contracts but have got no extra money for them," said Naylor. "We have

said for next year that we will continue to treat patients only if we get paid for them. We want to move to cost and volume contracts across the whole range of services because that means that the risk is shared with the purchaser. With block contracts purchasers have no risk: all of it is held by the provider.

"From April we will be encouraging emergency patients to come here because we will get paid for every additional patient that we treat. In the past we tried to minimise the number of patients we had to treat because we got paid the same amount of money for it. To encourage more patients to come here we will have to review our quality standards and put more effort into providing better quality care. At the end of the day that's what the reforms were about—to provide incentives for people to provide better services, to be more responsive to patients."

At present Naylor was contemplating replacing the line of managerial accountability that ran through managers ("with years of management experience") with one that ran through clinicians ("some of whom have only a few months' experience"). In this American model clinicians would be answerable to a medical director, who would play a much greater part in trust board decisions than the current medical director is allowed to do. "Whichever one we go for will dictate the relative status and roles of all the clinicians involved in management in the hospital," said Naylor. "Having clinicians rather than senior managers making the key decisions is a potentially high risk strategy."

More tangible evidence of structural changes to Heartlands is easy to find. A maternity unit and new operating theatres have opened, and building has begun on a new accident and emergency department. The region had already allocated this money to the hospital before it became a trust, but if the hospital hadn't been granted trust status the capital schemes would have been frozen—as they had been elsewhere in the west Midlands. Building was about to begin on a new day case surgery unit, "something we've wanted to do for years but have never had the capital for."

New outpatient departments for ophthalmology and AIDS and an extension to pathology had either happened or were about to begin. The trust had put up "a strong business case" to replace its back wards: if not funded from the public purse then private funding would be explored. Of five substantial new developments—all of which the hospital had wanted previously—Naylor doubts that any more than two would have been funded under the old arrangements.

Later this year a new renal unit opens. The hospital had entered a competition for "substantial funds" provided by an anonymous donor, and its proposal

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was judged the best. Later, Glaxo emerged as the benefactor.

Naylor tells people who want to know what the benefits of becoming a trust are to go outside and look at all the new buildings going up. "A couple of years ago more than 90% of the staff objected to us becoming a trust: now it's no longer an issue. People accept that we haven't short-changed staff, we haven't made staff redundant, and all around them they can see new buildings going up and new services coming on stream. From that point of view it's a very positive environment, particularly when you look at what's happening around us. In South Birmingham they're closing wards and hospitals and making staff redundant. So it's really very easy for me at the moment to demonstrate the benefits of trust status."

Embarrassment of riches

The builders were also in at the Craig Croft practice, now entering its third year of fundholding. About two thirds of its first year's savings of £66 000 were going towards a new extension, providing an extra consulting room, treatment area for day case surgery, nurse interview room, and common room/library.

Of more concern to the practice than working amid a building site was its savings in its second year of fundholding; a "horrendously large" £200 000. Only a fifth of this came from savings on the drug budget (attributable to the computer defaulting to a generic preparation unless the prescriber intervened). According to partner Dr Ken Dawson most of it came from the region getting the practice's figures for hospital services wrong. This was explained by the region scaling up their allocation to take account of hospital episodes uncoded by general practitioner. (Dawson's figures suggest no justification for this, at least in his practice.)

The practice was initially concerned that it was under-referring patients—but graphs in the practice's business plan suggest increasing activity since the year before fundholding began. Embarrassed by the overshoot they are returning £70 000 to the region. "At the end of the day it's health service money, and what's the point of us being awash with funds and the district scrambling around looking for it because it's been topsliced from them," said Dr Dawson.

The practice spent some of its money getting waiting lists down to no more than 12 months. Slightly unconventionally, it paid Solihull twice the going rate for a dozen tonsillectomies on their patients on condition that Solihull would admit a dozen patients from non-fundholding practices for surgery. "We got pretty badly hammered by our colleagues in Birmingham, who said that patronage is no way to run the health service. Fair comment, but it wasn't meant to be patronising—it was meant to try to get this concordat [to maintain the viability of Solihull General Hospital] kicked off."

Because neither Birmingham Heartlands nor the Solihull Eye Hospital could oblige them they referred seven patients to the local BUPA hospital for removal of cataracts. Although the operations were marginally cheaper than they would have been on the NHS, Dawson didn't like NHS money going to the private sector. "But if it gets us within our business plan of all cataracts done within a year then I'm happy to do that."

In future Dawson sees the function of his practice moving from providing primary care to providing some aspects of secondary care in the community. This means more in house consultant clinics. Craig Croft has had regular general surgical clinics since it became a fundholding practice and hopes to add cardiology and ear, nose, and throat surgery. Unlike some practices that insisted on consultants he wanted mixed consultant-registrar clinics, mainly because teaching would be an important part of the experience. "The interface between GP and registrar, registrar and primary care, and consultant and GP—the whole thing could work to everyone's benefit." He doesn't expect the exercise to be any cheaper than if patients attended hospital, but it will be more convenient for them.

How did Dr Dawson feel about being able to provide a service so much better than non-fundholders could provide? "To me that's an incentive for other practices to say 'I must get into it.' With any new system there are bound to be areas of inequality until it evens out. What I would hate is for it to go backwards and say well if everybody can't have it then nobody can have it."

"At present it's very fluid because not everybody's in the system, and they're featherbedding everybody," he said. "Things will change when you get up to 100% fundholding, which will happen in the next two to three years." He thinks that fundholding is providing a more cost effective cake, "but at the end of the day, whichever way you look at it, it's still the same sized cake."

He believes that merging family health services authorities and district health authorities would be logical. After that Dawson would like fundholders to be involved in long term strategy rather than at present, when they work to tactical plans ("here's your money for a year; how are you going to spend it?"). He used the example of the new district general hospital in Solihull. About 80% of Solihull's population are covered by fundholders: "if we all said we're going to send our patients elsewhere it folds up." His feeling was that there was still a place for a district plan, that fundholders should work within a long term strategy. "Otherwise you get a health service being run on annual tactical plans."

GPs are wild

"We're the wild cards, which I think initially was thought to be good because we would be a little prick in the side of the providers—they've got these great big block contracts to live on and the fundholders were meant to provide the icing on the cake. But now, we're a fairly large part; if we all start chopping and changing it could destabilise the system."

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A NEW NAME...A NEW FUTURE

Welcome to Birmingham Heartlands Hospital

WHY Birmingham Heartlands Hospital? Why change the name of the East Birmingham Hospital? The simple reason is to clearly demonstrate that we are no longer the old run-down isolated hospital of the past, but the newest and largest general hospital in Birmingham. As the first NHS Trust in the city we have decided to create a new identity to match our ambitious standards for the future.

Early last year we held a competition, open to all staff, to find a new name for the hospital. The most popular suggestion by a long way included the word 'Heartlands' in the title. Eventually the hospital's Trust Board decided on the title 'Birmingham Heartlands Hospital', which becomes effective this month.

As a hospital we are proud of our history, but like everything else in life we have to recognise that change is inevitable. Recent changes and improvements at the hospital are truly remarkable.

The new Maternity Unit is the health service equivalent of a five star hotel; soon there will be a new Renal Unit; a new Accident and Emergency Department; we have become the regional centre for a number of highly specialised services and our research has been recognised.

There are many similarities between the area we serve and the hospital itself — both have a commitment to upgrade our buildings and equipment, but we intend to make our services more sensitive to your individual needs. In this respect we have embarked on an ambitious quality assurance programme designed to move us towards our Mission Statement — 'To create a centre of excellence in health care and education'.

From the beginning of February, East Birmingham Hospital becomes the Birmingham Heartlands Hospital; a new name and a bright new future. At YOUR hospital and we want YOU to know how it is run, what is going on, what is planned for the future and above all how we can serve you better.

Birmingham Heartlands Hospital is like a small town with a population of some 900 patients. Looking after them is a staff of 2,000 — from doctors and nurses to the people who ensure that the food is cooked and the wards and linen are clean. Here are just a few, a cross section, of the people who make it one of the best hospitals in the city.

Just an ordinary day ...

JUST over nine months ago — on April 1st to be precise — the day began at East Birmingham Hospital just like any other day. It was business as usual — patients and staff going about their business.

HOW WE BECAME AN NHS TRUST

How Heartlands brought the good news to its potential patients

Plans to merge West, North, and East Birmingham Health Authorities were put on hold last month. A pan-Birmingham purchasing authority may yet emerge

Howard Shaw, East Birmingham Health Authority's chief executive, sees the fundholders as the mould breakers and standard bearers of the reforms, and given their contribution the government has "to let them rip." He agrees with Dawson that they're the joker in the pack and believes that the government is now struggling to get them back into the pack. "You can't play cards with mostly jokers," he says.

"Somebody will suddenly realise that giving all these doctors public money without accountability isn't right, especially if fundholders are getting more money than they know what to do with and patients of non-fundholders are dying for lack of treatment. Once a proper way of allocating money to fundholders is developed then you've got to relate your allocation to fundholders to that to district health authorities. If health authorities are getting less then you have to give fundholders less—so then you're into GP capitation. Once you go down that route you have to work out the needs of GP fundholders, and that's very difficult. And once you start down the needs-targeted allocation road for GP fundholders then you start going down the other route of saying to GP fundholders: we're into *The Health of the Nation*; we want you to reduce suicides and accidents. So it's not only that we want to have a very clear view of how much money you get, but we also want you to do these things. So you're into managing the GPs, which becomes the new role of a merged family health services and district health authority."

Mergermania

Opinions differed over the desirability of the various proposed mergers. Robert Naylor was in favour of merging the health authorities: it would bring economies of scale and benefits from sharing boundaries with local authority social services and the Birmingham Family Health Services Authority. And it would banish the parochialism that still exists: he believes that purchasers are supporting their local providers, "which can't be in the best interests of patient care overall."

Howard Shaw accepts these arguments for merging, but sees another side to them. He says that if you look at Birmingham City Council—the biggest local authority in the country—it has always struggled with how to divide the city up. At any one time education, social services, and environmental services are cut up in different ways. The council has never satisfactorily

resolved the problem of how to provide a coherent policy across the city and yet provide a service that relates to the different needs of the different communities across the city.

He wonders how an amalgamated health authority could provide locality purchasing. He thinks that East Birmingham (population 0.25 million) is small enough to purchase for its two main populations: poor whites and poor Asians. Similarly, North Birmingham has rich whites, poor whites, and a few Afro-Caribbeans. West Birmingham has Afro-Caribbeans and poor whites. "Each of these districts can busk through the locality question, but the merged health authorities can't because suddenly you realise you've got these great swathes of population; how can you carve it up?" Paradoxically, Shaw notes that while the health service is moving to bigger units local government is moving to smaller ones.

Robert Marriott of the West Midlands Health Service Monitoring Unit detected anxiety over the merger being masterminded by North Birmingham Health Authority. Its new health authority board may be dominated by people from the business community in the more affluent north of the city, who want to shore up local providers such as the Good Hope Hospital to the detriment of providers elsewhere, particularly those in the deprived inner city. East Birmingham Community Health Council is opposing the merger; with their client based contracts its local purchasers are simply "light years ahead" of purchasers in the other two districts.

The council also has reservations about the merger of the three authorities' mental health units. They see the services in East Birmingham as having a much more user than professional focus. (For example, in the design of new buildings users are given priority over professionals; a well developed user group exists.) The cultures of the other two units differ markedly from East Birmingham's: both are institutionally based, working within the medical model. Not only do they have to merge but they also have to move from directly managed unit to trust mode, a very tall order.

Market forces

What of the internal market, the great engine supposedly driving the reforms? Mrs Wai-Yin Hutton, East Birmingham's director of corporate management, believed that after two years the internal market was beginning to open up within Birmingham. Providers were beginning to compete over price and quality. She was considering giving some of her poorer providers notification of major change of contract in September and tendering for services for next April.

Was it good or bad that some poor performers might go to the wall? "Good," thought Mrs Hutton. "If after three years they can't persuade purchasers that they're beginning to improve you would want to question whether they should treat your patients. Do you allow them forever to provide something which is not value for money—I would say no. GPs are saying no. There are good providers around, and GPs are naturally referring their patients to them. Look on the positive side: where we have good providers why don't we encourage them to develop further?" If the GP multifund got off the ground it would accelerate this process. With a predicted budget of £30-40m (East Birmingham's is £79m) "they could really make a difference to the viability of some poor performing specialties."

Mrs Hutton was grateful that the new regional team seems to treat purchasers and providers more equally than before. Apparently they are paying much closer attention to providers' prices, and querying why in 1993-4 providers were expecting £17-30m more from

contracts than they received in 1992-3, without a parallel increase in activity. Last year, providers' deadlines for issuing prices slipped several times, causing chaos to purchasers. East Birmingham's last contract was signed in August instead of the preceding March. The new regional edict is: "There are deadlines; we do not accept changes thereafter."

Howard Shaw was less enthusiastic than his director of corporate management about the workings of the internal market. "We're two months ahead of last year, but I'm not sure we've learnt that much. I don't think we've understood how to play the market, or even if the market's to be played because of the whole complexity of the system. We've got 20 units providing 50 specialties—for inpatients, day cases, and outpatients. There's a price and a volume for each of these, and you

can have price and volume variance on all these contracts. So you've got this mass of data, and we can't make head or tail of it."

His opinion was echoed by Robert Marriott. He did not think that you could decide at this stage whether the outcome of the reforms was good or bad. "Mostly it seems confusion—because of the demands being made on both purchasers and providers." Perhaps in a year's time things will be clearer.

1 Delamothe T. East Birmingham: "the great bureaucratic square dance" begins. *BMJ* 1991;302:714-8.

2 Delamothe T. East Birmingham: running faster on the spot. *BMJ* 1991;303:842-4.

3 Delamothe T. East Birmingham: the beast was fed. *BMJ* 1992;304:1109-11.

4 Wilson F. Moving mountains to set up GP co-op. *GMS News Review* April 1993.

Lesson of the Week

Tuberous sclerosis and polycystic kidney disease

David W Webb, Maurice Super, I Colin S Normand, John P Osborne

Suspect tuberous sclerosis in young children with polycystic kidney disease

While there are many renal lesions in childhood associated with the development of cysts,¹ bilateral large polycystic kidneys are usually caused by either autosomal recessive polycystic kidney disease, autosomal dominant polycystic kidney disease, or tuberous sclerosis. Autosomal recessive disease is characterised by a delayed, mottled, or streaky nephrogram at intravenous pyelography and by microcysts on renal ultrasound. Autosomal dominant disease may present in children and is indistinguishable radiologically from the polycystic kidney disease found in tuberous sclerosis. Tuberous sclerosis is a well established association with a specific histological appearance² that is still misdiagnosed because of a lack of clinical suspicion. We present three recent cases which support this observation.

Case reports

Case 1—This boy presented at 6 months with gross abdominal distension. On examination he had bilateral renal masses, hypertension (blood pressure 155/70 mm Hg), and three hypomelanotic macules. Autosomal dominant polycystic kidney disease was diagnosed after intravenous pyelography. His parents had normal appearances on renal imaging, and genetic counselling was provided to suggest he was a sporadic case. At 12 months he was admitted with a convulsion associated with fever which lasted one hour. His blood pressure was 230/100 mm Hg, and he was treated with propranolol and chlorothiazide. At 23 months he had three or four vacant episodes. An electroencephalogram was normal. He was started on sodium valproate but was admitted at 30 months after a prolonged seizure lasting 90 minutes. Cranial computed tomography two years after presentation showed periventricular calcification and tubers consistent with tuberous sclerosis. He has since developed facial angiofibromas, and at 13 years of age is making slow academic progress. He has had no seizures for nine years and has normal serum creatinine concentration and blood pressure without taking antihypertensive agents.

Case 2—This girl presented at 5 years of age with gross haematuria after a minor fall. For six months before admission she had episodes of brief loss of consciousness, preceded by giggling and lip smacking.

Abdominal computed tomography scan showing bilateral polycystic kidney disease in child with tuberous sclerosis

Her development was normal and there was no family history of note. Examination showed a pimply facial rash, hypertension (blood pressure 145/101 mm Hg), and bilateral renal masses. Renal function was normal. Autosomal dominant polycystic kidney disease was diagnosed after intravenous pyelography and renal computed tomography (see figure) and she was discharged taking metoprolol. At follow up electroencephalography showed foci in the occipital and temporal lobes, and four months later cranial computed tomography showed periventricular calcification characteristic of tuberous sclerosis. At 7 years she has early facial angiofibromas and continues to do well in normal school. She has a normal serum creatinine concentration and blood pressure on metoprolol.

Case 3—This girl presented at 4 months with vomiting, flank masses, and hypertension (blood pressure 157/90 mm Hg). Renal ultrasound showed multiple bilateral translucent renal cysts, and autosomal dominant polycystic kidney disease was diagnosed. Both parents had normal findings on renal ultrasonography and were counselled that her disease was a new mutation. At 8 months she developed "absence seizures" and at 13 months was started on sodium valproate for suspected myoclonic epilepsy. Electroencephalography was not performed. By 18 months mild developmental delay was noted, and cranial computed tomography, performed 19 months

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