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(Accepted 11 May 1993)

The New NHS: The Second Year

West Suffolk: a new landscape

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

Geography favours stability in west Suffolk. One main acute district general hospital, a strong tradition of community services, and an established body of well founded group practices serve this rural population. Distance limits the possibilities for rapacious competition.

Nevertheless, the NHS reforms have touched West Suffolk in ways that would have been surprising two years ago.¹ West Suffolk Health Authority no longer exists, having merged with East Suffolk to form Suffolk Health Authority this April. At the same time West Suffolk Hospital in Bury St Edmunds became a trust, as did Mid Anglia Community Health, formerly the community and mental health services unit.

These changes in turn have opened up new horizons of change. Two years ago one of the surgeons at West Suffolk told me he felt as though he were on a helter skelter. For many people that impression has intensified, as each new turn of the spiral opens up new vistas of change.

Suffolk Health Authority

The merger with East Suffolk has been in the offing for some time,² having been sought by both authorities. Dr Roger West has moved from being director of public health of the old authority to the new and now has a department with six consultants in public health medicine. The merger, he feels, gives him much more time to spend on genuine public health work. Grant Elliott, who also moved from West Suffolk to be the finance director of the unified authority, hopes the move will save £250 000-300 000 a year in overheads. Though coterminosity is now much better, it is still not complete because part of Suffolk (and part of the area covered by Suffolk Family Health Services Authority) still lies in Great Yarmouth and Waveney Health District. This is widely seen as an anomaly—as is the fact that the family health services authority and the district health authority cannot merge.

Patterns of purchasing

One reason why Grant Elliott would like to merge with the FHSA is to get a handle on fundholders' spending. East Suffolk had fundholders from the outset; this year for the first time west Suffolk has four, though, significantly, they are all on the district borders, where they have genuine choice of providers. In one or two places within the area of the old West Suffolk Health Authority non-fundholding practices are forming consortiums to talk to the health authority and provider units about what they want. Roger West sees this as a positive development because if the authority agrees something with the practices "then it

will happen because they deliver the referrals." He sees such self selected groupings of practices as the basis of locality purchasing.

There is speculation about whether the numbers of fundholders will grow. Elliott fears that if they do they will start to form consortiums, to share resources and overheads, and "then you end up with two parallel purchasing authorities in a district." On the other hand, Chris Stevens, chief executive of Mid Anglia Community Health, regrets that there are not more: he sees fundholders as a boost to innovatory services.

Partly because of the merger there has been little immediate change in the pattern of purchasing. Indeed, west Suffolk was guaranteed stability in funding this year. The people of west Suffolk have traditionally feared the ability of Ipswich in the east to suck in resources, so for the first year the new authority promised that the revenue allocation that West Suffolk Health Authority would have had will be spent exclusively in west Suffolk.

Similarly, one of the fears at West Suffolk Hospital in Bury St Edmunds is of becoming marginalised within a bigger health authority. At the authority that fear is not seen as realistic. Roger West thinks that the problems of access in a rural area mean that there must be an acute district general hospital in the west of the county. "But we do have to be careful to ensure we do not prejudice the viability of West Suffolk Hospital. The lesson we learnt from Newmarket [see below] is that a hospital with less than a full range of specialties will lack a critical mass and start to decline." The change he does foresee is that people in west Suffolk might start to look to Ipswich rather than Cambridge for services they cannot get in Bury St Edmunds.

The health authority is looking for long term relationships with its providers, sharing its business plans with them and starting to explore longer term contracts. Ian Baines, chief executive of Suffolk Health Authority, agrees that there will always be a need for a major acute provider in both east and west Suffolk, but, he points out, the authority will if necessary flex its muscles to get a better service.

Baines thinks that contracting will become less about money and more about quality, and that quality will increasingly be defined by what patients and general practitioners want. He wants, for example, to unscramble the reasons why GPs refer patients to one consultant but not another in the same specialty. "We can then present that information to the providers" and expect them to do something about it. Bob Jones, the chief executive of West Suffolk Hospital, admits that such pressure from purchasers gives hospital managers the leverage to tackle clinical issues (which may be longstanding) with consultants.

West Suffolk Hospital: most of the changes are behind the scenes

ANDY ABBOTT/COMMUNIQUE

Allocating resources not purchasing

Such examples apart, all three directors I spoke to think that their health authority has not yet got to grips with purchasing. "We are still just allocating resources," said Grant Elliott. Though the authority knows much more about what it is getting in return for those resources there is a long way to go. "If the director of public health asks me how much we spend on coronary heart disease for 45-64 year olds, I can't yet tell him," he said.

Roger West agrees that there's a long way to go. He has only just started to talk to clinicians in the district about stopping doing things—for example some cosmetic procedures—but he expects to be doing more of it. "The lack of funds means that to develop new things we also have to look critically at what we already do and drop what is not effective. . . . I think that most consultants and GPs understand that."

West Suffolk Hospital

Last year West Suffolk Hospital came in £0.5m under budget, met all its contracts without slowing down in the new year, achieved trust status, managed the "downsizing" of Newmarket Hospital, and planned a new day surgery unit (due to open in April 1994). For 1993-4 it produced its price list in January, and all its contracts for 1993-4 were signed by mid-May, except for the final details of those with fundholders, who were late in getting their allocations from the region.

The new fundholders had not been particularly aggressive in contract negotiations. According to John Foreman, finance director, they seemed content to let things carry on as before but did use the negotiations as opportunities to pursue particular services they were bothered about. For example, the two Newmarket fundholders, together with one nearby in Cambridgeshire, have offered to send all their orthopaedic work to West Suffolk Hospital, which might allow the hospital to appoint another consultant. "That way the service is improved for all patients," said Dr John Calvert, one of the Newmarket GPs.

The big change for West Suffolk Hospital is the fact that it is now a trust. "Over the past 3-4 months there has been a much greater feeling that the future of the hospital is in the joint hands of clinicians and managers," said Foreman, and the clinicians agree with this analysis.

From the outset of the reforms Bob Jones, chief executive, has argued that the hospital needed a clinical management structure that maximised clinicians' input while minimising their management workload. As a result a system of clinical "leads" heading clinical service areas and sitting together in a medial advisory committee was established. The problem with this, according to Dr Henry Fell, director of pathology, was that it was not a proper directorate structure with full devolution of authority and responsibility—though he concedes that many of the leads in clinical disciplines were wary of that degree of responsibility (and some still are). Earlier this year the clinical leads and managers spent several days away with King's Fund trainers—described by Bob Jones as one of the best training sessions he had ever paid for—and rethought their management structure.

As a result there will be fewer, bigger clinical service areas, and the leads will be backed up properly with nurse and business managers. The trust's first medical director, Dr Roy Bannon, a radiologist in the hospital, is doing the director's job part time, but he thinks that his successors will have to do it full time. He wants doctors to play a full part in running their hospitals and thinks that management is a role that doctors have to take seriously—"it can't be left to someone in their last two years." He strongly supports the restructuring that will bring clinical leads together with non-clinical managers to form the operational board that runs the hospital.

Fundholders might not have made much impact this year "while they are overfunded," but Bannon thinks that in future the hospital will face competition from the private sector, whose costs are often lower. He would like to see some elective work performed at a local nursing home, freeing up space at West Suffolk for work at premium prices. But he will have to persuade his consultant colleagues to do that as NHS work for the hospital rather than as private work.

Evolving out of such changes Bannon sees consultants' careers becoming much more flexible: they will be hired on differential salaries to do different things—from providing sessions at peripheral units or in fundholders' surgeries to running an entire service. Nurse managers are starting to talk about staffing all beds according to the dependency of the patient rather than the specialty of the consultant. If that happens Bannon thinks that the pattern of consultant practice might be much more like that before 1948, with consultants having admitting rights rather than beds. Consultants will no longer have linear careers: they will "be much more like footballers." He admits that this is all speculation, but he sees such changes inherent in the demands of fundholders, the need to keep costs down and quality high, and the blurring of the boundaries between public and private. He also worries that no one seems to be controlling all these possibilities. "It is clear there has been a breakdown of management between trusts and the centre. The outposts haven't a clue what all these trusts are doing."

A DIFFICULT TRANSITION

Bob Jones too thinks the current system is unstable—which may be one reason why he has just resigned as chief executive of the trust. Jones has been a manager at West Suffolk Hospital for almost 20 years, was the former unit general manager and the trust's first chief executive, and he left last month to take up the job of director of the local hospice. Some in the district see Jones as a casualty of the reforms, though he does not. He resigned, he said, because he thought the role of chief executive was radically different from that of unit general manager, and one he liked less. Citing politicians who had stayed too long he said that he would rather go at a high point, having steered the

	%
Suffolk	81.6
North West Anglia	1.9
Cambridge	2.4
Norwich	9.1
North Essex	1.5
Fundholders	2.4
Extracontractual referrals	1.1
Total value	£42m

hospital into a trust, and before he received that kiss of death—"a vote of confidence from the trust board." He pointed out that of all the original East Anglian unit general managers only one remains as a chief executive of his old unit, and he is critical of the way the Department of Health failed to prepare general managers for their new role.

Efficiency gains

Neither Bob Jones nor Roy Bannon sees how the hospital can make its 2% efficiency gains this year. They cannot shut wards because that will affect their ability to meet contracts; they have already raided support services; and "purchasers aren't interested in reducing juniors' hours." Bob Jones sees the imposition of efficiency savings as just another example of the mixed messages that are coming from the centre. So does Chris Stevens in Mid Anglia Trust; he feels that the requirement favours acute services because it is weighted in favour of (hospital) finished consultant episodes rather than community contacts. He gave as an example Norwich Health Authority, which has a policy of shifting resources from secondary to community care and had planned to spend more with his trust in the Thetford area but was unable to do so because of the need to show efficiency savings.

The feeling that services are already squeezed to the bone is confirmed by general practitioner Dr Ted Cockayne, who, while agreeing that some services such as orthopaedics and urology have improved, still has difficulty in getting patients admitted to acute medical or geriatric beds. This problem has been exacerbated, he feels, by the closure of acute inpatient services at Newmarket Hospital.

Newmarket

Last year Newmarket dominated the life of West Suffolk Hospital; this year it will dominate the life of Mid Anglia Community Health. Despite local opposition Newmarket Hospital closed as an acute unit last year because it was no longer viable as a small unit in old buildings with high costs. But its redevelopment as a community hospital was approved.

In January management of the hospital transferred from West Suffolk Hospital, which had taken over most of the inpatient medical and surgical work, to Mid Anglia trust. This was much to the disappointment of West Suffolk Hospital, but to the delight of the Newmarket general practitioners, who had argued hard that a community hospital should be integrated with other community services.

The services that remain on the site are outpatient clinics (run by consultants from both West Suffolk Hospital and Addenbrooke's Hospital in nearby Cambridge), diagnostic and rehabilitation services, and beds for elderly patients. In the redeveloped hospital there will also be general practitioner beds, beds for the elderly mentally ill, and various day services.

Chris Stevens explained that his trust had two main tasks in Newmarket. The first is to secure contracts for this year's services at Newmarket (with Suffolk and Cambridge Health Authorities and fundholders). This has proved difficult because costs are much higher in Newmarket than elsewhere, but his managers have been spending a lot of effort reducing them, and he

hopes to be able to sign contracts soon. The second task is to produce a plan for rebuilding the old Emergency Medical Service buildings. The trust has set up an "ownership" group to steer the project: this includes a local general practitioner, a social services manager, a member of staff, chairman of the medical staff committee, and the chairman of the local action committee. "Our policy, said Stevens, "is to be completely open [with the community] from the beginning." Stevens wants to get the hospital redeveloped fast because once contracts have gone elsewhere it will be hard to get them back. However, he also sees the hospital's potential for joint ventures with social services—and with voluntary bodies and housing associations.

The change of use of Newmarket Hospital was the catalyst for Newmarket's two general practices to become fundholders. Although a reluctant fundholder, Dr John Calvert thinks that authorities and providers would not have listened to the Newmarket general practitioners as closely had they not been fundholders, and he thinks that they have managed to retain more services on the Newmarket site as a result. As well as the improvements in orthopaedic services, he cites the retention of outpatient sessions by a consultant chest physician from Cambridge and the fact that Addenbrooke's has provided an outpatient clinic in Newmarket to follow up discharged inpatients.

Community trust

Mid-Anglia trust is pleased to have retained all its old contracts and some new ones from fundholders. In turn the trust has pleased Dr Ted Cockayne and his partners in Woolpit because it has promised to extend their health centre. Chris Stevens thinks this is a good example of trusts' flexibility as previous bids to the region for capital had failed.

His trust has not yet gone out aggressively to expand its market, although the question will inevitably be raised why Suffolk needs more than one community trust. So far his trust and that covering east Suffolk are working together—for example, they have just appointed a joint health promotion manager. "We aim to come up with joint initiatives before the authority thinks of them itself."

Collaboration among the competition

This is not the only sign of collaboration between supposed competitors. Bob Jones said that this time last year there was a definite feeling of provider units keeping their cards close to their chests—a "commercial in confidence" attitude. He detected much less of that now. Indeed, the chief executives of trusts in East Anglia have regular meetings, as do the medical directors both with each other and with the chief executives. Roger West, director of public health, thinks it important that he maintains contacts with medical directors of trusts outside formal contract negotiations. And Dr Henry Fell is pleased that the regional medical advisory committee together with the regional director of public health has agreed that lone consultants in separate trusts should cover for each other. The risks of instability seem to be prompting people to create mechanisms to limit the dangers.

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2 Smith J. West Suffolk: a changing world. *BMJ* 1992;304:1036-9.