to undertake trials through the national trials organisations that exist (such as the groups mentioned above).

Fifthly, doctors in training need to be trained in clinical trial methods and receive recognition for time spent doing this. The need for first author publications has in some cases led to the proliferation of small scale studies which meet this need but have limited value. A personal log book recording participation in national trials could be an alternative to the need for publications.

Sixthly, clinicians should have the right to have incorporated into their contracts sessional time allocated for participation in clinical trials, and this needs to be reflected in consultant job plans.

Seventhly, nurse counsellors should be provided for oncology units to encourage entry and facilitate the conduct of trials. Nurses are needed to help in the explanation of the details of treatment and the process of randomisation to patients. Doctors will continue to seek informed consent.

Eighthly, the research and development directorate should appoint someone whose role is to work with reputable organisations to facilitate the conduct of trials. For example, in providing advice on what information needs to be given to purchasers and

providers. The Department of Health should organise the use of one standard proforma for all local research ethics committees.

Finally, the quality of cancer registry data should be improved. Pathology data should be linked directly to the registries. The Office of Population Censuses and Surveys should include information on tumour, stage, treatment, and outcome. There should also be cheaper access to survey data on outcomes so that the effects of new treatments could be monitored more easily.

The model which has been developed in Scotland (the Scottish cancer therapy network) to improve registration and entry into trials should be reviewed as a possible way forward for England.

Members of the United Kingdom Coordinating Committee on Cancer Research are Cancer Research Campaign, Imperial Cancer Research Fund, Institute of Cancer Research, Leukaemia Research Fund, Ludwig Institute for Cancer Research, Marie Curie Memorial Foundation, Medical Research Council, Tenovus Cancer Fund. Observers: Department of Health, Scottish Home and Health Department.

¹ Department of Health. *Assessing the effects of health technologies*. London: Department of Health, 1992.

NHS Update

Freeman Hospital: the will to survive

Sharon Kingman

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

The future looks uncertain for the Freeman Hospital trust in Newcastle upon Tyne. There are plans to rationalise the health service in Newcastle by shifting resources from secondary to primary care, and by providing more services locally for people who live in the region but outside Newcastle. These could reduce the level of contracts that purchasers place with the trust in the future. Staff at the trust say the service they provide is good value for money, but purchasers do not seem to take this into account. Instead of choosing from a "shopping list" of priced procedures, purchasers are forcing the trust to dovetail its prices to meet their budgets. There is also concern at the potential impact on the trust's financial situation of reduced working hours for junior doctors and the Calman proposals on training.

Turbulent times lie ahead for the health service in Newcastle. The Freeman Hospital, now entering its fourth year as a trust, is coming to grips with the unpalatable realisation that a hospital's geographical accessibility to patients seems to count more than whether the treatment it offers is good value for money or of better quality.

No one at the Freeman any longer expresses surprise that—contrary to the government's promises when the NHS reforms were launched—the money does not follow the patients. The grim truth is that, once again this year, the purchasers want the trust to treat more patients for less money. And at the same time, purchasers in the region are making plans to divert more resources from secondary to primary care and to attempt to change general practitioners' referral habits so that patients obtain care closer to home, rather than travelling to Newcastle for it. Their choice will become restricted.

All this puts the trust in an unenviable position. If

market forces are not allowed to operate, so that the cheapest and best hospitals attract more patients, and therefore more money, the lifeblood of the Freeman will drain away from it. For the first time since this series of articles began, people at the Freeman have begun to question whether the trust will survive in the future. After all, more than 70% of its patients currently come from outside the city.

In some ways, the past year has gone reasonably well. The Freeman has balanced its books. One of the costs of doing so was the loss of 68 staff—but this number was lower than the 100 job cuts that were feared to be in the offing at this time last year.

Gary Smith, chief executive of North Tyne Health (which represents North Tyneside and Newcastle Health Authorities), says the Freeman managed its contracts very well last year. Again, there was a price to pay: Mr Peter Wright, consultant general surgeon and the medical director of the trust, points out that sticking rigorously to the contracts has led to a large and rapidly building waiting list.

But look further than these simple objectives and you find uncertainty, discontent, and doubt. In radiology, for example, Dr Lakkur Murthy, clinical director, is wondering how much longer the department can carry on running at a loss. Radiology has a block contract with North Tyne Health to cover referrals by local general practitioners. It is based on the 1989-90 level of service.

"For the last three years," Dr Murthy says, "we have said to the purchasers, look at the actual activity, which is at least three times greater than in 1989-90. But so far they have not done so. We just want our costs to be met. They can't have something for nothing all the time."

The department's cumulative losses on this contract have now reached £100 000, Dr Murthy says. "We have given them a breakdown of what has been done

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and at what price. There is no argument about what is being provided. But they continue to hide behind this block contract. Hopefully the situation will change in 1994-5."

Dr Murthy realises that the health authority's budget is not unlimited, but he says, "In terms of setting priorities, the ball is in their court. If they don't have enough resources to pay for this service, they should say so. They should say, let's peg it at such and such a level, and recognise the limitations of the service."

Specialties feel the pinch

In internal medicine, the specialty manager, Madeleine Rae, says it has been difficult to predict how many emergency admissions the Freeman is likely to be asked to take, because this depends on the level at which purchasers have set contracts at the two other Newcastle hospitals—and whether and when they close their doors to admissions. Last winter, all three hospitals were overshooting their contracts for medical emergencies. The purchasers said, however, that they were prepared to pay the hospitals only marginal costs—about £140—for each extra patient's entire stay.

The Freeman countered by asking for money to pay for additional staff so that it could cope with the extra workload. So far, no money has been forthcoming—which has meant that the trust has been unable to appoint the extra staff. Miss Rae says, "Because we only see the workload from our perspective, it is difficult to know whether the contract that is set is realistic or not. And it seems to be difficult to get quick decisions taken on changes to the contract when it turns out, midyear, that there are going to be problems."

In pathology, Dr Kate Gould, clinical director, says the department has been through a tough year. Pathology has lost five out of 65 whole time equivalent staff, two of whom were made redundant. She says: "Everyone is working harder—we have lost staff but the workload is up. In microbiology alone it is up by 40%." The gloom has not been entirely unrelieved: the department managed to demonstrate a need for a second, whole time microbiologist, who has now been appointed—but without financial support from purchasers.

Management costs in Freeman Hospital Trust (white bar) and other acute units nationwide 1993-4: (top) general managers, senior managers, senior nurses; (middle) all staff above plus G and F grade nurses; (bottom) all staff above plus A and C staff

Costs for core services in Newcastle, 1992-3

	Freeman	Royal Victoria Infirmary	Newcastle General Hospital	Specialty average
General medicine*	610	698	774	694
General surgery*	926	1338	886	1043
Geriatrics†	79	94	82	85
Provider total	1615	2130	1722	1822

*Cost per patient treatment episode.

†Cost per patient day.

But overall, she says, the future looks as bleak as it did this time last year. "We're still locked in wrangles with purchasers regarding contract levels. The work is out there for us to do, but there are concerns about who can pay for it."

In surgery, too, there is dissatisfaction at the way that the contracting process is operating. Mr Wright says, "The message is the same as last year: the reforms are not working in the way we believe they should. Our understanding was that the internal market would bring an element of competition, with cost, quality and volume being prime considerations in the contract, as well as accessibility. And we know—from external assessment—that we are probably one of the most cost effective trusts in the country and that we deliver good quality care. Yet the purchasers still come to us for arbitrarily imposed efficiency savings."

There is no longer any incentive to be efficient, Mr Wright says: those providers who already are efficient are asked to make the same efficiency savings as those who still have plenty of fat to trim away.

Cutting costs

Len Fenwick, chief executive of the trust, agrees. He says: "Our argument is that the purchasers do need to purchase on grounds of cost and quality and must recognise what can and can't be afforded. We have to survive through income. We manage an order book which we run along business lines. But there is little point in doing more if you're not going to be paid for it."

The trust as a whole is suffering from the same "blanket" approach to resource allocation from purchasers that Dr Murthy complains of. Mr Fenwick says, "We have supplied purchasers with detailed prices for the whole range of our services. What some health authorities have done is simply to set a budget and then ask us to dovetail our prices to meet that budget—rather than regarding the prices as a shopping list against which to compare and contrast with competitors and then set priorities. We are pressing hard for a managed, value for money market, rather than annualised resource allocations."

In 1993-4, the purchasers asked the Freeman to do the same amount of work as in 1992-3 for 2% less money. For 1994-5, the "cost improvement" target is to do more or less the same again for yet less: this year, 2.5% less than in 1992-3.

Yet, as a purchasing intelligence report from the Northern Regional Health Authority has shown, the Freeman is already very good value for money for purchasers (table). The Freeman trust was also one of several national pilot sites for research being carried out by the Audit Commission's Health Services Directorate. This review found that the trust's management costs fall well within good practice guidelines (figure).

Competition and contracting

A document reporting these findings to the trust's board concluded that, in terms of service costs, management costs, and productivity, overall perfor-

mance was in many respects substantially better than average. The competitive placing of the Freeman Group in relation to service costs and management overheads has been drawn to the attention of purchasing authorities, the paper says. But it adds: "There has yet to be any evidence of this influencing value for money decisions in relation to the 1994/95 trading year." (Unlike many trusts, the Freeman trust board meets in public and such performance data are readily available.)

Phil Sculthorpe, head of contracting at North Tyne Health, concedes that contracting has tended to concentrate on cost not quality. "It's a caricature, but it feels as though contracting has become a discussion between accountants, rather than a discussion about what our purchasing priorities should be." Three years on from the introduction of the reforms, "We're beginning to recognise that we are not in a free market—we're in something much more complex. We're now both having to learn the appropriate behaviour for the type of market we are in."

Contracting has turned into a relatively adversarial process, Phil Sculthorpe admits. "But basically we are both in the same game: they want as much care for their clients as possible and so do we. We have to turn that into a creative tension."

As in previous years, Newcastle is a major capitation loser and the health authority has less money to buy services this year than it had last year. Mr Sculthorpe says: "We have said to all our providers that they will either have to lower their prices or lower their activity." A "substantial" gap existed between the amount that North Tyne Health could offer the Freeman and the prices the trust wanted to charge for activity, Mr Sculthorpe says. At the time of writing, the two sides were in the final throes of agreeing the contract for 1994-5.

Acute services

Gary Smith agrees with Mr Fenwick that the Freeman is one of the more efficient hospitals in terms of its prices and points out that North Tyne Health has asked for smaller efficiency savings from the trust than from some other hospitals. But he has other items on his agenda. One is the Newcastle Acute Services Review, which will put the city's entire health services in the hands of three trusts: the Freeman, the Royal Victoria Infirmary, and the newly created Newcastle City Health Trust, which has been formed from a merger between the mental health trust, community services, and other non-acute services in the city.

The Newcastle City Health Trust will run new style ambulatory services on the site of Newcastle General Hospital. These will include day surgery, outpatient work, diagnostic work, and new services run by general practitioners. Mr Smith says that the aim is to make services both more viable and more accessible to patients, in terms of speed, geography, and style.

"Newcastle has a population of less than 280 000 people. We don't need three hospitals. We have duplication and triplication of services at the moment and we believe we are wasting about £30 million a year." In conducting the acute services review, Mr Smith says, the city health services have bitten the bullet that they have failed to bite for the past 15 years.

New alliances will spring up from the new arrangements. As Mr Smith says, "Seven health authorities together accounted for 85% of the funding of the three Newcastle hospitals. So if we can get a joint purchasing strategy and the trusts agreeing to deliver on that, it gets pretty powerful."

Secondary care

Dr Chris Drinkwater, a general practitioner in Newcastle and a member of the local medical com-

mittee, says local general practitioners are concerned that the acute services review could restrict their access to secondary care for their patients. But, he says: "there is a better balance to be achieved between tertiary care in Newcastle and the provision of secondary care within the outlying districts. There should be good quality services, and these should be as close to the patient as possible." This could mean shifting services from secondary care into primary care, secondary care hospitals providing more specialised services than they have in the past, and tertiary hospitals (like the Freeman) doing less secondary care work.

"The agenda in Newcastle now is whether the number of acute beds in the city can be reduced, by using Newcastle beds more efficiently for Newcastle residents rather having them occupied by residents of other districts. General practitioners here feel very strongly that we would like to see beds available in Newcastle for Newcastle residents—which has not always been the case."

At Dr Gordon Chalmers's practice in Gosforth, Maureen Rillands, chief executive of the practice, continues to be enthusiastic about the service the Freeman provides for their patients. "They are very keen to deliver the services that we want," she says, adding that the trust manages to combine all the services it provides as a centre of excellence with those the practice would expect from any district general hospital.

Contracting with the Freeman has gone well, but there is still plenty of fine tuning to be done, particularly on maximum waiting times and the proportion of day case surgery. "We will be looking to build standards on waiting times into our contracts for 1995/96," Ms Rillands says. "These are that patients should wait no longer than 26 weeks for outpatient appointments, and no longer than one year for a procedure. We hope that, together with the Freeman, we can deliver those aims for our patients."

Last year, the practice was worried that it would have to reduce the size of its contracts for acute services at the Freeman because of a shortfall on its budget for community services. Fortunately for the Freeman, this proved not to be necessary. But there was a close shave of a similar kind this year, when the practice was told at the eleventh hour that the budget that had been agreed with the family health services authority was being reduced. Ms Rillands says the Northern Regional Health Authority stepped in to save the day and reinstate the agreed budget.

Painful repercussions?

The Chalmers practice, which is on the hospital's doorstep, may be continuing to support the trust but the overall trends in Newcastle towards diverting more resources into primary care, and purchasers placing more contracts at local hospitals, could have painful repercussions for the trust. One document put out by Northumberland Health in November last year shows how. The paper examines "the potential for removing work from Newcastle providers and placing it in peripheral hospitals and community services." It says that there is "undoubted scope and commitment to achieve significant reversals of flows into Newcastle over time."

Northumberland Health estimates that 15-17% fewer patients could be referred to Newcastle units between 1993-4 and 2000, amounting to 8000-9000 fewer patients being treated in the city.

The Freeman has already had a foretaste of what can happen when more services are provided locally for patients who live in more distant parts of the region. This year a new cardiothoracic centre has opened

Freeman Hospital

NEWCASTLE EVENING CHRONICLE

at the South Cleveland Hospital in Middlesbrough. Dr Rodney Bexton, clinical director of cardiothoracic services at the Freeman, says, "Everyone was all in favour of it being built because we knew that there was a need for an additional cardiothoracic centre in the Northern region."

But it was a bitter blow to the Freeman to discover that, now that the new centre is up and running, purchasers are continuing to buy only the same amount of cardiothoracic work as before. True, the contracts for cardiothoracic surgery in the Northern region as a whole are 10% greater than last year's, but the Freeman is now receiving only two thirds of the cake, instead of all of it.

As a result, the amount of money the trust earns from cardiothoracic surgery has dropped by £1.8m—mainly because two purchasers in the south of the region have reduced the work they send to the Freeman to the bare minimum. To balance the books, the hospital had to close a ward and halve its use of an operating theatre. About 40 staff lost their jobs. Although many were relocated within the hospital, some of them were made redundant. The Freeman, however, remains much cheaper than its competitor, which is also receiving a subsidy from the region to get it going.

Dr Bexton says that, last year, the Freeman did 920 coronary artery bypass grafts, roughly equivalent to 300 operations per million population. "But the royal colleges and the Cardiac Society say that in this country, we should be doing about 600 per million population. That estimate is for a standard population but here in the north east we have a very high incidence of coronary artery disease, so we estimate that we should be doing about 750 coronary artery bypass grafts per million population per year."

There is no question that there is a need for another cardiothoracic centre, he says. "The problem lies with the purchasers, who are not purchasing for the needs of their population. We have put this argument to the purchasers repeatedly and we get the same reply from all of them. They say they have not got the money."

The region has contributed a one-off grant of £250 000 to the Freeman to help tide it over. Dr Bexton says the region has indicated that purchasers have been set a target for buying coronary artery bypass surgery of 400 per million population in future and that the figure will rise still further as time goes by. "If that holds true, we should be back to the level of surgery we were at last year within two years. But there's no promise—this is only a recommendation."

He describes the situation as a disaster for the regional cardiothoracic centre. "This is medicine, not British Leyland. Here we are, closing a ward, closing half a theatre, and making people redundant when 100 yards down the road there are people who need the treatment who can't get it. It's a farce." The centre did investigate selling its surgery to patients from outside the region but, apart from the practical difficulties, Dr Bexton says he feels it is morally wrong to treat such cases, who can afford to pay, while local people go without.

Prices to be paid

Many people at the Freeman fear that the price to be paid for moving services closer to where people live is the loss of centres of excellence. Indeed, the cynics among them suspect that this is the hidden agenda to all the upheaval: dismantle the expensive centres of excellence and replace them with cheap local services irrespective of the clinical outcome.

Mr Wright points out that people are willing to travel if they know they will get better care: if the surgeon who will do their operation has a better success rate than the surgeon at the local hospital. He warns: "If we become more like a district general hospital, it means we will wind down many of the areas of specialist expertise that we have at present—and end up with a more mediocre service. As things stand, every day that passes brings us closer to such a scenario."

Sue Pearson, chair of the community health council in Newcastle, agrees that this is a risk. She says: "It is clear, particularly in certain specialties, that your chances of recovery are demonstrably greater in those hospitals that specialise and have a concentration of high quality expertise. This is one aspect of the health service reforms that seems to be generating some tension at present—and it needs to be thought through."

So what does the future hold? Mrs Pearson spells it out: "If purchasers from outside Newcastle don't purchase sufficient of what is left over after Newcastle patients have had their turn, then the Freeman trust does look very shaky financially, because so many of its patients are from outside the city and it depends on such a wide group of purchasers."

Mr Wright says that the implementation of reduced working hours for junior doctors, which are set to fall to an average of 56 hours a week by the end of this year, could cause the trust's problems with its contracts to pale into insignificance. This—combined with the Calman proposals on training, the trend towards shifting resources from secondary into primary care, and the failure of money to follow patients under the reforms—makes it very difficult to predict the future, he says.

Is the survival of the trust in doubt? Mr Wright says it is very difficult to answer that question. "It's impossible to be certain about our future financial viability until we know what the impact of these various factors is going to be."

Dr Murthy says the trust has delivered everything that has been asked of it during the past three years. If the reforms were not meant to allow servicesto be purchased on grounds of cost and quality, he asks, then what was the point of them? "If the trust is to be hounded out of existence, then someone is working to a different agenda. If we are to lose more work for being efficient, it's a travesty of justice."

Can it succeed? Dr Murthy says: "If common sense prevails, then it should, and we will certainly flourish. If it does not, then the patients—and the taxpayers—will be the losers."